Tradition Reinvented: The Reimagination of Kanpō Medicine in Twentieth Century Japan

By

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Abstract

This dissertation examines the ideological development of classical Japanese medical (later known as kanpō) philosophy and practice between the Edo period (1603-1868) and the mid-twentieth century. During this time, kanpō evolved from a system based in classical Chinese medical theories and practices into one heavily reliant on Western conceptions of disease and scientific practices, with seemingly ever less connections to classical practice. I argue that this shift occurred through a series of progressive intellectual reinventions of the kanpō paradigm beginning in the Edo period. Ultimately, the scientific rationalization of the kanpō paradigm and the development of a mass manufacturing process for kanpō medicinal extracts in the twentieth century undergirded the renewal of kanpō's social relevance in Japan while simultaneously stripping its connections with classical medical practices. Though marketed as "traditional", much of contemporary kanpō is a thoroughly "modern" creation, a reinvented tradition.

Acknowledgements

A central belief of the subjects of this dissertation, the physicians of the Kanpō Revival Movement, was that knowledge of the past informs the present. With this in mind, I would like to take a moment to reflect on all of the past mentors that have led me to this point.

Looking back, my family introduced the study of history to me at a very young age. Through their own personal interest, they were avid consumers of popular military history publications. Some of my earliest memories are of flipping through the glossy pages of these books and looking at historical photographs. When my parents were working, I often stayed with my grandparents. Each morning, my grandfather, a veteran of the Second World War, sat me down at his kitchen table to teach me important life lessons. In these discussions, he frequently talked about his experiences during the war. I remember vividly his poignant recollection of his participation in the liberation of Dachau concentration camp and its aftermath. His memories were my first encounters with history as a lived experience.

For two years in high school, I was lucky to have a teacher brimming with enthusiasm for historical study. From his lectures, you could tell that history excited Joe D. Rogers. Almost every class, Mr. Rogers brought in artifacts as props, such as a gladius for our Ancient Rome unit or a gas mask for our World War I unit, to help students visualize history. An essay exam calling on students to discuss the varied factors that led to a historical event invariably followed each unit. These tests prepared me to think more seriously about the multifaceted nature of historical causation. In the end, it was Mr. Rogers who encouraged me to study history in college and provided a model of its feasibility as a career. I am grateful to Mr. Rogers for his role in inspiring me to study history.

I determined my field of historical study during my second semester at my undergraduate institution when I took my first course on Japanese history with Dr. Paul Clark. At the time, I had had little prior exposure to Japanese, or even East Asian, history, so everything was new to me. I devoured our readings with an insatiable curiosity. Toward the end of the semester, Dr. Clark encouraged me to consider taking other courses that he offered on East Asian history, which I did, thereby launching my academic career in the field. Over the next few years, he took a deep interest in my development as a scholar, providing a wealth of insight into the academic world that still serves me today. It was through his guidance that I was able to secure funding and arrange a yearlong independent study abroad program in Japan through my university. This was my first trip abroad and it opened my eyes not only to the world, but also to the vast and previously unknown possibilities available to me in life. I returned with a determination to continue studying Japanese history at the graduate level. Dr. Clark guided me through the process of applying to graduate school, ultimately leading to my graduate studies at the University of Kansas (KU). No amount of thanks could ever be enough to repay Dr. Clark for the support he gave me as I began my academic career.

At KU, I had the privilege of studying with several talented mentors who each played a unique role in my development as a historian. My initial advisor, Dr. William Tsutsui, or Bill as he is known by his acquaintances, always encouraged me as I tried to find my footing as a new graduate student. Dr. Eric Rath, through his rigorous courses on premodern Japanese history, inculcated in me a similar standard for scholarship. Dr. John Janzen introduced me to medical pluralism as an anthropological concept and significantly impacted my decision to study the history of kanpō. Dr. Megan Greene, who served as my advisor after Bill departed KU, demonstrated endless patience as I slowly moved toward the completion of this project while

working full time over the past several years. It is impossible for me to convey all the ways in which the aforementioned individuals supported and helped me day after day as I moved through the graduate program at KU. Truly, their aid has been incalculable.

Generous financial support from the Japan Society for the Promotion of Science allowed me to spend a year in Japan conducting archival research for this dissertation at the National Diet Library, Waseda University Library, and a number of other smaller collections in the Tokyo area. During that time, Dr. Tateno Masami of Nihon University in Tokyo served as my mentor. Himself a scholar of the history of kanpō medicine, Dr. Tateno offered innumerable leads on sources and scholarly contacts that I would not have been aware of without his help. Through his affiliation with the *Tōa igaku kyōkai* (Association of East Asian Medicine, 東亜医学協会), I was able to access complete collections of several early twentieth century kanpō revivalist journals not widely available to the public at the time. It was also through his introduction that I made the acquaintance of Kobayashi Hajime, a kanpō scholar whose work on the history of patent medicine in Tashiro domain served to inform the study of patent medicine in this dissertation. I sincerely thank Dr. Tateno for his ongoing support throughout my dissertation research.

Finally, I owe a tremendous debt to my wife Candice, who encouraged me tirelessly through many late nights over the past several years. Her emotional support kept me moving forward on this project, even when it seemed like there was no end in sight. To paraphrase the eighth century Tang dynasty poet Han Yu (韓愈), hardship is the boat upon which we traverse the sea of learning.

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Abbreviations

AEAM	Association of East Asian Medicine
CCM	Classical Chinese Medicine
CJM	Classical Japanese Medicine
JSOM	Japanese Society of Oriental Medicine

Introduction - The Power of Names

Uirō (外郎) or *uirō-mochi* (外郎餅) is an iconic Japanese traditional confection. A chewy steamed cake typically composed of rice flour and sugar as a base, with an expansive assortment of local variations, *uirō* is a familiar sight in most Japanese convenience stores. For Japanese, it is a much loved and much consumed connection to the past. Even visitors to Japan, who may not be familiar with the name of the confection, will be familiar with its image, as the product is frequently used in Japanese promotional advertising. Yet while most are familiar with the *uirō* confection itself, far fewer are aware of the product's namesake, *uirō* medicine, and the origins of both in the history of medicine.

Uirō medicine derives from a classical Chinese medicine recipe known as *reihōtan* (C. *lingbaodan*, 霊宝丹). Following the collapse of the Yuan Dynasty in 1368, a Chinese doctor named Chen Yanyou (J. *Chin Enyū*, 陳延祐) fled to Japan for safety, where he became known as Chen Wailang (J. *Chin Uirō*, 陳外郎), in reference to his former position as a vice director (C. *yuanwailang*, 員外郎) in a bureau (C. *qinglisi*, 清吏司) of the Ministry of Rites (C. *libu*, 禮部) in the court of the Yuan Dynasty.[1] The Ashikaga Shogunate sought Chen's services; however, Chen refused its request, instead choosing to become a Buddhist monk and taking the name Sōkei (宗敬). Following Sōkei's death, his son Sōki (宗奇), also a doctor, took a position with the Ashikaga

[1] Sugiyama Shigeru, "Naka-kinsei ni okeru uirōka to baiyaku tōchinkō no tenkai ni kansuru yakushigakuteki kenkyū" [The Middle and Recent Past of Uirō Sellers and Patent Medicine: Pharmaceutical Historical Research Concerning Tōchinkō] (PhD diss., Chiba University, 1996), 5.; Xie Baocheng, *Brief History of the Official System in China*, trans. Chen Mirong (Beijing: Social Sciences Academic Press, 2013), 79.

Shogunate where he was in charge of receiving foreign emissaries and advising on medical matters.[2] Later, he returned to his father's hometown of Taizhou (J. *Daishū*, 台州) in modern Zhejiang province (J. *Sekkōshō*, 浙江省) in China at the request of the Ashikaga Shogunate. There he obtained the recipe for *reihōtan* and brought it back to Japan. *Reihōtan* contains ginseng, musk, and cinnamon, among other herbal components and is thought to be effective in treating a range of ailments, including digestive issues and headaches. It appears to have been quite a pungent concoction as one Japanese emperor is said to have referred to it as "*tōchinkō*" (透頂香) or "thoroughly fragrant", giving the medicine a secondary moniker. Aristocrats are said to have kept the medicine in their hats during the summer months, where, due to the heat, the medicine would partially melt, releasing a pleasant fragrance.[3] An analysis of the characters that form *tōchinkō* indicates that this is a likely explanation for the origin of the term: 透 (crown of the head) + 頂 (thoroughly) + 香 (fragrant). One version of the story states that the medicine was also reportedly bitter, such that Sōki provided his guests with steamed sweet cakes to mask the taste. These cakes were referred to as *uirō* (外郎), the Japanese pronunciation of Chen Wailang's Yuan Dynasty court title. Another version claims that *uirō* medicine was initially produced in cake form and that, as it grew in popularity, merchants sought to profit by selling sweetened non-medicinal cakes of a similar style, which were also called *uirō*.[4] Sōki and his descendants began to sell *reihōtan*

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[2] Sugiyama, "Naka-kinsei ni okeru uirōka to baiyaku tōchinkō no tenkai ni kansuru yakushigakuteki kenkyū", 9-10.
[3] Sugiyama, "Naka-kinsei ni okeru uirōka to baiyaku tōchinkō no tenkai ni kansuru yakushigakuteki kenkyū", 6.
[4] Sugiyama, "Naka-kinsei ni okeru uirōka to baiyaku tōchinkō no tenkai ni kansuru yakushigakuteki kenkyū", 83-84.

commercially with success, such that the product was available for sale in Kyoto and several major regional centers by the late 1600s.[5] However, the product became most associated with Odawara after one of Sōki's descendants moved the family there at the invitation of the influential Hōjō clan in 1504. Over time, *reihōtan* came to be known colloquially as *uirō*, as the popularity of the steamed sweet cakes overshadowed the accompanying medicine. Further evidence of the product's enduring popularity can be found in the fact that one of the so-called *Kabuki jūhachiban* (歌舞伎十八番), a list of the eighteen best Kabuki plays compiled by renowned actor Ichikawa Danjūrō VII in the early 1800s included one titled, *Uirō uri* (*The Uirō Salesman*, 外郎売り). *Uirō uri* functions essentially as an extended advertisement for the *uirō* medicine, as the play opens with a speech by the actor in the role of a medicine peddler extoling *uirō's* history, efficacy and ingredients.[6] *Uirō* medicine continues to be available for sale today, though it is far less known than the *uirō* steamed cakes that are now ubiquitous throughout Japan. A fundamental idea shared by both classical Chinese medicine and classical Japanese medicine is *ishokudōgen* (C. *yishitongyuan*, 医食同源), that medicine and food are of equal importance in maintaining health. In the case of *uirō*, this idea may be taken literally.

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[5] Sugiyama, "Naka-kinsei ni okeru uirōka to baiyaku tōchinkō no tenkai ni kansuru yakushigakuteki kenkyū", 9-15.
[6] Utei Enba and Katsukawa Shuntei, "Uirō uri" [The Uirō Salesman], *Kabuki jūhachiban* Vol. 2, (Edo: Tsuruyakiemon, 1811), 12-13, https://archive.wul.waseda.ac.jp/kosho/bunko01/bunko01_01767/bunko01_01767_0002/bunko01_01767_0002.pdf (accessed November 11, 2020).

The Power of Names

The purpose of the preceding vignette is not to convey the stories of *uirō* cake and medicine, which may be found in other sources in more detail, but to introduce the idea that names have power; they irrevocably influence the destinies of everything to which individuals attach them. The obviousness of this statement may seem to preclude its further consideration, yet scholars frequently overlook the importance of the obvious in pursuit of the obscure. Names, both informal and formal, betray the intent of their creators and can be a means by which to influence the perceptions of the artifact in question. Put more simply, names can be a form of advertising. Take *reihōtan/tōchinkō/uirō* as an example. The characters for *reihōtan* (霊宝丹) translate literally as "sacred treasure balls", indicating an intent to emphasize the precious and efficacious nature of the medicine in the mind of the consumer. *Tōchinkō*, a reference to the scent of the medicine, evokes a pleasant, fragrant, and ultimately positive mental association. *Uirō*, as a reference to a dynastic court rank, evokes authority, which when taken in association with a medicine might conjure images of efficacy or, in the case of a steamed cake, quality or largesse. Without further research, it is not possible to say definitively that these were the specific concerns that led to the creation of these names; however, for this illustrative example, it is merely important to recognize that a specific intent, whether overt or subconscious, existed behind the creation of these names.

The history of the *uirō* cake and medicine provides an example of the unintended historical consequences of names. As previously mentioned, one version of the *uirō* narrative is that Sōki provided *uirō* cake to his guests as a supplement to *reihōtan* in order to mask its taste. Sōki's intention in naming his cakes "*uirō*" was likely not to promote his cakes, but instead his medicine. The choice of the name *uirō* may be attributed to vanity. Similarly, according to the second version

of the *uirō* narrative related above, *uirō* cakes were named as such to profit from the one-time popularity of *uirō* medicine. Yet, with time, *uirō* cakes became ubiquitous throughout Japan, while *uirō* medicine, though famous for a time, faded from public awareness. For the purposes of this study, it is not important why this occurred, but merely to recognize that Sōki's choice to name his product *uirō* had significant and lasting effects on the historical development of both *uirō* cake and medicine.

The history of what is popularly known today as kanpō medicine in many ways parallels the developments that transformed *uirō* over the course of centuries. A variety of names have been attached to the practice of kanpō medicine, significantly impacting the historical development of the discipline to the extent that what is popularly known as kanpō today would be unrecognizable to a Japanese medical practitioner three hundred years ago. Following its introduction from China more than fifteen hundred years ago, the discipline was initially known as simply *igaku* (medicine, 医学), denoting its function and implicitly recognizing its status as the then dominant medical system in Japan. Concurrently, aspects of the practice were occasionally referred to as kanpō (Chinese method, 漢方) to neutrally denote their Chinese origin. The growing political and military power of the West and the prevalence of Western medicine in Japan in the eighteenth and nineteenth centuries led to a proliferation of new names for each as the two were defined in opposition to each other. Supporters and detractors of each coined new names to serve their political and economic ends. Proponents of Japanese medicine attempted to undermine the establishment of Western medicine in Japan by emphasizing its foreign nature in a succession of names such as *nanban igaku* (medicine of the southern barbarians, 南蛮医学), *oranda igaku* (Dutch medicine, オランダ医学), *kōmōryū igaku* (red-hair method medicine, 紅毛流医学), and

seiyō igaku (Western medicine, 西洋医学). For proponents of Western medicine, Japanese medicine became *dentōteki* (traditional, 伝統的), in contrast to *gendaiteki* (modern, 現代的) Western medicine. In its nineteenth century context, the term "traditional" held negative associations such as a lack of progress, backwardness, or oldness. Conversely, "modernity" was associated with progress, vitality and newness. To this end, one of the new names for Western medicine adopted by its proponents was *nisshin igaku* (Japan's New Medicine, 日新医学). During this time, what would become the most recognizable name for classical Japanese medicine, "kanpō", became popularized by its detractors as a means of reinforcing the discipline's association with China, which, at the time, was in a state of political fragmentation. The purpose of creating this association was to support political efforts aimed at the delegitimization of classical Japanese medicine in favor of Western medicine. By the early twentieth century, proponents of Western medicine had largely succeeded in their campaign to supplant Japanese medicine.

In the early twentieth century, a new generation of Japanese physicians and scholars sought to revive classical Japanese medicine by taking ownership over its names and redefining them. Countering past aspersions cast on its foreign origin, scholars recontextualized classical Japanese medicine within the prism of cultural nationalism as an authentically Japanese cultural property through a series of progressive reimaginations of the discipline. The term "kanpō" was reclaimed without its pejorative connotations. Wada Keijūrō (和田啓十郎, 1872-1916) emphasized the dual nature of kanpō through its synthesis of both Chinese and Japanese medical practices with his re-popularization of the nineteenth century term *wakanyaku* (Japanese-Chinese medicine, 和漢薬). Building on Wada's work, Yumoto Kyūshin (湯本求真, 1876-1941) emphasized kanpō's

assimilation of Chinese medical practices into a preexisting classical Japanese medicine through the terms *kōkokuhō* (皇国方- Imperial country method) and *kōkan igaku* (Imperial Han/Chinese medicine, 皇漢醫學). Nakayama Tadanao (中山忠直, 1895-1957) viewed kanpō as having transcended both Chinese and Western medicine through integration and improvement, resulting in a superior tradition known as "*Nihon no igaku*" (Japan's medicine, 日本の医学). Adopting Nakayama's notion of kanpō's superiority, scholars of the 1930s came to refer to kanpō as *tōyō igaku* (Oriental medicine, 東洋医学). To these, having surpassed all its continental competitors, kanpō represented the future of medicine. Postwar scholars reconceptualized *tōyō igaku* as a category encompassing the historical medical practice of East Asia defined by its complementary nature to Western biomedicine. As in the case of *uirō*, the names associated with kanpō changed over time and took on new meanings that were often dependent on the audience and context. In turn, these new designations continually redefined the boundaries of kanpō medicine, such that much of what is thought of as kanpō medicine today, would likely be considered to be within the boundaries of Western medicine by kanpō practitioners of the Edo period. Indeed, much of what constitutes kanpō today bears little resemblance to the kanpō of three hundred years ago, despite their historical connection, just as the *uirō* consumers of today are likely shopping for something different from the *uirō* consumers of earlier eras.[7]

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[7] The early nineteenth century comic novel *Tōkaidōchū hizakurige* (東海道中膝栗毛) by Jippensha Ikku (十返舎一九, 1765-1831) contains a scene in which the protagonists mistake the uirō medicine for the uirō confection during a visit to Odawara.

Historiography

Despite kanpō's more than 1500-year history, scholarly understanding of the history of kanpō medicine remains poorly developed due to a relative lack of attention from the broader historical community. Until recently, the bulk of all historical research on kanpō originated from kanpō medical practitioners in Japan. Most of these individuals were not trained historians, but instead clinicians with an interest in the development of their field. While practical knowledge of kanpō served to provide these authors with a greater technical understanding of the clinical aspects of kanpō than a non-specialist historian might have, a corresponding lack of historical training led to the production of works either narrowly conceived around specific historical kanpō practices or general overviews of kanpō.

While there are works on the history of kanpō predating the twentieth century, such as Asada Sōhaku's (浅田宗伯, also known as Asada Ritsuen, 淺田栗園, 1815-1894) 1834 *Kōchō ishi* (Medical History of the Imperial Court, 皇朝医史), kanpō as a field of historical inquiry developed from the efforts of kanpō physicians in the early twentieth century to promote understanding and acceptance of kanpō within the field of medicine.[8] In 1910, Wada Keijūrō introduced the concept of the synthetic kanpō tradition in *Ikai no tettsui* (Rules of the Medical World, 醫界の鉄椎) by detailing how kanpō had developed over time through the incorporation of new practices from other medical systems and the cumulative experiences of practitioners.[9] In

[8] Asada Sōhaku, *Kōchō ishi* [Medical History of the Imperial Court], manuscript 1834, https://rmda.kulib.kyoto-u.ac.jp/item/rb00002398#?c=0&m=0&s=0&cv=0&r=0&xywh=-4519%2C-209%2C14652%2C4160 (accessed November 11, 2020).
[9] Wada Keijūrō, *Ikai no tettsui* [The Iron Hammer of the Medical World] (1910; repr., Tokyo: Shun`yōdō, 1932).

1927, Yumoto Kyūshin's *Kōkan igaku* (皇漢醫學) built on this idea by emphasizing cultural ownership over these practices through a historical process of assimilation.[10] Concurrently, Nakayama Tadanao asserted the superiority of kanpō as a uniquely Japanese medicine, going so far as to publish a historical justification for kanpō's decline.[11] Along with Nakayama, subsequent Japanese scholars of the late 1920s and 1930s, such as Arai Kinzō (荒井金造, 1883-1971), Shimizu Tōtarō (清水藤太郎, 1886-1976), Koyanagi Ken'ichi (小柳賢一, 1906-1966), and Takeyama Shinichiro (竹山晋一郎, also known as Takeyama Shinmin 竹山晋民, 1900-1969) adapted this idea to the needs of Japanese expansionism, asserting that, through its history of assimilation, kanpō as a medical system had surpassed the classical medicines of East Asia and was on the brink of exceeding Western biomedicine.[12] Consequently, these scholars argued that kanpō should be promoted in Japan's colonies as a means of exercising control and buttressing popular support. While these were works with an ideological agenda aimed at convincing the Japanese scientific community and populace of the utility of kanpō medicine, they drew on the history of kanpō to make the case.

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[10] Yumoto Kyūshin, *Kōkan igaku* [Imperial Chinese Medicine] (1927; repr., Tokyo: Taian, 1962).
[11] Nakayama Tadanao, "Kanpō igaku fukōron" [Theory and Revival of Kanpō Medicine], *Nihon oyobi nihonjin* [Japan and the Japanese] 109 (1926): 4-72.; Nakayama Tadanao. *Kanpō igaku yodan* [Kanpō Medicine's Digressions] (Tokyo: Nakayama kenkyūjō shuppanbu, 1929).
[12] Nakayama Tadanao, *Nihonjin no erasa no kenkyū* [Studies of Japanese Excellence] (Tokyo: Shokasha, 1933). Arai Kinzo, "Shin tōa kensetsu no ichiyokutare" [A Part of the Construction of a New East Asia], *Tōa igaku* 1, no. 2 (1939).; Shimizu Tōtarō, *Kokumin hoken to kōkanyaku* [National Health Preservation and Imperial Chinese Medicine] (Tokyo: Shingi shingonshū, 1939).; Koyanagi Kenichi, "Tairiku iryō taisaku no seikyokuteki igi" [The Proactive Significance of Continental Medical Treatment Measures], *Tōa igaku* 2, 1 (1939): 11-12.; Takeyama Shinichiro, *Kanpō ijutsu fukkō no riron* [Theories on the Restoration of Kanpō Medicine] (Tokyo: Moriyama shoten, 1941).

While the most well-known works on kanpō of the twentieth century prewar period were intended primarily as justifications for the revival of kanpō medicine, there existed a number of publications dedicated to the rediscovery of "lost" knowledge and publication of new research. Nakayama Tadanao published a book-length work concerning new research into kanpō.[13] *Tōyō igaku* (Oriental Medicine, 東洋医学), *Tōa igaku* (East Asian Medicine, 東亜医学), and *Kanpō to kanyaku* (Kanpō and Chinese medicine, 漢方と漢薬) were journals that carried articles on topics ranging from Edo period pharmacology and biographies of past kanpō luminaries to laboratory research on the effects of kanpō herbs. While none of these journals survived the Second Sino-Japanese War (1937-1945), during their years of publication, they served as a forum for the community of kanpō revivalists to discuss their research and vision for the future. For example, it was in *Tōa igaku* that Ōtsuka Keisetsu (大塚敬節, 1900-1980), perhaps the most prolific kanpō scholar of the twentieth century, first put forth his idea for the systematic, science-based training of future kanpō physicians.[14] By this point, Ōtsuka was already known for his promotion of kanpō medical pedagogy, having published one of the earliest primers on modern kanpō clinical practice, *Kanpō igaku rinshō teiyō* (A Clinical Outline of Kanpō Medicine, 漢方醫學臨床提要) in 1933.[15] In collaboration with Yakazu Dōmei (矢数道明, 1905-2002), the second most prolific kanpō scholar of the twentieth century, Kimura Chōkyū (木村長久, 1910-1945), and Shimizu Tōtarō,

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[13] Nakayama Tadanao, *Kanpō igaku no shinkenkyū* [New Research on Kanpō Medicine] (Tokyo: Hōbunka, 1931).
[14] Ōtsuka Keisetsu, "Kagaku no senrei wo uketaru kanpōi wo yōsei yo" [The Training of Kanpō Doctors Receiving the Baptism of Science], *Tōa igaku* 1, no. 1 (February 1, 1939): 3.
[15] Ōtsuka Keisetsu, *Kanpō igaku rinshō teiyō* [A Clinical Outline of Kanpō Medicine] (Tokyo: Shun'yōdō, 1933).

Ōtsuka released a revised primer titled, *Kanpō shinryō no jissai* (Practical Kanpō Treatment, 漢方診療の実際) in 1941.[16] Together, these two works served as foundational training guides for kanpō practitioners of the early postwar period. Despite their function as medical textbooks, each devoted significant attention to providing historical context to treatment with a recognition that most readers would have little awareness of kanpō's history. Similarly, other kanpō revivalists chose to research historical kanpō prescriptions and herbology.[17]

Despite the breadth of research topics, prewar research on kanpō suffered from several limiting factors. The absolute number of scholars engaged in research on kanpō was small, as was the community reached by the limited number of publications running at the time. Additionally, as previously mentioned, most of the scholars were more concerned with the practical clinical applications of their research than in producing quality historical works on kanpō. Consequently, the historical research contained in these works was fragmented and often not well supported. Many reflected the author's uncritical opinion of a subject; biographies of past kanpō doctors were often hagiographic. Despite their limitations, the body of research produced by kanpō scholars of the prewar period were some of the first works on the subject written in modern Japanese, as earlier sources were written entirely in *kanbun*, thereby allowing them to reach a greater audience.

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[16] Ōtsuka Keisetsu, Yakazu Dōmei, Shimizu Tōtarō and Kimura Chōkyū, *Kanpō shinryō no jissai* [Practical Kanpō Treatment] (Tokyo: Nanzandō, 1941).

[17] Yakazu Dōmei, *Kanpō igaku shohō kaisetsu* [Commentary on Kanpō Medical Prescriptions] (Tokyo: Japan Kanpō Medical Association, 1940).; Shimizu Tōtarō, *Kanpō yakubutsugaku* [Kanpō Drug Studies] (Tokyo: Shun'yōdō: Jikken kanpō igaku sōsho, 1934).; Shimizu Tōtarō, *Honzō jiten* [Medicinal Herb Dictionary] (Tokyo: Shun'yōdō, 1935).

Moreover, they laid the foundation for subsequent research into kanpō history by creating a general historical narrative of the discipline, which was adopted by later scholars.

Following the conclusion of the Second Sino-Japanese War (1937-1945), the surviving revivalists continued to support kanpō research through the reformation of kanpō professional organizations such as The Japanese Society of Oriental Medicine (*Nihon tōyō igakkai*, 日本東洋医学会 - abbr. JSOM) and Association for East Asian Medicine (*Tōa igaku kyōkai*, 東亜医学協会 - abbr. AEAM) and support of new journals like the *Kanpō no rinshō* (Clinical Kanpō, 漢方の臨床) and *Kampo Medicine*, also known as *Nihon tōyō igaku zasshi* (Japan Oriental Medicine Magazine, 日本東洋医学雑誌), as well as book-length publications. The two most productive postwar revivalists were Ōtsuka Keisetsu and Yakazu Dōmei. Ōtsuka published several works aimed at introducing kanpō practice to biomedical practitioners.[18] In 1954, he, along with Yakazu and Shimizu, issued a revised version of *Kanpō shinryō no jissai* (Practical Kanpō Treatment, 漢方診療の実際).[19] In 1957, he produced a dictionary of kanpō terms.[20] Ōtsuka also collaborated with Yakazu in the publication of *Kinsei kanpō igakusho shūsei* (A Compilation of Recent Works

[18] Ōtsuka Keisetsu, *Kanpō shinryō 30 nen: Chikenrei o shu to shita chiryō no jissai*. [Thirty Years of Medical Treatment by Traditional Chinese Medicine: Practice of Therapy Based on Successful Cases] (Osaka: Sōgensha 1959).; Ōtsuka Keisetsu. *Kanpō igaku* [Kanpō Medicine] (Osaka: Sōgensha, 1973).
[19] Ōtsuka Keisetsu, Yakazu Dōmei, and Shimizu Tōtarō, *Kanpō shinryō no jissai: Kaiteiban* [Practical Kanpō Treatment: Revised Edition] (Tokyo: Nanzandō, 1954).
[20] Ōtsuka Keisetsu, *Kanpō daiiten* [Kanpō Medical Dictionary] (Tokyo: Tōto shobō, 1957).

on Kanpō Medicine, 近世漢方医学書集成), a collection of unabridged historical writings on kanpō medicine, providing access to a number of lesser known kanpō texts to scholars.[21]

Postwar revivalist literature displayed a greater interest in the intellectual and historical development of kanpō than earlier works focused more narrowly on justifying kanpō's contemporary relevance. Such works placed more emphasis on kanpō's complementary, rather than competitive, role with biomedicine. In 1949, Shimizu Tōtarō published a general history of Japanese traditional pharmaceuticals.[22] Nishiyama Hideo (西山英雄, 1900-1981), a revivalist most active in the postwar period, expanded the then-bounds of historical inquiry into kanpō through examinations of its intellectual foundations, its relationship to Japanese folk medicine and the clinical treatment of women.[23] He also helped to expand understanding of kanpō medical terms through the compilation of a kanpō term dictionary, building off the earlier work of Ōtsuka Keisetsu.[24] Up until the publication of *Kanpō no rekishi* (The History of Kanpō, 漢方の歴史) in 2014 by Kosoto Hiroshi (小曽戸洋, 1950-present), Yakazu Dōmei's 1979 *Meiji hyaku-jūnen: Kanpō igaku no hensen to shōrai: Kanpō ryakushi nenpyō* (The 110th Year of Meiji: The Transition of Kanpō Medicine and Its Future: A Brief Historical Chronology of Kanpō, 明治百十年漢方医

[21] Ōtsuka Keisetsu and Yakazu Dōmei. *Kinsei kanpō igakusho shūsei* [A Collection of Recent Kanpō Medicine Books] 116 vol. (Tokyo: Meichō shuppan, 1979-1984).
[22] Shimizu Tōtarō, *Nihon yakugakushi* [Japanese Pharmaceutical History] (Tokyo: Nanzandō, 1949).
[23] Nishiyama Hideo, *Josei to kanpō* [Women and Kanpō] (Osaka: Sōgensha, 1974).; Nishiyama Hideo, *Kanpō igaku no kiso to shinryō* [Kanpō Medicine's Foundations and Treatment] (Osaka: Sōgensha, 1969).; Nishiyama Hideo, *Kanpōyaku to minkanyaku* [Kanpō Medicine and Folk Medicine] (Osaka: Sōgensha, 1963).
[24] Nishiyama Hideo, *Kanpō igo jiten* [Kanpō Medical Language Dictionary] (Osaka: Sōgensha, 1975).

学の変遷と将来:漢方略史年表) represented the closest scholars had to a book-length narrative history of kanpō and it is still an excellent starting point for kanpō historians.[25]

Though limited in breadth, the combined pre- and postwar corpus of revivalist research functions as the foundational historiography of kanpō and an essential starting point for kanpō historical research outside of the primary texts themselves. It also determined the direction of kanpō historical research for most of the twentieth century. For better or for worse, the drive to justify kanpō within the scientific paradigm, an implicit or explicit theme in virtually all revivalist literature, has made it difficult for scholars to examine the tradition on its own terms, rather than through the mirror of scientific inquiry.

Before moving to a consideration of recent kanpō historical research, it is important to consider the role of Ōtsuka Yasuo (大塚恭男, 1930-present), who can be considered the last of the revivalist scholars, in maintaining their legacy. Though not technically a revivalist kanpō scholar because he was too young to participate in the prewar revival movement, as the eldest son of Ōtsuka Keisetsu, he was keenly aware of the interests of the movement and these are reflected in his body of work. Like many of the postwar revivalists, the younger Ōtsuka published several general works aimed at introducing kanpō to a broader audience through an emphasis on its

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[25] Kosoto Hiroshi, *Kanpō no rekishi* [The History of Kanpō] (Tokyo: Taishūkan shoten, 2014).; Yakazu Dōmei, *Meiji hyaku-jūnen: Kanpō igaku no hensen to shōrai: Kanpō ryakushi nenpyō* [The 110th Year of Meiji: The Transition of Kanpō Medicine and Its Future: A Brief Historical Chronology of Kanpō] (Tokyo: Shun'yōdō shoten, 1979).

complementary nature to biomedicine.[26] He also promoted the dissemination of laboratory research on kanpō through his publications.[27] Finally, he sought to promote a more historical understanding of the tradition through emphasizing and building on the general structural narrative of kanpō's development endorsed by earlier revivalist scholars.[28]

The 1970s marked the first entry of Anglophone scholars into the field of kanpō studies with the publication of monograph-length studies of kanpō by anthropologists Margaret Lock and Emiko Ohnuki-Tierney. The question of medical pluralism in Japan was a popular topic in the field of medical anthropology in the 1960s and 1970s. Margaret Lock's *East Asian Medicine in Urban Japan: Varieties of Medical Experience*, based on field work at kanpō clinics in Kyoto in 1973 and 1974, remains the most extensive English language discussion of kanpō as it is patronized in the everyday clinical setting to this day.[29] It is a comprehensive work discussing the philosophical underpinnings of kanpō, the experiences of patients at kanpō clinics, *shiatsu* and *amma* massage, acupuncture and moxibustion, and the biomedical system, all in 264 pages. Anthropologist Emiko Ohnuki-Tierney was also interested in the issue of medical pluralism in Japanese society. By providing a broad overview of Japanese attitudes toward disease and the varieties of medical practice extant in Japan, from kanpō and religious/folk medicine to

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[26] Ōtsuka Yasuo, *Kanpō to kusuri no hanashi* [A Conversation about Kanpō and Medicine] (Kyoto: Shibunkaku shuppan, 1994).; Ōtsuka Yasuo, *Tōyō igaku* [Eastern Medicine] (Tokyo: Iwanami shoten, 1996).; Ōtsuka Yasuo, *Tōyō igaku o sagaru* [Searching for Eastern Medicine] (Tokyo: Nihon hyōronsha, 1973).
[27] Ōtsuka Yasuo, *Kanpō igaku no shinchishiki* [New Information about Kanpō Medicine] (Tokyo: Nihon hyōronsha, 1995).
[28] Ōtsuka Yasuo, "Tōyō igaku no rekishi to gendai" [The History of the Sino-Japanese Medicine and Its Situation in the Modern Japanese Medicine] *Nihon tōyō igaku zasshi* 47, no. 1 (1996): 5-11.
[29] Margaret Lock, *East Asian Medicine in Urban Japan: Varieties of Medical Experience*, Comparative Studies of Health Systems and Medical Care Number 4 (Berkeley: University of California Press, 1980).

biomedicine, Ohnuki-Tierney argued that Japanese experiences of health and healing are "culturally-patterned" and unique.[30] The breadth of these works, while impressive and immensely informative, overlooked two important aspects of medical pluralism related to kanpō in Japan. First, little attention was given to the implications of the prescription of kanpō medicines by biomedical practitioners and the implications of national health insurance coverage of kanpō medicines within the biomedical system. Second, there was no consideration of over-the-counter (OTC) kanpō medicines that were available in drug stores during the period. Furthermore, by focusing primarily on the small segment of the population that sought out treatment at kanpō clinics, Lock's work was unable to fully explore the role of medical pluralism in Japanese society as it related to the majority population that did not patronize kanpō outside of the biomedical system. As I demonstrate in my dissertation, by the kanpō boom period of the 1960s, OTC kanpō medicines represented the dominant strand of kanpō practice in Japan, a dominance that grew exponentially with the implementation of national health insurance coverage for certain kanpō prescriptions in the 1970s.

Postwar Research on Edo Period Kanpō

Non-revivalist scholarship on pre-twentieth century topics tends to fall into one of two categories: Studies of "traditional" treatments and "great" physicians of the Edo period and Meiji period studies of kanpō's encounter with science and Western medicine. Scholarly fixation on the

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[30] Emiko Ohnuki-Tierney, *Illness and Culture in Contemporary Japan: An Anthropological View* (New York: Cambridge University Press, 1984).

Edo period has been particularly pronounced within Japanese language studies of the history of kanpō. While a large portion of the research on Tokugawa medicine has focused on the development of the ranpō tradition, there have been some studies, in both book and article form, on the history of kanpō.[31] The problem with many of these studies is that they tend to be repetitive. Content to list the genealogies and achievements of prominent medical lineages within the Gōseiha (後世派) and Kohōha (古方派**)** Schools of Kanpō, they never get beyond sketching a general narrative.[32] It is unfortunate that many of the English language publications of prominent Japanese medicine scholars, such as Fujikawa Yu (富士川游, 1865-1940), Ōtsuka Yasuo, and Nagayo Takeo (長与健夫, 1921-present) fall into this category.[33] Despite this tendency, significant contributions to our understanding of kanpō during the Edo period have been made through focused Japanese language biographical studies of influential kanpō doctors like Nakagami Kinkei (中神琴渓, 1744-1833) and Yoshimasu Tōdō (吉益東洞, 1702-1773) by scholars such as Tateno Masami (舘野正美, 1954-present) and Terasawa Katsutoshi (寺沢捷年, 1944-present) and kanpō

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[31] Ranpō (欄方), meaning Dutch method, is a term for the school of Japanese doctors in the Edo period who combined aspects of Western medical knowledge (primarily related to surgery and anatomy) with kanpō in their practice.

[32] The Gōseiha and Kohōha schools were the two dominant schools of kanpō during the Edo period. Founded by Manase Dōsan in the early 1500s, the Gōseiha school emphasized cosmological explanations of disease based on understandings of Yin/Yang theory and five elements cosmology that were popular during the Jin and Yuan dynasties. Though it dominated the practice of medicine during the first half of the Edo period, the Gōseiha school was eclipsed by the Kohōha School in the late 1600s. The Kohōha School emphasized a return to Chinese Han period medical classics and a de-emphasis of cosmological theory in treatment. The Kohōha School's teachings have been the most influential in guiding the modern practice of kanpō.

[33] Fujikawa Yu, *Japanese Medicine*, trans. John Ruhrah (New York: Hoeber, 1934).; Ōtsuka Yasuo, "Chinese Traditional Medicine in Japan," in *Asian Medical Systems: A Comparative Study*, edited by Charles Leslie (Berkeley: University of California Press, 1976), 322-340.; and Nagayo Takeo, *History of Japanese Medicine in the Edo Era: Its Social and Cultural Backgrounds* (Nagoya: University of Nagoya Press, 1991).

medical lineage chronologies and bibliographic works by scholars such as Yasui Hiromichi (安井廣迪, 1947-present), Mayanagi Makoto (真柳誠, 1950-present), and Kosoto Hiroshi.[34]

English language research on kanpō has remained a small subset of the growing field of Japanese medical history among non-Japanese historians. Many prominent Anglophone historians of Japanese medicine, such as Ann Jannetta, James Bartholomew, and Ellen Gardner Nakamura, have generally remained content to focus on the ranpō tradition and various aspects of the implementation of the Western medical model in Meiji Japan.[35] Indeed, a majority of the published material in English on Japanese medical history focuses exclusively on medicine during the Edo and Meiji periods. A few scholars, such as William Johnston, whose history of tuberculosis in Japan extends into the mid-twentieth century, and Andrew Goble, whose work on intercultural

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[34] Tateno Masami, *Nakagami Kinkei igaku shisō no kenkyu: Bunkengakuteki – igakuteki gaikan*. [Research on the Medical Ideology of Nakagami Kinkei: Philological and Medical Concepts] (Tokyo: Isseisha, 2012).; Tateno Masami, *Yoshimasu Tōdō "Kosho Igen" no kenkyu: Sono shoshi to igaku shisō* [Research on Yoshimasu Tōdō's "Kosho Igen": Bibliography and Medical Ideology] (Tokyo: Kyuko Shoin, 2004).; Tateno Masami, "Yoshimasu Tōdō's Philosophy of Medicine: In Comparison with that in Ancient China," *Kampo Medicine* 63, no. 1, (2012): 41-48.; Terasawa Katsutoshi, *Yoshimasu Tōdō no kenkyū: Nihon kanpō sōzō no shisō* (Tokyo: Iwanami shoten, 2012).; Yasui, Hiromichi, "Nihon kanpō shogakuha no nagare" [The History of the Schools of Kanpō Medicine], *Nihon tōyō igakukai zasshi* [Japan Oriental Medicine Association Magazine) 58, no. 2 (2007): 177-202.; Mayanagi Makoto, Takashi Miura and Mathias Vigouroux, "Yang Shoujing and the Kojima Family: Collection and Publication of Medical Classics" in *Antiquarianism, Language, and Medical Philology: From Early Modern to Modern Sino-Japanese Medical Discourses*, edited by Benjamin Elman, 187-213, Sir Henry Wellcome Asian Series, volume 12 (Boston: Brill, 2015).; Kosoto Hiroshi, *Nihon kanpō tenseki jiten* [Dictionary of Japanese Kanpō Writings] (Tokyo: Taishūkan shoten, 1999).; Kosoto Hiroshi, *Chūgoku ishigaku koten to nihon* [Chinese Medical Classics and Japan] (Tokyo: Hanawa shobō, 1996).

[35] Ranpō existed for the majority of the Edo period as a sub-discipline within kanpō; however, many Western scholars of Japanese medicine during the Edo period, excluding Ann Jannetta, have failed to recognize this fact, instead considering ranpō as almost a separate medical tradition, emphasizing its nascent connection to Western medicine with only passing mention of its continuation of mainstream kanpō practices. Ann Bowman Jannetta, *The Vaccinators: Smallpox, Medical Knowledge, and the "Opening" of Japan* (Stanford: Stanford University Press, 2007).; James R. Bartholomew, *The Formation of Science in Japan: Building a Research Tradition* (New Haven: Yale University Press, 1989).; Ellen Gardener Nakamura, *Practical Pursuits: Takano Choei, Takahashi Keisaku, and Western Medicine in Nineteenth-Century Japan* (Harvard: Harvard University Press, 2006).

exchanges and medical syncretism in Japan covers the late Heian (794-1185) through the Sengoku (approx. 1467-1573) periods, have sought to expand academic discourse beyond these narrow time constraints, yet the field has been slow to expand its focus.[36] Goble's work in particular is notable for its recognition of the syncretic nature of the development of the system now known as kanpō, particularly in regard to non-Chinese influences. Earlier histories of kanpō from the revivalist period tended to gloss over or ignore influences on the tradition other than those from recognized Chinese or Japanese sources. Similar to Goble's work, Benjamin Elman's work on Tokugawa Sino-Japanese cultural exchanges helped to provide better insight into early modern Chinese influence on the development of kanpō through the introduction of Chinese foundational medical classics, such as the *Huangdi neijing* (J. *Kōtei naikei*, E. *Inner Canon of the Yellow Emperor*, 皇帝内経) and the *Shanghan lun* (J. *Shōkanron*, E. *Treatise on Cold Damage Disorders*, 傷寒論).[37] Building on Elman's work, Daniel Trambaiolo has explored how the Kohōha School of kanpō, ostensibly to return to the tradition's foundations, drew on these works to successfully promote a

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[36] Andrew Edmond Goble, Kenneth R. Robinson, and Haruko Wakabayashi, *Tools of Culture: Japan's Cultural, Intellectual, Medical, and Technological Contacts in East Asia, 1000s-1500s* (Ann Arbor: Association of Asian Studies, 2009).; Andrew Edmond Goble,"Kajiwara Shōzen (1265-1337) and the Medical Silk Road: Chinese and Arabic Influences on Early Medieval Japanese Medicine" in *Tools of Culture: Japan's Cultural, Intellectual, Medical, and Technological Contacts in East Asia, 1000s-1500s*, edited by Andrew Edmund Goble, Kenneth R. Robinson, and Haruko Wakabayashi, 231-257, (Ann Arbor, Michigan: The Association of Asian Studies, 2009).; Andrew Edmund Goble, *Confluences of Medicine in Medieval Japan: Buddhist Healing, Chinese Knowledge, Islamic Formulas, and Wounds of War* (Honolulu: University of Hawaii Press, 2011).; William Johnston, *The Modern Epidemic: A History of Tuberculosis in Japan*, Harvard East Asian Monographs (Cambridge: Harvard University Asia Center, 1995).

[37] Benjamin Elman, "Sinophiles and Sinophobes in Tokugawa Japan: Politics, Classicism, and Medicine during the Eighteenth Century" *East Asian Science, Technology and Society: An International Journal* (2008): 93-121.; Benjamin Elman, "Rethinking the Sino-Japanese Medical Classics: Antiquarianism, Languages, and Medical Philology" in *Antiquarianism, Language, and Medical Philology: From Early Modern to Modern Sino-Japanese Medical Discourses*, ed. Benjamin Elman, Sir Henry Wellcome Asian Series, volume 12 (Boston: Brill, 2015), 1-18.

new clinical understanding of kanpō medical treatment and practice, which helped to foster the introduction of Western medicine into Japan.[38] Building on this, in my dissertation I demonstrate how the ascendance of the empiricist Kohōha kanpō paradigm resulted in the shedding of classical Chinese medicine-derived theories of disease causation, ultimately making kanpō more readily adaptable to the scientific paradigm in the twentieth century, but also creating a distinct rupture between Edo period and post-Edo period kanpō. Susan Burns' has examined how this transition played out on the local level in her research on Nanayama Jundo, a mid-nineteenth century Japanese doctor who incorporated both Kohōha and Western techniques into his medical practice.[39] Alexander Bay and Christian Oberlander have provided compelling studies of the Japanese medical establishment's refusal to recognize any value in kanpō in the Meiji battle against beriberi, despite the latter's apparent success in combating the disease.[40]

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[38] Daniel Trambaiolo, "Ancient Texts and New Medical Ideas in Eighteenth-Century Japan" in *Antiquarianism, Language, and Medical Philology: From Early Modern to Modern Sino-Japanese Medical Discourses*, edited by Benjamin Elman, 81-104. Sir Henry Wellcome Asian Series, Volume 12 (Boston: Brill, 2015).; Daniel Trambaiolo, "Native and Foreign in Tokugawa Medicine" *The Journal of Japanese Studies* 39, no. 2 (Summer 2013): 299-324.; Daniel Trambaiolo, "Writing, Authority and Practice in Tokugawa Medicine, 1650-1850" (PhD diss., Princeton University, 2014).

[39] Susan L. Burns, "A Village Doctor and the Treatise on Cold Damage Disorders (Shanghan lun 傷寒論): Medical Theory/ Medical Practice in Late Tokugawa Japan" in *Antiquarianism, Language, and Medical Philology: From Early Modern to Modern Sino-Japanese Medical Discourses*, ed. Benjamin Elman, Sir Henry Wellcome Asian Series, volume 12 (Boston: Brill, 2015), 133-147.; Susan Burns, "Nanayama Jundō at Work: A Village Doctor and Medical Knowledge in Nineteenth-Century Japan," *East Asian Science, Medicine, and Technology* 29 (Aut. 2008): 61–82.

[40] Alexander Bay, "The Politics of Disease: Beriberi, Barley, and Medicine in Modern Japan" (PhD diss., Stanford University, 2006).; Alexander Bay, *Beriberi in Modern Japan: The Making of a National Disease* (Rochester, N.Y.: University of Rochester Press, 2012).; Christian Oberlander, "The Rise of Western "Scientific Medicine" in Japan: Bacteriology and Beriberi," in *Building a Modern Japan*, ed. Morris Low (New York: Palgrave Macmillan, 2005), 13-36.

Postwar Research on Twentieth Century Kanpō

The history of kanpō in the twentieth century has received far less attention from historians than that of earlier time periods. Given that the prewar period witnessed the birth of the scientific rationalization of kanpō, the guiding paradigm behind the majority of kanpō research and development in contemporary times, historians need to give more consideration to the history of kanpō medicine during this period. In both Japanese and English language works, the entire prewar period of the twentieth century is frequently ignored, either through omission or a narrow research focus unlinked to the greater historical context. Extant research on twentieth century kanpō tends to fall within a handful of research categories. The most numerous of these are general articles or truncated chapter-length surveys of the entire history of kanpō. Most of the histories of the postwar revivalists, such as those by Ōtsuka Yasuo, fall into this category and fail to offer more than superficial details of the kanpō revival movement without analysis or context.[41] Later scholars, such as Maki Umemura and Christian Oberlander have begun to more critically examine the kanpō tradition by linking early twentieth century developments in kanpō to the greater historical context; however, these studies are naturally limited by their article-length formatting.[42] Frequently

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[41] Ōtsuka Yasuo, "Chinese Traditional Medicine in Japan" in *Asian Medical Systems: A Comparative Study*, ed. Charles Leslie, (Berkeley: University of California Press, 1976), 322-340.; Ōtsuka Yasuo, "Introduction of Oriental Medicine: The Theory of Kampo Therapy" *Bulletin of the Oriental Healing Arts Institute of U.S.A.* 13, no. 4 (1988): 217-221.

[42] Maki Umemura, "Reviving Tradition: Patients and the Shaping of Japan's Traditional Medicines," in *The Historical Consumer*, ed. Penelope Francks and Janet Hunter (London: Palgrave Macmillan, 2012), 176-203.; Christian Oberlander, "Kanpō's Modern Myth: Changing Images of Japan's Traditional Medicine" in *Disease and Society. Proceedings of the 18th International Symposium on the Comparative History of Medicine – East and West*, ed. Ōtsuka Yasuo and Sakai Shizu (Tokyo: Ishiyaku EuroAmerica, 1997), 59-74.; Christian Oberlander, "The Modernization of Japan's Kanpō Medicine, 1850-1950" in *East Asian Science: Tradition and Beyond; Papers from the Seventh International Conference for the History of Science in East Asia, Kyoto 2-7 August 1993,* ed. Keizo Hashimoto, Catherine Jami, and Lowell Skar (Osaka: Kansai University Press, 1993), 141-146.

overlapping with the first category are works that provide an uncritical narrative of the kanpō revival movement. Perhaps unsurprisingly, much of the scholarship produced by revivalist scholars falls into this category. The result has been the perpetuation of a near-hagiographic narrative of the kanpō revival movement, with little recognition of their motivations taken in historical context. Because this period coincides with the intensification of Japanese imperial aspirations leading up to the Second Sino-Japanese War, this is likely evidence of a hesitancy on the part of some scholars to take a closer look at the motivation and activities of the revivalists in this period. However, this is necessary in order to have a more accurate understanding of the movement and is a topic I seek to illuminate in my dissertation.

Research on kanpō in the context of Japanese imperialism and the Second Sino-Japanese War has received little attention from historians. Only a handful of historians have published works focused on the history of kanpō during the 1930s and 1940s, excluding the publications of the kanpō revivalists documenting their own efforts during the period. Katsui Keiko (勝井恵子, 1984-present) has authored a couple of articles on the life of Hashida Kunihiko (橋田邦彦, 1882-1945), a Japanese official in the 1930s and Minister of Education from 1940 to 1943 who used his influence to promote acceptance of kanpō within the government with modest results.[43] Mayanagi Makoto has looked at the efforts of the kanpō revivalists in promoting kanpō in Japanese-occupied

[43] Katsui Keiko, "Hashida Kunikiho kenkyū - aru "hōmurareta shisōka" no shōgai to shisō [Author provided English title: A Study of Hashida Kunihiko's Thought: The Life History and Thought of an Outcast Thinker]" *Nihon ishigaku zasshi* 56, no. 4 (2010): 527-538.; Katsui Keiko, "Hashida Kunihiko ni okeru [i] no sanyōso" [Author provided English title: The Three Constituents of the Idea of "Medicine" in Hashida Kunihiko's Thought] *Nihon ishigaku zasshi* 56, no. 4 (2010): 473-483.

Manshūkoku (C. *Manzhouguo*, 満州国).[44] Mizuno Norihito's work looks at the role of the Association of East Asian Medicine and its activities in attempting to promote kanpō during the late 1930s.[45] The paucity of works on this period has made it difficult for historians to evaluate the accounts of the revival movement or even have a general narrative understanding of kanpō's development during this period. Postwar revivalist histories tend promote the "noble" efforts of the movement at its inception in the 1910s and 1920s before quickly glossing over its activities in the 1930s and 1940s. It is not uncommon to encounter general kanpō survey articles that devote only a paragraph or two to this time period in between pages devoted to kanpō in the nineteenth century and postwar period. This is understandable, because, as I demonstrate in my dissertation, many revivalist scholars willingly involved themselves to lesser or greater degrees in supporting Japanese expansionism as a means of reviving kanpō medicine. My intent is to provide a more holistic understanding of their activities and motivations during this time period in order to demonstrate how these affected the development of kanpō into the postwar period.

Patent medicine represents what is likely the most popular field of twentieth century kanpō studies and has grown in popularity in recent years. Although not all patent medicines are derived from kanpō, many Japanese patent medicines, in the guise of *kateiyaku* (family or home medicine, 家庭薬) or *baiyaku* (sold medicines, 売薬), are merely rebranded kanpō formulas that adopted

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[44] Mayanagi Makoto, "Manshū ikadaigaku kyūzō furu iseki no yukue" [Author provided English title: Whereabouts of the Old Medical Books collection of Manzhou Medical University] *Nihon ishigaku zasshi* 51, no. 1 (2004): 152-153.

[45] Mizuno Norihito, "Kampo in Wartime Sino-Japanese Relations: The Association of East Asian Medicine and the Search for a Tripartite Medical Partnership" *Science, Technology, and Medicine in the Modern Japanese Empire* (2016): 175-192.

modern imagery and packaging for commercial purposes at the time of kanpō's decline in the late nineteenth and early twentieth centuries. As with kanpō in general, there exists a large variety of general publications on Japanese patent medicine intended to introduce them to a popular audience. Despite being produced for popular consumption, some of these works, such as those by Machida Shinobu & Yamazaki Mitsuo, provide a fair amount of detail about the history of each product.[46] The *Kateiyaku kenkyūkai* (Family Medicine Research Association, 家庭薬研究会) has produced a general work on "long selling" medicines, many of which are derived from kanpō, which is a good source for images of historical packaging.[47] Product marketing provides insight into the way in which businesses perceive their product and how they seek to shape perception of their product.

Given that the transition to "patent medicine" from "kanpō" entailed the creation of entirely new and unrelated names and imagery for many of these products, the field is ripe for research on individual medicines navigating the transition. The works of Tamagawa Shinmei on *Hangontan* (反魂丹) and Tanaka Satoshi on *Seirogan* (正露丸) are examples of this trend.[48] Several scholars, including Endo Kazuko, Takahashi Yoshimaru, and Susan Burns have begun to research the marketing of Japanese patent medicines more generally, illuminating the dominant approaches taken to the marketing of medicine during that period; however, this field remains under-developed

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[46] Machida Shinobu, *Natsukashi no kateiyaku taizen* [Encyclopedia of Family Medicine] (Tokyo: Kadokawa shoten, 2003).; Yamazaki Mitsuo, *Nihon no meiyaku* [Japanese Well-Known Medicine] (Tokyo: Bunshun bunko, 2004).
[47] Kateiyaku kenkyūkai, *Kateiyaku ronguseraa no himitsu* [The Secret of "Long-seller" Family Medicine] (Tokyo: Yakuji nippōsha, 2010).
[48] Tamagawa Shinmei, *Hangontan no bunkashi – Etchū toyama no kusuri uri* [The Cultural History of Hangontan – Medicine Selling in Etchū, Toyama] (Tokyo: Shōbunsha, 1979).; Tanaka Satoshi, *Seirogan no rappa – Kusuri no kuni no zuzōgaku* [The Trumpet of Seirogan - Iconography of the Country's Medicine]. (Tokyo: Kawade shobō shinsha, 1994).

and is a topic I address in my dissertation.[49] There have also been localized studies of regions historically associated with the production of kanpō & patent medicines, such as Kobayashi Hajime's study of the Tashiro region of the historical Tsushima Domain located in modern Saga Prefecture and Endo Kazuko's work on Toyama Domain located in modern Toyama Prefecture.[50]

Despite the implicit connection between patent medicines and kanpō, little historical research has been carried out on medicines marketing themselves explicitly as kanpō during the first half of the twentieth century, even in the early postwar period. The role of kanpō products as objects of consumption and the topics of marketing campaigns in the twentieth century has received little to no consideration by both Western and Japanese scholars. Susan Burns' work on patent medicine advertisements touches directly on both of these topics; however, Burns' focus is confined primarily to kanpō medicines for women.[51] Laura Miller dealt with similar issues tangentially in a section of her work *Beauty Up: Exploring Contemporary Japanese Body Aesthetics*, detailing kanpō and faux-kanpō treatments at turn of the millennium beauty clinics in

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[49] Endo Kazuko, *Maaketingu on senkushatachi: Toyama no yakuuri* [Pioneers in Marketing – The Medicine Vendors of Toyama], (Tokyo: The Simul Press, Inc., 1993).; Takahashi Yoshimaru, *Retoro na yakutai no desain* [Packaging Design of Retrospective Medicine] (Tokyo: Mitsumura suiko shoin, 2011).; Susan Burns, "Marketing Health and the Modern Body: Patent Medicine Advertisements in Meiji-Taishō Japan" in *Looking Modern: East Asian Visual Culture from Treaty Ports to World War II*, ed. Jennifer Purtle and Hans Bjarne Thomsen (Chicago: Paragon Books, 2009), 179-202.; Susan Burns, "The Japanese Patent Medicine Trade in East Asia: 'Women's Medicines and the Tensions of Empire," in *Gender, Health, and History in East Asia*, ed. Izumi Nakayama and Angela Leung (Hong Kong: Hong Kong University Press, 2017), 139-165.

[50] Kobayashi Hajime, *Tsushimaryō tashirobaiyaku hattatsushi*, [The Developing History of Selling Patent Medicine in the Tashiro Region by the Tsushima Clan] (Tosu, Japan: Kobayashi Hajime, 1999).; Kobayashi Hajime, "Tashiro baiyaku no shiteki kenkyū" [Historical Research on Tashiro Patent Medicine], *Shisō* 15, (1972): 38-56.; Endo, *Maaketingu on senkushatachi*.

[51] Susan Burns, "Marketing 'Women's Medicines': Gender, OTC Herbal Medicines, and Medical Culture in Modern Japan," *Asian Medicine* 7, no.1 (2009).

the city of Tokyo.[52] Sherman Cochran's study of the marketing of TCM in China and Southeast Asia during the twentieth century, although not directly related to kanpō, is useful as a point of comparison to the marketing emphases of Japanese companies.[53] The only works in Japanese that address the topics of consumer society and marketing in regard to kanpō are company histories. Kotaro Kanpō Pharmaceuticals, Taishō Pharmaceuticals, Takeda Pharmaceuticals and Tsumura Juntendō, among others, have all published sponsored company histories with sections detailing their marketing strategies for their kanpō products.[54] These histories offer a wealth of information about product launches, advertising campaigns, and marketing strategies, none of which have been examined in any significant detail by historians, but which I examine in my dissertation.

Scholarly concern with the scientific rationalization of kanpō has remained a field of intense research throughout the twentieth century. Most postwar publications on kanpō fall into this category. Many are publications of scientific research on kanpō treatments. Many are popular works intent on justifying/explaining kanpō to the general public in scientific terms. Within the field of historical research, no longer content to use kanpō's historical legacy to justify kanpō to the public, the latest generation of kanpō scholars, such as Terasawa Katsutoshi, Narikawa Ichirō,

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[52] Laura Miller, *Beauty Up: Exploring Contemporary Japanese Body Aesthetics* (Berkeley: University of California Press, 2006).
[53] Sherman Cochran, *Chinese Medicine Men: Consumer Culture in China and Southeast Asia*, (Cambridge: Harvard University Press, 2006).
[54] Taishō seiyaku kabushiki gaisha shashi henshū jimukyoku, *Taishō seiyaku 80-nenshi* [The 80 Year History of Taishō Pharmaceuticals] (Tokyo: Taishō seiyaku kabushiki gaisha, 1993).; Tsumura Juntendō, *Tsumura Juntendō 70 nenshi* [The 70 Year History of Tsumura Juntendō] (Tokyo: Tsumura Juntendō, 1964).; Tsurumaki Yasuo, *Takeda yakuhin kogyō 200 nen no himitsu: "sekai no Takeda" e dasshu suru* [The 200 Year Secret of the Takeda Medicine Industry: The Dash to "Takeda's World"] (Tokyo: Tsushinsha shuppanbu, 1982).; Kotarō kanpō seiyaku kabushiki kaisha, *Kotarō kanpō gojūnenshi* [The Fifty-Year History of Kotarō Kanpō] (Osaka: Kotarō kanpō seiyaku kabushiki kaisha, 2002).; Tsumura Jusha, *Kanpō no hana: Juntendō jikki* [The Flower of Kanpō: A True Account of Juntendō] (Tokyo: Tsumura Juntendō, 1982).

and Tsumura Jusha, have extended the transcendentalist arguments of kanpō revivalists like Nakayama Tadanao in arguing that kanpō is more scientific and rational than biomedicine.[55] Echoing arguments by the detractors of biomedicine since the 1960s, Terasawa argues that contemporary biomedicine is reductionist, seeking simplistic solutions to complex diseases. Contemporary kanpō, which avoids labeling diseases and instead considers the variety of *shō* (症), or symptoms, manifested in a patient at a given time, offers a more rational and complex understanding of disease. Scholars such as Terasawa see potential for the development of kanpō/TCM as an augmentation to the global biomedical health system and hope to promote this eventuality through their publications.

Existing as a subset of works devoted to the history of the scientific rationalization of kanpō, are those which examine the development of the herbal extraction process. Kanpō revivalists viewed the standardization of crude herbs in terms of quality and quantity and in method of production of kanpō remedies as key in justifying the efficacy of kanpō within the scientific paradigm. Consensus agreed that the most feasible way of achieving this would be through mechanization of the creation of kanpō extracts, which was time-intensive using traditional

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[55] Terasawa Katsutoshi, "Evidence-based Reconstruction of Kampo Medicine: Part I – Is Kampo CAM?" *Evidence-based Complementary and Alternative Medicine* 1, no. 1 (2004): 11-16.; Terasawa Katsutoshi, "'Ikai no tettsui' kara isseiki tate [One century after "Ikai no tettsui"], *Kanpō Medicine* 63, no. 2 (2012): 89-97.; Terasawa Katsutoshi, "Evidence-based Reconstruction of Kampo Medicine: Part II – The Concept of Shō," *Evidence-based Complementary and Alternative Medicine* 1, no. 2 (2004): 119-123.; Terasawa Katsutoshi, "Evidence-based Reconstruction of Kampo Medicine: Part III – How Should Kampo be Evaluated?" *Evidence-based Complementary and Alternative Medicine* 1, no. 3 (2004): 219-222.; Narikawa Ichirō, *Gendai kagaku to kanpō seizai – kanpō no shuchō* [Modern Science and Kanpō Formulation – Advocacy of Kanpō] (Tokyo: Ken'yūkan, 1991).; Tsumura Jusha, *Kanpō no hana hiraku: Korai no jisseki ni kagaku no hikari wo* [The Flower of Kanpō Opens: Time-honored Results Become the Light of Science] (Tokyo: Zenponsha, 1993).

methods of preparation. From a commercial perspective, there was also a profit motive, as mechanization would facilitate mass production. Kikutani Toyohiko and Akiba Tetsuo have produced general overviews of the history of the development of kanpō extracts; however, both are limited in that they do not fully explore prewar attempts at modernizing the extract process.[56] Tsumura Kenkyūjō, a research unit associated with Tsumura Juntendō, has looked at the company's efforts to create its own extraction process, including the company's early prewar efforts.[57] A glaring omission in virtually all studies of the kanpō extraction process is the failure to consider how development of the process impacted the intellectual development of kanpō itself. My dissertation addresses this issue by demonstrating how the development of the kanpō extraction process intensified the abandonment of classical practices, leading to a schism within the kanpō community between popular kanpō and the kanpō clinic.

Scholars in both Japan and the West have tended to focus their historical research on kanpō narrowly in terms of theme and scope. Issues of clinical practice have often been emphasized over considerations of kanpō's historical development. In comparison to other fields, very little research on the history of kanpō in the first half of the twentieth century exists, while postwar research confines itself primarily to kanpō's ongoing scientific rationalization. Kanpō exists as a very real and significant tradition within Japanese society. Given the dearth of scholarly studies

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[56] Kikutani Toyohiko, "Kanpō seizai no ishigakuteki kentō" [A Study of Extracted Kanpō Drugs from the Standpoint of the History of Medicine], *Nihon ishigaku zasshi* 50, no. 1 (2004): 10-12.; Akiba Tetsuo, "Iryōyō kanpō seizai no rekishi" [History of Kanpō Extracts for Medical Use], *Kampo Medicine* 61, no. 7 (2010): 881-888.
[57] Tsumura kenkyūjō, *Tsumura kenkyūjō hōkoku* [Tsumura Research Institute Report] (Tokyo: Tsumura kenkyūjō, 1931).

on the history of kanpō since the Meiji period, it is difficult for historians to come to a broad understanding of how Japanese health practices have evolved over the past century.

The histories of kanpō and traditional Chinese medicine (TCM) offer many points for comparison in the late nineteenth and twentieth centuries. Both traditions faced similar challenges from the introduction of Western medicine and responded with similar measures, albeit with somewhat dissimilar outcomes. Today, TCM flourishes with state sponsorship and a global reach. Despite its revival, kanpō remains largely confined to Japan, and, as I demonstrate in my dissertation, has increasingly been subsumed into biomedicine. The origins of these disparate outcomes may lie in the fact that when biomedicine proponents proposed the abolition of TCM in the 1920s, Chinese TCM doctors were able to draw on the historical experience of kanpō, which had faced a similar crisis 50 years earlier in the 1870s. Indeed, as the research of Mayanagi Makoto and Gao Yuqiu demonstrates, many of the early efforts of the kanpō revival movement supported TCM through Chinese translations of their arguments in favor of kanpō and the reintroduction of CCM texts preserved in Japan that had been forgotten in China.[58] Hao Xianzhong, Bridie Andrews, and Sean Hsiang-lin Lei have examined how Chinese scholars deployed favorable arguments advanced by Japanese kanpō revivalists, such as those found in Yumoto Kyūshin's *Kokan igaku*,

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[58] Mayanagi Makoto, "Japan and Traditional Medicine in Modern China: The Impact of Japanese Medical Texts in the Period of Republican China", paper presented at Interweaving Medical Traditions: Europe and Asia, 1600-2000. An International workshop funded by the Asia-Europe Foundation, the European Alliance for Asian Studies, the Wellcome Trust and the Wellcome Trust Centre for the History of Medicine at University College London (Wolfson College, Cambridge, September 11-13, 2003).; Mayanagi Makoto, "Lu Xun no essei 'Kokan igaku' nitsuite" [About Lu Xun's essay "Kokan Igaku"] *Nihon ishigaku zasshi* 49, no. 1 (2003): 40-41.; Gao Yuqiu and Mayanagi Makoto, "Ding Fubao yu zhongri chuantong yixue jiaolu" [Ding Fubao and Sino-Japanese Medical Exchanges of Traditional Medicine] *Zhonghua yishi zazhi* [Chinese Journal of Medical History] 22, no. 3 (1992): 175-180.

in the debate over the future of TCM, to refute its detractors.[59] However, beyond these studies, there has been little historical consideration of the connections between CCM/TCM and kanpō following the end of the Edo period.

Dissertation Overview

My dissertation is an intellectual history tracing the changing perceptions by practitioners of classical Japanese medicine (later known as kanpō) of their own discipline from the late Edo period through the first few decades of the post-Second Sino-Japanese War period. This project began with an initial question as to how, within the span of a century and a half, kanpō evolved from a system based on classical Chinese medical theories and practices into one heavily reliant on Western conceptions of disease and scientific practices, with ever fewer connections to "traditional" practice. My dissertation demonstrates that this shift occurred through a progressive series of reinventions of the "essence of kanpō" beginning in the Edo period. The reinterpretation/rationalization of the kanpō tradition over the course of the twentieth century by medical scholars and corporate interests undergirded the revival of its social relevance in Japan while simultaneously stripping/sanitizing its connections with authentic traditional medical

[59] Hao Xianzhong, "Minguoshiqi weiyaozhongyi cunfeiwenti de lunzhan" [Debate on the Abolishment and Preservation of Traditional Chinese Medicine during the Republican Period] *Zhonghua yishi zazhi* [Chinese Journal of Medical History] 37, no. 1 (2007): 10-14.; Sean Hsiang-lin Lei, *Neither Donkey Nor Horse: Medicine in the Struggle over China's Modernity* (Chicago: University of Chicago Press, 2014).; Bridie Andrews, *The Making of Modern Chinese Medicine, 1850-1960* (Honolulu: University of Hawaii Press, 2015).

practices. Though marketed as "traditional", contemporary kanpō is a thoroughly "modern" creation.[60]

Chapter One introduces how classical Chinese medicine (CCM), though initially a foreign import, assimilated into Japanese society over the centuries following its introduction.[61] With assimilation came the development of indigenous Japanese interpretations, adaptations, and innovations of CCM theory and practice. By the seventeenth century, medical practice in Japan had diverged far enough from CCM that it could no longer be conceived of as CCM being practiced in Japan, but was instead its own unique variant, which I refer to as classical Japanese medicine (CJM). During this period, intellectual inquiry flourished as multiple schools of medical philosophy competed for control of the CJM paradigm by promoting their own interpretations of disease causation. However, by the eighteenth century, this period of diversity waned as the empiricist Kohōha School of Japanese medicine gained ideological dominance. Concurrently, the

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[60] For more information on the concept of modernity and invented traditions in the Japanese context, see Stephen Vlastos, *Mirror of Modernity: Invented Traditions of Modern Japan* (Berkeley: University of California Press, 1998).; Harry Harootunian, *Overcome by Modernity: History, Culture and Community in Interwar Japan* (Princeton: Princeton University Press, 2000).; Bill Sewell, "Reconsidering the Modern in Japanese History: Modernity in the Service of the Prewar Japanese Empire" *Japan Review* 16 (2004): 213-258.; Sheldon Garon, "Rethinking Modernization and Modernity in Japanese History: A Focus on State-Society Relations" *Journal of Asian Studies* 53, no. 2 (May 1994): 346-366. For more information about the general concept of invented traditions, see Eric Hobsbawm and Terence Ranger, ed., *The Invention of Tradition* (Cambridge: Cambridge University Press, 1983).

[61] "Classical Chinese medicine" is used throughout this study rather than the more common phrasing "traditional Chinese medicine" for two reasons. First, it is necessary to distinguish between the medical practices of "classical" China and the "traditional" medicine of pre-Meiji period Japan, a system that, although based on classical Chinese medicine, existed distinctly and independently from it. To refer to both as "traditional" would foster confusion in the reader. Second, the term "classical Chinese medicine" has grown in popularity amongst scholars of "traditional" medicine in China to refer to Chinese medicine as practiced prior to the scientific rationalization of Chinese medicine that occurred in China during the early years of the People's Republic of China. By using the term, "classical" in the context of pre-Meiji Japan, I also seek to draw a distinction between the "classical" medicine of Japan, i.e. classical Japanese medicine, as it was practiced before the implementation of the rationalization process and the "traditional" medicine of the post-rationalization period, traditional Japanese medicine.

Ranpō School, composed initially of physicians who drew on both Japanese and Western medicine in their practice, emerged as a branch within Japanese medicine. However, by the mid-nineteenth century, as ranpō doctors grew in social and political influence and began to eschew Japanese medical practices in favor of those drawn exclusively from Western medicine, competition intensified between the two medical paradigms.

Chapter Two examines how former ranpō practitioners, now more properly identified as physicians of Western medicine, used their political influence within the Japanese government to delegitimize Japanese medicine, which they referred to as kanpō medicine. Following the Meiji Restoration of 1868, the new government embarked on an ambitious modernization campaign aimed at revamping Japanese society to meet the challenges posed by Western imperialism in Asia. Medical policymakers, most of whom were formerly ranpō physicians, advocated successfully for the implementation of a Western-style healthcare system adapted from the German model. By functionally codifying the Western biomedical paradigm into law, the new healthcare system's establishment in 1874 precipitated a crisis within the community of kanpō physicians. One of the key requirements of the new regime was that physicians must be licensed and that in order to obtain a license, one must pass a licensing exam testing knowledge of biomedical practice. No provision was made for the continued practice of kanpō medicine other than to allow current practitioners to continue to practice without passing the licensure exam. Kanpō was not explicitly outlawed, but the new laws meant that no future physicians could practice kanpō without first passing a biomedical licensing exam. Over the course of the 1870s, 1880s and 1890s, kanpō doctors attempted to resist these reforms through the formation of public pressure organizations aimed at convincing Japanese policymakers that kanpō was a distinct and equally efficacious

discipline alongside Western medicine. However, despite their efforts, they failed to gain significant political or public support for their cause. Concurrently, the number of kanpō practitioners in Japan plunged over the last three decades of the nineteenth century as biomedical reforms took their toll. By 1900, there were very few kanpō practitioners left in Japan as the last generation of Edo period kanpō doctors passed away.

Chapter Three addresses the efforts of a small group of Japanese physicians who, though trained in biomedicine, sought to promote the revival of kanpō medicine. These physicians had practical experience with both kanpō and Western medicine and recognized kanpō as a complementary source of medical knowledge capable of supplementing modern biomedical practice in Japan. Whereas kanpō physicians of the latter nineteenth century argued that kanpō was culturally distinct from and equal to Western biomedicine, kanpō revivalists of the 1910s and 1920s reconceived kanpō as syncretic, scientific, and modern. This reconceptualization gave kanpō intellectual space within the biomedical paradigm to justify its existence in terms that were recognizable and acceptable to the Japanese biomedical establishment. Popular and scholarly interest in kanpō began to rebound with the creation of specialist organizations and professional journals. As this new understanding of kanpō gained traction, by the 1920s some revivalists began to promote a more radical conception of the discipline, arguing that its syncretic nature would allow it to supersede biomedicine. By assimilating the strengths of biomedicine, kanpō would replace it. Exhibiting a strain of cultural exceptionalism that foreshadowed imperialistic drives of the 1930s, these revivalists argued that kanpō's supplanting of biomedicine was natural as it was a superior and culturally Japanese form of medicine.

Chapter Four details the intellectual and physical efforts of kanpō revivalists to situate kanpō within the context of Japanese imperial expansion. Building on earlier conceptions of kanpō's supposed syncretic and superior nature, revivalists argued that kanpō represented the highest achievement in medicine to date, perfected through the assimilation of the strengths of biomedicine and Japanese domestic improvements to classical medical practice. As a result, Japanese kanpō, rebranded as "oriental medicine", was promoted as superior to all forms of medicine currently existing in Asia. The exportation of kanpō to Japan's colonies would serve pacification efforts by promoting goodwill. To this end, revivalists promoted the study of traditional medicine through the establishment of specialist organizations, bilingual Chinese/Japanese publications, and scholarly exchanges relating to the study of classical East Asian medicine, in Japan, its colonies, and its areas of influence. Ultimately, by 1941, the exigencies of war took precedence forcing the abandonment or downscaling of these efforts as kanpō organizations were effectively disbanded through incorporation into the *Taiseiyokusankai* (Imperial Rule Assistance Association, 大政翼賛會) and many revivalists were selected for military service as a result of their medical expertise.

Chapter Five explores the postwar expansion of popular consumption of kanpō medicine and its lasting effects on kanpō practice. Following the conclusion of the Second Sino-Japanese War, surviving revivalists reestablished professional organizations and journals aimed at the promotion of kanpō, emphasizing clinical and historical research. While a conception of kanpō as syncretic, scientific, and modern, as well as Japanese, continued to be promoted, allusions to its purported superiority largely vanished from scholarship in the postwar period. At the same time, efforts to standardize and rationalize kanpō began to bear fruit as the development of the herbal

extract manufacturing process for kanpō medicine in 1954 facilitated the mass production of a range of standardized kanpō herbal medicines for commercial sale. Though kanpō-derived patent medicines had enjoyed limited popularity in the early twentieth century, it was the development of the herbal extraction process that allowed for kanpō medicines to repenetrate throughout Japanese society. In the decades following the Second Sino-Japanese War, popular use of kanpō medicine in Japan experienced a resurgence after decades of decline as the application of modern manufacturing and marketing techniques to its production led to its increasing commoditization. While earlier kanpō revivalists and patent medicine producers strived to portray kanpō as modern to appeal to consumers, postwar Japanese pharmaceutical companies intentionally invoked tradition in their marketing. Blending idealized notions and imagery of an imagined monolithic Japanese tradition suffused with reassurances that kanpō was safe and natural to assuage contemporary concerns, advertisers used emotional appeals to draw consumers. Yet, despite their "traditional" packaging, the mass-produced kanpō medicines of the postwar period were thoroughly modern creations. Representing the culmination of the standardization and rationalization efforts of twentieth century revivalists, these products, though based on classical kanpō recipes, were marketed to treat ailments conceived within the mainstream biomedical paradigm without concern for kanpō classifications. They were divorced entirely from their "traditional" prescription within the kanpō medical paradigm, which held that prescriptions must be tailored to the individual circumstances of the patient. Given the means of production and encouraged use, postwar mass-produced kanpō medicines functioned effectively as biomedicines cloaked in the trappings of kanpō. Despite this, mass-produced kanpō grew in popularity, resulting in an increasing commercialization and corporatization of the practice of kanpō medicine in Japan

that split the discipline into two distinct branches: a dominant one centered on the drugstore and a much lesser known one centered on classical practice in the kanpō clinic. As in the case of the *uirō*, what is popularly known as kanpō today is not the kanpō of yesterday.

Chapter One - The Formation of "Kanpō" Medicine

All notions of health and illness within a society are culturally-constructed ideas based on deeply rooted, civilization-specific traditions and beliefs that mold the way in which individuals perceive their world. Classical Chinese medicine (CCM), though initially a foreign import, assimilated into Japanese society over the centuries following its introduction. With assimilation came the development of indigenous Japanese interpretations, adaptations, and innovations of CCM theory and practice. By the seventeenth century, it would be inaccurate to refer to mainstream medical practice in Japan as CCM. It might more accurately be described as classical Japanese medicine (CJM). At its peak in the seventeenth though nineteenth centuries, classical Japanese medicine witnessed the development of multiple, competing schools of medical thought. Yet this pluralistic inquiry began to fade at the midpoint of this period as the Kohōha School gained ideological dominance, and with it, its empiricist philosophy of medicine. As empiricism eroded kanpō's ideological and pluralistic foundations, it lost its voice, as treatments became increasingly divorced from the medical theories upon which they were originally predicated. The influence of empiricism and kanpō's resultant ideological incoherence facilitated the rise of the Ranpō School in the early nineteenth century as Western disease theories, legitimated by empiricism, began to fill the ideological vacuum left by kanpō. By the mid-nineteenth century, the influence of Western medical theories allowed Japanese physicians of Western medicine to use their newfound influence to establish Western medicine as the dominant medical system in Japan.

Classical Chinese Medicine in Pre-Edo Period Japan

Following their introduction to Japan, classical Chinese medical theories increasingly supplanted indigenous Japanese medical traditions based in shamanism and animism as the

dominant foundation for medical practice in Japan prior to 1868. Classical Chinese medicine is a textually grounded, humoral medical tradition based on practices originating as far back as the Shang Dynasty (14th-11th Centuries BCE). However, the most influential text of the early CCM corpus is the Han period (206 BCE–220 CE) classical treatise *Huangdi neijing* (J. *Kōtei naikei*, E. *Inner Canon of the Yellow Emperor*, 皇帝内経). The *Huangdi neijing* established a humoral conception of disease based on balancing yin/yang, maintaining proper relationships between the five phases, (C. *wuxing*, J. *gogyō*, 五行) i.e. metal, wood, fire, water, and earth, within the body and maintaining a continuous flow of *qi* (J. *ki*, life force, 気) throughout the body. Over successive centuries, subsequent physician scholars further refined these foundational ideas to produce an extensive written corpus of medical theory.

Historians have been unable to agree on a specific date regarding the introduction of classical Chinese medicine into Japan by way of the Korean Peninsula; however, the most common estimates are that it entered Japan sometime between the 5th and 7th centuries CE. One version is that the practice was introduced during the reign of the Emperor Kōgen (孝元天皇, ca. 273BCE-ca. 158BCE) when an unnamed Chinese physician fleeing after the establishment of the Han Dynasty presented the Japanese emperor with an herbal elixir of immortality that could only be prepared by the "chaste and pure hands" of his entourage.[1] Another is that "medical envoys" from

[1] Willis Norton Whitney, *Notes on the History of Medical Progress in Japan*, Transactions of the Asiatic Society in Japan 12 (Yokohama: R. Meiklejohn & Co., 1885), 259.

Korea introduced the practice during the reign of Emperor Ingyō (允恭天皇, 376CE-453CE).[2] Still another is that Japanese scholars brought the practice to Japan after studying in China at the direction of the Empress Suiko (推古天皇, 554CE-628CE,) in 608CE.[3] Other scholars have attributed its introduction to Chung Chi, a Chinese doctor, who in 561CE-562CE is said to have "brought more than a hundred books on theoretical medicine" to Japan.[4]

While there is significant disagreement regarding the date of the initial introduction of classical Chinese medicine into Japan, evidence indicates that it likely entered piecemeal over the early centuries of the first millennium CE and was present in Japan in a significant form by the start of the 8th Century CE. Though it is unclear when the practice began, by the Nara (710CE-794CE) and Heian (794CE-1185CE) periods, the Japanese court regularly sent envoys to China to pay tribute to the Chinese emperor.[5] Upon their return to Japan, these emissaries frequently

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[2] Workshop on Alternative Medicine, *Alternative Medicine: Expanding Medical Horizons: A Report to the National Institutes of Health on Alternative Medical Systems and Practices in the United States* (Washington DC: U.S. Government Printing Office, 1995), 185.

[3] The Open Court, "The Introduction of Buddhism into Japan," *The Open Court: A Weekly Journal* 8 (1894): 4324, https://opensiuc.lib.siu.edu/cgi/viewcontent.cgi?article=4910&context=ocj (accessed November 11, 2020).

[4] Margaret Lock, *East Asian Medicine in Urban Japan: Varieties of Medical Experience*, Comparative Studies of Health Systems and Medical Care Number 4 (Berkeley: University of California Press, 1980), 27.; It is possible that the "Chung Chi" to which Lock refers in her work is actually Zhang Ji, also known as Zhang Zhongjing (張仲景, 150CE-219CE), the author of the *Shanghan Lun*, a CCM text which had immense influence on the development of CJM during the Edo period, as his name is transliterated in the Wade-Giles romanization system, which was the dominant system of transliteration of Chinese in the West at the time of her writing, as "Chang Chi". If Zhang Ji is the Chung Chi to whom she refers, it is unlikely that he played a role in introducing CCM to Japan.

[5] Throughout the imperial period up until the end of the Qing dynasty in 1912, foreign trade in China tended to be highly regulated and was often confined to border regions. Foreigners wishing to trade in the Chinese interior, particularly the capitol, could often only do this by way of a tributary mission to the imperial court. Diplomatic envoys were permitted to trade in the Chinese interior over the course of their journey to and from the Chinese imperial court. Therefore, imperial tributary missions were the most significant source of inter-civilizational trade in medical knowledge between China and Japan before the establishment of the Kamakura Shogunate in 1185, as traders acquired medical texts, amongst other items, in the course of their travels to and from the Chinese court, which they brought with them back to Japan.

brought back with them new forms of knowledge and technology from the continent. It was in this manner than many important innovations such as the Chinese writing script and Buddhism entered Japan. Classical Chinese medicine may have first entered Japan through a similar exchange. The presence of this new medical knowledge was evident in the creation of the *Tenyakuryō* (Bureau of Court Physicians, 典藥寮) in Japan in 702CE. The creation of *Tenyakuryō* was part of an overall administrative reorganization laid forth in the Taihō Code of 702CE, which codified the creation of a bureaucratic system of government in Japan based on that of Sui (581CE-618CE) and Tang Dynasty (618CE-907CE) China.[6] Modeled on the *Taiyishu* (Imperial Medical Bureau, 太醫署) of the Tang Dynasty, *Tenyakuryō* was tasked with overseeing the medical affairs of the imperial court, including treatment for members of the aristocracy, excluding the imperial family, and for the cultivation of medicinal herbs.[7] A second bureaucracy modeled on the Tang Dynasty's *Shangyaoju* (lit. esteemed pharmacy, typically translated in English as the Palace Medical Service, 尚藥局) known as the *Naiyakushi* (Inner Medicine Department, 内藥司) handled treatment of the imperial family.[8] These two organizations were eventually combined by the court in 896CE. The staff of the *Tenyakuryō* included general physicians, acupuncturists, anma (按摩) massage specialists, herbalists, doctors specializing in treating women and spiritual cleansers (*jugonhakase*, lit. expert in vanquishing spirits with charms, 呪禁博士).[9] This structure mirrors the staffing of

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[6] Nihon rekishisha, *Nihon rekishi* [Japanese History] (Tokyo: Nihon rekishisha, 1986), 22.
[7] Kyōtofu ishikai, *Kyōto no igakushi* [The Medical History of Kyoto] (Kyōto: Shibunkaku shuppan, 1980), 1246.
[8] Shinmura Taku, *Kodai iryō kanninsei no kenkyū: Tenyakuryō no kōzō* [Research on the Ancient System of Medical Officials: The Structure of the Tenyakuryō] (Tokyo: Hōsei daigaku shuppankyoku, 1983), 13.
[9] Sakai Shizu, *Nihon no iryōshi* [The History of Japanese Medical Treatment] (Tokyo: Tokyo shoseki, 1982), 95.

the *Taiyishu* during the Sui and subsequent Tang period and helps to demonstrate the extent of Chinese cultural influence on Japanese society at this time.[10]

Presented to the Heian Court in 984CE by physician Tanba Yasuyori (丹波康頼, 912CE-995CE), *Ishinpō* (醫心方) is Japan's oldest extant medical text. It is a 30-volume compilation of excerpts organized by subject from more than 200 Sui and Tang Dynasty Chinese medical texts, including the *Treatise on the Many Illnesses* (C. *Zhubing yuanhou lun*, J. *Shobyōgenkōron*, 諸病源候論), an influential medical encyclopedia compiled during the Sui Dynasty by Chao Yuanfang (巢元方, ca. 550CE-ca. 630CE).[11] It is likely that most of these texts entered Japan during this period as the result of an imperial tributary mission. *Ishinpō* contained a foundational, though not systematic, understanding of classical Chinese medicine. The number of actual Chinese medical texts and domestic interpretations of Chinese medical texts in Japan likely remained small in comparison to the vast CCM corpus extant in China by the time of *Ishinpō*'s publication. Consequently, the topical and methodological emphases contained in the work, would have reflected the perspectives of the authors whose texts happened to reach Japan. The result was that the Japanese body of medical knowledge derived from CCM was limited and fragmented from the outset. Additionally, the descendants of Tanba Yasuyori restricted access to the *Ishinpō* through

[10] Dolly Yang, "Prescribing 'Guiding and Pulling': The Institutionalization of Therapeutic Exercise in Sui China (581–618 CE)" (PhD diss. University College London, 2018), 205-209.
[11] Kosoto Hiroshi, *Kanpō no rekishi: Chūgoku – Nihon no dentōteki igaku* [The History of Kanpō: The Traditional Medicine of Japan and China] (Tokyo: Taishūkan shoten, 1999), 109.

the end of the Kamakura period, which hindered the dissemination of the information contained within to practitioners.[12]

During the 1100s and 1200s, increasing contacts between Buddhist religious orders in China and Japan facilitated an expansion of classical Chinese medical knowledge in Japan. Records indicate examples of Chinese monks bringing previously unknown prescriptions to Japan on their visits, as well as Japanese monks returning from study in China with new medical texts and practices, which were then spread to their orders.[13] As historian Andrew Goble demonstrated in his research on Kajiwara Shōzen (梶原性全, 1266-1337), a thirteenth century Japanese monk of the Shingon-Risshū (真言律宗) sect from the Gokurakuji Temple in Kamakura, a significant number of Song (960-1279) and Yuan Dynasty (1271-1368) medical works were available in Japan at the time.[14] The significance of this lies not only in the number of works, but, taken in historical context, their relatively recent creation within the preceding 300 years.[15] In contrast, *Ishinpō* drew heavily on texts, such as the *Huangdi neijing*, written almost a thousand years prior. Out of a determination to create a reference work for practicing Japanese physicians, Kajiwara compiled the 50-volume *Ton'ishō* (頓醫抄) in 1304 and the 62-volume *Man'anpō* (万安方) in

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[12] Andrew Edmund Goble, "Kajiwara Shōzen (1265-1337) and the Medical Silk Road: Chinese and Arabic Influences on Early Medieval Japanese Medicine," in *Tools of Culture: Japan's Cultural, Intellectual, Medical, and Technological Contacts in East Asia, 1000s-1500s*, ed. Andrew Edmund Goble, Kenneth R. Robinson, and Haruko Wakabayashi, Asia Past and Present: New Research from the AAS, no. 2 (Ann Arbor: Association of Asian Studies, 2009), 233.
[13] Andrew Edmund Goble, *Confluences of Medicine in Medieval Japan: Buddhist Healing, Chinese Knowledge, Islamic Formulas, and Wounds of War* (Honolulu: University of Hawaii Press, 2011), 7.
[14] Goble, *Confluences of Medicine in Medieval Japan*, 11-12.
[15] Goble, "Kajiwara Shōzen (1265-1337) and the Medical Silk Road," 233-234.

1327 drawing on his access to a number of Chinese medical works and his own experience.[16] Copies of these works circulated within the Buddhist community, disseminating knowledge of classical Chinese medicine to a larger audience than in the past. As a result, *Ton'ishō* and *Man'anpō* became the most circulated Japanese medical texts through the establishment of the Tokugawa Shogunate (1600–1868).[17]

The transmission of medical knowledge from continental East Asia slowed between the 14th and 16th centuries as a result of political fragmentation in both China and Japan. Though Japanese tributary missions to China continued during the Ming Dynasty (1368-1644), the disintegration of political power into competing provinces in Japan following the Ōnin War (1467-1477) hindered the spread within Japan of medical knowledge transmitted from China during this period. However, civil society again flourished following the re-imposition of limited central authority under the Tokugawa Shogunate during the Edo period (1600-1868). In the realm of medicine, the Tokugawa peace allowed for the reestablishment of regular trade and tributary missions with China and, consequently, the transmission of new medical knowledge. Moreover, the lack of warfare, expansion of civil society, and flourishing of print culture facilitated the diffusion of this knowledge more readily throughout Japan, as well as greater communication between Japanese physicians.[18] Japanese physicians began to discuss and critique CCM treatises

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[16] Goble, "Kajiwara Shōzen (1265-1337) and the Medical Silk Road," 232.
[17] Goble, "Kajiwara Shōzen (1265-1337) and the Medical Silk Road," 232.
[18] For more information on the expansion of civil society and print culture in Edo period Japan, see Mary Elizabeth Berry, *Japan in Print: Information and Nation in the Early Modern Period* (Berkeley: University of California Press, 2007).

as well as write their own. Diverse medical lineages began to form as a result of this intellectual exchange. While the practice of medicine in Japan was never at any point in its history solely a transplantation of CCM, up to the start of the Edo period, as evidenced by the sources for the *Ishinpō*, *Ton'ishō* and *Man'anpō*, many of its practices were derivative of CCM. However, this changed during the Edo period, as Japanese medicine shed this derivative status and coalesced into a unique medical tradition in its own right, which for the purposes of this study, will be referred to as classical Japanese medicine (CJM). Today, this tradition is more commonly known as kanpō medicine.

The Development of Classical Japanese Medicine in Edo Period Japan

Though indigenous Japanese medical practices, such as those stemming from animistic and shamanistic traditions, continued to be practiced in Japan during the Edo period, classical Japanese medicine based on the CCM medical paradigm had supplanted these alternative traditions to become the dominant medicine of the day. During this period, "care by physicians and commodified medical care became available for the first time in rural areas".[19] Competing interpretations (and reinterpretations) of the CCM-derived medical paradigm formed as Japanese physicians/scholars began to adapt and develop it based on their independent clinical experience. This, coupled with the tendency of Japanese physicians to entrust accumulated medical knowledge and techniques to a chosen successor while limiting outside access to these resources, culminated

[19] Susan L. Burns, "A Village Doctor and the Treatise on Cold Damage Disorders (Shanghan lun 傷寒論): Medical Theory/ Medical Practice in Late Tokugawa Japan," in *Antiquarianism, Language, and Medical Philology: From Early Modern to Modern Sino-Japanese Medical Discourses,* ed. Benjamin Elman, Sir Henry Wellcome Asian Series, volume 12 (Boston: Brill, 2015), 133.

in the formation of medical lineages. These medical lineages reinforced divisions between competing interpretations, resulting in the creation of clearly delineated schools of medical thought, which, in sum, comprised classical Japanese medicine.

It is this classical Japanese medicine of the Edo Period that would come to be labelled derisively as kanpō (Chinese method, 漢方) medicine by the early Meiji period (1868-1912). While today the term kanpō is often used to refer to the practice of CCM-derived medicine throughout Japanese history, the term itself does not appear to have come into widespread usage until the late Edo and Meiji periods.[20] By the end of the Edo period, it became widely used to emphasize the differences between the CJM and Western biomedical paradigms and implied the inferiority of the former through emphasis on CJM's historical connections to China, which was in a state of contemporary political disarray. However, this label belies the diversity of medical thought that flourished during the Edo period by implying the existence of a unified CJM tradition. Though multiple schools of medical thought contributed to the diversity of classical Japanese medicine, the three dominant interpretations of the period were the Goseiha School, Kohōha School, and Ranpō School.

The Goseiha School

The Goseiha School (Latter-Day School, 後世派, also known as Goseihō, Latter-Day Method, 後世方) founded by Tanki Sashiro (田代三喜, 1465-1537) and his student Manase

[20] Kokushi daijiten henshū iinkai hen, *Kokushi daijiten* [Comprehensive Japanese History Dictionary] (Tokyo: Yoshikawa kōbunkan, 1979), 931.

Dōsan (曲直瀬道三, 1507-1594), originated in Neo-Confucian reinterpretations of CCM taking place in Jin (金, 1115-1234) and Yuan Dynasty (元, 1271-1368) China that arrived in Japan during the late fifteenth and early sixteenth centuries.[21] Consequently, it is also known as the *Kingen* (C. *Jinyuan*, 金元) School. Goseiha took a textually-based approach to medical practice by focusing on the importance of understanding disease causation through familiarity not only with the foundational works of CCM, but also later dynastic treatises detailing the applications of foundational concepts to clinical practice.[22] At its most general, as with CCM, Goseiha adhered to *inyōgogyōsetsu* (yin-yang, five phases theory, 陰陽五行説) to explain disease causation. While precise diagnosis could be quite complicated, at its simplest *inyōgogyōsetsu* explains disease as a state resulting from the interrelation between yin and yang and the five phases inside the body and their relative balance/imbalance.[23] *Ki* (C. *Qi*, 気), or the body's vital energy, is considered in the same context.[24] Climatic or environmental influences may also be factored in as playing a role in the creation of these balances/imbalances.[25] Sanki spent several years studying in China, during which time he was influenced by the ideas of the Tonifying Earth and Nourishing Yin Schools that developed during the period of the Jin-Yuan medical reforms in China.[26] The Jin-Yuan medical reforms facilitated the development of four schools of CCM that dominated medical practice in

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[21] Yasui Hiromichi, "Nihon kanpō shogakuha no nagare," *Nihon tōyō igakukai zasshi* 58, no. 2 (2007): 180.
[22] Daniel Trambaiolo, "Native and Foreign in Tokugawa Medicine," *The Journal of Japanese Studies* 39, no. 2 (Summer 2013): 303.
[23] Yasui, "Nihon kanpō shogakuha no nagare," 180.
[24] Ng, *The I Ching in Tokugawa Thought and Culture*, 162.
[25] Fujikawa Yu, *Nihon igakushi kōyō* [An Outline of Japanese Medical History], ed. Ogawa, Teizō (1933; repr., Tokyo: Heibonsha Wide Edition Tōyō Bunko, 2003), 70.
[26] Kosoto, *Kanpō no rekishi*, 143.

China until the Qing Dynasty (清, 1644-1912): 1. School of Cooling (J. *kanryōha*, C. *hanliangpai*, 寒涼派), 2. School of Attack and Purgation (J. *kōjaha*, C. *gongxiepai*, 攻邪派), 3. Nourishing Yin School (J. *jiinha*, C. *ziyinpai*, 滋陰派), and 4. Tonifying Earth School (J. *hodoha*, C. *butupai*, 補土派).[27] The Nourishing Yin School and Tonifying Earth School both emphasized the use of herbal prescriptions to remediate (tonify) bodily deficiencies related to yin/yang, the five phases, Qi, and/or the climate/environment.[28] Accordingly, Goseiha was known for similar emphases.

Goseiha flourished in Japan during the seventeenth and eighteenth centuries. Manase Dōsan published the 8-volume *Keitekishū* (啓廸集) in 1574, a work propounding the medical philosophy explained above, which marked the establishment of the Goseiha School. The influence of the *Keitekishū* upon the creation of Goseiha was such that the School is sometimes also referred to as Dōsan's Medicine (*Dōsanryū ijutsu* or *Dōsanryū igaku*, 道三流醫術 or 道三流醫學 respectively).[29] Dōsan's son, Manase Gensaku (曲直瀬玄朔, 1549-1631) built on his father's work through the publication of a compilation of clinical case studies based on the Goseiha approach known as *Igakutenshōki* (Medical Records of the Tenshō Era (1573-1592), 醫學天正記). Goseiha's interest in herbal prescriptions led to its popularization of new herbal treatments, such as those found in the *Taiping Huimin Hejiju Fang* (J. *Taihei keimin wazai kyokuhō*, 太平恵

[27] Paul U. Unschuld, *Medicine in China: A History of Ideas* (University of California Press, 1985), 172-179.
[28] Unschuld, *Medicine in China*, 175-179.
[29] Yakazu Dōmei, "Manase Dōsan no igaku nitsuite" [About the Medicine of Manase Dōsan], *Nihon tōyō igaku zasshi* 42, no. 2 (1991): 190.

民和剤局方), a Song Dynasty herbal formulary compiled in 1110.[30] Of these new formulas, there are several that are still in use in kanpō today, including *Shikunshitō* (四君子湯) and *Shimotsutō* (四物湯), incidentally both of which are typically used to treat issues afflicting female patients.[31]

Heavily theoretical in outlook, the Goseiha School came under attack during the mid-eighteenth century by detractors who saw it as overly reliant on abstract explanations for illness. For example, Goseiha was known for its use of divination practices from the *Yi Jing* (Book of Changes, 易經) for the purposes of diagnosis in addition to *inyōgogyōsetsu*.[32] Its critics believed that Goseiha's emphasis on *inyōgogyōsetsu* and divination in explaining disease was impractical and disconnected from actual clinical treatment. This point will be discussed in more detail below. For these reasons, its primary competitor, the Kohōha School, opposed the teachings of the Goseiha School and greatly contributed to the latter's decline over the course of the Edo period. In fact, "Goseiha" is actually a pejorative term coined by Kohōha to denigrate the former by emphasizing that its teachings were "Latter-Day", i.e. corrupted by their removal from past practices, a revisionist perversion. The term also served to contrast with the Kohōha School's supposedly "ancient" roots, which will be discussed more below. As in the case of the term "kanpō", Goseiha, despite its pejorative origins, over time became the most recognizable name for

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[30] Yakazu Dōmei. *Kinsei kanpō igakushi: Manase Dōsan to sono gakutō* [Recent Kanpō Medical History: Manase Dosan and His Teachings] (Tokyo: Meicho shuppan, 1982): 22.
[31] Dōmei. *Kinsei kanpō igakushi*, 47, 57.
[32] Ng, *The I Ching in Tokugawa Thought and Culture*, 162.

the School. By the late eighteenth century, under pressure from Kohōha, Goseiha lost its position as the dominant medical lineage in Japan.

The Kohōha School

In contrast to the Goseiha School, the Kohōha School (Ancient Methods School, 古方派 or Ancient Methods Method, 古方方), founded by Nagoya Gen'i (名古屋玄醫, 1628-1696) and Gotō Konzan (後藤艮山, 1659-1733), rejected Neo-Confucian reinterpretations of the CCM medical classics and promoted textual analysis of the foundational medical works of the Han period (漢, 202BCE-9CE & 25CE-220CE) to uncover the original teachings of these texts.[33] Kohōha physicians argued that empirical, clinical observation would confirm the results of their textual research and the accuracy of these early works; however, as demonstrated below, Kohōha's adherence to the teachings of the early CCM classics was superficial and largely confined to the re-popularization of classical formularies. Consequently, Kohōha drew on only a small number of available CCM and/or CJM texts for ideological support while promoting clinical observation.[34]

The Kohōha School was most influenced by the Han period CCM medical treatise *Shanghan lun* (J. *Shōkanron*, E. *Treatise on Cold Damage Disorders*, 傷寒論) attributed to Zhang Zhongjing (張仲景, 150CE-219CE). Numerous Japanese commentaries on this text were published over the Edo Period. True to its name, the *Shanghan lun* is a medical text focused on the

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[33] Daniel Trambaiolo, "Writing, Authority and Practice in Tokugawa Medicine, 1650-1850," PhD diss., Princeton University, 2014. 19.

[34] Yasui, "Nihon kanpō shogakuha no nagare," 181. For a more detailed comparison of the Goseiha and Kohōha Schools, see Ng, *The I Ching in Tokugawa Thought and Culture*, 162.

identification and treatment of diseases attributed in CCM etiology to "exposure to cold, wind, and dampness".[35] The popularity of the *Shanghan lun* among adherents of the Kohōha School derives from the way in which they were able to utilize sections of the text as affirmations of their reductionist medical philosophy, while ignoring other sections that did not support this philosophy. An example of this is Nagoya Gen'i's explanation of the role of "cold" in causing disease, purportedly based on his study of the *Shanghan lun*. "Of the myriad diseases, there is none that does not come from wind, cold, and dampness. If one wants to be specific and distinguish between them, one can speak of these three elements, but in general terms there is just the single one, cold."[36] This is a questionable statement from the perspective of the basic tenets of CCM medical theory. According to the basic tenets of CCM medical theory and the text of the *Shanghan lun* itself, wind, cold, and dampness are distinct causes of disease; though they may at times be interrelated in the causation of disease, this is not always the case.[37] An example might be an ailment stemming from excessive dampness in a hot and humid locale.[38] Beyond addressing the basic vectors of wind, cold and dampness, the entire text of the *Shanghan lun* is structured around explaining how yin and yang interrelate with these vectors resulting in manifestations of illness. The text is organized into six stages to show how these diseases advance in accord with yin and

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[35] Burns, "A Village Doctor and the Treatise on Cold Damage Disorders (Shanghan lun 傷寒論): Medical Theory/ Medical Practice in Late Tokugawa Japan," 134.
[36] Nagoya Gen'i, "Ihōmonyo" [Questions on Medical Treatments], in *Kinsei kanpō igakusho shūsei* [A Collection of Early Modern Kanpō Medical Texts], vol. 102. ed. Ōtsuka Keisetsu et al. (Tokyo: Meichō shuppan, 1979): 5.
[37] Zhang Zhongjing & Liu Guohui, *Discussion of Cold Damage (Shanghan Lun): Commentaries and Clinical Applications* (London: Singing Dragon, 2016), 27-32.
[38] Ilza Veith, trans., *The Yellow Emperor's Classic of Internal Medicine* (University of California Press, 2002), 106.

yang: 1. *Tai yang* (J. *taiyō*, E. Greater yang, 太陽), 2. *Yang ming* (J. *yōmei*, E. Bright yang,陽明), 3. *Shao yang* (J. *shōyō*, E. Lesser yang, 少陽), 4. *Tai yin* (J. *taiyin*, E. Greater yin 太陰), 5. *Shao yin* (J. *shōin*, E. Lesser yin, 少陰), and 6. *Jue yin* (J. *ketsuin*, E. Faint yin, 厥陰).[39] Given the complexity of the disease etiology proposed in the *Shanghan lun*, Nagoya's assertion of a single origin for illness can be taken as an indication that he rejected CCM/CJM etiology based on *inyōgogyōsetsu*. It is also an example of the overall disregard with which Kohōha School physicians held abstract explanations for disease.

Yoshimasu Tōdō (吉益東洞, 1702-1773), another key figure in the Kohōha School, echoed Nagoya's single origin understanding of disease etiology and moved the Kohōha School further from classical medical theory by asserting that all disease comes from a single poison. In his work titled *Idan* (Medical Decisions, 醫断), Tōdō declared, "all disease comes from one poison. All medicines are poison and poison is used to attack poison. When the poison leaves, the body recovers."[40] This theory came to be known as *manbyō ichidokusetsu* (Many Diseases, One Poison Theory, 万病一毒説). Tōdō espoused Nagoya's disregard for classical etiology, stating that it was only important for physicians to be familiar with the *Shanghan lun* and the *Jingui yaolue* (J. *Kinkiyōryaku*, E. *Essential Prescriptions from the Golden Coffer*, 金匱要略) in practice.[41]

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[39] Zhang & Liu, *Discussion of Cold Damage (Shanghan lun)*, 27.
[40] Yoshimasu Tōdō, *Idan* [Medical Decisions] (Kyoto: Hakubundō, 1759). 30-31, https://archive.wul.waseda.ac.jp/kosho/ya09/ya09_00418/ (accessed November 11, 2020).
[41] The *Jingui yaolue* is a companion medical text to the *Shanghan lun* that is also believed to have been written by Zhang Zhongjing. It is believed that they were originally written as a single text and later divided into two works. Sakai Shizu, *Nihon no iryōshi* [A History of Japanese Medical Treatment] (Tokyo: Tokyo shoseki, 1982), 243.

Consider the following statement by Tōdō from his work *Kosho Igen* (Medical Expressions from Ancient Books, 古書醫言).

> We should not talk about human affairs in accordance with the theory of yin-yo go-gyo [*inyōgogyō*]. But now, such talk has become fashionable, and the true way of medicine went out of use.[42]

Tōdō's rejection of *inyōgogyō* was made more explicit in the *Idan*.

> We can see the theory of yin-yo go-gyo [*inyōgogyō*]…. However, those are merely the words of the theoretical formulations. If adopted to our pharmaceutics, it would bring about wrong results. This is why we do not take it.[43]

In *Yakucho* (Characteristics of Medicine, 藥徵), Tōdō rejected the need to explain the origin of disease in its entirety.

> It is nonsense to discuss disease origin because it is a product of speculation…. We rely only on what we have seen.[44]

Tōdō's statements demonstrated an unequivocal rejection of not only *inyōgogyōsetsu*, the most significant foundational concept for explaining disease in both CCM and CJM to this point, but consideration of disease causation in general. In its place, Tōdō promoted the association of classical formulas with groupings of symptoms, which is the origin of *shohō* (Symptom-Formula, 証方), the method by which illnesses are identified in contemporary kanpō.[45] As noted by historian

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[42] Yoshimasu Tōdō, *Kosho igen*, cited in Tateno, "Yoshimasu Tōdō's Philosophy of Medicine: In Comparison with That of Ancient China," 46.
[43] Yoshimasu Tōdō, *Idan* [Medical Decisions], cited in Tateno, "Yoshimasu Tōdō's Philosophy of Medicine: In Comparison with That of Ancient China," 46.
[44] Yoshimasu Tōdō, *Yakucho* [Characteristics of Medicine] (Kyoto: Shibundō, 1785), 3-4, https://archive.wul.waseda.ac.jp/kosho/ya09/ya09_01073/ (accessed November 11, 2020).
[45] Terasawa Katsutoshi, "Evidence-based Reconstruction of Kampo Medicine: Part II—The Concept of Sho," *Evidenced-based Complementary and Alternative Medicine*, 1, no. 2 (2002): 122.

Terasawa Katsutoshi, *shohō* represents "a dual concept expressing both diagnosis and indication for Kampo prescriptions".[46] For example, if a patient suffers from a disease that is treated by penicillin, the patient would be diagnosed as penicillin-*sho*. Given the emphasis on prescription, it is unsurprising that for Tōdō, the *Shanghan lun* and *Jingui yaolue* were useful to physicians only in so far as they contained prescriptions that could guide treatment.[47] To this end, Tōdō published a number of works, including *Ruijuhō* (1764, 類聚方), *Hōkyoku* (方極, 1764), and *Yakuchō* (藥徵, 1785) containing formulas derived from *Shanghan lun* and *Jingui yaolue*, which he reorganized based on symptom clusters.[48] This reflected Tōdō's rejection of the basic explanatory framework of CCM, preferring to match formulas to manifested symptoms without regard to the classical etiological explanation of these symptoms.[49] Consequently, the primary utility that Tōdō and other Kohōha physicians found in the *Shanghan lun* and *Jingui yaolue* were in their prescription recipes.[50] Tōdō's approach to medicine foreshadowed the approach of kanpō doctors in the early twentieth century who sought to standardize treatment without regard to any underlying theory of treatment. It also directly contradicted the CCM imperative that each patient was unique, and treatment must therefore be adjusted accordingly.

> The Yellow Emperor asked: When the physicians treat diseases, do they treat each disease differently from the others and can they all be healed? Ch'i Po

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[46] Terasawa, "Evidence-based Reconstruction of Kampo Medicine: Part II—The Concept of Sho," 122.
[47] Unsurprisingly, as a result of this focus, Kohōha became well known for the production of formularies.
[48] Daidoji Keiko, "The Adaptation of the Treatise on Cold Damage in Eighteenth-century Japan: Text, Society, and Readers," *Asian Med (Leiden)*. 8, no. 2 (2013): 367.
[49] Tateno, *Yoshimasu Tōdō "Kosho Igen" no kenkyu: Sono shoshi to igaku shiso* [Research on Yoshimasu Tōdō's "Kosho Igen": Bibliography and Medical Ideology], 5-7.
[50] Daniel Trambaiolo, "Native and Foreign in Tokugawa Medicine" in *The Journal of Japanese Studies* 39, no. 2 (2013): 308.

> answered: "Yes, they can all be healed according to the physical features of the place where one lives….
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> The ancient sages combined these various treatments for the purpose of cure, and each patient received the treatment that was most fitting for him. These treatments were so extraordinary and so different in each case that all diseases were healed. Thus, the circumstances and needs of each disease were ascertained and the principle of the art of healing became known.[51]

Therefore, Tōdō's conception of associating symptom clusters with prescriptions irreconcilably contradicted the *Huangdi neijing* in this regard. As one of the oldest and most respected CCM texts, it might initially be surprising that a physician of the Kohōha School, which viewed its methods as a return to the original truth of the CCM classics, would adopt a position in fundamental conflict with the text such as this, but, as indicated above, Kohōha's embrace of the CCM classics was superficial at best.

The Ranpō School

The mid-sixteenth century saw the gradual introduction of a limited number of Western medical practices into Japan by Jesuit missionaries traveling on primarily Portuguese ships from the country's newly established colonies and trading posts in Southeast Asia. Though it enjoyed a brief period of success during the waning years of the Sengoku (approx. 1467-1573) and Azuchi-Momoyama (approx. 1573-1603) periods, this modest influx of Western knowledge slowed with the implementation of the *sakoku* (seclusion, 鎖国) policy of the new Tokugawa Shogunate (1603-1868), which effectively limited all international trade to Tsushima Island (Korea), the Ryūkyū island chain (China), and the port of Nagasaki (Dutch & China). All Western ships were officially

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[51] Veith, trans., *The Yellow Emperor's Classic of Internal Medicine*, 148.

banned from making port in Japan except for those of the Dutch, whom the Shogunate allowed to maintain a small trading post on the island of Dejima in Nagasaki harbor. Between the early seventeenth century and the mid-nineteenth century, the Dutch physicians posted at this small outpost, along with the medical tracts and experience that they brought with them, constituted the near totality of Japanese exposure to Western medical knowledge until the late Edo period.[52] Despite this, Western medical practices exhibited a limited, but ever-growing influence over the practice of medicine in Japan during the Edo period.

Over the two and a half centuries of Tokugawa rule, a small number of Japanese doctors went to study Western techniques, primarily surgery, with the Dutch surgeons posted in Nagasaki. These doctors constituted the first direct and stable source of Western medical knowledge in Japan. Western surgical techniques attracted interest because surgery was a medical discipline that was not well-developed within the CCM/CJM traditions. In other words, it filled a gap in knowledge and was therefore adopted by some CJM practitioners. Other branches of Western medicine initially attracted little attention as they were considered inferior to the well-developed herbal treatments of CJM practice. As a result, medicine practiced by physicians who utilized both CJM and Western treatments became known as ranpō (Dutch method, 蘭方), medicine during the Edo

[52] Jesuit missionaries had been responsible for the initial introduction of Western medicine; however, they were banned from entering Japan with the implementation of the *sakoku* policy due to the perceived threat of their proselytization efforts to political and social stability. The Dutch were allowed to continue trading directly with Japan on a limited basis because they were perceived as traders lacking a religious motive for their presence. Though the importation of Western books was officially banned once in 1630, a large trade continued in medical books and basic Western medical compounds like borax, gum, alum in the years after. Andrews, *The Making of Modern Chinese Medicine, 1850-1960*, 70.

period.[53] Prior to the Edo period, Western medicine was known as *nanban igaku* (medicine of the southern barbarians, 南蛮医学). During the Edo period, ranpō was also sometimes referred to as *oranda igaku* (Dutch medicine, オランダ医学) or *kōmōryū igaku* (red-haired medicine, 紅毛流医学). Though initially small, the number of Japanese doctors who began to study Western medical techniques, hereafter known as ranpō doctors, grew consistently over succeeding centuries as a result of the transmission of their knowledge through medical lineages. In these medical lineages, as with the kanpō lineages discussed earlier, the founding doctor would pass on his secret medical techniques to a trusted successor. If the successor was not a blood relative, frequently that person would change his surname and be adopted into the doctor's family.[54] These lineages were instrumental in the transmission of medical knowledge for both kanpō and ranpō practitioners.

While interest in and knowledge of Western medical techniques among Japanese doctors greatly expanded during the Edo period, the absolute number of physicians that incorporated Western-derived medical techniques into their practice remained low in comparison to those who exclusively practiced CJM. Non-ranpō CJM was publicly patronized by the Tokugawa Shogunate and remained the dominant medical paradigm in Japan until the late nineteenth century.[55] Indeed,

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[53] Kokushi daijiten henshū iinkai hen, *Kokushi daijiten* [Comprehensive Japanese History Dictionary] (Tokyo: Yoshikawa kōbunkan, 1979), 934.
[54] Trambaiolo, "Writing, Authority and Practice in Tokugawa Medicine, 1650-1850," 12.
[55] In 1839, in an incident known as the *Bansha no Goku*, the Tokugawa Shogunate attempted to suppress Western studies by Japanese scholars as a result its fear of the increasing influx of Western ideas into the country. Western medicine was initially exempted from the ban on Western knowledge; however, between 1849 and 1858 all ranpō practices except for ophthalmology and surgery were officially banned. By this time though, the government was not sufficiently strong to enforce this edict and it was rescinded a couple years later. However, a few ranpō scholars were prosecuted under this act and some were even executed. Ellen Gardner Nakamura, *Practical Pursuits: Takano Chōei, Takahashi Keisaku, and Western Medicine in Nineteenth-Century Japan*, Harvard East Asian Monographs 255, (Cambridge, Massachusetts: Harvard University Press, 2005), 53.

the Ranpō School cannot and should not be considered an independent medical paradigm in opposition to CJM during the Edo period. A more accurate way of depicting ranpō in this period would be to conceive of it as a CJM medical lineage that increasingly utilized Western medical techniques and ideas over time. The Ranpō School, while similar to the Kohōha School in its regard for experience over theory, nevertheless existed essentially as a hybrid school. In general, ranpō doctors recognized "that Western methods were more advanced in surgery and pathology, while Chinese techniques were superior in internal medicine and anesthesia."[56] For much of the period, ranpō physicians increasingly integrated Western techniques into CJM medical theory by conceiving of them in CJM terms; however, the late Edo period saw the gradual conversion of ranpō from a primarily CJM-based school of thought to one embracing the fundamentals of Western biomedicine.

The Ascendance of Western Medicine in Japan

Kohōha's rejection of CCM/CJM etiological theories led to an ideological incoherence amongst the CJM Schools which proponents of the Ranpō School and Western medicine came to exploit over the late eighteenth and nineteenth centuries. In 1775, Sugita Genpaku of the Ranpō School provided the following assessment of CJM.

> Chinese medicine has methods, but it has no principles. Of course, it has its so-called principles, but the foundation for what are called principles is not clear. Theories were created and principles expounded catering to whatever people preferred, and these have been called principles of treatment. This is why ten books espouse ten different theories and there is yet to be any agreement.[57]

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[56] Ng, *The I Ching in Tokugawa Thought and Culture*, 166.
[57] Sugita Genpaku, "Kyōi no gen" [Words of a Crazy Doctor], in *Nihon shisō taikei 64: Yōgaku* [Compendium of Japanese Thought 64: Western Learning], ed. Numata Jirō, 227-243 (Tokyo: Iwanami Shoten, 1976), 243.

Over the eighteenth and nineteenth centuries, this lack of ideological unity permitted the increasing introduction of ideas derived from Western medicine through the Ranpō School into Japan. It also resulted in the Ranpō School drifting away from the other schools of CJM over time in terms of practice and ideology. This process was further facilitated by Kohōha's promotion of empiricism within the CJM paradigm, a philosophy that undergirded Western medicine and helped to support its acceptance in Japan.

Historians recognize three important historical events during the Edo period that increased the acceptance of Western medical techniques within the Japanese medical community and eventually established Western medical practice as a distinct discipline in Japan: the translation of Johann Adam Kulmus' anatomical text *Ontleedkundige Tafelen* into Japanese in the eighteenth century, the introduction of the Jennerian smallpox vaccine in the nineteenth century, and the experiential scientific medical training offered to ranpō doctors in Nagasaki by Dutch physicians such as Philipp Franz von Siebold and Johannes Pompe van Meerdervoort in the 1820s and 1850s respectively. As these sets of historical circumstances softened resistance to Western medical ideas and techniques, they also served to hasten the paradigm shift of the Ranpō School away from CJM to Western biomedicine. By the early Meiji period (1868-1912), the Ranpō School's connections with CJM ceased to be a recognizable as it largely became synonymous with Western biomedicine.

Anatomical Conceptions

In 1771, Sugita Genpaku (杉田玄白, 1733-1817), Maeno Ryōtaku (前野良沢, 1723-1803), and Nakagawa Jun'an (中川淳庵, 1739-1786), all students of ranpō medicine, were granted

permission by the Tokugawa authorities to observe a dissection of a criminal's body.[58] Autopsies were extremely rare in Japan before the late nineteenth century. In Confucian terms, the act was viewed as a desecration of the body provided to the individual by their parents. According to the *Xiaojing* (J. *Kōkyō*, *Classic of Filial Piety*, 孝經), the foundational Confucian text on the subject, "Since we receive our body, skin, and hair from our parents, we do not dare let it be injured in any way. This is the beginning of filial piety."[59] In other words, autopsies were seen as unfilial, a grave crime in the Confucian context. Moreover, up to this point CCM medical theories implicitly rejected a structural conception of the internal organs of the human body, instead viewing them as variable and dependent on individual morality and health factors, a perspective adopted by the Goseiha School.[60] To this end, CCM works on anatomy tended to focus on function over form. Consequently, structural anatomy remained an underdeveloped field of medicine within CCM for much of its history. What was most unique about the 1771 dissection was that Sugita and his colleagues are said to have observed it while consulting Johann Adam Kulmus' *Ontleedkundige Tafelen* (*Anatomical Tables*), as well as an unidentified Chinese anatomical chart believed to have

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[58] A dissection observed by Kohōha physician Tōyō Yamawaki conducted in Japan in 1754 required a special dispensation from Shogun Tokugawa Ieshige before it could proceed. Takeo Nagayo, *The History of Japanese Medicine in the Edo Era: Its Social and Cultural Backgrounds*, (Nagoya: University of Nagoya Press, 1991), 58.
[59] Patricia Ebrey Buckley, "The Classic of Filial Piety" in *Chinese Civilization: A Sourcebook* (New York: Free Press, 1993), 64.
[60] Trambaiolo, "Ancient Texts and New Medical Ideas in Eighteenth-Century Japan," 91. Though possibly apocryphal, it has been said that some Japanese CJM scholars attempted to explain the differences between the Western and Chinese anatomical drawings and the cadaver examined at Sugita's autopsy as a matter of morality; specifically, that the positioning of an individual's internal organs depended on the moral composition of that individual. The argument went that the Chinese chart depicted the internal structure of a morally upright individual while the cadaver was that of a criminal. True or not, the story does reflect the CCM/CJM concern with organ function over position, in contrast with the Western mechanistic understanding of anatomy.

been dated to the third century CE.[61] Upon comparison of these two texts, the ranpō doctors found the Chinese chart to be anatomically inaccurate while Kulmus' work paralleled their visual observations. Inspired by their discovery, the three men determined to translate Kulmus' book into Japanese, publishing it in 1774 as *Kaitai shinsho* (New Text on Anatomy, 解体新書).

Kaitai shinsho's emphasis on empirical observation directly challenged Goseiha's CCM-derived speculative approach to anatomy, while supporting Kohōha's emphasis on practical medicine. In the years leading up to the publication of *Kaitai shinsho*, Kohōha had been widely critical of Goseiha's emphasis on theory over experience. While the anatomical inaccuracies of the aforementioned Chinese chart are understandable given the Confucian restriction on conducting autopsies and the consequent underdevelopment of internal anatomy as a discipline within CCM/CJM, Kohōha used the chart's inaccuracies as evidence of the failure of Goseiha.[62] In the end, the publication of *Kaitai shinsho* served to undermine Goseiha in Japan and simultaneously bolstered the credibility of Western medical practices and empiricism in general to Japanese physicians.[63]

The Smallpox "Vaccine"

The dissemination and success of the Jennerian smallpox vaccine in Japan served to heighten the influence of ranpō practitioners within the Japanese medical community and increase acceptance of the efficacy of Western medicine. At the time, smallpox was an endemic disease

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[61] John E. Van Sant, "Rangaku Medicine and 'Foreign' Knowledge in Late Tokugawa Japan," *Southeast Review of Asian Studies* 34 (2012): 208-209.
[62] Trambaiolo, "Ancient Texts and New Medical Ideas in Eighteenth-Century Japan," 91.
[63] Nakamura, *Practical Pursuits,* 10.

with a high rate of mortality throughout much of the world. During the last decade of the 1700's, Edward Jenner, an English physician, discovered that a person who contracted cowpox gained immunity from the related, but more deadly disease of smallpox. By transferring pus from the wound of a person infected with cowpox into an open wound on another person, Jenner created an effective smallpox vaccine. Once the second person developed pustules, pus from their wounds could be used to infect, and thereby vaccinate, others. In other words, Jenner's solution to the problem of smallpox was to engineer the spread of cowpox. The Western colonial powers quickly reproduced his "vaccine" and sent batches of it to their colonies around the world. After hearing about the treatment from Dutch representatives in Nagasaki, several ranpō doctors requested it from the Dutch colonial government in Batavia (present-day Jakarta). After several unsuccessful tries over the course of the first few decades of the 1800's, due to the difficulties in preserving and transporting the virus to Japan and the lack of institutional and governmental support for the effort in Japan, a live sample of the cowpox virus finally made it to Japan in August 1849.[64] Using a method of arm-to-arm transmission, wherein infected fluid from the pustule of an individual infected with cowpox was injected into the arm of a non-infected individual, ranpō doctors were able to spread the vaccine throughout the countryside over the course of several months.

Historian Ann Jannetta has characterized ranpō doctors in this period as having been part of an informal network based on lineage ties and a dedication to Western studies that allowed them

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[64] Ann Jannetta, *The Vaccinators: Smallpox, Medical Knowledge, and the "Opening" of Japan* (Stanford: Stanford University Press, 2007), 5.

to function as a proto-medical community in the modern sense.[65] She argues that "the process of importing this new technology, exceedingly slow and fraught with difficulties, created a new social and intellectual elite in the first half of the nineteenth century" comprised of Ranpō doctors and other Western-oriented *rangaku* (Dutch studies, 蘭学) scholars.[66]

The actual process of importing the smallpox vaccine and distributing it around Japan was important to the formation of the proto-medical community to which Jannetta refers; however, it merely served to strengthen existing relationships. Medical discourse between the physicians of different lineages existed long before the smallpox vaccination effort, as evidenced by the very existence of CJM schools like Goseiha and Kohōha. An example of this discourse was the wide-ranging debate between the schools over the importance of the *Shanghan lun* to medical practice.[67] Another example would be the circulation and publication of formularies by Kohōha physicians, which served to facilitate the standardization of medical treatment by its practitioners to a certain extent. It would not have been possible for ranpō physicians to have succeeded in procuring and disseminating the smallpox vaccine without the prior existence of these very relationships and networks. From this perspective, the success of the smallpox vaccine is evidence of the strength and breadth of the existing medical lineages.

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[65] Historian Ellen Gardner Nakamura also emphasizes the interconnectedness of late Edo period ranpō doctors in her work, *Practical Pursuits: Takano Chōei, Takahashi Keisaku, and Western Medicine in Nineteenth-Century Japan*.
[66] Jannetta, *The Vaccinators*, 181.
[67] Burns, "A Village Doctor and the Treatise on Cold Damage Disorders (Shanghan lun 傷寒論): Medical Theory/ Medical Practice in Late Tokugawa Japan," 145.

Still, it is important to recognize that a significant number of kanpō physicians opposed the vaccination effort, particularly those associated with the Kohōha School. In line with Yoshimasu Tōdō's single poison etiology, many doctors viewed the expression of smallpox symptoms as necessary in order to expel the poison causing the disease. Vaccination, it was believed, resulted in this poison remaining in the body to possibly cause a later relapse.[68] From this perspective, symptoms were a necessary part of the smallpox treatment, so management, not removal, of these symptoms was considered to be the best course of treatment.[69]

The success of the smallpox vaccine demonstrated the efficacy of Western medicine to the Japanese medical community and led to the emergence of ranpō specialists as an influential segment of society. Prior to the introduction of the smallpox vaccine in Japan, smallpox existed as an endemic disease that regularly claimed the lives of a significant percentage of adults and children. Records indicate that in the eighteenth century, in Hida Province, outbreaks of smallpox occurred every three to four years, resulting in up to 20% of the child population succumbing to the disease in each outbreak.[70] Even after the introduction of the vaccine, smallpox continued to be a significant source of mortality for several decades due to the difficulties in maintaining live virus samples for injection and systematically tracking vaccinations. There were additional issues with ensuring that the injected virus was of sufficient strength and quantity to grant immunity. Despite these quality control issues, the smallpox vaccine reduced the incidence of the disease, a

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[68] Daniel Trambaiolo, "Vaccination and the Politics of Medical Knowledge in Nineteenth-Century Japan," Bulletin of the History of Medicine 88 (2014): 435.
[69] Trambaiolo, "Vaccination and the Politics of Medical Knowledge in Nineteenth-Century Japan," 436.
[70] Jannetta, *The Vaccinators*, 19.

feat that would make a significant impression upon a populace resigned to the sacrifice of such a large percentage of the population to smallpox.[71] It was simple for ranpō doctors to contrast this qualified success with the "failure" of CJM to end the threat of smallpox over the past centuries.

Perhaps the most influential endorsement of the smallpox vaccine emanated from the Chrysanthemum Throne, albeit unintentionally. The Emperor Kōmei (孝明天皇, 1831-1867), known for his anti-Western stance, remained unvaccinated. In January 1867, Emperor Kōmei contracted smallpox and died the same month. His heir and successor, Emperor Meiji (明治天皇, 1852-1912), had been vaccinated, never contracted smallpox and lived until 1912. Given that this occurred during a time of open factional conflict over relations with the West, the symbolism could not have been more apparent.[72] The influence of the Ranpō School increased significantly as a result.

The Availability of Experiential Training in Western Medicine

Concurrent with the effort to obtain and distribute the smallpox vaccine in Japan was the growing ability of ranpō physicians to access in-person, experiential training with Dutch physicians stationed at the trading enclave of Dejima. Interpersonal exchanges between the Dutch traders and the Japanese were severely limited by the Tokugawa Shogunate. Except in exceptional circumstances requiring permission from the local authorities, the Dutch traders were forbidden from crossing to the mainland from Dejima, while Japanese, outside of the workers supporting the

[71] Jannetta, *The Vaccinators*, 179.
[72] Van Sant, "Rangaku Medicine and 'Foreign' Knowledge in Late Tokugawa Japan," 214.

Dutch presence on the island, were forbidden from traveling to Dejima. However, this contact expanded, particularly during the eighteenth and early nineteenth centuries as a result of the growing interest in Western medical techniques, fluency of Ranpō physicians in the Dutch language, increasing imports of Western medical texts (perceived to be of Dutch origin initially), and, most importantly, the willingness of the Dutch physicians posted to Dejima to engage with their Japanese counterparts.[73]

Philipp Franz von Siebold (1796-1866), though in actuality German, served as a physician for the Dutch trade enclave on Dejima in Nagasaki Harbor from 1823 until he was expelled by order of the Tokugawa Shogunate in late 1829.[74] During his tenure at Dejima, he was allowed to set up a small school to train Japanese doctors in Western medical practices. The establishment of Siebold's school, *Narutaki-juku* (鳴滝塾), denotes a turning point in the history of the Ranpō School. By providing a central location for the formal study of Western medicine, Siebold provided his students (no more than fifty in number) with applied clinical training in Western medical techniques.[75] Before this period, virtually all knowledge of Western medicine had come from translations of books imported through the Dutch trade mission in Nagasaki. Now, students of Western medicine could learn directly from a Western physician and practice under his tutelage. Moreover, Siebold's training introduced emergent new scientific methods of medical practice

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[73] Nakamura, *Practical Pursuits*, 32.
[74] In 1828, during a trip to Edo, Siebold purchased several Japanese maps from a vendor. After returning to Nagasaki, he stored these maps on a ship in Nagasaki Harbor in preparation for a return voyage to Europe. However, before he left, a storm beached the ship and his maps were discovered by shogunal authorities. Unbeknownst to him, it was illegal to try to take Japanese maps out of the country. He was accused of spying and was ultimately exiled from the country in 1829. These events are today referred to by historians as the "Siebold Incident".
[75] Richard Rubinger, *Private Academies of the Tokugawa Period* (Princeton: Princeton University Press, 2014), 116.

largely unavailable to earlier ranpō physicians relying on translations of by-then outdated medical texts. Siebold's clinical demonstrations made the possibility of a Ranpō School based entirely on Western medical practices for the first time a practical possibility.[76]

Following Siebold's exile from Japan, *Narutaki-juku* was closed by order of the Tokugawa Government. Siebold's attempt to obtain and exit Japan with maps deemed critical to Japanese national security provoked a strong reaction from the Tokugawa Shogunate.[77] The intervening forty years between Siebold's return to Europe and the Meiji Restoration witnessed successive, yet unsuccessful, attempts by the Shogunate to control and restrain the influx of Western knowledge, not only in the realm of medicine, but in a variety of disciplines. Ranpō might have been forced to return to its reliance on translations in studying Western medicine were it not for the appointment of Johannes Pompe van Meerdervoort (1829-1908) to the post of physician at Dejima in 1857. During his tenure, Pompe resumed the training of Japanese physicians and expanded on the curriculum offered by Siebold, attempting to give a comprehensive overview of the practice of Western medicine to his students. He also convinced the domain government in Nagasaki to fund a Western-style hospital, *Nagasaki Yōjōsho* (長崎養生所), complete with an adjacent medical school, in 1861.[78]

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[76] Masayoshi Sugimoto and David L. Swain, *Science and Culture in Traditional Japan, A.D. 600-1854*, The M.I.T. East Asian Science Series (Cambridge, Massachusetts: The MIT Press, 1978), 387.
[77] See footnote above regarding the "Siebold Incident."
[78] Miyanaga Takashi, *Ponpe: Nihon kindai igaku no chichi* [Pompe: The Father of Japan's Modern Medicine] (Tokyo: Chikuma shobō, 1985), 152.

Siebold and Pompe van Meerdervoort trained a small, but soon to be elite cadre of ranpō doctors. Among their students were several figures who would play important roles in facilitating Japan's transition to a medical system based on Western biomedicine in the Meiji period. To name a few, Matsumoto Ryōjun (松本良順, 1832-1907, an influential military doctor of the Meiji period), Satō Shōchū (佐藤尚中, 1827-1882, future founder of Juntendō University, a prominent medical school), and Nagayo Sensai (長与専斎, 1838-1902, future architect of Japan's modern public health system) all spent time in Nagasaki studying with either Siebold or Pompe van Meerdervoort.[79]

Shogunal Resistance to Ranpō

Concerned by the growing influence of Western ideas and practices over CJM, in 1791 the Tokugawa Shogunate created an institution known as the *Igakukan* or alternatively, the *Igakkan* (医学館) to serve as its official medical school in an attempt to create a CJM medical orthodoxy. Previously known as the *Seijukan* (躋寿館), this institution was originally a private medical school run by the Goseiha-affiliated Taki (多紀) family medical lineage. With the school's elevation to official status, the Taki family gained immense influence over the direction of mainstream CJM in Japan. The school's hereditary director (the head of the Taki family) was given the sole power to recommend doctors for employment by the Shogunate.[80] Furthermore, doctors appointed by the

[79] William Johnston, *The Modern Epidemic: A History of Tuberculosis in Japan*, Harvard East Asian Monographs 162 (Cambridge: Harvard University Press, 1995), 167.
[80] Sugimoto and Swain, *Science and Culture in Traditional Japan*, 302.

Shogunate were expected, if not required, to send their successors to study at the Igakukan.[81] In 1849, the Igakukan was given control over the printing of all medical books.[82] By these means, the Tokugawa Shogunate hoped to buttress CJM's preeminent position in Japan.

The Tokugawa Shogunate did not want to suppress all Western learning, it merely wanted to control its introduction into Japanese society. Mindful of the social problems that accompanied the introduction of Christianity into Japan in the sixteenth and early seventeenth centuries, the Shogunate feared the potential repercussions of an unmediated influx of Western knowledge. From this perspective, the Western medical techniques relied upon by ranpō physicians were perceived as subversive, with the potential to impact many other areas of Japanese life, such as social organization or filial piety. Through institutions such as the *Igakkan* and the *Bansho Shirabesho* (Institute for the Study of Barbarian Books, 蕃書調所), the Shogunate hoped to investigate and introduce Western learning that it found appropriate to Japanese society at a slow and controlled pace.

Despite its best efforts, belated Shogunal attempts to regulate medical practice in Japan failed. By the time of the establishment of the *Igakkan* in 1791, Goseiha was already in decline as a result of relentless doctrinal attack from Kohōha. By raising the position of the Goseiha-affiliated Taki family, the Shogunate alienated both Kohōha and Ranpō adherents. Moreover, the establishment of the *Igakkan* as the official medical school of the Shogunate with its emphasis exclusively on CJM doctrinal-focused medicine put it in a position of authority ostensibly

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[81] Sugimoto and Swain, *Science and Culture in Traditional Japan*, 302.
[82] Sugimoto and Swain, *Science and Culture in Traditional Japan*, 347.

representing all CJM practitioners. As the country edged toward the Meiji Restoration, within the realm of medicine, the existence of the *Igakkan* allowed for the impression of a unified tradition of CJM standing in opposition to ranpō/Western medicine to be promoted by its enemies. Ranpō doctors, increasingly alienated from the Shogunate due to the latter's suspicion of foreign studies, were consequently largely supportive of efforts to overthrow the Shogunate. To this end, they framed their efforts as a conflict between the Shogunate and CJM practitioners on one side and the revolutionaries and ranpō practitioners on the other. For ranpō practitioners, CJM became a failed tradition holding Japan back. At this point, around the time of the Meiji Restoration, the Ranpō School effectively completed its transition to Western medicine as its adherents openly rejected CJM practices in favor of Western ones.

With the fall of the Tokugawa Shogunate in 1868, CJM practitioners lost all official support. Dominant within the newly ascendant Meiji government were numerous ranpō practitioners who quickly set about erecting a national healthcare system based on a Western model. Abandoning the last vestiges of CJM influence upon the ranpō tradition, these physicians facilitated the importation and implementation of Western medical theories and practices, from germ theory to public health policies. As part of this agenda, medical reformers sought to delegitimize CJM medical practice in Japan by labeling the CJM "tradition" in Japan, with all of its diverse lineages, as simply "kanpō medicine". Kanpō was popularized by the new medical establishment as an ideological counterpoint to Western biomedicine. Meiji medical reformers viewed kanpō as an undesirable backward tradition, while Western biomedicine (formerly ranpō) epitomized modernity and signaled Japan's level of civilizational enlightenment to the Western powers.

Conclusion

Approximately fifteen centuries in the making, it was only with the intensifying clash between Shogunal authorities and ranpō practitioners in the nineteenth century that the formation of kanpō medicine came to fruition. Belied within its name is the centuries-long process of transformation by which CCM melded into the unique variant of CJM, as well as the diversity of medical thought that existed within CJM during the Edo period. Though today generally perceived as a single, unified system of medicine, this kanpō is a fiction of the late Edo period, a caricature that became reality over the decades following the Meiji Restoration.

Chapter Two - From Kanpō to Ranpō: Shifting Medical Paradigms in Meiji Japan

Following the Meiji Restoration of 1868, Japan's new governing elites implemented Western-style reforms throughout the government, economy and society aimed at modernization. In the realm of medicine, policymakers, many of whom were formerly ranpō physicians, took action to erect a healthcare system along the model of the soon-to-be unified German Empire. Following the creation of Japan's modern medical system in 1874, classical Japanese medicine, now known as kanpō medicine, lost legal recognition, as all doctors came to be required to be licensed in Western medicine to practice. In the place of kanpō, legislation effectively codified the Western biomedical paradigm as the guiding ethos for medical practice in Japan. Beginning in 1879, kanpō doctors started to organize in order to resist these medical reforms and preserve the status of kanpō in Japanese society. Through their activities, they sought to distance kanpō from its associations with China at a time of heightened tensions and nationalism while convincing Japanese policymakers that kanpō was a distinct and equally efficacious discipline alongside biomedicine. Ultimately, due to growing public hostility toward China with the advent of the First Sino-Japanese War (1894-1895) and the entrenched scientific bias of the Japanese ruling establishment, these practitioners failed to obtain legal recognition of kanpō as a legitimate medical practice from the government. By 1900, kanpō appeared to be on the verge of irrelevancy as the number of practitioners fell drastically as the last generation of Edo period kanpō doctors passed away.

The Iwakura Mission and the German Medical System

In 1868, the Tokugawa Shogunate was overthrown primarily for its perceived weakness stemming from its capitulation to Western demands for trade concessions and extraterritoriality agreements. The leaders of the new Meiji government that had fought a civil war on slogans emphasizing confrontation with the West quickly put into motion plans to strengthen Japan against Western imperialism by importing Western ideas and technology. While the new government's abrupt shift from an anti-Western to pro-Western stance may seem ironic, it was based on a realpolitik analysis of Japan's position vis-à-vis the Western powers. Cognizant of the contemporary political situation in China, where the Western powers were in the process of dividing China into spheres of influence, the Meiji leaders made the decision that in order to resist colonization, Japan must become militarily, economically, and politically strong through the importation of Western technology. To this end, in the Charter Oath, also known as the Oath in Five Articles, which laid out the aims of the new government in April 1868 on the occasion of the Emperor Meiji's enthronement, the government declared that "Evil customs of the past will be discontinued, and new customs will be based on the just laws of nature." and "Knowledge will be sought throughout the world in order to promote the welfare of the empire."[1] Perhaps it is a testament to the inclusion of numerous ranpō doctors within the ranks of the anti-Shogunate forces that by February 1868, two months before the issuance of the Charter Oath and only one month after the formation of the Meiji government, the government had already submitted a petition to

[1] Daijōkan, "Gokajō no goseimon" [Oath in Five Articles], *Daijōkan nisshi: Keiō year 4 dai 1-2 kan* [Journal of the Grand Council of State: Keio Year 4 Volumes 1-2] (Edo: Daijōkan, 1868) 39.

the Emperor Meiji calling for the adoption of Western medicine in Japan, which was approved on March 8, 1868.[2] The decision to close the Igakkan, the official kanpō school of the Tokugawa Shogunate, occurred shortly thereafter also in March 1868.[3]

To accomplish the adoption of Western medicine, the Meiji government invited Western experts to advise and train Japanese medical personnel. Though some of these advisors hailed from America or the British Empire, a large proportion were German in origin. This did not happen by chance. The government was far from unanimous at this point on the issue of emulating German medicine, but after some shrewd politicking, Sagara Tomoyasu (相良知安, 1836-1906) and Iwasa Jun (岩佐純, 1836-1912), both pro-German doctors who had studied Western medicine with Dutch physicians in Nagasaki prior to the Meiji Restoration, were assigned the duty of determining from which countries Japan should request medical experts.[4] Over the next four years, a succession of German doctors, including Benjamin Mueller and Theodor Hoffman in August 1871, Albrecht Wernich in 1874, and Erwin Baelz in 1876, travelled to Japan as government advisors.

Not content to rely solely on importing Western expertise, the Meiji government decided to go abroad personally to gather information about the West. The Iwakura Mission (1871-1873)

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[2] The title of the memorial is *Seiyō ijutsu saiyouhō kenpaku* (Petition for the Adoption of Western Medicine, 西洋医術採用方建白). Kōseishō, *Isei hyakunenshi: Shiryōhen* [A Hundred Year History of the Medical System: Document Collection] (Tokyo: Gyōsei, 1976), 665.

[3] Oshima Tomoo, "The Japanese-German System of Medical Education in the Meiji and Taisho Eras (1868-1926)," in *The History of Medical Education: Proceedings of the 6th International Symposium on the Comparative History of Medicine - East and West*, ed. Teizo Ogawa (Tokyo: Saikon, 1983), 214.

[4] Johnston, *The Modern Epidemic*, 168.

was a diplomatic mission led by Prince Iwakura Tomomi (岩倉具視, 1825-1883) in which several of the founding members of the new government spent two years traveling around the world studying Western technology, government, economics, and culture with the intention of taking the knowledge obtained during their travels and using it to modernize Japan. Nagayo Sensai (長与専斎, 1838-1902) was tasked by the newly created *Monbushō* (Ministry of Education, 文部省) to study Western medical education during the Iwakura Mission.

Prior to the Meiji Restoration, Nagayo had been a ranpō doctor. Several of his direct ancestors were kanpō practitioners; however, both his grandfather and father had become interested in ranpō in the course of their duties as hereditary physicians for the *daimyō* (ruler, 大名) of Ōmura domain. With the death of his father at an early age, Nagayo became the family heir, and at the behest of his grandfather, began to train in ranpō medicine.[5] In 1858, Nagayo was sent by his grandfather to study Dutch language at *rangaku* (Dutch studies, 蘭学) scholar Ogata Koan's (緒方洪庵, 1810-1863) *Tekijuku* (適塾) school in Osaka, since knowledge of the Dutch language was then a prerequisite to studying medicine with the Dutch physicians of Dejima.[6] In 1859, Ogata convinced Nagayo to go to Nagasaki to study medicine with Dutch physician Johannes Pompe van Meerdervoort.[7] During the 1860's, Nagayo continued to work in Nagasaki, first as a student of

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[5] Ann Bowman Jannetta, "From Physician to Bureaucrat: The Case of Nagayo Sensai," in *New Directions in the Study of Meiji Japan*, ed. Helen Hardacre with Adam L. Kern (Boston: Brill, 1997), 153.

[6] Many future Meiji luminaries attended this school during the 1840s and 1850s, such as Fukuzawa Yukichi (福澤諭吉, 1835-1901), the founder of Keio University, and Sano Tsunetami (佐野常民, 1823-1902), the founder of the Japan Red Cross.

[7] Nagayo Sensai, "Shōkō shishi," (1902), in *Tekijuku to Nagayo Sensai: Eiseigaku to Shōkō Shishi*. by Tadayasu Ban, (Osaka: Sōgensha, 1987), 110.

ranpō medicine and later as an independent doctor at *Yōjōsho* (養生所, also known *Seitokukan*, 精得館), a hospital of Western medicine established in 1857 by Matsumoto Jun (松本順, 1832-1907), personal physician to the last Tokugawa shogun Tokugawa Yoshinobu (徳川慶喜, 1837-1913) and future architect of the Imperial Japanese Army medical corps.[8] It was also during this time that he became acquainted with Kido Kōin (木戸こういん, also known as Kido Takayoshi, 木戸孝允, 1833-1877) and Itō Hirobumi (伊藤博文, 1841-1909), both future Meiji leaders.[9] As a result of these relationships, he was well positioned to become a leader in the budding Meiji medical establishment.

During the course of the Iwakura Mission, Nagayo obtained a more nuanced understanding of the philosophy, terminology, and priorities of Western medicine as practiced in the 1870s. In his 1902 memoir *Shōkō shishi* (Shōkō's Private Aspiration, 松香私志), Nagayo wrote that he learned the meaning of the English words "health" and sanitary" while traveling with the Iwakura Mission through the United States and Great Britain.[10] However, Nagayo said that it was not until he reached Germany that he came to understand many of their implications. There, he encountered another new word, "*Gesundheitspflege*" (health care), which, although by his own admission he did not initially understand this word, would have great implications for the future of Japanese

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[8] Jannetta, "From Physician to Bureaucrat," 154. The establishment of *Yōjōsho* by the Tokugawa Shogunate represented a belated attempt to bring the study of Western medicine in Nagasaki under direct government control.
[9] Nagayo Sensai, "Shōkō shishi," (1902), in *Tekijuku to Nagayo Sensai: Eiseigaku to Shōkō Shishi*. by Tadayasu Ban, (Osaka: Sōgensha, 1987), 133-134.
[10] Nagayo used Shōkō as his pen name. Nagayo, "Shōkō shishi," 145.

medicine as the foundational concept around which he would construct the new Japanese medical system.[11]

In order to fully understand how Nagayo's encounter with German medicine influenced his creation of the Japanese medical system, it is important to consider the state of German medicine in the 1870s. During the nineteenth century, medicine in Germany had undergone nothing short of a revolution in terms of medical practice, education, and research methodology. Increasingly state-centered, in a world full of decentralized medical systems, by the 1870s, German medicine was in many ways unique in comparison to that of other Western nations. With an emphasis on epidemic control by means of state-led initiatives facilitating refuse removal, water sanitation, and the rapid reporting of disease outbreaks, Germany's state-centered approach provided a stark contrast to the uncoordinated and often abortive attempts of other Western nations to control disease.

In terms of education, while most Western nations still relied on an apprenticeship system for the training of new doctors, by the 1870s, virtually all doctors in Germany were trained through a state-mandated, standardized university curriculum. This had the effect of raising the general quality of practitioners in Germany and helped to control "quackery."[12] A secondary effect of Germany's standardized medical curriculum was that its students were continually exposed to the latest medical discoveries, as well as laboratory methodology. In German universities of the mid-

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[11] Nagayo, "Shōkō shishi," 145-146.
[12] Dorothy Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (New York: Routledge, 1999), 105.

to-late nineteenth century, students were routinely trained in a laboratory setting utilizing scientific instruments, such as microscopes, a practice that developed far more slowly in other Western medical schools of the period.[13] This had the effect of training an entire generation of German physicians to think of medicine as both a scientific and professional discipline, departing from prior conceptions of it as primarily a vocational trade.[14] The application of scientific methods and apparatuses to the study of medicine led to the development of rigorous standards for evaluating the efficacy of medical treatment, as well as the growth of new sub-disciplines such as bacteriology, leading to wide recognition of the achievements of German medicine by the 1870s. With the growing acceptance of germ theory in the latter nineteenth century, bacteriology became one of the premier fields of study for Western doctors.

While the relative merits of scientific laboratory research vis-à-vis more empirical experience-based approaches were still being hotly debated in the Western medical community during this period, it was generally recognized that a German medical student's exposure to the latest medical theories and research provided better preparation as a clinician than, say an apprentice physician in rural America. Many of the medical advances of the late nineteenth and early twentieth centuries occurred as a direct result of the popularization of laboratory-based theoretical approaches to research, yet in the 1870s there was still significant resistance within the Western medical community to an approach that many doctors found frivolous and extraneous to

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[13] Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945* (Oxford: Oxford University Press, 1995), 234.
[14] Bonner, *Becoming a Physician*, 232.

the actual practice of medicine. The apparent successes of the laboratory approach, particularly in the realm of bacteriology, gradually wore down the resistance of its detractors; however, anti-laboratory sentiment remained noticeable among a small minority of physicians, particularly in America and Britain, into the early twentieth century.[15] Despite this, German medical education was increasingly recognized, though often grudgingly, by non-German Western doctors as superior to that found in their own countries. According to one contemporary American observer, "A third-rate poverty stricken German university turns out more [scientific teaching and research] each year than our fine and wealthy foundations elaborate in ten."[16] Over the late nineteenth and early twentieth centuries, students came from around the world to train as doctors in German universities. [17] Emphasizing a balanced approach to medical study through standardized scientifically based university training for doctors utilized in conjunction with practical clinical training, nothing short of a medical revolution occurred in Germany.

However, German medicine had not always occupied this prestigious position at the pinnacle of the Western medical world. In fact, the scientific medical system was a recent development as systematic reform efforts had only begun in earnest in the early nineteenth century. At that time, concerns over quackery, lack of professionalization, epidemic control, and drug adulteration led an increasing number of German physicians to call for greater government

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[15] Bonner, *Becoming a Physician*, 284.
[16] This quote is attributed to Thomas Henry Huxley. Gerald B. Webb and Desmond Powell, *Henry Sewall, Physiologist and Physician* (Baltimore: Johns Hopkins University Press, 1946), 47, quoted in Bonner, *Becoming a Physician*, 232.
[17] This is less surprising given the fact that there were more medical schools in Germany during this period than anywhere else in the world. Even as early as the 1830s, there existed 24 university medical schools and 30 practical schools of medicine in German Europe. Bonner, *Becoming a Physician*, 160.

regulation of medicine. Drawing on the ideas of German hygienist Johann Peter Franck (1745-1821) found in his treatise *System Einer Vollständigen Medicinischen Polizey* (A Complete System of Medical Policy), a number of German states responded with the creation of bureaucracies staffed by non-specialists aimed at asserting state control over these issues.[18] While Franck's work spans nine volumes and touches on a wide array of topics, at its simplest, Franck advocates for the state, as the sole entity with the authority and power to do so, to take on the role of developing and implementing nationwide medical policies through the enforcement of regulations and laws by administrative bureaucracies.

Supporters of the Social Medicine movement, particularly Prussian physician Rudolf Virchow (1821-1902), popularized Franck's ideas and applied political pressure to secure their implementation. Virchow's name looms large within the history of medicine due to the number of substantive contributions he is credited with making to medical research, such as his work on cell division theory and discovery of how cancer cells replicate. He is credited as the founder of the entire field of cellular pathology. With this professional success came public recognition in the form of invitations to join academic societies, such as the Royal Swedish Academy of Sciences (1861) and the Prussian Academy of Sciences (1873), and eventually awards, such as the Copley Medal he received from the British Royal Society in 1892 for his work on pathology. Most importantly, success brought public visibility and influence, which Virchow turned into political power, serving in both the Prussian House of Representatives (1862) and later the Reichstag of the

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[18] Porter, *Health, Civilization and the State*, 105.

German Empire (1880). Virchow used his professional and political success as a platform to advocate for a wide range of reforms; however, his promotion of Social Medicine is the most relevant to the current study. As propounded by Virchow, Social Medicine emphasizes the importance of social and economic inequality in determining health. Virchow recognized that poverty, contaminated water and food supplies, and cramped dwellings, as well as ignorance and lack of medical care, virtually ensured the spread of epidemic disease. While it was beyond the means of individual physicians to remedy such far ranging and systemic problems, like Franck, Virchow realized that there was one entity with the power and ability to alleviate the aforementioned social ills. According to Virchow, it was the "moral duty of the state to guarantee the equal right of all to a healthful existence."[19] Virchow famously argued that "Medicine is a social science, and politics nothing but medicine at a larger scale", implying that it was a literal duty of the state.[20] Moreover, in addition to this imperative, maintaining the health of its population also served the economic and military interests of the state in that "good food, clean dwellings, a healthy environment, and proper medical care" were necessary to keep the poor at work, fit for military service and to stop them from being a burden on national coffers in the form of poor houses and sanitariums.[21] To this end, Virchow and his supporters successfully advocated for state

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[19] Rudolf Virchow, "Die offentliche Gesundheitspflege" (1848) in *Gesammelte Abhandlungen zur offentlichen Medicin und der Seuchenlehre* (Berlin: 1879): 14-30, quoted in Johanna Bleker, "To Benefit the Poor and Advance Medical Science: Hospitals and Hospital Care in Germany, 1820-1870," in *Medicine and Modernity: Public Health and Medical Care in Nineteenth and Twentieth Century Germany*, ed. Manfred Berg and Geoffrey Cocks, German Historical Institute Series, (Cambridge: Cambridge University Press, 1997), 26.
[20] Rufolf Virchow, "Der Armenarzt" Medicinische Reform (1848): 125-127, quoted in JP Mackenbach, "Politics is nothing but medicine at a larger scale: reflections on public health's biggest idea", *Journal of Epidemiology & Community Health* 63, (2009): 181.
[21] Bleker, "To Benefit the Poor and Advance Medical Science," 27.

construction of modern water filtration and sewer systems, and trash removal services throughout the German states, as well as a professionalized bureaucracy staffed by medical specialists to oversee the administration of state policies related to the health of the populace.[22]

While Franck's work effectively laid the intellectual foundations of the administrative component of the modern notion of public health, the efforts of Social Medicine advocates like Virchow brought it into practice. By the eve of German unification in 1871, most states had in place sophisticated health bureaucracies empowered to enact/regulate quarantines, epidemic control, sale of drugs, medical malpractice ("quackery"), medical education standards, forensic medicine, and implement disease reporting systems.[23] The synergy created by combined German advances in medical education, research and public health measures resulted in the creation of likely the world's most centralized, effective and intrusive health system of the latter nineteenth century.

During his stay in Germany with the Iwakura Mission, Nagayo Sensai was greatly impressed by the achievements of German medicine. He showed particular interest in German ideas concerning the role of the state in maintaining the health and welfare of its subjects, i.e. public health.[24] Nagayo took it upon himself to translate "*Gesundheitspflege*", which he appears to have understood more narrowly as "public health" than its literal English translations as "health care", into Japanese in order to make its meaning more transparent to his fellow countrymen. He

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[22] Porter, *Health, Civilization and the State*, 107.
[23] Porter, *Health, Civilization and the State*, 107.
[24] Nagayo, "Shōkō shishi," 148-149.

chose the word *eisei* (C. *weisheng*, E. to defend or protect life, 衛生) from the Chinese Warring States period (475–221 BCE) Daoist text, *Zhuangzi* (莊子), to represent these seemingly revolutionary ideas, as he felt that existing terms such as *kenkō* (health, 健康) and *hoken* (health preservation, 保険) did not fully convey the implications of *Gesundheitspflege*.[25] Although the modern public health associations of *eisei* were not extant in the term as presented in *Zhuangzi*, Nagayo felt that the character 衛, with its implications of defense or protection, understood in conjunction with 生, meaning life, more fully encompassed the active role taken by the state in ensuring public health as expressed within the *Gesundheitspflege* concept. Today, *eisei* has multiple meanings, including sanitation, public health, and hygiene.

In 1873, during the course of the Iwakura Mission, the Meiji leadership appointed Nagayo to helm the newly established *Imukyoku* (Medical Affairs Department, 医務局) of the *Monbushō* (Ministry of Education, 文部省) with a mandate to draft plans for a modern Japanese medical system based on information gained from Western models during the course of the Iwakura Mission.[26] Despite its location within the Ministry of Education, the *Imukyoku* served as the primary bureaucratic authority governing medical affairs in Japan in the early Meiji years.[27] Reflecting this broad authority, the *Imukyoku* was renamed the *Eiseikyoku* (Sanitation Department,

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[25] Nagayo, "Shōkō shishi,"156.
[26] Nagayo, "Shōkō shishi,"151-153.
[27] Kōseishō, *Isei hyakunenshi* [A Hundred Year History of the Medical System], Henshu Koseishō Imukyoku (Tokyo: Gyosei, 1976), 671.

衛生局) and reorganized into the *Naimushō* (Ministry of Home Affairs, 内務省) on June 28, 1876 with Nagayo continuing to serve as department chief until 1891. With his new position and directive to craft a new Japanese medical system, Nagayo took heed of what he had learned in Germany and returned home, inspired to create a German-style medical system for Japan.

There are several reasons why the Japanese government was interested in modeling its medical system on Germany. First, as has been previously noted, many in the Western world recognized the German medical system for its effectiveness. A recurring theme in virtually all studies of Japanese modernization during the early Meiji period is the high level of concern that Japanese leaders had for Western opinion and expertise. In other words, because many Western leaders believed that German medicine was the best, the Meiji leadership favored it as a model in order to increase their national prestige.

Second, Meiji leaders were also somewhat predisposed to favor a German medical model as a result of the fact that much of ranpō had been drawn from German language sources. Though virtually all the books imported into Nagasaki through the Dutch trade mission were written in the Dutch language, at least until the late Edo period, many were actually originally published in German. *Ontleedkundige Tafelen*, which guided Sugita Genpaku's famed autopsy, had a German author. Additionally, though he served in the Dutch trade mission, Philipp Franz von Siebold, who helped train many of the top doctors of the Meiji generation, was also a German physician. The pervasive presence of German medical ideas in Japan in the form of translations, as well as the actual presence of a few German doctors, no doubt helped to encourage Japan to embrace German medicine during the Meiji period.

Third, modern German notions of public health and sanitation ultimately served the interests of Japanese national security and afforded great power to the state. Even a cursory examination of early Meiji political history reveals that Japanese leaders intended to create a highly centralized national polity with power concentrated in the hands of a relatively small number of individuals. Though it has been argued that sanitation levels in Japan before the introduction of Western public health methods were actually superior to those in the West after the advent of public health, the German state-centered model of medicine emphasizing identification, control, and prevention of disease through bureaucratic regulation and enforcement for the first time gave the Japanese government a powerful tool with which to check the spread of epidemic disease.[28] One must remember that disease epidemics were rampant in early Meiji Japan as increased mobility stemming from the end of Edo period travel restrictions, the expansion of foreign trade, and military mobilizations facilitated the spread of many diseases.[29] In the words of Nagayo Sensai, Japan needed a "comprehensive administrative department dedicated to removing dangers to life and ensuring the welfare of the nation …. [to combat] prevalent diseases and epidemics".[30]

Finally, Japan hoped to emulate Germany's swift rise to prominence. At the time, both nations were newly unified and looking to improve their global stature. By adopting a German-

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[28] Historian Susan Hanley, among others, has noted that certain Japanese cultural practices such as frequent bathing and the use of human night soil as fertilizer during the Edo period helped to limit the spread of epidemic disease. Bathing, as well as the systematic removal of human waste from cities, was not widespread in the West until at least the late nineteenth century. Susan Hanley, *Everyday Things in Premodern Japan: The Hidden Legacy of Material Culture* (Berkeley: University of California Press, 1997), 178-181.

[29] For example, serious cholera epidemics (10000+ deaths each) occurred in 1858-1860, 1862, 1877-1879, 1882, 1886, 1890, and 1895. William Johnston, "Cholera and the Environment in Nineteenth-Century Japan," *Cross-Currents: East Asian History and Culture Review* 30 (2019): 12-13.

[30] Nagayo, "Shōkō shishi,"155.

style medical system, Japan partially hoped to recreate its success. Germany ultimately served as a model for Japanese modernization in many other areas outside the realm of medicine. For example, the Prussian Army served as an organizational model for the then newly organized Imperial Japanese Army.

Upon his return to Japan following the Iwakura Mission, Nagayo drafted a plan for a state-centered medical system based on the German model. Under his plan, implemented with the *Isei* (Medical System, 医制) Act of August 18, 1874, a German-style bureaucracy was codified, centralizing state control over public health. The Act formalized the *Imukyoku's* role and broadened its authority to enact public health regulations in areas such as sanitation, epidemic control, and smallpox vaccination registration and enforce said regulations in cooperation with the *Keihokyoku* (Police Affairs Department, 警保局) of the *Naimusho*.[31] It also provided for the renaming of the *Imukyoku* as the *Eiseikyoku* and its transfer to the *Naimusho* to reflect its heightened status. The Act further provided for the invitation of Western specialists to staff newly-created medical schools that emphasized a Western scientific approach to medicine as a means of increasing the numbers of Japanese doctors training in Western medicine.[32] All medical students were required to learn German in order to complete their studies. The Act also created a medical licensing system that required physicians and pharmacists to have a medical license to practice. In order to receive a license, they were required to pass a test demonstrating initially their training in

[31] Koseishō, *Koseishō gojūnenshi* (Tokyo: Seisaku hanbai chuo hoki shuppan kabushiki kaisha, 1988), 58-62.
[32] Mikio Toyama, *Iryō fukushi no so Nagayo Sensai* (Kyoto: Shibunkaku shuppan, 2002), 86-87.

both Western and kanpō medicine, but within a few years recognition of kanpō was phased out and recognition was extended solely to Western training.[33] However, kanpō doctors who had started practicing medicine before 1875 were exempt from the need to be certified in Western medicine.[34]

Like the German medical system, the new Meiji system was highly centralized with (for the time) a heavy reliance on bureaucracy and police enforcement. For example, in order to further reduce the spread of smallpox in Japan, the government implemented a national vaccination system in which a person would be given a certificate to keep as proof of vaccination. Though simply for verification purposes initially, by 1885 police were allowed to request a person's documents to ensure compliance and escort those who could not prove compliance to the nearest vaccination clinic.[35] Concurrently with this, Japanese doctors were required to maintain statistics not only about the patients they vaccinated, which were to be forwarded to the *Eiseikyoku* at regular intervals, but were also required to report all cases of "malignant prevalent diseases" or epidemic diseases (*akusei ryūkō byō*, 悪性流行病) to the police.[36] Police officers effectively served as frontline public health officers, enforcing ordinances and funneling information and statistics back to the *Eiseikyoku*. Within little more than a decade, Meiji Japan successfully transitioned from

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[33] Koseishō, *Koseishō gojūnenshi*, 59-60.
[34] Koseishō, *Koseishō gojūnenshi*, 59-60.
[35] Ann Bowman Jannetta, "Jennerian Vaccination and the Creation of a National Public Health Agenda in Japan, 1850-1900," *Bulletin of the History of Medicine* 83, no. 1 (2009): 137.
[36] These "malignant prevalent diseases" included cholera, smallpox, typhus and measles. Johnston, *The Modern Epidemic*, 165-166.

decentralized medical system based on CJM to a heavily centralized and intrusive model based on Western medicine.

The Culture of Biomedicine

With the implementation of the Isei Act, biomedicine became the dominant paradigm within the Japanese medical community. The term "biomedicine" is used in the context of this study to refer to the system of medicine heretofore referred to as *seiyō igaku* or Western medicine as it existed in Japan from 1874 forward. This shift in terminology acknowledges the transition of the intellectual framing of the competition between kanpō and Western medicine that occurred following the passage of the Isei Act in 1874. From this point forward, detractors of kanpō increasingly came to refer to what was formerly known as Western medicine as *gendai igaku* (modern medicine, 現代医学), *kindai igaku* (present day medicine, 近代医学) or just *igaku* (medicine, 医学).[37] Conversely, kanpō acquired a secondary appellation as *dentō igaku* (traditional medicine, 伝統医学) in the process.[38] The prioritization of biomedicine served to further the delegitimization of kanpō by amplifying the othering effect of terms like "kanpō" and "*dentō igaku*" through the creation of false dichotomies (i.e. Chinese method medicine vs medicine; traditional medicine vs modern medicine) while conversely implying the sole legitimacy of biomedicine as what is often referred to popularly as "mainstream medicine". By using the term "biomedicine" to refer to Western medicine in Japan from 1874 forward, this study recognizes that biomedicine,

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[37] Takeyama Shinichiro, *Kanpō ijutsu fukkō no riron* [Theories on the Restoration of Kanpō Medicine] (Tokyo: Moriyama shoten, 1941), 156-160.
[38] Takeyama, *Kanpō ijutsu fukkō no riron*, 228.

despite its success, coexisted with other systems of medicine in Japan and that to privilege it as superior or more central than the others undermines the process of historical inquiry.

Beyond merely recognizing the intellectual evolution of the competition between kanpō and Western medicine, usage of the term "biomedicine" serves to highlight the evolution of Western medical practice in Japan itself as formalized in the passage of the Isei Act. As discussed previously, German medicine experienced a period of rapid change in the mid-nineteenth century. The development of state public health institutions, standardization of medical education, expansion of laboratory-based research, and increased emphasis on adherence to scientific procedures constituted a new medical culture, distinct from Western medicine as practiced in previous centuries. Introduction of this culture of biomedicine into Japan quickened with the passage of the Isei Act and arrival of foreign medical advisors, displacing older ranpō-derived understandings of Western medicine. Embraced by the Japanese state medical establishment, biomedicine led to an abrupt shift in the state's understanding of disease in terms of etiology, research and prevention.

An example of the abrupt shift witnessed in disease etiology and prevention is the transformation of Japanese conceptions of leprosy. Prior to the Meiji period, lepers were historically seen as victims of karmic retribution in Japan. They were outcast from society but were allowed to live in their own colonies or in shelters maintained by religious establishments. Most lepers subsisted on begging. People had believed that giving alms to a leper would bring a person good karma or luck. In the early Meiji period, lepers came to be viewed by the state as a threat to both public health and national security. Furthermore, chauvinistic Western imperialist ideas held that leprosy was a disease of primitive civilizations, an appellation that Japan sought to

avoid as it pursued parity with the West. This idea, along with the later acceptance of germ theory, by Japanese elites resulted in laws aimed at containing the spread of leprosy. In 1872, a law was passed banning the organized collection of alms, which destroyed the livelihood of lepers. Over the course of succeeding decades other laws followed that ultimately called for the incarceration of lepers in newly constructed leprosaria.[39]

The extent to which the Japanese medical establishment embraced Western conceptions of disease etiology, research and prevention can also be seen in their response to the threat of beriberi. Beriberi is a wasting disease caused by thiamine deficiency that affects the nervous system. Beriberi is commonly found in societies with a diet heavily reliant on polished white rice such as Japan. At the time, beriberi had received little study by Western doctors because it was seen as principally afflicting Asian populations. Within East Asia, a number of CCM physicians, including Hua Tuo (華佗, ca. 140CE-208CE), Chao Yuanfang (巢元方, 550CE-640CE), and Sun Simiao (孫思邈, 581CE-682CE), had acknowledged and proffered treatments for beriberi in the guise of *jiaoqi* (J. *kakke*, E. foot qi, 脚気) early in the first millennium CE. In Japan, the *Ishinpō* (醫心方), the earliest extant CJM text, addressed berberi as *kakubyō* (脚病) and provided several possible causes drawn from CCM works, including wetness, coldness, kidney deficiency and diet.[40] By the

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[39] Susan Burns, "From 'Leper Villages' to Leprosaria: Public Health, Nationalism, and the Culture of Exclusion in Japan," in *Isolation: Policies and Practices of Exclusion*, ed. Alison Bashford and Carolyn Strange (New York: Routledge, 2003), 104-118.

[40] Tanba Yasuyori, *Ishinpō: Dai 8 kan Teashi* [Ishinpō: Volume 8 Hands and Feet], (984), http://www.emuseum.jp/detail/100173/008?word=&d_lang=en&s_lang=&class=&title=&c_e=&region=&era=&cptype=&owner=&pos=1&num=1&mode=&century= (accessed November 11, 2020).

Edo period, berberi was popularly known as *Edo wazurai* (Edo sickness, 江戸煩い), due to its prevalence in the city. At the time, polished white rice was more expensive than alternative foodstuffs, such as brown rice or barley, limiting its regular consumption to the wealthier strata of society. In comparison to the rest of Japan, Edo's relatively wealthier population could better afford and therefore consume polished white rice more regularly, leading to a higher incidence of beriberi.[41]

Following the introduction of state-centered biomedicine, the Meiji government considered beriberi a threat to national security. Two of the final three Tokugawa shoguns died from it, as did the sister of the Meiji Emperor. During the Seinan War of 1877-1878, almost 40% of the army contracted it.[42] As a result, the Meiji government set up a beriberi hospital in 1878 and tasked both biomedical and kanpō specialists with the search for a cure. The biomedical approach to treatment focused on a mix of diuretic drugs to stimulate the passing of the nonexistent microorganism then presumed to cause beriberi and consumption of a Western diet of meat, eggs and milk, while kanpō practitioners took an entirely dietary approach, replacing polished white rice in their patients' diets with boiled barley and rice, buckwheat soba and adzuki beans.[43] Their plan of treatment was not original, but instead reflected a standard treatment for beriberi within the CCM and CJM traditions from as early as the 6th century CE.[44] Though it may not have been explained as such initially by

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[41] Alexander Bay, "Beriberi, Military Medicine, and Medical Authority in Prewar Japan," *Japan Review* 20 (2008): 114.
[42] Christian Oberländer, "The Rise of Western 'Scientific' Medicine in Japan: Bacteriology and Beriberi," in *Building a Modern Japan: Science, Technology, and Medicine in the Meiji Era and Beyond*, ed. Morris Low (New York: Palgrave 2005), 15.
[43] Bay, "Beriberi, Military Medicine, and Medical Authority in Prewar Japan," 114.
[44] Bay, "Beriberi, Military Medicine, and Medical Authority in Prewar Japan," 114.

CCM/CJM practitioners, this treatment reflects an implicit recognition of a nutritional deficiency as the cause of beriberi. Polished white rice, which contains little thiamine, was replaced with barley, buckwheat, and adzuki, all of which are high in thiamine. While the fate of the patients involved in the 1878 study is unclear, it was recognized within the Japanese medical community that kanpō treatments for beriberi seemed to be more effective than Western ones, yet the possible reasons for this were not seriously examined due to official hostility to kanpō's inability to explain its health outcomes in scientific terms. Biomedical elites attributed the recovery of patients who received kanpō dietary treatments to the recuperative effects of eating well, while remaining convinced that the origin of beriberi could only be discovered through bacteriological research in a laboratory.[45]

In 1880, Takaki Kanehiro (高木兼寛, 1849-1920), the director of the Tokyo Naval Hospital, began his own beriberi inquiry. He began by questioning why beriberi was uncommon among Western sailors in East Asia but endemic among native Asian sailors. He rejected popular chauvinist theories that beriberi was a racially bound disease as well as the certitude of biomedical doctors that it must be caused by a microorganism. He came to believe that the differences in diet between Western and Japanese sailors might be related to the varying incidences of beriberi. Takaki tested his theory by having a Japanese naval vessel use Western-style food rations including meat and bread for a period of time. Standard Japanese naval rations often consisted solely of polished white rice. He subsequently discovered that changing to a Western diet dropped

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[45] Yamashita Seizō, *Ōgai Mori Rintarō to kakke funsō* [Ōgai Mori Rintarō and the Beriberi Dispute] (Tokyo: Nihon hyōronsha, 2008), 21-22.

the beriberi rate among the crew from 40% to 13%.[46] Later, Takaki implemented a modified Japanese diet supplemented with barley and buckwheat and found that the beriberi rate remained low.[47] Takaki declared that beriberi must be the result of a nutritional deficiency resulting from a diet consisting primarily of polished white rice and lobbied the Meiji government to supplement military food rations accordingly.

The scientific and medical establishment in Japan savaged Takaki's research as "unscientific" and worked to block the implementation of his proposal. Concurrently, biomedical doctor Ogata Masanori (緒方正則, 1853-1919) declared that he had discovered the bacillus responsible for beriberi in April 1885 about a month after Takaki completed his experiment. Although Ogata's "discovery" was quickly disproven, biomedical doctors still rejected Takaki's theory. According to Baron Ishiguro Tadanori of the Imperial Army Medical Bureau and strident critic of kanpō,

> The theory that barley consumption reduces beriberi is based not on accumulated data on personnel and disease, but on the statistics for one year - and not even on a comparison of previous years. For this reason, I do not believe the theory that barley either prevents or is a cure for beriberi.[48]

While Ishiguro's rejection of Takaki's theory on these grounds given the promising results and scientific basis of Takaki's study seems illogical, it is indicative of the extent to which the Japanese biomedical establishment embraced laboratory bacteriological research as the standard for medical progress. It may also reflect interservice rivalry and nationalistic concerns, as Ishiguro and his

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[46] Oberländer, "The Rise of Western 'Scientific' Medicine in Japan," 31.
[47] Bay, "Beriberi, Military Medicine, and Medical Authority in Prewar Japan," 116.
[48] Ishiguro Tadanori, *Kakkedan* [Beriberi Discussion] (Tokyo: Eirandō, 1885), 43-44.

allies, such as Doctor Mori Rintarō (森林太郎, 1862-1922), used their influence to keep the Imperial Army using polished white rice rations, while the Imperial Navy adapted its rations in line with Takaki's recommendations. The result was that beriberi remained a major problem for the Imperial Army well into the twentieth century as the Japanese biomedical community vainly sought the nonexistent microorganism that caused beriberi.[49] The *kakke ronsō* (Beriberi Controversy, 脚気論争) or *kakke funsō* (Berberi Dispute, 脚気紛争), as this disagreement is known in Japanese history, continued into the 1920s, when accumulating biomedical "discoveries" of the role nutritional deficiencies play in causing disease, coupled with the isolation of vitamins in a laboratory setting finally brought it to an end. The fact that the Japanese government was willing to ignore a successful treatment for a disease that severely undermined the operational ability of the Japanese military in an era of high nationalism and at least two major wars (the First Sino-Japanese War of 1894-1895 and the Russo-Japanese War of 1904-1905) is a testament to the pervasiveness of official vitriol aimed at kanpō during this period as well as official faith in the biomedical paradigm.

Why did the Meiji government decide to fully implement a Western-style medical system while dismissing Japan's own medical traditions? There are several reasons for this. First, the Meiji government was attempting to protect its own interests and sovereignty by adopting Western medicine. Cognizant of the situation that had developed in China as a result of Western interference

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[49] Alexander Bay, "The Politics of Disease: Beriberi, Barley, and Medicine in Modern Japan," PhD diss., Stanford University, 2006.

in the country, the Meiji oligarchs hoped to demonstrate to the West that Japan was "modern" and strong in order to deter Western imperialism through both international opinion and national strength. In this era, the definition of "modernity" was largely written by the governments of the ascendant West, who typically found it to be synonymous with Western civilization. In other words, this version of modernity could be achieved only through Westernization. In the realm of medicine, to the West, only Western medicine was considered "modern and civilized," therefore, to be viewed as modern, Japan was obliged to adopt it.

However, the Meiji government did not decide to adopt Western practices simply for the sake of appearances; they firmly embraced what one scholar has called the "culture of progress."[50] Itself a Western import, the Meiji oligarchs firmly believed that a nation's level of science and technology determined its national power and therefore its position within the hierarchy of civilizations. While grossly oversimplified, according to this model, in terms of civilizational development, generally any practice perceived to be modern (typically Western) was seen as "beneficial for society regardless of its actual utility while anything perceived as "traditional" (typically native or non-Western) was seen as harmful to society. In the case of medicine, biomedicine came to be symbolic of civilization and progress within this narrative while kanpō was considered regressive and traditional.

Second, as has been previously mentioned, virtually all of the leading members of the Meiji medical establishment had been trained as ranpō doctors in the late Edo period. As Thomas Kuhn

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[50] David G. Wittner, *Technology and the Culture of Progress in Meiji Japan*, Routledge/Asian Studies Association of Australia (ASAA) East Asia Series 10, ed. Tessa Morris-Suzuki and Morris Low (New York: Routledge, 2008).

has noted, "the assimilation of either a new sort of phenomenon or a new scientific theory must demand the rejection of an older paradigm."[51] Training in Western methods made ranpō doctors receptive to the biomedical paradigm and invested in its perpetuation. Kuhn also notes, "Men whose research is based on shared paradigms are committed to the same rules and standards for scientific practice."[52] Non-scientific medicine was not medicine according to the prevailing biomedical paradigm. As a result, men like Nagayo Sensai came to see kanpō as a danger to the nation. In the case of beriberi, Takaki Kanehiro's conclusions could not be accepted by the Meiji medical establishment because his methods were perceived as deviating from the established practices of Western medical research in that they did not occur within a laboratory setting and derived from kanpō. As a result, they were considered invalid. It is a testament to the strength of the biomedical paradigm that the Japanese medical establishment spent the next few decades looking for the source of beriberi under a microscope.

Finally, despite its flaws, Western medicine offered what many Japanese doctors considered a more compelling way of understanding disease than had previously been available. Departing from the esoteric understanding of disease etiology present in Goseiha kanpō medicine and the outcomes-based approach of the Kohōha School, Western medicine purportedly offered directly observable physical evidence of disease via the microscope. It is always easier to believe that which can be seen. Moreover, Western medicine had proven itself to be very effective as was

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[51] Thomas S. Kuhn, *The Structure of Scientific Revolutions*, 3rd ed. (Chicago: University of Chicago Press, 1996), 95.
[52] Kuhn, *The Structure of Scientific Revolutions*, 11.

evidenced by the large reduction in mortality that accompanied the spread of the smallpox vaccine to Japan and the usefulness of Western techniques in controlling the spread of a series of cholera epidemics in the late Edo period.[53]

While the Meiji Restoration is most often conceived of as political revolution, it should also be considered a scientific revolution. "The successive transition from one paradigm to another via revolution is the usual developmental pattern of mature science."[54] Thomas Kuhn defines a scientific revolution as "a noncumulative developmental episode in which an older paradigm is replaced in whole or in part by an incompatible new one."[55] Though information about Western medicine had been available in Japan to varying degrees for centuries, it was only with the ascendance of the Meiji biomedical establishment that it achieved dominance. By fully implementing a Western-style medical system in Japan within such a short period of time, elite Meiji physicians enacted nothing short of a scientific revolution.

It was in this political context that the discipline of classical Japanese medicine was increasingly viewed with derision and hostility by Japanese policy makers, who used the term kanpō as a slur. With the passing of the Isei Act, the Japanese Diet had enacted legislation denying doctors of classical Japanese medicine the right to legally practice medicine without first demonstrating proficiency in biomedicine. Kanpō itself was no longer recognized officially as an independent medical system. Kanpō's detractors in the Meiji government used its long history in

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[53] Oshima, "The Japanese-German System of Medical Education in the Meiji and Taisho Eras," 214.
[54] Kuhn, *The Structure of Scientific Revolutions*, 12.
[55] Kuhn, *The Structure of Scientific Revolutions*, 92.

Japan as a political weapon, derogatorily referring to it as *dentōteki* (traditional, 伝統的). The popular current of thought at the time held that traditions had stunted Japan's progress, and the East in general, while the West had surged forward to become *kindaiteki* (present day, 近代的) or *gendaiteki* (modern, 現代的) and powerful. In this context, the word *tradition* functioned as an epithet to imply undesirability, while the word *modern* indicated desirability. Similarly, in the realm of medicine, relative perceptions of how scientific a practice was served as a proxy for determining its relative degree of modernity. For example, in 1895, Ishiguro Tadanori, then the Army Surgeon General, continued to reject Takaki's findings, despite a decade of statistics demonstrating the near total elimination of beriberi from the Imperial Navy following the adjustments made to naval rations.[56] Ishiguro stated, "the army does not need traditional medicine (*dentō igaku*), statistical speculation, or 1,860 year-old theories to solve its beriberi problems; it needs scientific knowledge based on experimental medicine."[57] The derogatory compound terms "*dentō igaku*" and "*kanpō igaku*" specifically developed in this period in order to differentiate classical Japanese/Chinese medical practices from Western biomedicine. By the Meiji period, China under the Qing Dynasty was an empire in steep decline; wracked by internal rebellion and subjected to numerous defeats by the Western colonial powers, China became a symbol of the supposed failures of Eastern traditions from which Japanese political elites sought to distance

[56] For precise statistics regarding the precipitous decline of beriberi incidence in the Japanese Imperial Navy between 1878 and 1888, see Bay, "Beriberi, Military Medicine, and Medical Authority in Prewar Japan," 121.
[57] Takada Kame, "Ishigami daigun'i-sama hoka gōippōsama e ukagai sōrō" [Inquiries to Military Doctor Ishigami and the Other One] *Tokyo iji shinshi* 921 (1895): 34.

Japan. For example, according to well-known author and educator Fukuzawa Yukichi (福澤諭吉, 1835-1901), "Because the Chinese and Korean peoples are profoundly superstitious, if we know nothing about science, Western scholars will certainly think that Japan too is a country that believes in yin/yang and the five phases."[58] The implication here is that yin/yang and the five phases, important concepts within CJM, are artifacts of superstition associated with continental East Asia, of which Japan should be ashamed. This perspective became increasingly entrenched over the course of the Meiji period with the concomitant rise of Japanese industrial and commercial power. As such, the term "kanpō" was intended to discredit classical medical practice in the eyes of the Japanese nation. Conversely, Western medicine acquired the sobriquet *nisshin igaku* (日新医学, Japan's New Medicine), a name unsubtle in its implication, i.e. that it was replacing "Japan's Old Medicine," kanpō.[59]

Learning from the Past – The Onchisha

Yet classical Japanese medicine practitioners resisted attacks on their profession by attempting to coopt the terms "kanpō" and "traditional" for their own use while diminishing their negative connotations. Kanpō doctors were increasingly marginalized as a result of the enshrinement of Western biomedicine as authoritative knowledge within Japanese political circles that came about with the passing of the Isei Act, as well as the onerous demand that they undertake the study of Western medicine in order to receive medical licensure. In response to the

[58] Fukuzawa Yukichi, "Datsuaron" [Argument for Leaving Asia] *Jiji Shinpō*, March 16, 1885.
[59] Oberlander, "The Modernization of Japan's Kanpō Medicine," 142. *Nisshin igaku* later became the name of a prestigious biomedical journal in Japan.

implementation of the Isei Act, in 1879, prominent kanpō practitioners, such as Asai Kokkan (浅井国幹, 1848-1903), Asada Sōhaku (浅田宗伯, also known as Asada Ritsuen, 淺田栗園, 1815-1894), and Yamada Gyōkō (山田業広, 1808-1881), mounted a political movement to obtain official recognition for their practice and combat negative perceptions of kanpō.[60]

In contrast to the ranpō doctors of the late Edo period, Asai, Asada, and Yamada all studied medicine at the Shogunate's Igakkan under the direction of the Kohōha-affiliated head of the school, Taki Motokata (多紀元堅, 1795-1857).[61] Known at the time for its rejection of Western medical ideas, curriculum at the Igakkan likely inculcated in the men a staunch respect for orthodox Kohōha teachings which would define their future literary, medical and political careers. Yamada even subsequently served as a teacher there from 1858 until its closure. Following the Meiji Restoration in 1868 and the disbanding of the Igakkan the same year, Yamada opened a kanpō clinic in Tokyo, while Asada and Asai served as doctors in the court of the Meiji Emperor.[62] With the enactment of the new medical system based on Western medicine in 1875, the three men, acquainted through their time at the Igakkan, began to organize kanpō practitioners to pursue political recognition of kanpō as a medical practice within the framework of the new medical system.

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[60] Yakazu Dōmei, *Meiji hyaku-jūnen: Kanpō igaku no hensen to shōrai: Kanpō ryakushi nenpyō* [The 110th Year of Meiji: The Transition of Kanpō Medicine and Its Future: A Brief Historical Chronology of Kanpō] (Tokyo: Shun'yōdō shoten, 1979), 111.
[61] Kimura Chōkyū, "Asada Sōhaku sensei ni tsuite" [About Asada Sōhaku] *Kanpō to kanyaku* 5, no. 1 (1938): 86.
[62] Yakazu Dōmei, "Kokkan Asai Tokutarō sensei wo omou" [The Thought of Kokkan Asai Tokutarō] *Kanpō to kanyaku* 6, no. 2 (1939): 15-16.

Founded on March 10, 1879, Asai, Asada and Yamada formed an umbrella association to represent the interests of kanpō practitioners in Japan. The association was known as the *Onchisha* (Review Knowledge Association, 温知社).[63] At its height, it is estimated to have had about 2000 associated members with 18 branches around Japan, still a small percentage of the overall number of physicians in Japan.[64] Crafted by Asada Sōhaku, who was also a noted Confucian scholar, the name *Onchisha* derives from the Confucian idiom, *wenguerzhixin, keyiweishiyi* (温故而知新, 可以為師矣), meaning, if you review the old and know the new, you may become a teacher.[65] In Japanese, this idiom is commonly truncated to 温故知新 (*onkochishin*), review the old and know the new. In its truncated version, the phrase is typically understood to mean that one should learn from the past in order to understand the present/future.[66] Taken in its historical context, the association's name, *Onchisha*, evokes the group's political aspiration to attain equal recognition for kanpō by reminding of the importance of remembering past teachings. Additionally, with the full idiom in mind, the name also implies equality between past teachings (e.g. kanpō) and new teachings (e.g. Western biomedicine), as both are requirements to teach others. As such, it is

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[63] The *Onchisha* is typically referred to as the Movement for the Preservation of Kanpō Medicine in English language publications. It is also sometimes mistranslated as the Warm Knowledge Association, as "warm" is the most common meaning today of the character 温; however, in classical Chinese 温 is frequently used with the meaning "to review a lesson". Asada Sōhaku, as a Confucian scholar, would have been intimately familiar with this understanding of 温 through his study of the Confucian classics. Dōmei, *Meiji hyaku-jūnen*, 111.
[64] Oberlander, "Kanpō's Modern Myth", 66.
[65] Asada Sōhaku, "Onkochishin" [Review the Old and Know the New] *Onchi idan* 1, (1879): 19-24; Kongzi, *Lunyu* [The Analects], Ch. 2 Weizheng [The Practice of Politics], Line 11 (Project Gutenberg, 2007), http://www.gutenberg.org/cache/epub/23839/pg23839-images.html (accessed November 11, 2020).
[66] Ōtsuka Keisetsu, "Onkochishin to iu koto" [Speaking of Onkochishin] *Kanpō to kanyaku* 2, no. 6 (1935): 1.

appropriate that the organization advocated for equal recognition of kanpō and Western medicine, rather than merely for the restoration of kanpō.

One method by which the *Onchisha* sought to raise awareness of kanpō and sway opinion toward their discipline was through print publications. Asada notably authored several works aimed at explaining the practice and history of kanpō to a larger audience. For example, in "*Igaku dokushoki*" (Standards of Medical Reading, 醫學読書規), Asada provided an annotated bibliography of CCM texts, such as the *Huangdi neijing* and *Shanghan lun*, along with his own commentaries. In it, Asada emphasized the need to be familiar with these classics while criticizing his followers for having a shallow understanding of the texts. However, he emphasized balancing the need for flexibility in treatment over rote memorization/application of the texts.[67] Collectively, the *Onchisha* published the *Onchi idan* (温知醫談) journal between 1879 and 1889 with a run of 105 issues and *Keikō ihō* (継興醫報), published between 1893 and 1897, in which *Onchisha* members sought to raise awareness of kanpō and put forth their arguments for the continued viability of their discipline. They called for a separate licensing system for kanpō practitioners on the lines of that set up for physicians of Western medicine by the Isei Act.[68] To this end, they advocated for a standardized curriculum based on the classic texts of CCM/CJM, such as the *Shanghan lun* (J. *Shōkanron*, E. Treatise on Cold Damage Disorders, 傷寒論), *Jingui yaolue* (J. *Kinkiyōryaku*, E. Essential Prescriptions from the Golden Coffer, 金匱要略), *Ishinpō* (醫心方)

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[67] Asada Sōhaku, *Igaku dokushoki* [Standards of Medical Reading] (Nihonbashi: Onchisha, 1883), 1.
[68] Fukagawa Shindō, *Kanyō igaku tōsōshi* [History of the Kanpo-Western Medicine Conflict] (Tokyo: Iseisha, 1981), 271.

and *Bencaojing* (J. *Honzōkyō*, E. The Classic of Herbal Medicine, 本草經), eliminating much of the lingering heterogeneity found in Edo period classical Japanese medicine. This formed the basis of the curriculum at the kanpō medical school founded by the movement's members called the *Wakan igaku kōshūjo* (Sino-Japanese Medicine Training School, 和漢醫學講習所) founded in 1882.[69] Yamada Gyōkō served as the first head of the school, with Asada Sōhaku and Asai Kokkan succeeding him in turn. The school later changed its name to the *Onchi igakkō* (Onchi Medicine School, 温知醫學校).[70]

Following the promulgation of the Constitution of the Empire of Japan in 1889, *Onchisha* members formed the *Teikoku wakan ikai* (Imperial Sino-Japanese Medical Association, 帝国和漢醫會) in 1890 to lobby the newly created Diet for official recognition of their position. For members of the *Onchisha*, in the drive toward modernization, Japan had abandoned too many of its "traditions" in favor of Western notions of modernity. Beginning in the 1880s, this was a popular attitude in Japan as nationalist sentiment grew. The decision to include the term *teikoku* in the title of their new organization likely was an attempt to draw support for their cause by associating it with the state and throne. *Onchisha* members argued that kanpō was a domestic Japanese discipline that deserved legal recognition. They also pointed out that the majority of kanpō practitioners were members of medical lineages stretching back several generations and centuries, whose legacy and livelihood would be lost without official recognition. [71] This may well

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[69] Asada, *Igaku dokushoki*, 3, 10.; Fukagawa, *Kanyō igaku tōsōshi*, 319.
[70] Yakazu, *Meiji hyaku-jūnen*, 112.
[71] Fukagawa, *Kanyō igaku tōsōshi*, 271.

have been the aim of policy makers within the biomedical establishment, as it would be far easier for kanpō to fade into obscurity than to ban its practice outright. According to government records, there were 23015 kanpō doctors in 1874.[72] Records of the number of kanpō practitioners from the early twentieth century vary widely, likely a testament to the extent of kanpō's decline; however, in 1910 the *Yomiuri Shimbun* estimated that there were only 8 practitioners left in Japan.[73] While this statistic likely significantly underestimates the number of kanpō doctors in the country, historians reckon that the number of kanpō practitioners in Japan steadily declined over successive decades until 1925 when they accounted for less than five percent of all medical practitioners.[74]

Onchisha scholars argued that kanpō was a distinctly Japanese, yet equally effective system of medical practice in comparison to Western biomedicine. To this end, they emphasized that Western and kanpō treatments were equally efficacious, a dubious claim to kanpō's detractors. To be clear, they viewed kanpō as an equal system of medicine in competition with biomedicine.[75] Unlike kanpō scholars of the twentieth century, they did not contemplate the synthesis of Western and kanpō techniques. This position is somewhat ironic given the fact that the *Onchisha*'s methods of promotion, such as publishing medical journals, standardizing curriculum, forming professional organizations, and founding kanpō hospitals, which reflected the growing, but as yet unrecognized, influence of scientific thought on kanpō, were largely based on scientific organizational principles

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[72] Kōseishō, *Isei hyakunenshi: Shiryōhen* [A Hundred Year History of the Medical System: Document Collection] (Tokyo: Gyōsei, 1976), 45
[73] *Yomiuri Shimbun*, July 21, 1910.
[74] Mahito Fukuda, "Health in Modern Japan: From Regimen to Hygiene," in *The History of Public Health and the State*, ed. Dorothy Porter, Clio Medica 26, (Amsterdam: Rodopi, 1994), 385-402.
[75] Yamada Gyōkō, "Igaku kokoroekata tairyaku" [An Outline of the Direction of Medical Knowledge] *Onchi idan* 1, (1879): 3.

imported into Japan with biomedicine. The *Onchisha*'s unwillingness to compromise on equality made it more difficult for them to gain political traction with their calls for official recognition.[76] However, given the previously mentioned example of beriberi treatment, kanpō proponents might have been able to gain traction on this point had their opponents been willing to listen.

Onchisha supporters no doubt hurt their cause unwittingly through some assertions that, although completely legitimate when viewed through the prism of classical Japanese medicine, would have seemed unintelligible to their scientifically-oriented brethren, such as the lack of utility to be found in studying Western anatomy and the supposed incompatibility of Western medicine with the Japanese climate.[77] The ideological violence done to classical Japanese medical etiology by the empiricists of the Kohōha School in the Edo period in their exclusive focus on clinical experience over explanation made competition with scientific explanations for disease only that much more difficult. The authority of all medical systems derives primarily from their ability to provide convincing explanations for disease to a given population. Kanpō's detractors, such as Baron Ishiguro Tadanori, portrayed practitioners of classical Japanese medicine as superstitious fraudsters. In 1892, in response to the *Onchisha*'s push for recognition by the Japanese Diet, Ishiguro published a series of lectures in which he warned readers against the damage that would be done to Japan's status in the world if kanpō practitioners were exempted from biomedical licensing requirements and allowed to practice medicine.[78]

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[76] Fukagawa, *Kanyō igaku tōsōshi*, 281.
[77] Oberlander, "Kanpō's Modern Myth," 65.
[78] Bridie Andrews, *The Making of Modern Chinese Medicine, 1850-1960* (Honolulu: University of Hawaii Press, 2015), 78.

The *Onchisha* attempted to downplay the relationship between kanpō and China, avoiding use of the term kanpō as tensions with China grew in the 1890s, but it was likely this association that ultimately derailed their reform efforts. After significant lobbying, the issue of legal recognition for kanpō practitioners was accepted for consideration in the Japanese Diet; however, the vote occurred in February 1895, during the First Sino-Japanese War. Anti-Chinese sentiment, coupled with hostility toward kanpō's perceived anti-modern qualities led to the defeat of the provision and ultimately the end of the *Onchisha*'s lobbying efforts, with the organization dissolving in 1898.[79] By the early 1900s, there were very few practitioners of kanpō medicine still active in Japan. The kanpō tradition was fading into obscurity.

Conclusion

Culture is continually reinforced by the authority accorded to traditions, customs, and beliefs within human society. Shifts in belief patterns within a society must reconcile themselves with the authority of past practices within that society. In regard to conceptions of disease, this implies that a change in etiology within a society would likely take several decades or even centuries to reach fruition. Yet in the case of Japan this process primarily took place over the course of just two decades. The dominance of ranpō-turned-biomedical practitioners within the ranks of anti-Shogunate forces made them well placed to reshape the Japanese medical landscape following the Meiji Restoration. Through the creation of a centralized medical system based on the German model staffed from their own ranks, these individuals effectively forced an abrupt paradigm shift

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[79] Andrews, *The Making of Modern Chinese Medicine*, 78.

in Japanese medicine from a Sino-Japanese-based conception of disease etiology to a Western-based one. Efforts on the part of kanpō practitioners to gain acceptance within the new system failed. Kanpō found itself outside the bounds of recognized medicine, the numbers of its practitioners dwindling. As the nineteenth century came to a close, it appeared that the story of kanpō too had reached its conclusion.

Chapter Three - A New Paradigm Emerges: Scientific Rationalization and the Construction of "Japan's Medicine"

By the turn of the twentieth century, kanpō medicine had reached its nadir, fading into obscurity with the successive passing of its ever-dwindling number of practitioners. However, in the 1910s, its fortunes began to reverse as a new generation of biomedically-trained physicians turned to kanpō as a potential source of "untapped" medical knowledge capable of innovating biomedical practice in Japan. Conceived within the written works of Wada Keijūrō (和田啓十郎, 1872-1916), Yumoto Kyūshin (湯本求真, 1876-1941), and Nakayama Tadanao (中山忠直, 1893-1957), a new kanpō paradigm emerged, rallying what is known historically as the Kanpō Medicine Revival Movement (*Kanpōyaku no fukkatsu undō*, 漢方薬の復活運動), a movement of early to mid-twentieth century kanpō scholars dedicated to the revival of its practice in Japan. Revising the earlier arguments of mid-Meiji period *Onchisha* (Review Knowledge Association, 温知社) scholars, who emphasized kanpō's cultural distinction from and equal standing with biomedicine, these three men reconceived kanpō as a syncretic, scientific, modern, and, ultimately, uniquely superior Japanese discipline over the course of the 1910s and 1920s.[1]

Wada Keijūrō – An Argument for the Synthesis of Biomedical and Kanpō Techniques

Following the collapse of the *Onchisha's* efforts to gain official recognition for kanpō within the medical system from the Japanese Diet in 1895, as discussed in Chapter Two, the

[1] A note on terminology in this chapter: When referencing the practice of biomedicine in Japan, Wada, Yumoto and Nakayama used a variety of terminology, such as *seiyō igaku* (Western medicine, 西洋医学), to contrast biomedicine's origin with that of kanpō. Consequently, when refence is made to "Western medicine" in this chapter, it should be understood as referring the practice of biomedicine in Japan as it existed during the period.

number of practicing kanpō doctors continued to decline as those trained in the final years of the Edo period passed away. As if to emphasize this point, from July 21st through July 24th in 1910, the *Yomiuri Shinbun* (Yomiuri Newspaper, 読売新聞) ran a four-part series titled, "The Last Days of the Kanpō Doctors" (*Kanpōi no matsuro*, 漢方医の末路), in which it profiled 3 of the purportedly last 8 kanpō doctors living in Tokyo.[2] While it is unclear how the *Yomiuri Shinbun* came by this statistic, this series evidences the perceived extent of kanpō's decline by this period. Indeed, kanpō scholarship had effectively ceased following the dissolution of the *Onchisha*, as it appears that there were not any books on kanpō published in Japan between 1895 and 1910 and not any kanpō journals between 1895 and 1923.[3]

This began to change with the publication of Wada Keijūrō's *Ikai no tettsui* (*Rules of the Medical World,* also known as *The Iron Hammer of the Medical World*, 醫界の鉄椎) on August 5, 1910. Wada was a staunch proponent of kanpō despite its contemporary official unpopularity. Wada was born in Matsushiro in Nagano Prefecture. When he was six or seven years old, a close family member contracted an unspecified illness for which they sought treatment from physicians trained in Western medicine for 5-6 years, visiting a number of doctors. The treatments were unsuccessful, so Wada's family turned to a kanpō physician for help. Under this physician's treatment, the family member made a full recovery. This personal experience convinced Wada of

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[2] Yomiuri Shinbun, "Kanpōi no matsuro (1): Tōkyō shinai ni wazuka 8 nin" [The Last Days of the Kanpō Doctors: No More Than 8 Inside Tokyo], *Yomiuri Shinbun*, July 21, 1910.
[3] Yakazu Dōmei, *Meiji hyaku-jūnen: Kanpō igaku no hensen to shōrai: Kanpō ryakushi nenpyō* [The 110th Year of Meiji: The Transition of Kanpō Medicine and Its Future: A Brief Historical Chronology of Kanpō] (Tokyo: Shun'yōdō shoten, 1979), 126.

the practical efficacy of kanpō and led him to pursue medicine as occupation.[4] In 1892, Wada moved to Tokyo to study biomedicine at *Saisei gakusha* (Saisei School, 済生学舎), the forerunner of today's *Nihon ika daigaku* (Japan Medical School, 日本医科大学). After receiving his medical degree, Wada studied under a kanpō doctor named Tada Tamino (多田民之) before opening his own clinic in Akasaka, Tokyo. His experiences with kanpō in a clinical setting working with Tada, and at his own clinic, reinforced his confidence in the efficacy of kanpō. Critical of the low regard in which the biomedical community in Japan held kanpō, Wada determined to pen a defense of kanpō based on his own experiences, which he saved money to self-publish in 1910, after fifteen years of writing, under the title *Ikai no tettsui*.[5]

Much of the work focuses on the details of kanpō clinical treatments, historical understandings of disease, such as *inyōgogyōsetsu* (yin-yang, five phases theory, 陰陽五行説), and specific diseases; however, *Ikai no tettsui*'s influence derived from Wada's medical philosophy as presented in the work. Innovative for the time, Wada argued that kanpō could act as a therapeutic supplement to Western medical, i.e. biomedical, practice. He recognized that while Western medicine excelled at the diagnosis of disease, there were many chronic diseases, such as diabetes, for which it was unable to provide any treatment.[6] Wada believed kanpō, through its

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[4] Wada Keijūrō, preface to *Ikai no tettsui* [The Iron Hammer of the Medical World] (1910, repr., Tokyo: Shun`yōdō, 1932), 1-2.
[5] Terasawa Katsutoshi, "'Ikai no tettsui' kara isseiki tate [One century after "Ikai no tettsui"], *Kanpō Medicine* 63, no. 2 (2012): 89-92.
[6] In some ways Wada was ahead of his time, as widespread recognition of this limitation of biomedicine in the 1950s and 1960s helped to stimulate the postwar boom in kanpō consumption, as will be discussed in Chapter Five. Wada Keijūrō, *Ikai no tettsui* [The Iron Hammer of the Medical World] (1910, repr., Tokyo: Shun`yōdō, 1932), 32-36, 39.

holistic approach, could provide treatment in cases where Western medicine proved ineffectual by stimulating the body's self-healing abilities.[7]

Wada castigated biomedical physicians and scholars, who denigrated kanpō without having any actual practical experience with it. One such individual was Ishiguro Tadanori (石黒忠憲, 1845-1941), one-time Army Surgeon-General and a prominent opponent of the *Onchisha* during its efforts to secure legal recognition for kanpō in the 1890s. As previously discussed in Chapter Two, he had been a vocal opponent of kanpō from the 1880s forward, who publicly denounced kanpō and published anti-kanpō tracts to sabotage the revival efforts of the *Onchisha*. Wada opened a dialogue with Ishiguro, asking him to write a preface for what would become *Ikai no tettsui*. Ishiguro refused, stating that there was nothing of value in kanpō. Wada responded by asking if Ishiguro had ever had practical experience with kanpō, to which Ishiguro admitted that he had not. Wada chided him that it was futile to attempt to understand kanpō through the prism of the biomedical paradigm, as practical experience with kanpō would demonstrate its utility through its success in clinical treatments.[8] Wada subsequently volunteered to serve as a military doctor during the Russo-Japanese War in order demonstrate the utility of kanpō, ultimately impressing Ishiguro with his efforts. Ishiguro's attitude toward kanpō appears to have softened as a result as, following the war, he allowed Wada to open Wada's aforementioned kanpō clinic on one of his properties.[9] By the publication of *Ikai no tettsui*, Ishiguro appears to have come to regret

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[7] Wada, *Ikai no tettsui*, 31, 39.
[8] Wada, *Ikai no tettsui*, 274-276.
[9] Terasawa Katsutoshi, "'Ikai no tettsui' kara isseiki tate [One century after "Ikai no tettsui"], *Kanpō Medicine* 63, no. 2 (2012): 90-91.

his lifelong opposition to kanpō, though it is unclear if he ever expressed this sentiment publicly. According to Wada, Ishiguro eventually confessed that "In the past, I put forth my best effort to try to abolish kanpō medicine…. When I look at it today, it is as if of the past 50 years, 49 years I have been mistaken."[10]

In *Ikai no tettsui*, Wada detailed the common criticisms of kanpō, many of which had been leveled initially by Ishiguro, refuting each in turn. The following is a list of common criticisms of kanpō, along with Wada's defense.

- Kanpō medicine is archaic.[11]
    - Kanpō is not archaic. It began almost 2000 years ago and has constantly evolved and improved since then as a result of clinical experience.[12]
- Kanpō books are irrational and absurd.[13]
    - Kanpō books are not absurd. Varying theories of disease and treatment emerged and gained or lost popularity as a result of clinical experience.[14]
- Herbs alone have no curative effect.[15]
    - Not all herbs have curative effects. The herbs that humans consume as part of their regular diet may have little or no observable effect; however, when people are ill,

[10] Wada, *Ikai no tettsui*, 357-358.
[11] Wada, *Ikai no tettsui*, 6.
[12] Wada, *Ikai no tettsui*, 13-17.
[13] Wada, *Ikai no tettsui*, 6.
[14] Wada, *Ikai no tettsui*, 17-21.
[15] Wada, *Ikai no tettsui*, 6.

herbs with a certain potent effect, such as those used in kanpō medicine, are needed for re-balancing in order to cure illness.[16]

- Kanpō medicine has no foundation.[17]
    - Kanpō medicine has evolved over the course of thousands of years. The foundation of its medicine lies in the accumulated years of practical experience of its doctors and consequent refinements to the tradition.[18]
- Kanpō medicine only treats symptoms, rather than the cause of disease.[19]
    - Kanpō's understanding of symptoms and causation are different than those of biomedicine. Symptoms are analyzed in kanpō to determine and treat the cause of disease.[20]
- Kanpō treatments are indirect and insufficient to treat disease.[21]
    - Kanpō medicines can be fast acting, but more often slow, gradual treatment is needed for better rebalancing in the body.[22]

Wada went beyond identifying kanpō as a potential supplement to Western medicine, instead arguing for a synthesis of Western and kanpō approaches, i.e. that they could be used side-by-side in treatment. Although scientific rationalization of kanpō as a concept does not find full expression until the publication of Yumoto Kyūshin's *Kōkan igaku* seventeen years later, the

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[16] Wada, *Ikai no tettsui*, 21-29.
[17] Wada, *Ikai no tettsui*, 6.
[18] Wada, *Ikai no tettsui*, 29-32.
[19] Wada, *Ikai no tettsui*, 6.
[20] Wada, *Ikai no tettsui*, 32-42.
[21] Wada, *Ikai no tettsui*, 6.
[22] Wada, *Ikai no tettsui*, 42-47.

origins of this approach exist in *Ikai no tettsui*. For example, Wada promoted the scientific study of *wakanyaku* (Sino-Japanese drugs, i.e. unrefined herbs, 和漢薬) to learn more about their individual potential medical properties and potential utility alongside biomedicine.[23] In promoting the synthesis of biomedical and kanpō approaches to treatment, Wada diverged from the previous generation of *Onchisha* kanpō proponents such as Asai Kokkan (浅井国幹, 1848-1903), Asada Sōhaku (浅田宗伯, also known as Asada Ritsuen, 淺田栗園, 1815-1894), and Yamada Gyōkō (山田業広, 1808-1881), who had advocated for kanpō to be recognized as a separate and distinct system of practice from Western biomedicine. For Wada, synthesis with biomedicine was a natural extension of kanpō's historical syncretic heritage.

> Outside of mainstream kanpō there are a lot of other influences on kanpō. Before Western medicine came in, there existed the Japanese method *(kōkokuhō*, Imperial country method, 皇国方), and the Korean method, and the Chinese method, which was also mixed with Indian medicine. All of these work together and have their ups and downs…it is called kanpō, despite the mixtures of medicines and the improvement of hundreds of years of experiences.[24]

From Wada's perspective, kanpō was an organic system of practice that had developed over the centuries through the incorporation of practices derived from other medical systems and the cumulative experiences of its practitioners. The combination of biomedical and kanpō techniques in treatment merely represented a continuation of kanpō's syncretic tradition.

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[23] Mayanagi Makoto, "Japan and Traditional Medicine in Modern China: The Impact of Japanese Medical Texts in the Period of Republican China", paper presented at Interweaving Medical Traditions: Europe and Asia, 1600-2000. An International workshop funded by the Asia-Europe Foundation, the European Alliance for Asian Studies, the Wellcome Trust and the Wellcome Trust Centre for the History of Medicine at University College London (Wolfson College, Cambridge, September 11-13, 2003), 1.
[24] Wada, *Ikai no tettsui*, 7.

Wada's promotion of doctrinal synthesis within kanpō represented an anomaly in Japanese kanpō scholarship, as late Edo period scholars, particularly those affiliated with the *kokugaku* (national studies or native studies, 国学) school of thought, such as Hirata Atsutane (平田篤胤, 1776-1843), as well as scholars of the *Onchisha* period, grudgingly accepted the existence non-Japanese influence upon the discipline.[25] In recognizing kanpō's syncretic heritage by emphasizing its continual improvement over time and calling for the utilization of Western scientific/biomedical practices in harmony with kanpō, Wada, ironically, provided the intellectual foundation for future Japanese scholars to discount kanpō's foreign influences and claim it as a distinctly "Japanese" cultural practice on nationalist grounds, which will be discussed in more detail later in this chapter and in Chapter Four.

Despite its critics, such as biomedical practitioner Ryuken Hirade (平出隆軒), who deployed many of the abovementioned common criticisms of kanpō in an article in the *Nichii shūhō* (Japanese Medical Weekly,日医週報) panning Wada's publication, *Ikai no tettsui* served as an inspirational work for a small number of biomedical practitioners in Japan who were sympathetic to kanpō, as well as a number of classical medicine practitioners in continental East Asia concerned with the fate of their own disciplines (which will be discussed in more detail in Yumoto Kyūshin's section below).[26] Wada Keijūrō's *Ikai no tettsui* was republished domestically

[25] The perspective of Hirata Atsutane, a nineteenth century *kokugaku* scholar, will be discussed in more detail later in this chapter.
[26] Terasawa Katsutoshi, "Wada Keijūrō cho 'Ikai no tettsui' to kanpō no kadai" [Wada Keijūrō's work "Ikai no tettsui" and the Subject of Kanpō], *Nihon tōyō igaku zasshi* 61, no. 7 (2010): 939-940.

four times between 1910 and 1922 and quickly translated into Korean and Chinese.[27] Within Japan, Wada's recitation of his personal encounters with the limitations and failures of biomedicine resonated with a small number of practitioners who had had similar experiences with the shortcomings of biomedicine. Wada's work was advertised, and functioned, as a clarion call, enticing many, including Yumoto Kyūshin who will be discussed in detail below, to begin studying kanpō.[28] This marked the beginning of what is known in Japanese history as the Kanpō Medicine Revival Movement (*Kanpōyaku no fukkatsu undō*, 漢方薬の復活運動).

Yumoto Kyūshin – The Scientific Rationalization of Kanpō Medicine

In Japan, a new generation of kanpō scholars drew on Wada's work as they published their own testaments to kanpō's efficacy. Today, these scholars and their works are collectively referred to by historians of Japan as the Kanpō Medicine Revival Movement. Wada served as the progenitor of the movement. While numerous scholars participated in this movement, the two most prominent individuals from the late 1920s whose works served as a doctrinal foundation for other scholars of the movement and consequently guided the direction of kanpō medical philosophy into the 1930s were Yumoto Kyūshin (湯本求真, 1876-1941) and Nakayama Tadanao (中山忠直, 1893-1957).

With this new generation of kanpō scholars, Wada's call for doctrinal synthesis, the utilization of kanpō and biomedicine side by side, gave way to assimilation in the form of a call

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[27] Makoto, "Japan and Traditional Medicine in Modern China," 6, 8.
[28] Yumoto Kyūshin, preface to *Kōkan igaku* [Imperial Chinese Medicine] (1927; repr., Tokyo: Taian, 1962), 1. For an example advertisement, see Nankōdō shoten, "Zōtei niban Ikai no tettsui" [New and Revised Second Edition Ikai no tettsui] *Asahi Shinbun*, October 9, 1915.

for the application of biomedical and scientific approaches to kanpō practice. Concurrently scholars stressed kanpō's position as a "Japanese" cultural tradition while deemphasizing foreign influence on its historical and contemporary development. Wada's successors came to argue that while foreign ideas had influenced medical practice in Japan over the centuries, the Japanese had continually refined these ideas, maintaining a superior and distinctly Japanese discipline.

One of these scholars was Yumoto Kyūshin. Yumoto was born in 1876 in what is now Nanao City of Ishikawa Prefecture. In 1901, he graduated with a biomedical degree from *Kanazawa igaku senmon gakkō* (Kanazawa Medical Vocational School, 金澤醫學專門學校), the forerunner of the Medical Department of *Kanazawa daigaku* (Kanazawa University, 金沢大学). In 1910, Yumoto's daughter perished from dysentery, despite Yumoto's attempts to use his biomedical training to save her. That same year, Yumoto read *Ikai no tettsui*. Wada's own story of personal loss, the limitations of biomedicine, and the potential of kanpō moved Yumoto to begin studying kanpō.[29] Yumoto published his first scholarly work on kanpō in 1917; however, his most influential work, indeed possibly the most influential work on kanpō published in the twentieth century, was *Kōkan igaku* (Imperial Han/Chinese medicine, 皇漢醫學) published in three volumes in 1927 (Volume 1) and 1928 (Volumes 2 & 3).[30]

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[29] Yumoto, preface to *Kōkan igaku*, 1.

[30] Yumoto's first publication on kanpō was *Rinshō ōuyō kanpō igaku kaisetsu* [An Explanation of Kanpō Clinical Applications]. Yumoto Kyūshin, *Rinshō ōuyō kanpō igaku kaisetsu* [An Explanation of Kanpō Clinical Applications] (Tokyo: Dōzumigō shobō, 1917). Yamada Terutane, "Nihon kanpō igaku no denshō to keifu" [The Tradition and Genealogy of the Kanpō Medicine], *Nihon tōyō igaku zasshi* 46, no. 4 (1996): 509.

As with Wada's work, *Kokan igaku* focuses primarily on elucidating kanpō clinical treatments, diseases and herbal formularies; however, its most significant contribution is how it reshaped understanding of kanpō. Building on Wada's work, Yumoto Kyūshin re-contextualized kanpō as *kōkan igaku* by reviving a term that, despite what its literal translation suggests, draws on associations with Edo period Sino-Japanese cultural studies (*kōkangaku*, Imperial (Japanese)-Chinese studies, 皇漢学), itself closely related to the more well-known *kokugaku* movement of the same period, which will be discussed later in the chapter.[31] In the compound term *kōkan igaku* (皇漢醫學), Yumoto uses the character 皇 (*kō*, emperor) to reference Japan and the character 漢 (*kan*, Han Dynasty/China) to reference China to express his understanding of the dual influence each country had on kanpō's development.[32] The compound term *kōkan igaku* originated around 1882 concurrently with the term *wakan igaku* (Japanese-Chinese medicine, 和漢医学) in the writings of early *Onchisha* scholars.[33] The purpose of these terms was to differentiate classical Japanese medical practices from Western style medicine and the terms were used interchangeably.[34] However, the term *kōkan igaku* was not popularly used until the publication of *Kōkan igaku* in 1927.[35] In the context of Yumoto's work, the usage of this term is important

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[31] Mayanagi Makoto, "Kanpō ya tōyō igaku to yobu iware" [The Name Origin of Kanpō and Tōyō Igaku], *Fukuiken yakuzaishi kaihō* 121 (1997): 41.
[32] Yumoto, *Kōkan igaku*, 1-2.
[33] Yumoto acknowledges the connection between his work and that of the *Onchisha* from the outset in *Kōkan igaku* through the inclusion of a stylized calligraphy print of the Confucian idiom *onkochishin* (review the old and know the new, 温故知新), from which the name of the *Onchisha* derived.
[34] Mayanagi, "Kanpō ya tōyō igaku to yobu iware," 41.
[35] Use of the term *kōkan igaku* remained popular through the end of the Second Sino-Japanese War. Following the war, use of the term virtually ceased due to the perceived negative connotations of its use of the character 皇 in the wake of Japan's defeat. Mayanagi, "Kanpō ya tōyō igaku to yobu iware," 41.

because it marks the abandonment of an acceptance of kanpō's diverse origins, as espoused in Wada's work, and the beginning of an increasing emphasis by scholars on the "Japaneseness" of kanpō. For example, the following is an excerpt from Yumoto's discussion of the CCM/CJM method of abdominal diagnosis.

> The method of abdominal diagnosis was first introduced by Zhang Zhongjing in the *Shanghan lun* and *Jingui yaolue* during the Eastern Han period. China originated this method of diagnosis; however, its medical practices have gradually degraded and been lost …. When the method came to Japan, it saw the dawn of light. With our rapid development, it became our most important diagnostic measurement, just as Western medicine relies on anatomy. It acts as the foundation of our medicine…[36]

Here, Yumoto recognizes the Chinese origin of abdominal diagnosis, but posits that Japan improved it and assimilated it as a foundational medical practice. This example supports his argument that the system of medical beliefs and practices that later came to be known as "*kanpō igaku*" in Japan developed as an amalgamation of the two traditions. However, for Yumoto, the Japanese and Chinese-derived elements of kanpō are at least equal in composition; as such the term kanpō (Chinese method, 漢方) is a misnomer. To this end, Yumoto encouraged usage of the term *kōkan igaku* to emphasize kanpō's dual origin.[37] In other words, he acknowledged the influence of CCM upon kanpō, but did not acknowledge influence from any other traditions, such as those referenced previously in Wada's work.

On the topic of Western medicine, similar to Wada, Yumoto recognized the utility of combining biomedical and kanpō methods of treatment. However, Yumoto went further than

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[36] Yumoto, *Kokan igaku*, 6-7.
[37] Yumoto, *Kokan igaku*, 1.

Wada by arguing for the application of scientific methods/techniques to kanpō clinical practice, medicine production, and medical education in order to standardize medical practice and health outcomes.

> I will use Western medical theory to explain the advantages of classical medicine based on the writings of Zhang Zhongjing, as well as the disadvantages of modern medical treatment in hopes of combining the two medicines.[38]

Yumoto believed that scientifically rationalizing kanpō would lead to the creation of a "new medicine" (*shin ijutsu*, 新醫術) more effective than either biomedicine or kanpō of the past.[39] Virtually all members of the kanpō revival movement came to embrace this notion of scientifically rationalized kanpō. While the Western origin of the aforementioned scientific techniques was recognized by Yumoto in *Kōkan igaku*, this fact was deemphasized. Rather than emphasizing such techniques as Western, Yumoto used a different vocabulary, "science" (*kagaku*, 科学) and "modern" (*gendaiteki*, 現代的).[40] Yumoto respected "the knowledge of experience, but, at the same time, cannot ignore the knowledge of modern science."[41] Implicit in his argument is the fact that kanpō can become scientific and modern without becoming Western. Considering the biomedical criticisms of kanpō discussed previously in Chapter Two of its purported "traditional"

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[38] As discussed in Chapter One, Zhang Zhongjing (張仲景, 150CE-219CE) is credited as the author of the *Shanghan lun* (J. *Shōkanron*, E. Treatise on Cold Damage Disorders, 傷寒論), the primary CCM text upon which much of kanpō practice has been based since the rise of the Kohōha School of kanpō in the late eighteenth century. Yumoto, *Kōkan igaku*, 1.
[39] Yumoto, *Kōkan igaku*, 2-3.
[40] Yumoto, *Kōkan igaku*, 2.
[41] Yumoto, *Kōkan igaku*, 2.

and unscientific nature, Yumoto's terminology provided the foundations of an approach to defend kanpō as modern that was adopted by revivalist scholars going forward.

While Wada's *Ikai no tettsui* may function as the historical starting point of the Kanpō Medicine Revival Movement, it is *Kōkan igaku* that determined its ideological course and drew enough supporters to the cause for it to coalesce into an academic movement. Yumoto's call for the scientific rationalization of kanpō presented a solution to the historical problem of justifying kanpō's efficacy to the biomedical world on its terms. As such, this concept became the focus of the majority of prewar and postwar revivalist literature from the publication of *Kōkan igaku* forward. Through *Kokan igaku*, Yumoto drew a number of the most influential and well-known revivalist scholars to the movement, including Ōtsuka Keisetsu (大塚敬節, 1900-1980) and Shimizu Tōtarō (清水藤太郎, 1886-1976).[42] While the activities and publications of these scholars will be discussed in more detail in Chapters Four and Five, it is worth noting that Yumoto's subsequent influence was such that a special issue of the revivalist journal *Kanpō to kanyaku* (Kanpō and Chinese Medicine, 漢方と漢薬) was published in 1941 and dedicated to Yumoto upon his death, with several scholars submitting works on his life and influence.[43]

Both Wada's *Ikai no tettsui* and Yumoto's *Kokan igaku* were successful abroad, particularly in China. In China in the 1920s, CCM doctors utilized both Wada's and Yumoto's

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[42] Ōtsuka Keisetsu, "Yumoto sensei yasuraka ni meimokuserareyo," [Dr. Yumoto was Able to Peacefully Close His Eyes] *Kanpō to kanyaku* 8, no. 11 (1941): 5.; Shimizu Tōtarō, "Yumoto sensei yuku," [Dr. Yumoto Passes Away] *Kanpō to kanyaku* 8, no. 11 (1941): 7.

[43] Nihon kanpō igakkai, "Yumoto Kyūshin sensei Ishii Shūsan sensei tsuitōgō," [Memorial Issue for Dr. Yumoto Kyūshin and Dr. Ishii Shūsan] *Kanpō to kanyaku* 8, no. 11 (1941).

works in their own efforts to prevent its abolition and recover lost CCM knowledge destroyed in the wars of the nineteenth and early twentieth centuries. Wada and Yumoto's arguments for the synthesis and later assimilation of kanpō and biomedicine provided a blueprint for CCM practitioners to follow in advocating for the continued relevance of their discipline.[44] To this end, there were four Chinese reprint editions of *Ikai no tettsui* published between 1911 and 1930 and six reprint editions of *Kōkan igaku* between 1929 and 1939.[45] Yumoto's *Kōkan igaku* appears to have been the most popular of all Japanese texts on classical medicine to enter China during the latter nineteenth and early twentieth centuries, as it refined Wada's argument for the ongoing utility of classical medicine in the modern world.[46] In the preface to the 1929 Chinese translation of *Kōkan igaku* (C. *Huanghan yixue*), the translator, Zhou Zixu (周子叙), a CCM doctor with more than 10 years of experience, summed it up as follows:

> What Yumoto says is what I want to say but cannot. Facing the extinction of traditional medicine, surely through this text we can revive it. Yumoto's scientific experiments are not extreme. They make clear the beneficial effects of our ancient prescriptions, which cannot simply be put mechanically into practice. Yumoto's scientific experiments are the standards of the medical world and the basis for the revival of our people.[47]

As in the case of Wada's *Ikai no tettsui*, *Kōkan igaku* provided ideological support to physicians of CCM in their efforts to prevent the abolition of classical medicine. Its influence was such that

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[44] Gao Yuqiu and Mayanagi Makoto, "Ding Fubao yu zhongri chuantong yixue jiaolu" [Ding Fubao and Sino-Japanese Medical Exchanges of Traditional Medicine], *Zhonghua yishi zazhi* [Chinese Journal of Medical History] 22, no. 3 (1992): 179.
[45] Makoto, "Japan and Traditional Medicine in Modern China," 8.
[46] Makoto, "Japan and Traditional Medicine in Modern China," 7.
[47] Yumoto Kyūshin, preface to *Kōkan igaku* [C. *Huanghan yixue*, E. Imperial Chinese Medicine], trans. Zhou Zixu (Shanghai: Shanghai zhonghua shuju yinshuahang, 1929), 1.

Yu Yan (余巖, also known as Yu Yunxiu, 余雲岫, 1879-1954), the primary architect of the effort to abolish CCM in the 1920s, attempted to mitigate its influence by publishing a rebuttal to *Kōkan igaku*.[48] *Kōkan igaku* has retained its popularity in China to the present and remains in publication.

Nakayama Tadanao - Japan's Medicine as an Ideological Construct

Nakayama Tadanao was unlikely candidate for membership in the Kanpō Medicine Revival Movement. Born in Kanazawa City in Ishikawa Prefecture, Nakayama attended *Waseda daigaku* (Waseda University, 早稲田大学) to study commerce. Unlike virtually every other kanpō revivalist, he did not have formal medical training. However, he was a writer, penning a number of works on kanpō, Japanese exceptionalism, culture, and science fiction.

Writing concurrently with Yumoto, Nakayama Tadanao, a strident advocate for the revitalization of classical kanpō medicine, published an article titled, "*Kanpō igaku fukōron*" (A Discussion of the Revival of Kanpō Medicine, 漢方醫學復興論) in 1926. In this work, Nakayama argued for the imminent realization of a new method of medicine combining scientific biomedicine and kanpō medicine that would emanate from Japan and "shine throughout the world."[49] Made possible through the unique cultural strengths of Japan's "*tensai minzoku*" (genius race, 天才民族), "*Nihon no igaku*" (Japan's medicine, 日本の醫學) would eclipse "*seiyō igaku*" (Western

[48] Sean Hsiang-lin Lei, *Neither Donkey Nor Horse: Medicine in the Struggle over China's Modernity* (Chicago: University of Chicago Press, 2014), 93.
[49] Nakayama Tadanao, "Kanpō igaku fukōron" [Theory and Revival of Kanpō Medicine], *Nihon oyobi nihonjin* [Japan and the Japanese] 109 (1926): 6.

medicine, i.e. biomedicine, 西洋医学) and "draw students from all over the planet".[50] Nakayama's usage of the Japanese particle "の", which indicates ownership or possession, in the phrase *Nihon no igaku* is intentional. From a grammatical perspective, both "*Nihon igaku*" (Japanese medicine, 日本醫學) and "*Nihon no igaku*" (Japan's medicine) convey similar meanings; however, "*nihon no igaku*" provides more explicit localization, emphasizing that the "medicine" to which Nakayama is referring is from Japan, i.e. not China. Steeped in exceptionalist rhetoric, Nakayama's work sought to distance kanpō, the most important aspect of this new medicine, from its Chinese origins by emphasizing and evaluating Japanese "improvements" to the tradition.[51]

> When it comes to imitation, do the Japanese people always improve things? In ancient times, we imported mathematics, herbology and medicine from China. We familiarized ourselves with them and mastered them before surpassing China. Today there are many fields of study imported form the West. In the same way we intend to surpass them as well.[52]

To this end, Nakayama reconceptualized scholarly understanding of the character 漢 (*kan*) in 漢方 (*kanpō*). Before Nakayama, the character 漢 in 漢方 was most commonly understood as a reference to China; however, 漢 in its literal sense is a reference to the Han Dynasty (J. *Kanchō*, C. *Hanchao*, 漢朝, 202BCE-9CE & 25CE-220CE). In this way, Nakayama built on the syncretic and assimilationist conceptions of kanpō advanced by Wada and Yumoto to argue for the transcendence of "Japan's medicine" over all others.

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[50] Nakayama, "Kanpō igaku fukōron," 5, 11-14.
[51] Nakayama, "Kanpō igaku fukōron," 5.
[52] Nakayama, "Kanpō igaku fukōron," 5.

Nakayama's conception of "Japan's medicine" paralleled that advanced by *kokugaku* (national studies or native studies, 国学) scholar Hirata Atsutane (平田篤胤, 1776-1843) in the early nineteenth century.[53] Hirata believed that classical medicine had originated in Japan, though he also acknowledged the existence of Chinese improvements to the tradition.

> Though introduced into Japan from abroad, the practice of medicine was originally taught to foreign countries by our gods. Later, medicine came to be widely practiced in Japan. Even though it may have foreign origins, this not a reason for us to dislike it. However, the truth is that medicine developed to such an extent in China because of the presence of disease everywhere resulting from the country's evil nature.[54]

Nakayama did not go so far as to posit that Japanese deities introduced CCM to China, but he did embrace the same spirit of Japanese exceptionalism and condescension toward China as Hirata. Nakayama accepted that Chinese medicine had been influential in the development of kanpō; however, he believed that kanpō practitioners over the centuries had taken Chinese medical ideas and refined them, resulting in an inherently superior medical tradition. It is important to note that Nakayama rejected the concepts of invention and originality. He did not believe in their existence. He argued that what might customarily be perceived as invention or originality constituted mere imitation and improvement.

> Westerners (*ōbeijin*, 欧米人) argue that the advancement of Japan today is the result of imitation. However, imitation is not that simple of a thing. Learning

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[53] *Kokugaku* was an intellectual movement of the late eighteenth and early-to-mid nineteenth centuries in Japan. Formed in opposition to *kangaku* (Chinese studies, 漢学), *kokugaku* emphasized the existence of a pre-Chinese influence Japanese culture, while simultaneously rejecting the contemporary influence of Chinese theories, such as Neo-Confucianism, on Japanese society.

[54] Hirata Atsutane, *Shizu no iwaya* [*Shizu no iwaya*] (Edo: Ibukinoya, 1811), 27. *Shizu no iwaya* is also the name of a legend about the Shinto deities *Ōkuninushi* (大国主神) and *Sukunabikona* (少名毘古) found in the *Man'yoshu* (万葉集), a Japanese collection of waka poetry dated to around the eighth century CE.

> from imitation itself is proof of extraordinary ability. Imitation is not something that monkeys and barbarians can do; it is one of the characteristics of cultured men. The process of learning is imitation; academic pursuits and culture are merely mimicry and improvement. All scientific advancement is about give and take; one invention is going to lead to another invention and then become the foundation of a later one. These are not independent inventions, rather, they are well connected inventions. Therefore, the races (*minzoku*, 民族) of Britain, America, France and Germany are the best at imitation.[55]

The Japanese, according to Nakayama, excelled at imitation and improvement, positioning them to be the best at all pursuits.[56] Again, Nakayama's rejection of originality as a concept mirrored Hirata's argument from a century prior.

> Japanese should study all kinds of learning, even if foreign, in order to be able to choose the good features of each and use them for the country. We can speak of not just Chinese, but also Indian and Dutch learning as Japanese learning. This should be understood by all Japanese who study foreign learning.[57]

In other words, cultural ownership of knowledge is not static; it shifts depending on one's perspective. From his own perspective, Nakayama could argue that kanpō is an authentically Japanese practice because it was the result of Japanese refinement of CCM practice. Similarly, kanpō would remain Japanese after its scientific rationalization because it merely constituted the assimilation of a "good feature" from a formerly foreign practice. For example, Nakayama argued that Japanese medicine was superior to Western medicine prior to the development of the microscope and consequent discovery of bacteria.[58] It was only the initial unavailability of this instrument in Japan that had stunted the development of Japanese medicine, but by imitating and

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[55] Nakayama, "Kanpō igaku fukōron," 4.
[56] Nakayama, "Kanpō igaku fukōron," 4-5.
[57] Hirata Atsutane, *Kodō taii* [Summary of the Old Way] (1811; repr., Tokyo: Hirata gakkai jimusho, 1912), 7.
[58] Nakayama, "Kanpō igaku fukōron," 11-12.

improving upon Western techniques, "the golden age of medicine will be achieved by the hands of the Japanese race."[59] Nakayama was not concerned with the Western origin of these techniques, because he believed that Japanese doctors had already assimilated and improved upon them.

"*Kanpō igaku fukōron*" appears to have been well received in Japan. The *Asahi Shinbun* (Asahi Newspaper, 朝日新聞) advertised its publication and included an positive review on October 14, 1926.[60] On April 1, 1927, the *Yomiuri Shinbun* described Nakayama's work as seeking to "return the light of the East" (*tōhō no hikari ni kaere*).[61] Following the success "*Kanpō igaku fukōron*", Nakayama continued to expand his ideas on kanpō and Japanese exceptionalism, ultimately publishing several books on the topics.[62]

Conclusion

On October 21, 1927, the *Asahi Shinbun* acknowledged the existence of a Kanpō Medicine Revival Movement (*Kanpōyaku no fukkatsu undō*, 漢方薬の復活運動) in Japan, bringing to fruition a process made possible by the works of Wada, Yumoto and Nakayama.[63] Building on Wada's conception of kanpō's doctrinal synthesis, Yumoto's conception of assimilation found in

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[59] Nakayama, "Kanpō igaku fukōron," 13.
[60] Asahi Shinbun, "Nihon oyobi Nihonjin: Shūki zōkan" [Fall Special Issue of Japan and the Japanese], *Asahi Shinbun*, October 14, 1926.
[61] Yomiuri Shinbun, "Tōhō no hikari ni kaere: Nakayamakun no 'Kanpō igaku fukkatsuron'" [Return the Light of the East: Nakayama's Discussion of the Revival of Kanpō Medicine] *Yomiuri Shinbun*, April 1, 1927.
[62] Nakayama Tadanao, *Kanpō igaku yodan* [Kanpō Medicine's Digressions] (Tokyo: Nakayama kenkyūjō shuppanbu, 1929).; Nakayama Tadanao, *Kanpō igaku no shinkenkyū* [New Research on Kanpō Medicine] (Tokyo: Hōbunka, 1931).; Nakayama Tadanao, *Nihonjin no erasa no kenkyū* [Studies of Japanese Excellence] (Tokyo: Shokasha, 1933).
[63] Asahi Shinbun, "Kanpōyaku no fukkatsu undō" [Kanpō Medicine Revival Movement], *Asahi Shinbun*, October 21, 1927.

Kōkan igaku and Nakayama's notion of the transcendence/superiority of "Japan's medicine" redefined domestic perceptions of kanpō medicine as a "Japanese" cultural practice. Taken together, the concept of a scientifically rationalized kanpō, superior to continental classical medicine, became a foundational belief for the Pan-Asianist kanpō revivalists of the Second Sino-Japanese War (1937-1945) period. As discussed in Chapter Four, by the 1930's, the concept of kanpō as a syncretic, scientific, modern, and uniquely Japanese medical tradition would be promoted by kanpō scholars and find full expression through the concept of *tōyō igaku* (Oriental medicine, 東洋医学).

Chapter Four - Tōyō Igaku: Japanese Pan-Asian Ideology and the Promotion of Kanpō Medicine in East Asia During the Second Sino-Japanese War

In the 1930s, as Japan's colonial aspirations peaked, kanpō scholars saw an opportunity to advance the revival of their discipline by promoting study of the shared medical heritage of East Asia in Japan's colonies, particularly Manchukuo (J. *manshūkoku*, 滿洲國, sometimes alternatively written as 滿州國). Classical Chinese Medicine (CCM) had served as the foundation for the dominant classical medical systems of East Asia, so there were significant continuities of practice. However, the study of continental classical medicine was a secondary concern supported only in so far as it advanced the development and exportation of scientifically rationalized kanpō to continental East Asia. Cloaked in the language of inclusivity through the adaptation of contemporary geopolitical abstractions such as *tōa* (East Asia, 東亜), *tōyō* (Orient, 東洋) and *shina* (China, 支那), scholars promoted kanpō as a superior Japanese refinement of continental classical medicine, stripped of superstitious etiology and legitimized by science as a supplement to biomedicine. Lamenting the challenges that continental classical medicine faced in the form of poorly trained practitioners, de-legitimization efforts by the biomedical establishment and the general chaos of the period, these scholars declared it to be their "mission" to inform and support their brethren in the colonies.[1] Reflecting the Pan-Asian sentiment of the time, they argued that the promotion of this unifying factor among the "family" of races in East Asia would facilitate

[1] Kimura Chōkyū, "Tōa igaku no hakkan ni saishite" [On the Occasion of the Publication of East Asian Medicine], *Tōa igaku* 1, no.3 (February 1, 1939): 5.

peace and cooperation.[2] Through their actions, scholars sought to align themselves with the Japanese government's Pan-Asian unity propaganda drive and thereby gain support for official recognition of kanpō within Japan.

The Association of East Asian Medicine

To advance their goals, scholars supported the establishment of specialist organizations, such as the Association of East Asian Medicine (*Tōa igaku kyōkai* – abbr. AEAM, 東亜醫學協會). The AEAM was founded in Koishikawa, Tokyo on November 23, 1938 by Ōtsuka Keisetsu (大塚敬節, 1900-1980), Yakazu Dōmei (矢数道明, 1905-2002), Kimura Chōkyū (木村長久, 1910-1945), Shimizu Tōtarō (清水藤太郎, 1886-1976), Yanagiya Sōrei (柳谷素霊, 1906-1959), Kazuo Tatsuno (龍野一雄, 1905-1976) and Ishihara Yasuhide (石原保秀, 1877-1943).[3] It served as an umbrella organization for efforts to promote kanpō in Japan and abroad. Its stated mission was to pursue the "renewal and encouragement" of classical medicine in East Asia and promote

[2] A note about terminology: The terms "classical" and "traditional" are used in reference to medicine throughout this chapter with specific intent. When referring to kanpō and associated classical Chinese medicine-derived systems in East Asia, Japanese medical scholars of the early twentieth century would have described such as "traditional medicine". However, today, the phrase "traditional medicine" in reference to kanpō can be used in Japan to refer to kanpō as it existed at any point in its history. This is problematic as contemporary kanpō practice has largely been reconceived by practitioners from a scientific perspective since the early 20th century. This is also true, though to a much lesser extent, of "traditional" medicine in other East Asian countries. In other words, contemporary "traditional" kanpō in Japan is not authentically traditional. Therefore, in order to avoid confusion, the term "classical" is used in reference to kanpō and medicine in continental East Asia when the intent is to invoke medicine as practiced prior to its reconceptualization within the scientific paradigm. Conversely, "traditional" is used in reference to kanpō and medicine in continental East Asia when the intent is to invoke medicine as practiced during or after to its reconceptualization within the scientific paradigm.

[3] Tōa igaku kyōkai, "*Tōa igaku kyōkai* setsuritsu nitsuite" [About the Establishment of the Association of East Asian Medicine], *Kanpō to kanyaku* 5, no. 12 (1938): 100.

cooperation between the Japanese, Chinese, and Manchu races.[4] At its inaugural meeting, Chinese and Korean physicians of classical medicine were invited by the AEAM's members and interpreters were provided in order to facilitate their participation.[5]

Through the AEAM and its Japan-oriented partner organizations such as the *Nihon kanpō igakkai* (Japan Kanpō Medical Association, 日本漢方醫學會), scholars promoted a number of initiatives relating to the study of classical East Asian medicine, in Japan, its colonies, and its areas of influence. They supported the establishment of scholarly publications, such as *Manshū no kangaku* (*Manchuria's Chinese Studies*, 滿州の漢學), *Tōyō igaku* (*Oriental Medicine*, 東洋醫學), *Tōa igaku* (*East Asian Medicine*, 東亜醫學), and *Kanpō to kanyaku* (*Kanpō and Chinese Medicine*, 漢方と漢藥), dedicated more broadly to the historical and contemporary study and practice of East Asian classical medicine than earlier Japanese publications which had tended to focus more exclusively on kanpō medicine.[6] *Tōa igaku* was particularly notable for its inclusion of travel reports on the status of continental classical medicine based on visits by AEAM members, such as Koyanagi Ken'ichi, editor of *Tōa igaku*, who toured several cities in northern China in order to interview local classical medicine practitioners and investigate local medical conditions in 1939.[7] Similarly, *Tōa igaku* featured a series of articles in 1939 and 1940 by two Imperial Japanese Army

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[4] Ōtsuka Keisetsu, "Kagaku no senrei wo uketaru kanpōi wo yōsei yo" [The Training of Kanpō Doctors Receiving the Baptism of Science], *Tōa igaku* 1, no. 1 (February 1, 1939): 3.
[5] Yakazu Dōmei, "Tōa igaku kyōkai hakkai kaikai no ji" [Opening Address of the meeting of the Association of East Asian Medicine], *Tōa igaku* 1, (1939): 9.
[6] *Tōa igaku* was the official monthly journal of the AEAM. *Kanpō to kanyaku* was published by the *Nihon kanpō igakkai*. *Tōa igaku* merged with *Kanpō to kanyaku* in 1941 and continued publishing under the latter's name.
[7] Koyanagi Ken'ichi, "Shina iyaku eisei jijō shisatsu hōkokusho" [Chinese Medicine and Sanitation Conditions Inspection Report], *Tōa igaku* 4 (1939): 2.

doctors, First Lieutenant Nakajima Torao (中島寅男) and First Lieutenant Honda Seiichi (本多精一), detailing their experiences with kanpō and classical medicine in China. In addition to general articles on the state of classical medicine in China, Honda published two articles based on his interviews with classical doctors in Suzhou and Shanghai, expressing his views and theirs on the state of classical medicine in China and the utility of scientifically rationalized kanpō.[8] Nakajima reported on his interviews with and observations of CCM physicians in practice around Beijing and Tianjin. In his discussions with these classical medicine doctors, he emphasized the need for kanpō and CCM practitioners to make common cause for the future of the East Asia and their respective disciplines, arguing for the benefits of scientifically rationalized kanpō, going so far as to give out a Chinese translation of Yumoto Kyūshin's *Kōkan igaku* on at least one occasion.[9] Nakajima also displayed an interest in the practical use of CCM and kanpō treatments, recording detailed descriptions of treatments he witnessed by CCM doctors as well as his own use of kanpō to treat malaria in the Imperial Army.[10]

In addition to their journals, the AEAM also promoted the study of kanpō and classical medicine on the continent, particularly in Manchukuo, through the publication and dissemination of bilingual Chinese/Japanese kanpō medical lectures. Stemming from the association of much of

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[8] Honda Seiichi, "Soshū no meii Kissen sensei wo tazunete" [Meeting the Noted Doctor Juquan of Suzhou], *Tōa igaku* 13 (1940): 104.; Honda Seiichi, "Shanhai no meii: Ji Itsujin sensei wo tazunete" [Noted Doctor of Shanghai: Visiting Shi Yiren], *Tōa igaku* 19 (1940): 149.
[9] Nakajima Torao, "Senjin nikki" [Battlefield Journal], *Tōa igaku* 1 (1939): 8.
[10] Nakajima Torao, "Mararia no kanpō chiryō" [Kanpō Malaria Treatment], *Tōa igaku* 22 (1940): 174.; Nakajima Torao, "Mararia ni taisuru kanpō ryōhō nitsuite" [Concerning a Kanpō Treatment Regarding Malaria], *Kanpō to kanyaku* 7, no. 10 (1940): 8-13.

its leadership with the Kanpō Department at Takushoku University (Colonization University, 拓殖大學), the AEAM secured kanpō teaching materials to donate to continental schools and planned exchange programs.[11] Another initiative was the creation of a research organization known as the East Asian Medicine Research Institute (*Tōa igaku kenkyūjo*, 東亜醫學研究所) to promote the sale of kanpō drugs in China.[12] Efforts were made to promote the research and procurement of herbal components for use in kanpō for export to Japan as well. Proposals were made for the foundation of kanpō schools, libraries and hospitals on the continent, though it does not appear that any of these plans were carried out. Though the AEAM's initiatives were ambitious, their actual achievements, with the exception of their development of a classical medicine licensing system for the Government of Manchukuo, which will be discussed later in this chapter, were modest and largely confined to the realm of research and scholarly exchange due to their limited financial resources and the practical constraints placed upon their activities by the war in China.[13]

Ideological Justifications

To fully understand the implications of these efforts one must first consider the ideological justifications of these initiatives separately from the initiatives themselves. From the outset, it is

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[11] Mizuno Norihito, "Kampo in Wartime Sino-Japanese Relations: The Association of East Asian Medicine and the Search for a Tripartite Medical Partnership" in *Science, Technology, and Medicine in the Modern Japanese Empire*, ed. David Wittner and Phillip Brown (New York: Routledge, 2016), 182-183.
[12] Tōa igaku kyōkai, "Kyōkai kenkyū no kanpōyaku: Shin keishiki no shimo ni seihinka saru, Tōa igaku kenkyūjo yori hatsubai" [The Association's Kanpō Herbal Medicine Research: Commercialized under the New Format, Launched by the East Asian Research Institute], *Tōa igaku* 2, (1939): 17.
[13] Mizuno, "Kampo in Wartime Sino-Japanese Relations," 184.

important to understand that the AEAM's drive to facilitate the study of classical medicine in East Asia was motivated by self-interest. They did not envision a future where classical Chinese medicine (CCM) dominated in China, Manchurian-Chinese medicine (*Manshū kanigaku*, 滿州漢醫學) in Manchuria, and kanpō medicine in Japan, with each branch maintaining its own unique attributes and approaches to healing.[14] Instead, according to the AEAM's statement of purpose, they sought to "internationalize kanpō" by spreading it to Japan's colonies.[15] However, there is more to this story than Japanese doctors seeking to impose kanpō on the rest of East Asia.

Previously, during the 1920s and early 1930s, Japanese scholars of kanpō, most of whom were initially trained in biomedicine, had begun to consider kanpō from a scientific perspective. They sought to rationalize kanpō practice, standardize its treatments and scientifically verify its efficacy. They recognized the limitations of Western medicine in dealing with medical issues other than bacteriological infections and surgery. Kanpō, they believed, could augment biomedicine, addressing ailments of which the latter had little understanding. By combining the strengths of these two traditions, medical practice would "become perfect", in the words of kanpō scholar Kimura Chōkyū.[16] Consequently, efforts to promote classical medicine in East Asia were focused on exporting the scientifically rationalized kanpō paradigm to the Japanese periphery through scholarly exchange in order to innovate and unify the various traditions. Secondarily, these efforts aimed at procuring herbal components and potentially uncovering lost knowledge, as well as "new"

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[14] Kazuo Tatsuno, Manshū kanigaku no honshitsu to shishōrai [The Essence of Manchurian-Chinese Medicine and Its Future], *Tōa igaku* 25 (1941): 200.
[15] Kimura, "Tōa igaku no hakkan ni saishite," 5.
[16] Kimura, "Tōa igaku no hakkan ni saishite," 5.

classical medical approaches to disease, that could be rationalized and incorporated into kanpō. As with their predecessors from the empiricists of the Kohōha School of kanpō forward, these scholars were interested primarily in the study of pharmacopoeia and physical medicine; little consideration was given to classical ideas of disease causation and transmission. The purpose of these efforts was to support the development of kanpō, not the region's classical practitioners.

Returning to the ideological goals of the organization, building on the work of earlier kanpō nationalists like Nakayama Tadanao (中山忠直, 1895-1957), many members of the Association of East Asian Medicine saw their actions as part of a larger policy to promote long-term cooperation and peace in East Asia, consistent with the Pan-Asian ideology being promoted by the Japanese government at the time. Revivalists branded kanpō internationally as *tōyō igaku* (Oriental medicine, 東洋醫學), advertising it as the culmination of thousands of years of shared cultural heritage of classical medicine, with the aim to strengthen the bonds between China, Japan and Manchukuo. According to Ōtsuka Keisetsu, "the treasure of the friendship between Japan and China is elevated by the beauty" of working with Chinese medicine.[17] Beyond facilitating bonds though, the promotion of kanpō was meant to serve a greater purpose of helping to usher in a "new age in East Asia" (J. *tōa no shin jidai*, 東亜の新時代*)*, an age of "eternal peace" (*eien heiwa*, 永遠平和).[18] In other words, the promotion of kanpō*/tōyō igaku* in East Asia was intended to facilitate the accomplishment of Japan's pacification of the region in line with the words of Ōtsuka

[17] Ōtsuka, "Kagaku no senrei wo uketaru kanpōi wo yōsei yo," 3.
[18] Ōtsuka, "Kagaku no senrei wo uketaru kanpōi wo yōsei yo," 3.

Keisetsu, "war is a method of breaking down an old culture to create a new culture".[19] Assertions of Pan-Asian unity and shared heritage were a means to an end.

In order to better understand this point, one must consider the precise meanings and implications of three influential Japanese contemporaneous political concepts as applied to medicine: *tōa* (East Asia, 東亜), *tōyō* (Orient, 東洋) and *shina* (China, 支那).

Tōa (東亜)

Tōa (East Asia, 東亜) was a term used to refer to East Asia in a physical, territorial, and temporal sense.[20] When kanpō revivalists referred to *tōa igaku*, they were speaking of medicine in East Asia as it actually existed and was practiced in the region.

Tōyō (東洋)

According to historian Stefan Tanaka, *tōyō* (lit. eastern seas, typically translated as Orient, 東洋) was a much broader term, "a geo-cultural entity" encompassing the non-West; however, for members of the Association of East Asian Medicine, it was used most often to refer more narrowly to East Asia – Japan, Korea, Taiwan, Manchukuo and China.[21] *Tōyō* was a late nineteenth century ideological construction of "the Orient" from a Japanese perspective meant to serve in binary opposition to the ideological conception of *seiyō* (the West, 西洋). During the Meiji period (1868-

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[19] Ōtsuka Keisetsu, "Sensō ha bunka no haha" [War is the Mother of Culture], *Tōa igaku* 2, no.5 (1939): 15.
[20] Stefan Tanaka, *Japan's Orient: Rendering Pasts into History* (Berkeley: University of California Press, 1993), 223.
[21] Tanaka, *Japan's Orient*, 4.; Hata Kamon, "Tōyō igaku no juritsu" [The Establishment of Oriental Medicine], *Kanpō to kanyaku* 2, no. 10 (1935): 15.; Shimizu Totarō, "Tōyō koigaku no ken'isha Nihon" [Japan as the Authority on Ancient Oriental Medicine], *Kanpō to kanyaku* 6, no. 8 (1939): 106.

1912), the influx of Western ideas and technology led to significant changes in Japanese societal structures and daily life. Consequently, many Japanese expressed concern at what they saw as an ongoing abandonment of Japan's traditional culture. Though technologically dominant at the time, Japanese proponents of this view argued that the West (*seiyō*) was spiritually and culturally poor in comparison to the Orient (*tōyō*). This idea of *tōyō* was prominently represented in the popular Meiji period political slogan *tōyō dōtoku, seiyō geijutsu* (Eastern ethics, Western technology, 東洋道徳西洋芸術). This phrase encapsulated in simple terms how Japanese intellectuals developed *tōyō* into an ideological counterpoint to *seiyō* during the Meiji period; *tōyō* served as a reservoir of cultural vibrancy, upright morality and civilizational continuity, while *seiyō* represented the discarding of tradition, moral degradation, and civilizational disruption.[22] It is worth noting that this understanding was almost the exact reverse of that posited by many Western writers of the latter nineteenth century who argued that Japan should implement Western ideas, social structures, and technology in order to join the ranks of the so-called "advanced" nations of the world. For many Japanese scholars of the early twentieth century, *tōyō* evoked an idealized interpretation of East Asia's past, present and future that could and was frequently utilized in intellectual debates by nationalist scholars to justify the nation's colonial ambitions, as well as its "duty" to enlighten the inhabitants of East Asia, such as in the case of kanpō.[23]

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[22] Kamon, "Tōyō igaku no juritsu", 153.
[23] For examples of this usage, see Kamon, "Tōyō igaku no juritsu," 153.; Shimizu, "Tōyō koigaku no ken'isha Nihon," 106.; Ōtsuka Keisetsu, "Kagaku no senrei wo uketaru kanpōi wo yōsei yo," 3.; and Yakazu, "Tōa igaku kyōkai hakkai kaikai no ji," 9.

In reviewing the terminology used to refer to medicine in two of the major AEAM affiliated publications of the period, *Tōa igaku* (pub. 1939-1941) and *Kanpō to kanyaku* (pub. 1934-1944), the term *tōa igaku* is most common, appearing generally in articles concerning the practical aspects of medicine, with *tōyō igaku* appearing only in more philosophical articles. *Tōa igaku* was an inclusive term referring to East Asian medicine as practiced while *tōyō igaku* existed as an idealized form toward which Eastern civilization was thought to be progressing.

Shina (支那)

The term *shina* (China, 支那), a derogatory Japanese term for China in this period, was inseparable from the concept of *tōyō* as understood by Japanese intellectuals in the early twentieth century. *Shina* only became popularized in the early twentieth century as a replacement for the word *chūgoku* (middle kingdom,中國), though *shina* had been in usage for centuries without derogatory implications.[24] The term *chūgoku* was increasingly rejected in Japan in the nineteenth century on nationalist grounds because it implied that China was the center of Asian, or even global, civilization. Given Japan's growing economic and political status and China's complementary political fragmentation, this implication clashed with Japan's own rising self-image; consequently, usage of the word *shina* grew as the balance of power in Asia shifted toward the Japanese Empire in the early twentieth century, as it provided Japanese leaders with an alternate terminology to serve their political interests.[25] A name is a label by which, through the prism of culture,

[24] Tanaka, *Japan's Orient*, 5.
[25] Tanaka, *Japan's Orient*, 203.

individuals perceive other individuals or entities. Names may be aspirational, as in the case of *chūgoku*, which evokes the yearning of early residents of what is now known as China to be seen as a/the center of civilization. With this in mind, the rise in usage of *shina* represents a linguistic assault for political purposes aimed at literally decentralizing China in the linguistic context. The concept of *shina* provided a clear demarcation between Japan and China as they existed in the late nineteenth/early twentieth centuries, but it also came to represent "an idealized space and time" in the past "from which Japan developed" into an increasingly powerful and prosperous state.[26] Conversely, contemporary *shina* was a barbarous and benighted land that had once been great but was no longer. Japan had succeeded China as the "middle kingdom" of Asia by building off the cultural foundations bequeathed to it over successive centuries. As one Japanese revivalist kanpō scholar, Koyanagi Ken'ichi, put it, "China, the originator of our country's culture, has become a savage and worthless land."[27] However, Japanese scholars believed that by embracing those aspects of classical culture derived from China that were thought to have made successive imperial dynasties great in the past and improving upon them, Japan could strengthen itself, ward off Western moral corruption, and lead Asia into a new age. In the following quote from Shimizu Totarō, the notion of an unscientific China is contrasted with a research-oriented Japan to reinforce the latter's claim to be the authority on *tōyō igaku*.

> Ancient *tōyō igaku* is being rapidly revived as scientific. This medicine was originally primarily herbal, but, for European countries and Japan, modern science is becoming more important. In recent years, China (*shina*) has shown

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[26] Tanaka, *Japan's Orient*, 13.
[27] Koyanagi Kenichi, "Tairiku iryō taisaku no seikyokuteki igi" [The Proactive Significance of Continental Medical Treatment Measures], *Tōa igaku* 2, no. 1 (1939): 11.

> almost no scientific improvement. However, Chinese (*shinajin*) all use this medicine and do not use Western medicine at all. As the authority on *tōyō igaku*, Japanese are doing much research on this. Separated from superstition, these days, not only Europeans, but also Chinese (s*hinajin*) use Japanese research as their foundation.[28]

In this way, *shina* existed as a fundamental concept within the larger ideal of *tōyō* for Japanese scholars. *Tōyō*, as understood by these prewar Japanese scholars, could not exist without *shina*.

Imagining a Superior Form of Medicine

The incorporation of the *shina* concept within the idea of *tōyō* allowed Japanese scholars to reconcile the foreign origin (China) of aspects of its cultural heritage with the assertions of cultural continuity and vibrancy found in *tōyō*. Scholars asserted that the character *kan* (C. *han*, 漢) in kanpō (漢方) should be understood as referencing the Han Dynasty (C. *Hanchao*, J. *Kanchō*, 漢朝), a time in which China flourished, rather than as a reference to China in general.[29] Though China served as the arbiter of East Asia's past, Japan was to be its present and future. For example, though kanpō medicine entered Japan initially as a wholesale import of classical Chinese medicine, over the course of the Edo period (1603-1868) significant adaptations to classical practices occurred as the result of domestic innovations. While historians today cite this as the period in which kanpō developed fully into a uniquely Japanese cultural tradition, statements made by kanpō revivalists in the early twentieth century indicate that kanpō had yet to be fully accepted as a "native" tradition in Japan. The explanation for how classical medicine could be both "foreign"

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[28] Shimizu, "Tōyō koigaku no ken'isha Nihon," 106.
[29] Shimizu, "Tōyō koigaku no ken'isha Nihon," 107.

and “native” stems from the fact that kanpō’s foreign origin only became an issue of concern when the rise of nationalism and anti-foreign sentiment in Japan coincided with efforts to revive the discipline in the late nineteenth and early twentieth centuries. The promotion of kanpō, a discipline initially derivative of classical Chinese medicine, at a time of escalating tensions between Japan and China, at first glance would seem unlikely to succeed in such a hostile environment.

However, following the *tōyō* paradigm as elucidated above, kanpō revivalists of the early twentieth century recontextualized kanpō as the successor to classical Chinese medicine, and, by extension, its variants, on the East Asian continent. The fruition of these efforts came in the late 1920s in the work of Nakayama Tadanao (中山忠直, 1893-1957). Nakayama argued that kanpō represented a superior and uniquely Japanese form of medicine made possible by Edo period clinical advances and the application of scientific principles to etiology, treatment and medicine production. His nationalistic conception of kanpō as a superior Japanese form of medicine served as a foundational belief for the Pan-Asian kanpō revivalists of the Second Sino-Japanese War (1937-1945) period.

Japanese kanpō doctors could argue for the supremacy of kanpō while promoting classical Chinese medicine on the mainland because kanpō, though asserted to be superior to CCM, was a derivative of CCM. Therefore, it was beneficial for kanpō doctors to support research on CCM; it provided them with access to and influence over classical medical doctors and scholars on the continent and, somewhat ironically, provided them access to recent developments in CCM treatment. Notions of a degenerated *shina* to the contrary, there was a practical recognition of the mutual benefits that could be garnered through shared research.

The Chinese Perspective

The concept of *shina* finds clear expression in the following excerpt from a Chinese language article in the Association of East Asian Medicine's journal *East Asian Medicine* (*Tōa igaku*, 東亜醫學) titled, "The Backwardness of Chinese Medicine" (*Zhongguo zhi yixue luohou*, 中國之醫學落後) by Gao Qixiang (高其湘).

> Our Chinese culture is one of the earliest; therefore, we have been called an ancient civilization. At the same time, the medicine that we originated [(CCM)] is also one of the earliest. We are the elders of the whole planet. However, up to the present, we have not really improved our medicine; at the same time, we have been unable to hold on to our ancestor's creative spirit. This is because our people's character is to follow the old ways. It is also because the people lack guidance. All of this has led to the situation where our medicine has fallen behind [(lit. backward medicine - 落伍醫學)]. Therefore, it would be natural if Chinese medicine were to be eliminated. But it is lucky that the great and honorable Japanese people have made a vigorous effort to advance our medicine. They have considered it carefully …. this is lucky for the Chinese race and also lucky for Asia.[30]

Gao's statement reflected the Japanese immediate prewar notion of a degenerated *shina*, as well as an adoption of a contemporary Japanese notion of *tōyō*. He asserted that China is an "ancient civilization" that had since lost its "creative spirit", consequently its medicine had failed to develop.[31] Solely due to Japanese improvements to its medicine had CCM been able to advance. Gao continued by suggesting that only through Japanese scientific leadership could Chinese medicine evolve.

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[30] Gao Qixiang, "Zhongguo zhi yixue luohou" [The Backwardness of Chinese Medicine], *Tōa igaku* 25, no. 4 (Feb. 15, 1941): 198.
[31] Gao, "Zhongguo zhi yixue luohou," 198.

> Recently, the Japanese established a Japanese-Chinese research organization, which demonstrates their sincerity. I am thankful from the bottom of my heart …. At this time in China, science has not sprouted yet. There are no tools to help us check [the validity of our medical ideas]. Therefore, the things that you can see by your eyes are right; the things that you cannot see, you have to predict with your imagination, which can lead to big mistakes.[32]

Here, Gao was arguing for an empirical approach to classical medicine based on scientific principles. His reference to mistakes made when one predicts with one's imagination what one cannot see was likely a repudiation of CCM theories of disease causation based on *inyōgogyōsetsu* (yin-yang, five phases theory, 陰陽五行説), as this was a common way of phrasing criticism of CCM and kanpō etiology. Kanpō medicine progressively abandoned these ideas over the course of the Edo period, largely as a result of the influence of the Kohōha School, which argued that the efficacy of a treatment was paramount to one's ability to explain the reason for its efficacy.[33] To this end, they prioritized practical experience and observation over theories of disease causation. For their part, kanpō revivalists of the early twentieth century demonstrated very little interest in classical theories of disease causation.

Given the Second Sino-Japanese War context and the subservient tone of Gao's work, it is tempting to dismiss it as the self-serving statement of a Japanese collaborator. Yet even if this was the case, Gao was still parroting an ideological narrative of *tōyō igaku* and *shina* crafted by Japanese kanpō scholars and reflected in their own articles, in which they held an interest in

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[32] Gao, "Zhongguo zhi yixue luohou," 198.
[33] For more information, see Tateno Masami, *Yoshimasu Tōdō "Kosho Igen" no kenkyu: Sono shoshi to igaku shiso* [Research on Yoshimasu Tōdō's "Kosho Igen": Bibliography and Medical Ideology] (Tokyo: Kyuko shoin, 2004).

promoting publicly. Consequently, the question of Gao's true motives for writing what he did are not pertinent to the current study.

On the other hand, it is possible that a small kernel of Gao's praise may have been genuine, as Chinese interest in kanpō had been growing since the Meiji period and kanpō scholars enjoyed modest success in their medical exchanges with China from the 1910s forward, continuing into period of military conflict between the two countries. Interest in Chinese translations of Japanese kanpō texts had been growing since the mid-Meiji period. The republications of Edo period kanpō works, as well as their own bibliographic and formulary publications, by *Onchisha* (Review Knowledge Association, 温知社) scholars, particularly Asada Sōhaku (浅田宗伯, also known as Asada Ritsuen, 淺田栗園, 1815-1894) in the mid-Meiji period, drew the attention of CCM scholars in China, as they contained information on classical treatments that had been lost or forgotten within CCM.[34] While Edo period works were favored heavily by CCM scholars in the Meiji period, by the 1910's and 1920's, "more than half" of translations were of "post-Meiji medical texts", notably Wada Keijūrō's (和田啓十郎, 1872-1916) *Ikai no tettsui* (Rules of the Medical World, 醫界の鉄椎) and Yumoto Kyūshin's *Kōkan igaku* (皇漢醫學).[35] In other words, this period witnessed a surge in popularity of Chinese translations of the works of biomedically

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[34] Gao Yuqiu and Mayanagi Makoto, "Ding Fubao yu zhongri chuantong yixue jiaolu" [Ding Fubao and Sino-Japanese Medical Exchanges of Traditional Medicine], *Zhonghua yishi zazhi* [Chinese Journal of Medical History] 22, no. 3 (1992): 175-176.

[35] Mayanagi Makoto, "Japan and Traditional Medicine in Modern China: The Impact of Japanese Medical Texts in the Period of Republican China," paper presented at the Interweaving Medical Traditions: Europe and Asia 1600-2000. An International Workshop funded by the Asia-Europe Foundation, the European Alliance for Asian Studies, the Wellcome Trust and the Wellcome Trust Centre for the History of Medicine at University College London, Wolfson College, Cambridge, September 11-13, 2003. 2.

trained Japanese kanpō revivalists, who promoted a scientifically rationalized model of kanpō. As discussed in the Chapter Three, these doctors, including Wada Keijūrō, Yumoto Kyūshin, and Nakayama Tadanao believed that the accumulated experiential medical wisdom on which kanpō drew must contain useful medical knowledge that would allow them to complement and improve mainstream biomedical treatments.

The growing interest in the works of Japanese revivalist kanpō scholars stems from the fact that CCM practitioners in China faced similar delegitimization efforts from biomedical practitioners in the 1910s and 1920s to that kanpō had faced a half century prior. These delegitimization efforts came to a head in 1928 and 1929 when a plan for the abolition of CCM in China had gathered official momentum. Inspired by early Meiji period legislation which required Japanese kanpō doctors to be certified in Western medicine in order to practice, Yu Yan (余巖, also known as Yu Yunxiu, 余雲岫, 1879-1954), the architect of the plan, proposed to do the same in China.[36] Cognizant of the Meiji period decimation of kanpō doctors caused by such licensing requirements, Chinese CCM doctors organized to resist the abolition efforts. The Japanese model of scientifically rationalized classical medicine served as an attractive blueprint for Chinese CCM doctors seeking to justify their existence to biomedical proponents. It served two purposes: 1. Undercutting the arguments against CCM advanced by its opponents within China, specifically that CCM was not scientific, and 2. promoting Chinese nationalism on the grounds that

[36] Hao Xianzhong, "Minguoshiqi weiyaozhongyi cunfeiwenti de lunzhan" [Debate on the Abolishment and Preservation of Traditional Chinese Medicine during the Republican Period], *Zhonghua yishi zazhi* [Chinese Journal of Medical History] 37, no. 1 (2007): 11.

scientifically rationalized CCM, as a distinctively Chinese medical system, would support the modernization and strengthening of China without the need for foreign support.[37] While the details of the CCM anti-abolition movement lie outside the bounds of the current study, it successfully rebutted the efforts of the abolitionists as a result of the utilization of the strategy outlined above and interest in the development of scientifically rationalized CCM grew.

Historian Mizuno Norihito has shown that despite the outbreak of ongoing hostilities between Japan and China in 1937, some interest remained for CCM-kanpō scholarly exchanges on the Chinese side. Yang Yiya (楊醫亞, 1914-present), publisher of the *Guoyi dizhu* (Pillar of National Medicine, 國醫砥柱) in Beijing frequently introduced kanpō works to his readers. From May 1939, he sent copies of his journal to the AEAM in Japan. The owner of a kanpō clinic in Shanghai and publisher of the journal *Zhongyi liaoyang zhuanggang* (Professional Journal of Chinese Medical Treatment, 中醫療養專綱), Qin Bowei (秦伯未, 1901-1970), exchanged publications with the AEAM as well during this period. The *Tianjin ribao* (Tianjin Daily Newspaper, 天津日報) profiled a treatment for dysentery based on a study by Ōtsuka Keisetsu in July 1939. That same year, after reading a Chinese translation of an article by Ōtsuka Keisetsu, Ye Juquan, (葉橘泉, 1896-1989) a CCM scholar, contacted Ōtsuka and arranged to exchange his own CCM research with Ōtsuka for copies of the journal *Kanpō to kanyaku* and kanpō medicines. Ōtsuka ultimately translated into Japanese and published some of Ye's research in the journal *Tōa*

[37] Gao Yuqiu and Mayanagi Makoto, "Ding Fubao yu zhongri chuantong yixue jiaolu" [Ding Fubao and Sino-Japanese Medical Exchanges of Traditional Medicine], *Zhonghua yishi zazhi* [Chinese Journal of Medical History] 22, no. 3 (1992): 179.

igaku in 1940. Ye later sent two of his students to study kanpō at Takushoku University.[38] Consequently, it seems that there was still some appetite for kanpō and the activities of the AEAM in China, at least during the early years of the war.

Exporting Tōyō Igaku

Previously, it was mentioned that many of the AEAM's members came to see their actions promoting classical medicine as part of a larger program to usher in a new age of peace in East Asia and that by guiding this new age they could advance East Asian civilization toward the ideal of *tōyō igaku*. "Guiding" may seem like a strong word to use, considering the AEAM's initiatives for the most part constituted little more than scholarly exchange: the publishing of articles and lectures, the formation of research groups, and facilitation of academic exchanges. Yet, "guide", in regard to East Asia, is just what some members of the AEAM hoped to do.

Some AEAM members recognized that control of medical treatment could act as an "expedient" in advancing "colonialism" and "economic development".[39] They recognized how the spread of Western medicine had helped to facilitate Western imperialism globally and locally in China and saw an opportunity for Japan to advance its expansion by a similar means. Arai Kinzō (荒井金造, 1883-1971), a Japanese kanpō scholar, recognized that "if you control the buying and selling of medicine, people will have to come to you. Over time a relationship will be built due to

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[38] Mizuno Norihito, "Kampo in Wartime Sino-Japanese Relations: The Association of East Asian Medicine and the Search for a Tripartite Medical Partnership," *Science, Technology, and Medicine in the Modern Japanese Empire* (2016): 182-185.
[39] Arai Kinzo, "Shin tōa kensetsu no ichiyokutare" [A Part of the Construction of a New East Asia], *Tōa igaku* 1, no. 2 (1939): 4.

the people's gratefulness."[40] Later, he directly referenced the need to force out Western traders, preachers and doctors from China, so that Japan could replace them with its own.

Not all members of the AEAM were as strident or blunt in making their case for medical colonialism in East Asia as Arai. For example, Ōtsuka Keisetsu and Yakazu Dōmei, who would go on to be two of the most prolific postwar kanpō scholars, couched their arguments in paternalism. They felt that colonization would allow them to more effectively export scientifically rationalized kanpō, which they considered superior to the classical medicines of China and other colonized areas, and thereby guide the future of East Asia in medical terms. Speaking of the establishment of Manchukuo, Yakazu expressly stated that it was the "obligation of Japan's new kanpō doctors" to fulfill "duty of the Japanese race" to develop *tōyō igaku* in the puppet state for the benefit of its residents. [41] He continued,

> When we look at the current situation of Chinese medicine in Manchuria, we have a profound understanding. Particularly when Chinese medicine doctors are facing unknown Western medicine, they feel intimidated and confused; their confidence in their own position is threatened with loss. The reason for this is that modern medicine is very much unknown to them. Guiding and improving the abilities of these Chinese medicine doctors by applying the best use of kanpō's special modern characteristics gradually in order to improve their study and skill by learning modern medicine and then specializing in kanpō medicine; this is the mission of Japan's new kanpō medical doctors.[42]

Despite the patronizing tone and condescension toward CCM practitioners exhibited in this passage, Yakazu seems to have had a genuine interest in improving medical practice in East Asia

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[40] Arai, "Shin tōa kensetsu no ichiyokutare," 4.
[41] Yakazu Dōmei, "Manshū kenkoku no risō to warera no shimei" [The Foundation of the Manchurian Nation and Our Mission], *Tōa igaku* 19, (1940): 147.
[42] Yakazu Dōmei, "Manshū kenkoku no risō to warera no shimei," 147.

through kanpō. For his part, Ōtsuka displayed a similar interest, publishing a large number of articles, far more than any of the other kanpō scholars, as late into the war as 1944 on studies of practical kanpō and CCM treatments for a variety of ailments including beriberi, dysentery and ocular issues.[43] Together Yakazu and Ōtsuka appear to have nostalgically contextualized their actions as a second chance at the Meiji moment, a second chance to prevent the downfall of classical medicine by learning from the mistakes of the past.

Lobbying for Government Support

For its part, the Japanese government expressed limited support for the cause of the kanpō revivalists. Outside of the circles of kanpō scholars, kanpō, even scientifically rationalized kanpō, was still seen as unscientific and unverifiable by Japanese biomedical elites. With the promotion of wartime slogans like "Do Science" (J. *kagaku suru*, 科学する) and "Scientific Japan" (J. *kagaku nihon*, 科学日本), it is understandable that Japanese government elites would remain skeptical of kanpō's utility.[44]

Hashida Kunihiko (橋田邦彦, 1882-1945) is an example of one official who worked to change this perception of kanpō in official circles. Hashida's father had been a kanpō doctor who participated in the failed efforts of the *Onchisha* to obtain official recognition for kanpō in the

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[43] Ōtsuka Keisetsu, "Kakke no kanpō ryōhō" [Beriberi's Kanpō Remedy], *Tōa igaku* 7 (1939): 53.; Ōtsuka Keisetsu, "Kanpōi no mita sekiri to sono ryōhō" [Observed Dysentery and Its Remedy by Kanpō Doctors], *Tōa igaku* 6 (1939): 45.; Ōtsuka Keisetsu, "Ganka chiryō ni okeru Shōkanron no unyō" [Practical Use of Ophthalmological Treatment with Regards to the Shanghan lun], *Kanpō to kanyaku* 5, no. 4 (1938): 36-54.
[44] Mizuno Hiromi, *Science for the Empire: Scientific Nationalism in Modern Japan* (Stanford: Stanford University Press, 2009), 4.

1880s and 1890s. Hashida's family lost its livelihood as a result of the restrictive laws placed on kanpō practitioners during that period, resulting in impoverishment. When he reached adulthood, he decided to follow the path of his father and become a physician. Initially trained in Western medical techniques, Hashida also studied kanpō. He came to believe that Western medicine could derive benefit from the incorporation of ideas found in kanpō. To him, Western medicine/science possessed treatment techniques superior to that of kanpō, but it lacked a "guiding philosophy" or "consideration of nature".[45] Echoing earlier statements by Nakayama Tadanao, he asserted that by synthesizing Western and kanpō medical approaches, a new form of "Japanese medicine" would emerge superior to both. These ideas made Hashida a natural ally of the kanpō revival movement.

Hashida's career in academia and government service allowed him to use his influence to promote public and official awareness of kanpō's ongoing scientific rationalization. In the 1930s, Hashida worked as a Professor of Physiology at Tokyo Imperial University. In 1935, he chaired a government-supported "Study Group for Japanese Medicine," which provided Hashida a forum in which he could present his ideas concerning the future of "Japanese medicine" to a wider audience. The effect was that support for kanpō began to gain some traction within certain nationalist factions of the government who appreciated Hashida's zeal for promoting Japanese traditions and recognized the potential actual and propaganda utility of promoting classical medicine in colonial territories to Japan's foreign policy aims. As a result of this growing profile, *Nisshin igaku*

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[45] Katsui Keiko, Hashida Kunikiho kenkyū - aru "hōmurareta shisōka" no shōgai to shisō [Author provided English title: A Study of Hashida Kunihiko's Thought: The Life History and Thought of an Outcast Thinker], *Nihon ishigaku zasshi* 56, no. 4 (2010): 532-533.

(Japanese Medical Progress, 日進醫學), a well-known mainstream medical journal, published an entire issue on kanpō titled, "Characteristics of Kanpō Treatment" in April 1939.[46]

From Ideas to Action: Manchukuo

Official lobbying by Hashida and the AEAM bore fruit in 1940, when the AEAM was permitted to advise the puppet government of Manchukuo on the handling of classical medicine practitioners within its new medical system. Yakazu Dōmei and Kazuo Tatsuno, as representatives of the AEAM, traveled to the capital of Manchukuo, Xinjing (新京, now known Changchun, 長春) to consult with Zhang Jiyou (張繼有, 1907-1991), head of the Epidemic Prevention Section of the Manchukuo Department of Home Affairs.[47] Yakazu and Tatsuno proposed a formal legislative plan for a licensing system requiring the retraining of classical medicine practitioners in scientifically rationalized kanpō and Western "anatomy", "physiology" and "epidemic prevention," which was implemented in 1941 in Manchukuo.[48] Practitioners were required to have five years or more prior experience in classical medical practice and had to pass an examination

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[46] Christian Oberlander, "The Modernization of Japan's Kanpō Medicine, 1850-1950" in *East Asian Science: Tradition and Beyond; Papers from the Seventh International Conference for the History of Science in East Asia, Kyoto 2-7 August 1993,* ed. Keizo Hashimoto, Catherine Jami, and Lowell Skar (Osaka: Kansai University Press, 1993), 145.

[47] The invitation was initially extended to Yakazu Dōmei and Ōtsuka Keisetsu. However, Kazuo took Ōtsuka's place when he was unable to travel. Mizuno, "Kampo in Wartime Sino-Japanese Relations," 184.

[48] In Japanese, the plan is known as *Manshūkoku no kanpō sonzoku hattesaku* [Manchukuo Kanpō Survival and Advancement Plan].; Kazuo Tatsuno, "Manshū no tabi" [Manchurian Trip], *Tōa igaku* 19, (1940): 153.; Manshūkoku seifu, "Manshūkoku kani kōshi kokoroe" [Guidelines of the Manchukuo Chinese Medicine Test], *Kanpō to kanyaku* 8, no 10 (1941): 943.

with oral and written sections.[49] Tatsuno returned to Manchukuo that year to attend the first licensing examinations, which appear to have been held without incident.[50]

What is most remarkable about the AEAM's activities in Manchukuo during the Second Sino-Japanese War is that they were permitted at all. The general attitude within the Japanese government toward kanpō during this time appears to have ranged from ambivalence to outright hostility. Revivalists made only incremental progress within Japan itself toward official recognition. In 1933, the government forbade kanpō clinics from using the word "kanpō" in their advertising. In 1944, the word kanpō was banned entirely.[51] Yet, despite its disdain for kanpō, the Japanese government, which fully controlled Manchukuo as its puppet state, permitted kanpō scholars to create and enact medical policies recognizing classical medical practitioners within the official medical system. While this initially seems inconsistent with the Japanese government's history of support for biomedicine and suppression of kanpō, there may be a simple explanation. The Japanese government may have agreed with the AEAM's assessment that the promotion of classical medicine, as a popular aspect of local culture, would help facilitate pacification of the population. However, unlike the AEAM, given its attitude toward kanpō in Japan, it may not have seen any actual medical benefit in it. Therefore, allowing the policy to be enacted by the puppet government of Manchukuo prevented the Japanese government from having to justify its support for the policy.

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[49] Manshūkoku seifu, "Manshūkoku kani kōshi kokoroe," 943.
[50] Mizuno, "Kampo in Wartime Sino-Japanese Relations," 184.
[51] Mizuno, "Kampo in Wartime Sino-Japanese Relations," 186.

After 1941, the exigencies of war began to hamper the efforts of the kanpō revival movement. Although *Kanpō to kanyaku* remained in publication until 1944, a number of the kanpō revivalists ceased publication until after the war for various reasons. Yakazu Dōmei was drafted into service and spent the rest of the war as a doctor with the Imperial Army in the Solomon Islands.[52] Others, such as Kimura Chōkyū and Ishihara Yasuhide, perished in the conflict. Through Hashida's support, an East Asian Treatment Institute (*Tōa chiryō kenkyūjo*, 東亜治療研究所) was created in Tokyo in 1943. There, Itakura Takeshi (板倉武, 1888-1958), the Director of the Institute, began clinical trials aimed at the development of a modern mechanized process for the creation of kanpō extracts (*ekisu*, エキス), a process which would later revolutionize the consumption of kanpō in the postwar period; however, the Institute was destroyed by fire from bombing during the war.[53] Hashida himself had served as Minister of Education from 1940 to 1943, notably at the time of the attack on US forces at Pearl Harbor in Hawaii. Consequently, he was charged for involvement with Class A war crimes by American occupation authorities. As military police arrived to take him into custody, he committed suicide on September 14, 1945.

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[52] Yakazu later published a memoir of his time in the Solomon Islands that is notable for his recollections of his studies of the local classical herbal medicine. Yakazu Dōmei, *Bōgenbirushima heitan byōin no kiroku: Moto dai 76 heitan byōin tsuki gun'i* [Record of the Bougainville Island Logistics Hospital: A Former Military Physician Attached to the 76th Logistics Hospital] (Tokyo: Ido no Nihonsha, 1976).

[53] Kosoto Hiroshi et al., "Tōa chiryō kenkyūjo nitsuite" [About the East Asian Treatment Institute] *Nihon ishigaku zasshi* 62, no. 2 (2016): 166.

Conclusion

As the Japanese imperial moment peaked in the 1930s and early 1940s, Japanese kanpō scholars took advantage of the opportunity to promote their interests in classical medicine by contextualizing their own cause within the greater one of Japanese imperial expansion. Classical medicine, as a shared cultural heritage, became a means to promote East Asian unity. The export of scientifically rationalized kanpō served to correct the "mistakes" of pure classical medicine, while establishing Japanese medical authority on the continent. Though the Association of East Asian Medicine went dormant after 1941 as the Second Sino-Japanese War intensified (it did return to life in 1954 with a different agenda), its organizational purpose reflects a little recognized facet of the history of Japanese imperialism.

Chapter Five - Manufacturing Tradition: The Rebranding of Kanpō Medicine in Early Postwar Japan

In the decades following the Pacific War, popular use of kanpō medicine in Japan experienced a resurgence after years of decline as the application of modern manufacturing and marketing techniques to its production led to its increasing commercialization. Building on the success of kanpō-derived patent medicines, which will be discussed for the first time later in this chapter, and the efforts of early twentieth century reformers to standardize and scientifically rationalize kanpō, the development of an herbal extract manufacturing process for kanpō medicine in 1954 facilitated the mass production of a range of standardized kanpō herbal medicines for commercial sale. Despite the thoroughly modern production process of such medicines and the marketing strategy of earlier kanpō-derived patent medicines utilizing images of modernity, Japanese pharmaceutical corporations of the postwar period sought to entice customers through emotional appeals in their advertisements emphasizing the "traditional" nature of their products. Yet, the "traditional" nature of these medicines was illusory, as most were proffered as treatments for ailments conceived within the mainstream biomedical paradigm and divorced entirely from their "traditional" prescription within the kanpō medical paradigm itself. This resulted in an increasing commercialization and corporatization of the practice of kanpō medicine in Japan that split the discipline into two distinct branches: one centered on the kanpō clinic and one centered on the drugstore.

Public Consumption of Kanpō Products During the Meiji and Taishō Periods

Despite official de-recognition of kanpō as a medical practice by the Japanese government in 1874, kanpō continued to be patronized by ordinary Japanese. Records indicate that there were

23,015 registered kanpō doctors and 5,274 doctors of Western medicine in Japan in 1874.[1] Classical kanpō practice in the clinical setting where a kanpō doctor would observe and treat patients directly faded in parallel with the decline in the number of kanpō practitioners over the Meiji period. In an article titled, "The Last Days of the Kanpō Doctors (*Kanpōi no matsuro*, 漢方医の末路), the *Yomiuri Shinbun* (Yomiuri Newspaper, 読売新聞) estimated that there were only eight kanpō practitioners left in Tokyo in 1910.[2] Though likely an exaggeration, the fact that the statement was made at all, not to mention the article's title, indicates the existence of a visibly precipitous drop in the number of kanpō practitioners in Japanese society. Numbers of kanpō practitioners remained low throughout the Taishō and early Shōwa periods, before increasing in the postwar period.[3] Despite the decline in kanpō practitioners and the government's promotion of biomedicine, Japanese continued to consume kanpō and folk remedies. In the Meiji period, kanpō was cheaper, more readily available and more familiar to ordinary Japanese than biomedicine.[4] Kanpō components continued to be sold for public consumption at herbal pharmacies or *shōyaku-ya* (生薬屋).[5] As a result, lay practitioners could continue to patronize kanpō. Kanpō was a deeply

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[1] Koseishō, *Isei hyakunenshi: Shiryōhen* [A Hundred Year History of the Medical System: Document Collection] (Tokyo: Gyōsei, 1976), 45

[2] Yomiuri Shinbun, "Kanpōi no matsuro (1): Tōkyō shinai ni wazuka 8 nin" [The Last Days of the Kanpō Doctors: No More Than 8 Inside Tokyo], *Yomiuri Shinbun*, July 21, 1910.

[3] Yakazu Dōmei, *Meiji hyaku-jūnen: Kanpō igaku no hensen to shōrai: Kanpō ryakushi nenpyō* [The 110th Year of Meiji: The Transition of Kanpō Medicine and Its Future: A Brief Historical Chronology of Kanpō] (Tokyo: Shun'yōdō shoten, 1979), 119.

[4] Maki Umemura, "Reviving Tradition: Patients and the Shaping of Japan's Traditional Medicines," in *The Historical Consumer*, ed. Penelope Francks and Janet Hunter (London: Palgrave Macmillan, 2012), 183.

[5] Many herbal pharmacies were generational businesses passed down in families and many continued operations into the postwar period.

rooted cultural practice that could not be quickly extinguished among the populace, despite the government's efforts.

By the mid-Meiji period, producers of kanpō herbs and medicines, many of whom had been wholesalers in the Edo period, began to rebrand their products as patent medicines as a means of coping with official de-recognition of kanpō. Kanpō medicines that had been around for centuries came to be referred to as *kateiyaku* (family or home medicine, 家庭薬) or *baiyaku* (sold medicines, 売薬). It is important to recognize that while many kanpō medicines came to be recognized as *kateiyaku* or *baiyaku*, not all *kateiyaku* or *baiyaku* medicines were derived from kanpō; many were derived from Japanese folk medicine. The kanpō industry in what is now Toyama Prefecture is a typical example. During the Edo period, Toyama was a major producer of kanpō components and medicines, which were sold in major population centers throughout the country. While its products were available for purchase in herbal pharmacies and wholesalers located in nearby regional population centers, as was the case with the products of other major kanpō producing areas, the key to its countrywide success was a sales practice originated by the medicine vendors of Toyama known as *okigusuri* (left behind medicine, 置き薬). Toyama employed a system of traveling apothecaries, known as *okigusurigyōsha* (left behind medicine traders, 置き薬業者) who maintained a network of medicine chests left at private residences. Toyama specialized in the production of digestives, anesthetics, fever reducers and calming medicines, such as *Hangontan* (反魂丹) and *Rokushingan* (六神丸) and it was a selection of these products that stocked their chests. The medicine in the chest was available to the holder on demand. *Okigusurigyōsha* returned at regular intervals to refill the chest and collect payment for any medicines used by the holder. This system began to breakdown in the early Meiji period as a result

of the efforts of medical practitioners working within the Japanese government to discredit kanpō in favor of biomedicine, as discussed previously in Chapter Two. While not directly prohibited from selling their wares, as with kanpō clinical practice, vendors of kanpō medicines and herbs faced the stigmatization of their ventures as a result of these efforts. They also encountered growing competition from imported Western biomedicines.[6] When official hostility to kanpō began to threaten their businesses, some responded by remarketing their products as patent medicines within the *kateiyaku/baiyaku* framework.

Beginning around the 1880s and continuing through the end of the Second Sino-Japanese War in 1945, patent medicine sellers began to utilize new forms of advertising media and evocative imagery to emphasize the modernity of products. Whereas Edo period advertising had relied primarily on store signs and the public distribution of text dense handbills detailing a medicine's origin story, efficacy and usage, beginning in the Meiji period, patent medicine sellers came to utilize primarily pictorial advertisements with little text that were published in magazines, newspapers, public posters and product calendars.[7] Advertisements rarely referenced the product's kanpō origins. Most were dominated by a prominent central pictorial image bordered by explanatory text. In many cases, the name of the product featured prominently in Latin script. Sometimes, advertisements even included English taglines. The usage of Latin script in Japanese

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[6] Endo Kazuko, *Maaketingu on senkushatachi: Toyama no yakuuri* [Pioneers in Marketing – The Medicine Vendors of Toyama] (Tokyo: The Simul Press, Inc., 1993), 201-222.

[7] Susan Burns, "Marketing Health and the Modern Body: Patent Medicine Advertisements in Meiji-Taishō Japan" in *Looking Modern: East Asian Visual Culture from Treaty Ports to World War II*, ed. Jennifer Purtle and Hans Bjarne Thomsen (Chicago: Paragon Books, 2009), 175. For examples of Edo period advertising, see Takahashi Yoshimaru, *Retoro na yakutai no desain* [Packaging Design of Retrospective Medicine] (Tokyo: Mitsumura suiko shoin, 2011), 268-274.

print was a new phenomenon in this period and gave the products a feeling of being new or modern. One example of a product marketed in this way was *Uzukyūmeigan* (宇津救命丸), a *kodomo yaku* (children's medicine, 子供薬) originating in the Edo period, which used images of a child and an adult woman, implied to be the mother, dressed in contemporary clothing to emphasize its modernity.[8] Similarly, advertisements for *Jitsubosan* (実母散), a *fujin yaku* (women's medicine, 婦人薬), typically included either images of a modern dressed woman and child or man and woman.[9] The man, implied to be the husband, in such ads was typically dressed in a Western suit and bowler hat to emphasize his modernity. *Chūjōtō*, (中将湯) another "women's medicine" used similar imagery of a Japanese man, woman and child, often in Western garb as an indicator of modernity.[10] Some of its advertisements went further by including additional signifiers of modernity, such as railroad locomotives and modern port facilities.[11]

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[8] See Figure 1. Kateiyaku kenkyūkai, *Kateiyaku ronguseraa no himitsu* [The Secret of "Long-seller" Family Medicine] (Tokyo: Yakuji nippōsha, 2010), 16.; Takahashi Yoshimaru, *Retoro na yakutai no desain* [Packaging Design of Retrospective Medicine] (Tokyo: Mitsumura suiko shoin, 2011), 182.
[9] See Figure 2. Kateiyaku kenkyūkai, *Kateiyaku ronguseraa no himitsu*, 24-25.
[10] See Figure 3. Machida Shinobu, *Natsukashi no kateiyaku taizen* [Encyclopedia of Family Medicine] (Tokyo: Kadokawa shoten, 2003), 61.; Yamazaki Mitsuo, *Nihon no meiyaku* [Japanese Well-Known Medicine] (Tokyo: Bunshun bunko, 2004), 157.
[11] See Figure 4. Takahashi, *Retoro na yakutai no desain*, 296.

Figure 1. Uzukyūmeigan promotional material - Woman and child in "modern" clothing.[12]

Figure 2. Jitsubosan advertisement - Woman and man in "modern" clothing.[13]

[12] Takahashi Yoshimaru, *Retoro na yakutai no desain* [Packaging Design of Retrospective Medicine] (Tokyo: Mitsumura suiko shoin, 2011), 182.
[13] Kateiyaku kenkyūkai, *Kateiyaku ronguseraa no himitsu* [The Secret of "Long-seller" Family Medicine] (Tokyo: Yakuji nippōsha, 2010), 16.; Takahashi Yoshimaru, *Retoro na yakutai no desain* [Packaging Design of Retrospective Medicine] (Tokyo: Mitsumura suiko shoin, 2011), 25.

Figure 3. Chūjōtō advertisement - Man and child in "modern" clothing with Chūjō princess.[14]

Figure 4. Chūjōtō advertisement - Chūjō princess in "modern" garb observing railway.[15]

[14] Takahashi, *Retoro na yakutai no desain*, 296.
[15] Takahashi, *Retoro na yakutai no desain*, 296.

Some patent medicine advertisements for kanpō-derived medicines referenced images from Japanese history or culture, but the purpose of these images was to evoke a nationalistic sense of the product's Japaneseness through an appeal to a cultural, often mystical, power, rather than the classical knowledge or origins underlying a product. The images chosen for such ads typically had little connection to the product. Kitani, the producer of *Jitsubosan*, used the image of Momotarō (桃太郎), the Peach Boy, to sell its product. In the traditional telling of the story, a childless woman discovers Momotarō in a peach and takes him as her own to raise. He later grows up to slay *Oni* (demons, 鬼). As *Jitsubosan* was marketed as a "woman's medicine", the implication is that by taking this product, the female consumer can be like the childless mother in the story who receives a son and raises him to be a hero. Viewed in the context of pronatalist rhetoric propounded by the Japanese government in the late nineteenth and early twentieth centuries, which encouraged women to be a "Good Wife, Wise Mother" (*ryōsai kenbo*, 良妻賢母) and procreate, the advertisement was implying that women could fulfill their patriotic duty, be more fertile, and serve the state by taking *Jitsubosan*.[16] *Chūjōtō* used the imagery and name of the *Chūjō* princess, a Heian era noblewoman, to assert a connection with Japanese royalty of the past.[17] Certain iterations of *Chūjōtō's* packaging paired this image with the following bold statement, in English only, "The only remedy for female complaints that ever [was] prepared in the world."[18] One advertisement pictured this princess radiating light and holding demons at bay while telling a

[16] See Figure 5. Kateiyaku kenkyūkai, *Kateiyaku ronguseraa no himitsu*, 25.
[17] Susan Burns, "Marketing 'Women's Medicines': Gender, OTC Herbal Medicines, and Medical Culture in Modern Japan," *Asian Medicine* 7, no.1 (2009): 156.
[18] See Figure 6. Takahashi, *Retoro na yakutai no dezain*, 35.

group of modern dressed Japanese women, “Fear not, good people, for where I am, they have no power”, implying that the product is imbued with a supernatural power from its connection to this courtier.[19] By doing this, *Chūjōtō* was attempting to provoke an association with an exceptionalist Japanese tradition. Similarly, *Hyakusōgan* (百草丸), a stomach medicine, used images of Mount Ontake (*Ontake-san*, 御嶽山), a sacred mountain in Shintoism and one of Japan’s tallest, to invoke nationalistic sentiment.[20]

Figure 5. Jitsubosan advertisement - Momotarō, the Peach Boy with Jitsubosan package.[21]

[19] See Figure 7. Takahashi, *Retoro na yakutai no dezain*, 36.
[20] See Figure 8. Kateiyaku kenkyūkai, *Kateiyaku ronguseraa no himitsu*, 20-21.
[21] Kateiyaku kenkyūkai, *Kateiyaku ronguseraa no himitsu*, 25.

Figure 6. Chūjōtō packaging - The only remedy for female complaints.[22]

Figure 7. Chūjōtō advertisement - Fear not good people.[23]

[22] Takahashi, *Retoro na yakutai no desain*, 35.
[23] Takahashi, *Retoro na yakutai no desain*, 36.

Figure 8. Hyakusōgan advertisement – Packaging with image of Mt. Ontake.[24]

Some patent medicines invoked recent imagery of Japan's colonial expansion for marketing purposes. *Hiyakiōgan* (樋屋奇応丸), a cold and digestive medicine, sometimes used imagery of a male child running toward the viewer with the medicine in one hand and a large flag in the other hand.[25] The overall image suggested that the child is charging into battle against disease. While this image did not directly draw on an association with an image/idea from ancient Japanese history, it drew strongly on prevalent popular contemporary portrayals of the Japanese military, such as in *sensō-e* (war print, 戦争絵) illustrations of the First Sino-Japanese War of 1894-1895 and the Russo-Japanese War of 1904-1905.[26] Similarly, the children's medicine *Uzukyūmeigan* typically dressed the male child in its advertisements in a contemporary student's

[24] Kateiyaku kenkyūkai, *Kateiyaku ronguseraa no himitsu*, 21.
[25] See Figure 9. Kateiyaku kenkyūkai, *Kateiyaku ronguseraa no himitsu*, 67.
[26] See Figure 10. For more examples, see Bradley M. Bailey, *Flash of Light, Fog of War: Japanese Military Prints, 1894-1905* (Chapel Hill, North Carolina: University of North Carolina at Chapel Hill, 2017).

garb based on a sailor's uniform, indicating that the child was a potential future soldier. The name of the product was frequently written on a life buoy or boat in which a female character, implied to be the boy's mother, was encircled, indicating that the medicine had some function in saving the female character.[27] Taken all together, such advertisements can be read as emphasizing the Wise Mother part of the Good Wife, Wise Mother ideal in that the pictured mother needed to provide medicine to her son so that he could fight for the nation and protect her later in life.[28]

Figure 9. Hiyakiōgan advertisement - Child holding medicine and flag running toward viewer.[29]

[27] See Figure 11. Takahashi, *Retoro na yakutai no dezain*, 182-185.
[28] Takahashi, *Retoro na yakutai no dezain*, 182-185.
[29] Kateiyaku kenkyūkai, *Kateiyaku ronguseraa no himitsu*, 67.

Figure 10. Example of a sensō-e from the First Sino-Japanese War.[30]

Figure 11. Uzukyūmeigan advertisement - Woman in life buoy with child.[31]

[30] Mizuno Toshikata, *Dai nippon teikoku banbanzai: Seikan shūgeki wagun taishō no zu* [Long Live the Japanese Empire - A Drawing of the Great Victory of the Japanese Army in the Attack on Seonghwan], 1894, Museum of Fine Arts, Boston, https://collections.mfa.org/objects/272210 (accessed November 11, 2020).
[31] Takahashi, *Retoro na yakutai no desain*, 183.

The prewar industry for kanpō-derived patent medicines served as a precursor to the postwar development of over-the-counter (OTC) kanpō. The application of modern marketing techniques, such as emotional appeals (modernity, nationalism) and wider publication in magazines, newspapers and radio allowed for medicine producers to "refresh" the image of their products and adapt to the public's changing perceptions by severing their products' overt connections to kanpō.[32] Production became more centralized and mechanized than in the past as patent medicine companies focused their resources on the production of a small number or sometimes a single medicine. Whereas Edo period producers sourced raw herbs directly from wholesalers and processed (i.e. crushed, ground, etc.) them as needed before mixing them to begin the production process, by the mid-Meiji period, some patent medicine producers began to source powdered herbs directly from factories created for this purpose. By eliminating time and labor-intensive steps at the beginning of the production process, patent medicine producers were able to gain efficiencies and continue operating on a smaller scale with a reduced product line as competition from biomedicine eroded some of their client base.[33] Most importantly, the kanpō-derived patent medicine industry was profitable. In 1928, Toyama Prefecture produced 34.5 million yen in patent medicines.[34] That same year, Tashiro City in Saga Prefecture, another traditional kanpō hub, produced 944,617 yen in patent medicines.[35] During the 1920s, some of the

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[32] Endo, *Maaketingu on senkushatachi: Toyama no yakuuri*, 236-254.; Kobayashi Hajime, *Tsushimaryō tashirobaiyaku hattatsushi* [The Developing History of Selling Patent Medicine in the Tashiro Region by the Tsushima Clan] (Tosu, Japan: Kobayashi Hajime, 1999), 338-342.
[33] Kobayashi, *Tsushimaryō tashirobaiyaku hattatsushi*, 338-342.
[34] Umemura, "Reviving Tradition," 185.
[35] Kobayashi, *Tsushimaryō tashirobaiyaku hattatsushi*, 568.

most successful kanpō-derived patent medicines, such as *Hangontan*, began to sell internationally in markets throughout East and Southeast Asia with great success.[36] By 1938, a study conducted in one Tokyo ward indicated that half of the household medical purchases of the study's subjects were for patent medicines.[37] By the 1930s, the enduring profitability of kanpō-derived patent medicines drew increasing interest from biomedical pharmaceutical corporations, as companies began to look for methods to fully mechanize the production process and bring more kanpō medicines to market.

The Origins of the Kanpō Boom

Over the course of 1940s and 1950s, various Japanese pharmaceutical companies competed, with varying degrees of success, to develop a process to facilitate the mass production of standardized traditional kanpō herbal prescriptions, as well as kanpō-derived patent medicines, for commercial sale. Prior to this time, kanpō herbal prescriptions were assembled from crude herbs at the time of purchase by a pharmacist, who would judge the necessary amounts of each ingredient

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[36] Kobayashi, *Tsushimaryō tashirobaiyaku hattatsushi*, 340-342.; Tamagawa Shinmei, *Hangontan no bunkashi – Etchū toyama no kusuri uri* [The Cultural History of Hangontan – Medicine selling in Etchū, Toyama] (Tokyo: Shōbunsha, 1979), 246-250.

[37] Beginning in March 1938 and continuing for one-year, biomedical researchers tracked the diseases suffered by and treatments chosen by 2215 residents of Takinogawa Ward in Tokyo. Recognizing that prior studies up to that point had taken a "vertical approach", i.e. studied only patients suffering from a single disease, through the Takinogawa study, researchers intended to take a "horizontal approach" to better understand the sociological implications of disease. Of particular note is the fact that the study indicated that a significant amount of medical pluralism remained in Japanese society in the form of the patronage of kanpō patent, folk and religious medicines, despite the more than 60 years that had passed since the establishment of the biomedical system and the start of official efforts to delegitimize heterodox medical systems in Japan. Akihito Suzuki, "Chiryō no shakaitekishiteki kōsatsu: Takinogawa kenkō chōsa (1938) wo chuushin ni" [Considering Medical Treatment from the Perspective of Social History: The Center of the Takinogawa Health Survey], in *Bunbetsu sareru seimei – 20 seiki no iryō senryaku* [Classifying Life: 20th Century Medical Treatment Strategy], ed. Osamu Kawagoe and Akihito Suzuki, (Tokyo: Hōsei daigaku shuppankyoku, 2008), 143.

following a general formula. The buyer would then need to decoct the mixture into liquid form before consumption. Complex formulas with unstandardized herbal ingredients, coupled with the need to liquefy the mixtures before use, greatly inhibited the viability of mass production. However, with the development of Kotarō Kanpō Pharmaceuticals' herbal extraction process in the mid-1950s, which allowed for active ingredients in kanpō mixtures to be extracted using hot water before conversion into granules, pharmaceutical companies were finally able to begin mass production of OTC kanpō prescriptions. Expanding production coincided with a period of increased public interest in kanpō, referred to in the media as the "Kanpō Boom" (漢方ブーム), as segments of the public became frustrated with the limitations and perceived dangers of Western biomedicine. The result was a commercial boon for the Japanese pharmaceutical industry, as individuals began to look to OTC kanpō as a safer, more natural, and "native" alternative to "artificial" Western medicine, a trend that has continued to the present.

The origins of kanpō's postwar resuscitation lie within a complex interplay of global and local trends in Japan. Globally, the decades following the Second World War witnessed growing popular dissatisfaction with mainstream biomedical treatments. Chronic lifestyle diseases such as diabetes, hypertension, arthritis, cancer and heart disease became increasingly prevalent and deadly in the developed world, including Japan. In Japan, media reports noted the rise of *seijinbyō* (adult, i.e. degenerative diseases, 成人病) and *nanbyō* (difficult, i.e. incurable diseases, 難病). Biomedicine, which had achieved global dominance at least partially as a result of its effectiveness in treating bacteriological diseases, faced difficulties in developing effective treatments for such ailments. Lifestyle diseases by their nature typically develop as the result of several interrelated factors that vary from individual to individual. An individual might develop diabetes, hypertension

or heart disease as a partial result of lack of exercise, consuming too much refined sugar, lack of sleep, stress and several other factors or only due to some of these factors. This contrasts with a bacteriological disease, which is caused by a single vector, the bacteria. The scientific method, which undergirds biomedical research, depends on the identification and limitation of variables to formulate reliable conclusions. In medicine, this lends its application to the study of ailments with precise, singular causes, but less so to the more complex chronic diseases.[38] As a result, biomedicine was viewed as disregarding the patient's subjective experience of discomfort and was lacking when it came to therapeutic treatments.[39] Consequently, some individuals began to look for "alternative" and "holistic" treatments outside the confines of biomedicine. In the case of Japan, some people looked to kanpō. The patient-centered theory of treatment found in classical Japanese medicine, in which prescriptions were adapted to the needs and circumstances of the individual, seemed to be a viable alternative.

Dissatisfaction with biomedicine also stemmed from growing public recognition of the side effects of many biomedicines. Today, consumers are typically made aware of potential pharmaceutical side effects on product packaging. However, such disclosures were not common in the first decades after the Second World War. Consumers of the day were largely unaware of the types of side effects that they might experience when taking a medicine. As a result, the appearance of side effects could be at once unexpected and difficult to attribute to a cause.

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[38] Kanpō historian Ōtsuka Yasuo believes that increased specialization in biomedicine has heightened this problem.; Ōtsuka Yasuo, "Chinese Traditional Medicine in Japan," 322.
[39] Emiko Ohnuki-Tierney, *Illness and Culture in Contemporary Japan*, 101.

Compounding this issue, was the synthetic nature of biomedicine. Consumers felt that they did not know what ingredients any given biomedicine actually contained and were concerned about the potential effects of unknown ingredients. In Japan, news stories about *yakugai* (medicine damage, 薬害) were common and with good reason. The 1960s witnessed an epidemic of *yakugai* related to the consumption of biomedicines. In the 1960s, thousands of people in Japan were afflicted with subacute myelo-optic neuropathy (SMON Disease), which can cause blindness, paralysis and death, that was eventually attributed to the consumption of the antifungal biomedical drug Clioquinol.[40] In 1962, the anticancer drug thalidomide was banned in Japan after it was linked to birth deformities. In 1965, cold ampoules were linked to several deaths.[41] Though not linked to the consumption of biomedicines, the recognition of pollution-based diseases in Japan, such as Minamata disease, served to fuel public concern.[42] In this climate, kanpō seemed to be a more natural and less hazardous alternative to biomedical treatments. Even the term for the crude herbal components that compose kanpō medicines, *shōyaku* (生薬) served to reinforce this in the mind

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[40] Ohnuki-Tierney, *Illness and Culture in Contemporary Japan*, 102.
[41] Umemura, "Reviving Tradition," 190.
[42] Minamata disease is a neurological disorder resulting from methylmercury poisoning. The disease came to the world's attention in 1956 with the case of a five-year-old girl living in the Japanese town of Minamata who began to experience convulsions and difficulty walking and talking. Subsequent investigations revealed that a significant number of adults, children and animals in the area had experienced similar or more severe neurological symptoms, such as paralysis, loss of vision, coma, and even death, going back to the 1930s. In the end, it was discovered that Chisso Corporation, a chemical company which had operated a production plant in the area since the 1930s, had been dumping methylmercury, a byproduct of its operation, into the ocean, where it accumulated in the local marine life, which formed the basis of the diet for the population of Minamata. For more information see, Hachiya Noriyuki, The History and the Present of Minamata Disease: Entering the Second Half of a Century," *Japan Medical Association Journal* 49, no. 3 (2006).

of consumers, as the character 生 can mean raw, natural or, in alternate usages, life, while 薬 means medicine.

For Japanese survivors of the Pacific War, perhaps the most salient reason for their openness to kanpō medicine was their wartime experience with kanpō treatments. During the latter part of the war, domestic biomedical pharmaceutical production was progressively reduced as a result of American bombing and imports were not available due to blockades. Consequently, biomedical supplies dwindled and were withheld for military use. During the American Occupation, the situation began to improve but biomedicines remained scarce for many years. Civilians increasingly turned to kanpō and folk medicines to fulfill their needs. Between 1946 and 1952, sales of kanpō and folk medicines from Toyama Prefecture increased from 7.5 billion yen to 43.9 billion yen.[43]

Disillusionment with the perceived inadequacies and dangers of Western medicine, as well as the travails of the war, resulted in a greater receptiveness to kanpō medicine than otherwise would have been likely. This receptiveness served as the foundation upon which kanpō revivalist scholars and kanpō pharmaceutical corporations built the Kanpō Boom.

Promotion of Kanpō by Revivalist Scholars in the Postwar Period

The efforts of kanpō revivalist scholars in the early twentieth century such as Ōtsuka Keisetsu (大塚敬節), Yakazu Dōmei (矢数道明), Nakayama Tadanao (中山忠直), Wada Keijūrō (和田啓十郎), and Yumoto Kyūshin (湯本求真) that were discussed in earlier chapters ran

[43] Umemura, "Reviving Tradition," 186.

parallel to the commercial efforts of the kanpō-derived patent medicine industry. Both had an interest in the promotion of kanpō medicine, but they did not directly engage with each other. During the prewar period, much revivalist scholarship focused on historical textual analysis, prescription compilations and clinical practice; however, the focus of revivalists on the scientific rationalization of kanpō treatments paralleled production modernization efforts within the patent medicine industry and these efforts continued in the postwar period. During the postwar period, specialist organizations and popular publications were the primary means by which kanpō scholars continued to promote kanpō as a complement to biomedicine. There were three primary postwar professional organizations dedicated to the promotion of kanpō: The Japanese Society of Oriental Medicine (*Nihon tōyō igakkai* abbr. JSOM, 日本東洋医学会) and the Association for East Asian Medicine (*Tōa igaku kyōkai* abbr. AEAM, 東亜医学協会) and the All Japan Kanpō Physician's Union (*Zen nihon kanpō ishi renmei*, 全日本漢方医師連盟).[44]

The dominant postwar professional kanpō organization was the Japanese Society of Oriental Medicine, which was founded in 1950 by Ōtsuka Keisetsu, Kazuo Tatsuno (龍野一雄, 1905-1976), Nagahama Yoshio (長浜義夫), and Yakazu Dōmei. The focus of the organization was academic research and professional development. Yakazu viewed the organization as having three main goals. 1. To participate in the Japan Medical Association, 2. To produce kanpō medical textbooks, and 3. To realize the creation of kanpō clinical departments in hospitals.[45] During the

[44] Yakazu, *Meiji hyaku-jūnen*, 119; 188-189.
[45] Yakazu, *Meiji hyaku-jūnen*, 120-121.

postwar period, JSOM was active in establishing educational standards for kanpō practitioners, standardizing clinical terms and English translations, and led lobbying efforts for national health insurance coverage for kanpō medicines in the 1960s and 1970s.[46] JSOM's journal, *Kampo Medicine*, also known as *Nihon tōyō igaku zasshi* (Japan Oriental Medicine Magazine, 日本東洋医学雑誌), has been published since March 1950 and publishes both Japanese and English articles.[47]

Another important postwar professional kanpō organization was the Association for East Asian Medicine, initially a prewar organization focused on spreading scientifically rationalized kanpō throughout continental East Asia, which was revived in 1950 with a focus on the transmission of kanpō traditions/history, without the expansionist agenda. *Tōyō igaku* (Oriental medicine, 東洋医学), a prominent medical concept of the prewar period promoted by the AEAM, remained a popular alternate term for kanpō in postwar publications, but many of its prewar associations were discredited with Japan's defeat in the Pacific War. Postwar kanpō scholars no longer referred to notions of kanpō's superiority over the other classical medical systems of East Asia or the need to spread kanpō to other East Asian nations. The Association began publishing a new journal titled the *Journal of Kanpō Medicine* (J. *Kanpō no rinshō*, E. lit. *Clinical Kanpō*, 漢方の臨床) in 1954. The AEAM maintained professional connections and coordinated activities

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[46] Sahashi Yoshiro, "Societies for Kampo Medicine," *The Journal of Kampo, Acupuncture, and Integrative Medicine* (KAIM) 1 (2005): 63.
[47] From 1950 through 1982, the journal was published under the name *Nihon tōyō igakkaishi* [Japanese Oriental Medicine Club Bulletin, 日本東洋医学会誌] before changing its name to *Nihon tōyō igaku zasshi*.

with the Japanese Society of Oriental Medicine.[48] In 1954, Yakazu Dōmei became chairman of the AEAM.

The third important postwar professional kanpō organization was the All Japan Kanpō Physicians Federation founded in 1954. This organization focused on the practical needs of practitioners and published a journal titled *Zenkanihou* (All Kanpō Physicians Report, 全漢医報). Yakazu Dōmei served as the first Chairman. It took the lead in negotiations with the Kōseishō (Ministry of Health and Welfare, 厚生省) and Japan Medical Association over the issue of the separation of medical and pharmacy practice (*iyaku bungyō*, 医薬分業), which was opposed by kanpō practitioners on the grounds that herbal pharmacists and drug store attendants did not receive proper training to dispense kanpō medicine.[49]

Kanpō revivalists of the postwar era helped to facilitate the Kanpō Boom by engaging in public outreach through the publication of a significant number of kanpō books meant for popular and clinical consumption. While there had been a significant number of publications on kanpō in the prewar period, most were in the form of journal articles aimed at specialists who already had an interest in kanpō. By broadening accessibility through the publication of more generalist works for biomedical practitioners, kanpō trainees and the general public, revivalists found greater success in spreading knowledge of kanpō. In 1941, Ōtsuka Keisetsu, Yakazu Dōmei, Kimura Nagahisa and Shimizu Tōtarō completed a basic handbook for kanpō practitioners titled, *Practice*

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[48] Sahashi, "Societies for Kampo Medicine," 64.
[49] Yakazu, *Meiji hyaku-jūnen*, 29.

of Kanpō Medicine (J. *Kanpō no shinryō no jissai*, 漢方診療の実際), which was updated and republished in 1954. Between 1950 and 1970, Ōtsuka Keisetsu and Yakazu Dōmei, the two most prolific kanpō scholars of the twentieth century published a number of kanpō textbooks, clinical handbooks, prescription compilations and histories.[50] The following is a partial list of their publications from this period.

Table 1: Selected Postwar Publications of Ōtsuka Keisetsu and Yakazu Dōmei

Title	Author(s)	Year of Publication
Practice of Kampo Medicine, 2nd ed. (漢方診療の実際)	Ōtsuka, Yakazu, Shimizu Tōtarō	1954
Kanpō Medicine (漢方医学)	Ōtsuka	1956
Kanpō Medical Encyclopedia (漢方大医典)	Ōtsuka	1957
Kanpo Treatment and Diagnosis (診断処法と漢方療法)	Ōtsuka	1957
Folk Medicine Treatment and Herbal Knowledge (民間薬療法と薬草の知識)	Ōtsuka	1957
An Explanation of the Vital Points of the Goseiha Method (漢方後世要方解説)	Yakazu	1959
Thirty Years of Medical Treatment by Traditional Chinese Medicine: Practice of Therapy Based on Successful Cases (漢方診療三十年：治験例を主とした治療の実際)	Ōtsuka	1959
100 Stories of Kanpō (漢方百話)	Yakazu	1960
Together with Oriental Medicine (東洋医学とともに)	Ōtsuka	1960
Practical Kanpō Treatments According to Symptoms (症候による漢方治療の実際)	Ōtsuka	1963
Medicinal Plants, Knowledge and Benefits: 250 Types of Medicinal Plants and the Secret Prescriptions of Noted Doctors (薬草と知識と効用：250種の薬草と名医の処方秘伝)	Ōtsuka	1964
Kanpō Medical Treatment (漢方療法)	Ōtsuka	1964
Oriental Medicine Encyclopedia: The Medical Books of One Million People (東洋医学大典：百万人（ノ）医書)	Ōtsuka	1964
Kampo Prescriptions, Clinical Applications (漢方処方解説：臨床応用)	Yakazu	1966
Shang Han Lun Commentaries: Clinical Applications (傷寒論解説：臨床応用)	Ōtsuka	1966
The Encyclopedia of Kanpō and Folk Medicine (漢方と民間薬百科)	Ōtsuka	1966
The 110th Year of Meiji: A Chronological Table of Kampo (明治百年漢方略史年表)	Yakazu	1968
Kanpō Medical Diagnosis Encyclopedia (漢方診療医典)	Ōtsuka, Yakazu, and Shimizu Tōtarō	1969

[50] In 1979, Yakazu Dōmei was given a lifetime achievement award by the Japanese Medical Association for his contributions to kanpō medicine.

Overall, the period from 1954 to 1967 witnessed an exponential increase in the number of books published about kanpō. In 1954, approximately 45 books per year were published on the topic of kanpō. By 1967, this number had jumped to approximately 200 new titles per year.[51]

The significant increase in postwar kanpō publications for popular consumption represents a commercialization of the kanpō tradition, as was the case with mass marketed kanpō medicines; however, what separated the two was intent. While the commercialization of mass marketed kanpō medicines was profit driven, as discussed in previous chapters, kanpō revivalist scholars such as Ōtsuka Keisetsu and Yakazu Dōmei were motivated to educate the public and advance kanpō medicine. Still, although most of the kanpō revivalist scholars were not directly involved in the promotion of the mass-marketed kanpō medicines that drove the Kanpō Boom, their efforts to provide a scientifically rationalized conception of kanpō practice provided the intellectual foundation for the commercial postwar expansion of corporate OTC kanpō and government re-recognition of kanpō as a medical discipline.

The Development of Kanpō Extracts

Prior to the twentieth century, taking kanpō medicine was a time-consuming process. The majority of kanpō prescriptions required decoction. Kanpō doctors would provide patients with a

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[51] By way of comparison, following the Meiji Restoration in 1868, the number of kanpō book publications rose year on year until reaching a peak in 1885 of 15 books. From 1885, there was a steep decline in annual publications, with no recorded publications between 1898 and 1907. In terms of kanpō journals, the decline was more serious as there were no recorded publications between 1898 and 1922. From 1907, book publications rose slowly, tallying 8 in 1922, before spiking to 33 in 1933. Book publications began to decline with the outbreak of the Second Sino-Japanese War; however, at its lowest point in 1943, 19 books were published on kanpō. From 1943 forward, book publication numbers continued to rise each year. Yakazu, *Meiji hyaku-jūnen*, 126.

mixture of various herbs intended to treat the patient's specific ailment. These herbs were minimally processed and typically remained in their natural form at the time of prescription. In order to prepare the medicine, patients would decoct the mixture by soaking and boiling the herbs and allowing some of the water to evaporate to concentrate it. This could be a pungent process. Once it had cooled, they would then drink the medicine. This process had to be repeated for each "dose". Given that many kanpō medicines require an individual to continue taking the medicine for weeks, months or years, a significant amount of time was lost to the process of decoction.

As the pace of Japanese daily life quickened and began to be measured in precise units of time during the Meiji period, consumers of kanpō medicine yearned for a more convenient alternative. Western biomedicine was available on the Japanese market in a readily consumable form by this point; however, there were several factors that limited its appeal. First, it was prohibitively expensive for ordinary Japanese. Second, due to their incompatible etiological paradigms, biomedicine was perceived as able to treat only a limited range of diseases since it did not recognize certain diseases conceived within the kanpō paradigm as diseases. Third, ordinary Japanese were less familiar initially with biomedicine and still considered it a foreign concept. Conversely, consumers of the Meiji period retained a familiarity with kanpō as the medicine of their elder family members and their own youth and, as a result, many continued to use it.

The expansion of kanpō-derived patent medicines in the Meiji and Taishō periods provided a quicker alternative to decoction in some limited cases; however, a large majority of kanpō prescriptions were never offered in patent medicine form. To begin with, the sheer number of kanpō prescriptions in existence meant that even some well-known ones were never offered in patent medicine form. However, this was not the primary reason that many kanpō medicines did

not make the transition to patent medicine form. First, processing limitations of the period restricted producers to working with medicines that either already were or could be easily converted into a form that could be packaged, shipped and stored without spoiling or losing its efficacy.[52] Most kanpō decoctions called for the patient to drink the medicine while it was still hot because this was when the active ingredients were thought to be at their most potent. However, there were also prescriptions that call for the decoction to be consumed when it had cooled to a warm, or even room temperature. Moreover, even if one were to bottle a decoction, there were further concerns about efficacy, as the decoction would not be fresh at the time of consumption and the consumer could not be certain of the actual ingredients of the decoction. Additionally, bacterial contamination was a concern and reboiling the medicine could be perceived as further degrading its efficacy in some cases.[53] Finally, given the large number of potential medicines one could produce, focusing on more than one or two was an onerous task for all but the largest enterprises. Prior to the Pacific War, most major Japanese pharmaceutical companies focused their production efforts exclusively on biomedicines, meaning that production of kanpō-derived patent medicines was largely carried out by the successors of classical producers who were more limited in scale by capital despite their growing profitability in this period. The result was that only the simplest and most popular kanpō medicines made the transition to patent medicines.

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[52] Kobayashi Hajime, *Tsushimaryō Tashirobaiyaku hattatsushi*, 338-341.
[53] Akiba Tetsuo, "Iryōyō kanpō seizai no rekishi" [History of Kanpō Extracts for Medical Use], *Kampo Medicine* 61, no. 7 (2010): 882-883.

In the early Shōwa period (1926-1989, 昭和), kanpō physicians began to research powderization as means to facilitate the standardization and mass production of kanpō medicine. Through powderization, kanpō proponents sought to create what is known in Japanese as *ekisu* (エキス), or extracts. Kanpō physician/scholars such as Ōtsuka Keisetsu and Yakazu Dōmei viewed standardization of ingredient amounts as an important step along the path toward parity of recognition with biomedicine. If kanpō medicines could be produced on a large scale in precise quantities based on precise formulas, as was the case with biomedicine, it would be much easier for its advocates to argue for the efficacy of kanpō within a scientific framework.

However, in order to create a viable powderization process, several processing factors needed to be overcome. First, a method was needed for dehydrating the decoction into a powdered form quickly enough to stop the growth of bacteria or mold. Second, once dried, a means of storage needed to be developed to prevent the powder from reabsorbing moisture. Third, a means was needed to prevent clumping following the dehydration of organic ingredients high in sugar content.[54]

The third factor proved to be the first to be overcome. In 1942, an article in *Kanpō to kanyaku* discussed the difficulties in powderizing dates due to their high sugar content. Kameoka Shin (龜岡晋) was attempting to create an extract for treating diarrhea, but the sugar from the dates resulted in uneven clumping. The solution he found was to insert a filler, which bound with

[54] Akiba, "Iryōyō kanpō seizai no rekishi," 882-883.

the sugar to prevent clumping, thus resolving the issue.[55] Subsequently it was discovered that fillers could also be used to effectively create clumping as well. More specifically, fillers could be inserted to bind with the processed extract powder to facilitate processing in granule or tablet form.[56]

Early extraction trials were undertaken by Itakura Takeshi (板倉武, 1888-1958), director of the East Asian Treatment Research Institute (*Tōa chiryō kenkujō*, 東亜治療研究所), in 1943. These trials continued until 1945, when the Institute burned following an American bombing run.[57] However, during his early trials, Itakura successfully created an extract of *Shōsaikotō* (小柴胡湯), a stomach medicine, in pill form.[58]

Following the conclusion of the Pacific War, research aimed at refining the extraction process continued on both the professional and popular fronts. In 1947, Watanabe Takeshi (渡辺武) and Gotō Minoru (後藤實) of Takeda Pharmaceutical Company (*Takeda yakuhin kōgyō*, 武田薬品工) ran extraction trials based on those conducted by Itakura Takeshi earlier in the decade. Following the conclusion of their trials, they issued a report of their findings, which was widely consumed by the community of parties interested in kanpō extracts.

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[55] Nihon kanpō yakuzaishikai, Geri ni taisuru kanpōyaku nitsuite [About the Kanpō Medicine for Diarrhea], *Kanpō to kanyaku* 9, no. 8 (1942): 25.
[56] Akiba. "Iryōyō kanpō seizai no rekishi," 882.
[57] Akiba, "Iryōyō kanpō seizai no rekishi," 883.
[58] Hara Momosuke, "Sengo no nihon kanpō igakukai no tenpō: Nihon tōyō igakukai oyobi tōa igaku kyōkai wo chūshin toshite" [Postwar Prospects of the Japanese Kanpō Medicine World: The Japanese Society for Oriental Medicine and the Association of East Asian Medicine as the Center], *Nihon ishigaku zasshi* 56, no. 3 (2010): 438. *Shōsaikotō* was used to treat malaria along the Yangzi River during the Pacific War. This may have been the reason Itakura chose *Shōsaikotō* for his extraction trials. Ōtsuka Keisetsu, "Chūgoku kanpō ikai no genkyō to nikka teikei nitsuite" [About the Chinese Current Medical World and Sino-Japanese Cooperation], *Tōa igaku* 2 (1939): 14.

Concurrently, there were attempts outside the scientific and corporate communities to experiment with extract creation. The most notable example is that of Hosono Shirō (細野史郎, 1899-1989). Hosono was a consumer of kanpō prescriptions. His work required him to travel much of the time and it was difficult for him to carry the herbs and decoction apparatus with him, so he hoped to find a more convenient method of preparing his medicine. At the same time, he wanted to ensure that any extract that he created was of the same quality as the decocted version. In 1950, he was successful in creating an extract of his medicine for personal use. Hosono maintained and published records of his experiments, which served to inform ongoing corporate research into the extraction process.[59]

The breakthrough came in 1954 when Kotarō Kanpō Pharmaceuticals (*Kotarō kanpō seiyaku kabushiki kaisha*, 小太郎漢方製薬株式会社) developed an extraction process applicable to the vast majority of kanpō prescriptions.[60] Following the issuance of Watanabe and Gotō's report, Kotarō hired Kuwano Shigeaki (桑野重昭) to refine and adapt the process for mass production.[61] Incorporating Hosono's research, Kuwano created the modern kanpō extraction process by synthesizing extracts for *Keishi bukuryogan* (桂枝茯苓丸) and *Goreisan* (五苓散).[62]

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[59] Akiba, *Iryōyō kanpō seizai no rekishi*, 883.
[60] The company that would become Kotarō Kanpō Pharmaceuticals began in 1929 as a *kuroyaki* (黒焼) store. *Kuroyaki* is a Japanese folk medicine where plants or animals are charred and then ground into powder for medicinal use.
[61] Kikutani Toyohiko, "Kanpō seizai no ishigakuteki kentō" [A Study of Extracted Kanpō Drugs from the Standpoint of the History of Medicine], *Nihon ishigaku zasshi* 50, no. 1 (2004): 10.
[62] *Keishi bukuryogan* is classified as a *fujin yaku* (women's medicine, 婦人薬) prescribed to improve circulation and harmonize qi and blood production. *Goreisan* is prescribed to help remove excess wetness from the body. By balancing yang and harmonizing qi, it improves kidney function and stimulates urination. Akiba, *Iryōyō kanpō seizai no rekishi*, 883.

Kuwano's process entailed four stages. First, the crude herbs were soaked and decocted into a liquid. Second, the liquid decoction was separated from the physical remnants of the crude herbs. Third, the liquid was concentrated and then dried to a powder in a vacuum using infrared light.[63] Powdered extracts were then kept in a moisture-controlled environment to prevent absorption. Fourth, the dry powder was mixed as necessary with fillers to produce the desired form of the finished product. At this point, the extract was ready for packaging.[64]

The perfection of the kanpō extraction process by Kotarō resulted in a large volume of kanpō extracts entering the Japanese market for public consumption from the mid-1950s forward. By 1957, Kotarō itself offered 31 kanpō prescription extracts for sale.[65] Other major pharmaceutical corporations, who had been conducting their own extraction trials, quickly adapted Kotarō's process to their own products. The result was a vast expansion of commercial kanpō as biomedical pharmaceutical companies sought to profit from public interest in kanpō by offering their own kanpō drugs.[66]

Though it already existed to a limited extent in the form of kanpō-derived patent medicines, the extraction process allowed for the creation of a broad field of OTC kanpō products.

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[63] This drying process was later replaced by a spray-drying process. Spray-drying speeds up the drying process and reduces the chances of bacteria or mold growth. Yasui Hiromichi, "Manufacturing Process for the Prescriptions of Kanpō Medicine," *The Journal of Kampo, Acupuncture, and Integrative Medicine* (KAIM) 1 (2005): 51-55.
[64] Arai Ichirō, "Nihon no kanpō seizai sangyō no rekishi" [History of Japanese Kanpō Medicine Manufacturers], *Yakushigaku zasshi* 50, no. 1 (2015): 2.; Yasui Hiromichi, "Manufacturing Process for the Prescriptions of Kanpō Medicine," *The Journal of Kampo, Acupuncture, and Integrative Medicine* (KAIM) 1 (2005): 51-55.
[65] Arai, "Nihon no kanpō seizai sangyō no rekishi," 2.
[66] In 1961, Japan was the world's fourth largest producer of all pharmaceuticals. By 1966, it was the world's second largest producer. U.S. Department of Commerce, Bureau of Domestic Commerce, C*hemicals: Quarterly Industry Report*, Volume 13, (1966): 12.

Commercial drug stores began to stock a range of kanpō medicines consisting of standardized pills, granules, and powders. Professional, standardized sealed packaging encouraged a perception of quality in the minds of consumers, as this mirrored the commercial presentation of biomedicines. It was also far more convenient for purchase and storage than traditional bagged herbs, which were inconvenient to prepare and could be quite fragrant. OTC kanpō prescription extracts became so popular that they began to be referred to in the media as mass medicine (*taishuyaku*, 大衆薬) or general medicine (*ippanyaku*, 一般薬).[67]

Manufacturing Tradition - Kanpō Branding

Japanese pharmaceutical companies expended significant effort in creating effective strategies to market kanpō products. Following the marketing model pioneered by Japan's tourism industry, many companies used tradition as an advertising ploy, writing products names in Chinese characters in ancient-looking fonts intended to evoke an image of ancient Chinese seal script.[68] Contrasting with the kanpō-derived patent medicines of the prewar period, packaging was devoid of the English phrases and alphabetic characters that had symbolized "modernity" for kanpō-derived patent medicines. Packages also often included images of herbal ingredients to promote an association with nature and traditional knowledge, something avoided in prewar patent medicine advertisements for the opposite reason. Additionally, whereas prewar patent medicine

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[67] Nihon yakushi gakkai, *Nihon iyakuhin sangyōshi* [The History of the Japanese Medicine Industry] (Tokyo: Yakuji nippōsha, 1995), 17.

[68] Millie Creighton offers an excellent account of the marketing of tradition in the Japanese tourism industry in "Consuming Rural Japan: The Marketing of Tradition and Nostalgia in the Japanese Travel Industry," *Ethnology* 36, no. 3 (Summer 1997): 239-254.

advertisements often contained bold images or women or historical/cultural artifacts, advertisements of the 1950s forward rarely featured images on packaging aside from pictures of herbs. *Shōsaikotō* (小柴胡湯), *Kakkontō* (葛根湯), and *Hachimijiogan* (八味地黄丸) provide clear examples of this. These were three of the most popular kanpō extracts during the early postwar period, so much so that they were offered for sale by multiple corporations.[69] Invariably, each was marketed in a package with herbal imagery, an indicator that it was a kanpō medicine, along with clusters of Chinese character explanations. The fact that many packages were densely covered with Chinese characters providing details about the medicine heightened the association with traditional knowledge through visual effect as it was reminiscent of the style of packaging used by kanpō medicines in the Edo period. Finally, whereas prewar patent medicine advertisements typically did not claim a connection to kanpō, advertisements for the OTC kanpō medicines of the 1950s forward typically expressed their connection to kanpō directly. Take, for example, Taishō Pharmaceuticals' (*Taishō seiyaku kabushiki kaisha*, 大正製薬株式会社) Taishō Kanpō Stomach Medicine (*Taishō kanpō ichōyaku*, 大正漢方胃腸薬). The word kanpō was included in the title of the product and written in Chinese characters on the product box. While the title was written in a standard machine font for characters, 漢方 (kanpō) was printed in a font similar to handwriting script that highlights it for the reader in a manner akin to italics for English script. The box was typically a bland yellow and brown or white and brown contrast with a picture of two unidentified herbs on the front, the implication being that this was an herbal medicine.

[69] Umemura, "Reviving Tradition," 193.

Drawing on popular fears of the dangers of synthetic and highly processed biomedicines, the image of herbs provoked a subconscious contrast between the two by evoking a perception in the consumer that the kanpō product contained natural and simple ingredients. This, in turn, created the impression that the product was "healthy" for the consumer. One tagline for the product, "From today, I am kanpō" (*Kyō kara boku ha kanpō*, 今日から僕は漢方), sought to further capitalize on the health sentiment.[70] The implication was that by choosing this kanpō product, the consumer was choosing to become/be healthy.

Figure 12. Taishō Kanpō Stomach Medicine advertisement - From today, I am kanpō.[71]

[70] See Figure 12. Taishō Seiyaku Kabushiki Kaisha shashi henshū jimukyoku, *Taishō Seiyaku 80 nenshi* [The 80 Year History of Taishō Pharmaceuticals] (Tokyo: Taishō Seiyaku Kabushiki Kaisha, 1993), 219, 230.
[71] Taishō Seiyaku Kabushiki Kaisha shashi henshū jimukyoku, *Taishō Seiyaku 80 nenshi* [The 80 Year History of Taishō Pharmaceuticals] (Tokyo: Taishō Seiyaku Kabushiki Kaisha, 1993), 230.

A more nuanced reading of the tagline for Taishō Kanpō Stomach Medicine highlights another key aspect of Kanpō Boom period advertisement: That kanpō was a Japanese cultural practice. Throughout the history of what is now known as kanpō, there have been periods when it was viewed as a foreign system of medicine. During the Meiji, Taishō, and prewar Shōwa periods, kanpō's historical connections to China placed it at a disadvantage in elite Japanese circles as tensions with China frequently ran high. As has been previously noted, kanpō-derived patent medicines of these periods attempted to avoid any overt association with kanpō for this reason, as well as its perceived anti-modern associations. Kanpō revivalist scholars such as Yumoto Kyūshin and Nakayama Tadanao had attempted to bolster kanpō's standing in Japan by arguing that Japanese improvements to the Chinese medical practices that formed the foundation of kanpō had rendered kanpō to be a superior Japanese medicine. Taishō Kanpō Stomach Medicine's tagline, "From today, I am kanpō", indicated the extent to which the idea of kanpō as a "Japanese" medicine had been internalized in Japanese culture by the postwar period. At its most basic element, the message was that the speaker closely associated themselves with kanpō. Conversely, it would seem outlandish for a biomedical product to use the tagline, "From today, I am biomedicine."

The Bifurcation of Kanpō Practice

While the optimization of the herbal extraction process allowed Japanese pharmaceutical companies to mass produce kanpō medicines, it also inevitably altered the way kanpō medicine was used by the populace, creating a bifurcated system split between commercial and clinical practice. Standardization of ingredients and dosage, mass production, increasing commercialization, and corporate market competition led to the disregard of kanpō etiological theories, as consumers engaged in self-diagnosis based on perceived symptoms. Classical kanpō

diagnosis relies on the kanpō doctor's use of their visual observations of the patient and knowledge of kanpō pharmacology to prescribe the correct mixture and dosage of herbs to treat the given ailment. The expansion of commercial OTC kanpō in the Kanpō Boom period resulted in the consumer taking over the role of the kanpō doctor as diagnostician and pharmacist, allowing for on-demand kanpō treatment. This may seem similar to the process consumers engage in when purchasing OTC biomedicine; however, there is one key difference. From the point when the Kohōha School of kanpō medicine gained dominance in the mid-1700s, the traditional etiology of kanpō medicine had been progressively deemphasized within kanpō practice in favor of empirical results. By the Kanpō Boom period, most Japanese did not have a working understanding of disease as it is conceptualized within the kanpō paradigm. On the contrary, most were far more familiar with biomedical conceptions of disease.

The result was that the OTC kanpō of the Kanpō Boom period paralleled biomedical categorizations of disease. Kanpō extract medicines were promoted in advertising for the treatment of conditions such as the cold, stomachache, sore throat, cough, etc. that had been conceived from the perspective of biomedicine. For example, Taishō Kanpō Stomach Medicine was marketed as a medicine one should take before eating or drinking to prevent upset stomach, heartburn, stomachache, or lack of appetite.[72] As this indicated, the focus of OTC kanpō medicines began to parallel the usage of OTC biomedicine in a shift in focus to the treatment of symptoms rather than

[72] See Figure 13. Taishō Seiyaku Kabushiki Kaisha shashi henshū jimukyoku, *Taishō Seiyaku 80 nenshi*, 213.

underlying cause of disease.[73] To this end, some OTC medicines marketed as "kanpō" began to be adulterated with biomedical compounds, such as the pain reliever acetaminophen (also known as paracetamol). This served a commercial interest, as consumers were more likely to purchase a medicine that produced quick and observable cessation of discomfort over one that worked more slowly.

Figure 13. Taishō Kanpō Stomach Medicine advertisement – Take before eating or drinking.[74]

At this point, two separate disciplines of kanpō developed centering on the corporate drug store and the kanpō clinic. Processed drug store OTC kanpō, though marketed as "traditional" and "drawing on ancient wisdom" bore little difference from Western drug store medicine in all but presentation. Drug store staff received some training in matching OTC kanpō medicine with a

[73] Although traditional kanpō practice called for the kanpō doctor to visually observe and analyze *shō* (symptoms - 証) to determine the correct herbal mixture to provide to a patient, the purpose was to determine and treat the underlying cause of the symptoms.
[74] Taishō Seiyaku Kabushiki Kaisha shashi henshū jimukyoku, *Taishō Seiyaku 80 nenshi*, 213.

patient's self-reported symptoms, but this was not extensive. Some stores offered consultations with staff or diagnostic questionnaires to aid the consumer in their purchases. However, the questionnaires only provided basic guidance to consumer in organizing their self-reported symptoms.

A more classical approach to kanpō practice continued in private kanpō clinics. These were staffed by doctors that had completed training in biomedicine, as required by law, who had decided to pursue kanpō. Anthropologist Emiko Ohnuki-Tierney estimates that there were only 100-150 doctors who solely practiced kanpō medicine at the time of her fieldwork in the late 1970s.[75] While some practiced both kanpō and biomedicine, the majority only practiced biomedicine. The kanpō practiced by these doctors was more personalized, relying on the doctor's trained observation of *shō* (symptoms, 証), as well as their biomedical training. This personalized kanpō treatment was expensive, as it was not initially covered by Japanese National Health Insurance.

Herbal pharmacies represented a liminal space for the consumer, existing between the drug store and the kanpō clinic in terms of practice. With the Kanpō Boom, most began to offer both OTC kanpō and herbs for sale, though the balance shifted in favor of OTC kanpō over time, likely due to popular demand and profit considerations. Many had been in existence for generations, but these were family businesses and many of the owners did not typically have special training in kanpō outside of their business experience. Anthropologist Margaret Lock noted during her fieldwork that the more "traditional" an herbal pharmacy appeared, the less authentic it actually

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[75] Emiko Ohnuki-Tierney, *Illness and Culture in Contemporary Japan*, 108.

was.[76] As with OTC kanpō, herbal pharmacies used indicators of "tradition" to enhance their appeal. Polished wood was on frequent display, as it gave a feeling of age. Exotic animal products, such as "rhinoceros' horns, vipers and charred monkey heads", were sometimes on display for advertising purposes to attract the attention of consumers.[77] However, despite these more superficial associations with kanpō, herbal pharmacies were also sites where consumers could access authentic kanpō knowledge. Through their subjective work experience and sometimes knowledge passed down from previous generations, herbal pharmacists typically were more knowledgeable about kanpō than their colleagues in mainstream drug stores. They were also more familiar with specific herbs due to constant handling, though ailments were often discussed in biomedical terms, as this terminology was most familiar to the consumer. They also typically kept semi-medical records of their customers purchases.[78]

Although the popularization of OTC kanpō created a bifurcated system of treatment for consumers, it, along with the efforts of kanpō revivalists to scientifically rationalize the tradition from an intellectual standpoint, laid the groundwork for governmental re-recognition of kanpō by nullifying many of the biomedical arguments used to discredit kanpō from the Meiji period forward. In the Meiji period, kanpō had been derided as unscientific, superstitious, and ineffectual. OTC kanpō was mass-produced according to precise and standardized manufacturing guidelines that could hardly be argued to be unscientific. Kanpō prescriptions typically contained several

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[76] Margaret Lock, *East Asian Medicine in Urban Japan: Varieties of Medical Experience*, 153.
[77] Emiko Ohnuki-Tierney, *Illness and Culture in Contemporary Japan*, 96.
[78] Margaret Lock, *East Asian Medicine in Urban Japan: Varieties of Medical Experience*, 152.

active ingredients that produced the desired effect when combined, not as individual ingredients, so it was difficult to isolate the effects of individuals ingredients. The creation of standardized extracts helped to mitigate this issue. Moreover, extracts were largely marketed in association with the presumably "rational" biomedical conceptions of disease. Finally, the popularity and profitability of kanpō medicines in the postwar period likely invalidated concerns as to its efficacy. All of this served to lay the foundation for government re-recognition of kanpō in the 1960s and 1970s.

Government Re-Recognition of Kanpō

Official re-recognition of kanpō as a medical discipline by the Japanese government had been the primary goal of the discipline's proponents since the passage of the Isei Act in 1874, which had required all kanpō practitioners to be certified in biomedicine. With the development of the kanpō extraction process and the concomitant boom in consumer interest, this goal became achievable. OTC kanpō represented the fruition of the efforts of early twentieth century kanpō scholars such as Wada Keijūrō, Yumoto Kyūshin, Nakayama Tadanao, Ōtsuka Keisetsu and Yakazu Dōmei, among others, to apply the scientific method and modern production techniques to kanpō. Ironically, OTC kanpō's general reliance on a biomedical understanding of symptoms helped most of all to facilitate its acceptance within the biomedical system.

Regulation represented the Japanese government's first step in re-extending recognition to kanpō medicine. In 1960, the Pharmaceutical Affairs Law (*yakuji hō*, 薬事法) created a system to regulate the manufacturing of kanpō drugs by formalizing and standardizing industry safety and quality protocols. Prior to 1960, there was little official regulation of kanpō medicine production because, from the government's perspective, kanpō was not medicine. Despite kanpō's perception

and promotion as a safer alternative to Western medicine, there continued to be safety and quality concerns going forward. In 1975, the Japanese government issued binding approval standards for kanpō medicine known as the *Ippanyō kanpō shohō no tebiki* (Guide to General Kanpō Prescriptions, 一般用漢方処方の手引き).

With the implementation of the modern Japanese national health insurance (NHI) system in 1960, momentum grew for kanpō prescriptions to receive reimbursement coverage. In 1960, crude herbal components used in kanpō were finally recognized as falling within the sphere of medicine through the publication of official prices as required under the Japanese national health insurance system; however, reimbursement payments were not yet covered under the NHI. Surprisingly, given its decades of competition with kanpō, the biomedical community was supportive of kanpō's inclusion in the NHI. One of its key supporters was Takemi Tarō (武見太郎, 1904-1983), President of the Japan Medical Association from 1957 to 1982, the country's primary professional biomedical organization. Takemi was a consumer of kanpō medicine and believed that kanpō, as well as other cultural medicines, should serve as a complement to biomedicine.[79] Throughout his tenure at the Japan Medical Association, he gave numerous public talks calling for re-recognition of kanpō and its coverage under the NHI.[80] In 1967, the first four kanpō medicines were approved by the Japanese government for prescription use, but still not for reimbursement coverage under the NHI.

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[79] Takemi Tarō, "Igaku no risō" [The Ideal of Medicine], *Nihon ishikai zasshi* 66, no. 5 (1971): 518.
[80] Terasawa Katsutoshi, "Kanpō igaku: Kako, gendai, mirai" [Kanpō Medicine: Past, Present, Future], *Kampo Medicine* 48, no. 2 (1997): 169.

The 1960s and 1970s witnessed the opening of several public research organizations dedicated to the study of kanpō. The development of these centers represented the first official governmental support for kanpō research since the end of the Edo period. In 1963, Toyama University opened the *Wakanyaku kenkyūshitsu* (Sino-Japanese Medicine Laboratory, 和漢薬研究室). In 1973, the government-funded Kitasato Research Institute opened a branch dedicated to the study of kanpō medicine. The Kitasato Research Institute was created in 1914 as a private biomedical research facility and was named after Kitasato Shibasaburō (北里柴三郎, 1853-1931). Kitasato Shibasaburō achieved fame for his identification of the bubonic plague bacillus in 1894. As the nation's premier biomedical research facility, it is ironic that the facility became a site of Japan's government-funded kanpō research center after a century of official neglect. In 1977, Hyōgo Prefecture opened the *Tōyō igaku kenkyūjo* (Research Institute for Oriental Medicine, 東洋医学研究所). The opening of public kanpō research centers served as overt acknowledgment of kanpō's status as a medical discipline.

The final step in kanpō's re-recognition came with the coverage of kanpō prescriptions under the NHI. Coverage of limited kanpō prescriptions under the NHI progressively widened the availability and popularity of kanpō in Japan. In 1976, the first 6 kanpō extracts were covered for reimbursement by the NHI. Coverage has progressively expanded to today where 148 kanpō extracts are covered for reimbursement under the NHI.[81] Exclusive kanpō treatment remained and

[81] Arai Ichiro and Kawahara Nobuo, "Kampo Pharmaceutical Products in the Japanese Healthcare System: Legal Status and Quality Assurance," *Traditional and Kampo Medicine* 6, no. 1 (2019): 3.

continues to remain expensive for uncovered medicines; however, for covered medicines, the reduction in cost greatly expanded availability for consumers. At the same time, NHI coverage provided added legitimacy and cost efficiency to kanpō for biomedical practitioners. Statistics indicate a significant increase in the percentage of physicians stating that they used both biomedicine and kanpō in their practice during the 1970s and 1980s. In 1979, 28% of physicians indicated that they prescribed kanpō medicines to patients. By 1989, this number jumped to 69%.[82] Kanpō had become a fully integrated part of the modern Japanese medical system.

Conclusion

Fulfilling the vision of early twentieth century proponents of scientifically rationalized kanpō, the perfection of the mechanized kanpō herbal extract manufacturing process in the 1950s facilitated the re-recognition of kanpō by the Japanese biomedical community and the expansion of its use in Japanese society. Mechanization allowed companies to mass produce extracts utilizing standardized ingredients, mirroring the production method of biomedicines. Mass production, in turn, led to increased commercialization, as companies could profit from selling to a postwar public made increasingly receptive through its fear of the dangers of biomedicines. By appealing to a sense of Japanese tradition in the advertising of these medicines, kanpō manufacturing companies reassured the public of kanpō's safe and domestic nature through implicit reference to its historical and classical origins. Yet the tradition alluded to in these advertisements was invented. It is true that the history of kanpō medicine stretches back more than 1500 years; however, aside

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[82] Umemura, "Reviving Tradition," 192.

from rough formulations, the mass produced kanpō of the postwar period had little in common with classical kanpō medicine as practiced even as recently as the 1890s. As a result, mass produced kanpō of the postwar period existed in a liminal state, functioning conceptually and in practice as a biomedicine in its OTC form and as scientifically rationalized kanpō in the kanpō clinical setting.

Conclusion

In many ways, the story of kanpō between the seventeenth and twentieth centuries is comparable to the myth of the phoenix. Classical Japanese medicine flourished in the seventeenth and eighteenth centuries resulting in the development of multiple competing schools of medical thought. Its zenith came with the ascendance of the Kohōha School of kanpō in the eighteenth century; however, as this dissertation has shown, Kohōha's unique medical philosophy blending an emphasis on empiricism with a deemphasis on etiology laid the foundation for kanpō's decline in the nineteenth century by undermining it ability to cogently explain disease causation, the basis from which all medical systems derive their authority. Following the implementation of the Japanese biomedical system and subsequent restrictions on kanpō practice in the 1870s, kanpō clinical practice almost disappeared as its practitioners passed away. It is true that kanpō medicine continued to be consumed on a popular level throughout the prewar period, but, from the perspective of the time, the future of the discipline looked bleak. Yet, similar to the phoenix, the seed of kanpō's rebirth was found in its means of destruction. The same "scientific" processes, rationalization and standardization, that had supported biomedicine's doctrinal assault on kanpō in the late nineteenth century fueled its rebirth in the early to mid-twentieth century. Interest in kanpō rebounded following Japan's defeat in the Pacific War. On September 10, 1954, the *Asahi Shinbun* (Asahi Newspaper) published an article on the Kanpō Boom titled, "Kanpō Herbal

Medicine's Return to Life."[1] By the 1960s and 1970s, even the Japanese government and the Japan Medical Association, the primary biomedical professional organization in Japan, arguably the successors to kanpō's nineteenth century detractors, took steps to publicly acknowledge kanpō as a legitimate medical practice. A century in the making, this acknowledgement restored kanpō to its status as a Japanese medical tradition.

However, where this analogy fails is in the fact that kanpō, as it existed in the 1960s and 1970s, bore little resemblance to the classical Japanese medicine from which it derived as recently as the late nineteenth century. As detailed in this dissertation, kanpō medicine, as practiced in the twentieth century was largely an invented tradition, created through a series of progressive ideological reimaginations/reinterpretations of the practice between the eighteenth and twentieth centuries. This process began with the Kohōha School of kanpō's abandonment of classical *inyōgogyō* (yin/yang, five phases) etiology in favor of empiricism, which resulted in inconsistent explanations of disease among kanpō practitioners and a general deemphasis on etiology as part of medical practice in late eighteenth and early twentieth century Japan. Bolstered by the political and military power of Western countries from the mid-nineteenth century forward, its own foundation in empiricism, and kanpō's etiological incoherence, Western medicine gained acceptance as a rival medical paradigm to kanpō. Following the Meiji Restoration, the new government enacted medical reforms establishing Western medicine as the sole official medical system in Japan. Despite an abortive attempt by kanpō practitioners to regain official recognition

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[1] Editorial, "Iki wo fukukaesu kanpōyaku" [Kanpō Herbal Medicine's Return to Life], *Asahi Shinbun*, September 10, 1954.

for their practice in the 1880s and 1890s, by the turn of the twentieth century, classical Japanese medical practice was fading as the last of the Edo period kanpō physicians passed away.

It is at this point that the invented tradition of twentieth century kanpō began to form. Beginning in the 1910s, a group of biomedically-trained doctors with personal interests in kanpō, hereafter known collectively as the kanpō revivalists, reimagined kanpō within the conceptual framework of biomedicine. By justifying kanpō through the language of science and standardizing production and medical education, the kanpō revivalists originated what they envisioned to be a new style of medicine combining the strengths of both kanpō and biomedicine, superior to both. More than the practical efficiencies to be gained from blending, their confidence in the superiority of this new tradition drew on the exceptionalist arguments of *kokugaku* [national studies, 国学] scholars of the Edo period like Hirata Atsutane by reconceiving kanpō as "Japan's Medicine" by the mid-to-late 1920s. During the 1930s, this led to revivalist support of the export of this medical practice, reconceived as *tōyō igaku* (Oriental medicine), throughout East Asia in support of Japan's imperial expansion. After Japan's defeat in the Pacific War, revivalists continued to promote their scientifically rationalized version of kanpō domestically, having replaced its nationalistic overtones with allusions to its continuity with Japan's premodern culture.

Concurrent with the efforts of revivalist scholars to promote this new kanpō were the actions taken by traditional producers of kanpō herbs and medicines. In response to the Meiji period modernization policies that de-established kanpō as an official medical practice, many producers used advertising techniques to rebrand and repackage their products as "modern" patent medicines and deemphasize links to their origins in CJM/CCM. These efforts were successful, leading to the development of a profitable patent medicine industry that spread throughout Japan

and East Asia by the outbreak of the Pacific War. A key limiting factor in both the commercial efforts of these entrepreneurs and efforts of the revivalists to promote kanpō usage was the cumbersome and time-consuming process of mixing, decocting and storing kanpō medicines. This led to efforts beginning in the early twentieth century on the part of both groups to research the possibility of creating an extraction process that would allow for the mass production of kanpō medicines. The successful development of the extraction process by Kotarō Kanpō Pharmaceuticals in the mid-1950s and the subsequent mass production of an increasing number of kanpō extracts led to the Kanpō Boom of the 1960s when growing numbers of Japanese began to turn to kanpō for their medical needs.

The development of what this dissertation refers to as drug store kanpō, resulting from the fact that the corporate mass-produced extracts of the 1960s were sold predominately at drug stores rather than kanpō clinics, had the effect of splitting kanpō into two distinct practices distinguished primarily by who plays the role of diagnostician in the process of treatment. In one practice, typically taking place at a kanpō clinic, a kanpō physician would examine the patient's symptoms and prescribe a treatment. However, the more popular practice relied on self-diagnosis to choose the appropriate mass-produced kanpō treatment, a radical departure from classical practice and emphatic rejection of the CCM/CJM imperative of individualized treatment. Moreover, unlike in the case of treatments prescribed by kanpō doctors, mass-produced kanpō drugs tended to be marketed for biomedical symptoms exclusively without reference to classical etiology or nosology. Given this, it is unsurprising that, with the advent of national health care coverage for certain kanpō treatments, a significant proportion of the kanpō prescriptions in Japan came to be made by

biomedical doctors with almost no kanpō training.[2] Consequently, modern mass-produced kanpō treatments function effectively as biomedical treatments, despite being cloaked in packaging and advertising that draws on "traditional" cultural imagery to assert continuity with classical Japanese medicine. In other words, drug store kanpō is a modern innovation masquerading as an artifact of Japan's intangible cultural heritage, an invented tradition.

A brief look at the development of traditional Chinese medicine (TCM) in the twentieth century offers some insight into the evolution of kanpō into its contemporary form. CCM faced similar delegitimization efforts from modernizers during the early twentieth century and drew on kanpō's historical experience in responding with the introduction of modern and scientific processes into the practice of medicine, resulting in what this dissertation refers to as TCM to distinguish it from the classical practice of CCM. A key difference is that Chinese practitioners continued to utilize classical etiology and nosology as these new processes were introduced into the TCM paradigm. In this way, TCM maintained significant ideological continuity with CCM that was lacking between kanpō and CJM. This fact likely played a large role in TCM's ability to develop into a robust medical system of equal standing alongside biomedicine in China today. While this is a vast oversimplification of the process by which TCM evolved into its contemporary form, it is indicative of the impact that kanpō's rejection of classical etiology and nosology, beginning with the Kohōha School in the Edo period, had on its development.

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[2] Katayama Kotoe et al, "Prescription of Kampo Drugs in the Japanese Health Care Insurance Program," *Evidence-Based Complementary and Alternative Medicine* (2013): 4.

Today, TCM has spread globally and is increasingly receiving recognition within the international biomedical community, while kanpō, with some limited exceptions, is largely contained to Japan where it exists as an alternative medical practice supplementing biomedicine. In the 1920s, Nakayama Tadanao posited that the combination of biomedicine and kanpō would result in the creation of a superior form of medicine that would "shine throughout the world".[3] Accepting that this is a hyperbolic statement, TCM has arguably made significant progress in achieving Nakayama's goal with its global reach. Yet without knowledge of the historical experience of kanpō as reference for Chinese TCM physicians, it is conceivable that the outcome may have been different. Historian Sean Hsiang-Lin Lei has noted in his research on the development of TCM in the twentieth century that detractors of its efforts to adapt modern and scientific processes into the tradition referred to TCM as "Neither Donkey Nor Horse"(C. *feilu feima*; J. *hirohiba*, 非驢非馬). While the intent of this phrase was derogatory, implying essentially that the efforts were an abomination, the essence of the idiom is accurate when applied to the experience of kanpō without the derogatory implications, more so even than in the case of TCM. TCM successfully adapted modern scientific processes to its practice while retaining much of its classical philosophy and practice. The same cannot be said for kanpō. The introduction of empiricism, science and mechanization left kanpō in a bifurcated liminal state, existing to a degree as both a system of medical practice and Japanese cultural tradition in the kanpō clinical setting and as a derivative form of herbal medicine, heavily dependent upon biomedicine for its identity,

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[3] Nakayama Tadanao, "Kanpō igaku fukōron" [Theory and Revival of Kanpō Medicine], *Nihon oyobi nihonjin* [Japan and the Japanese] 109 (1926): 6.

in the drug store and biomedical clinical settings. In this way, accepting that all practices evolve over time, today's kanpō remains neither the classical Japanese medicine of the Edo period, nor has it evolved into the transcendent Japanese medicine to which Nakayama Tadanao aspired, but instead has transitioned to something in between, something neither donkey nor horse.

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