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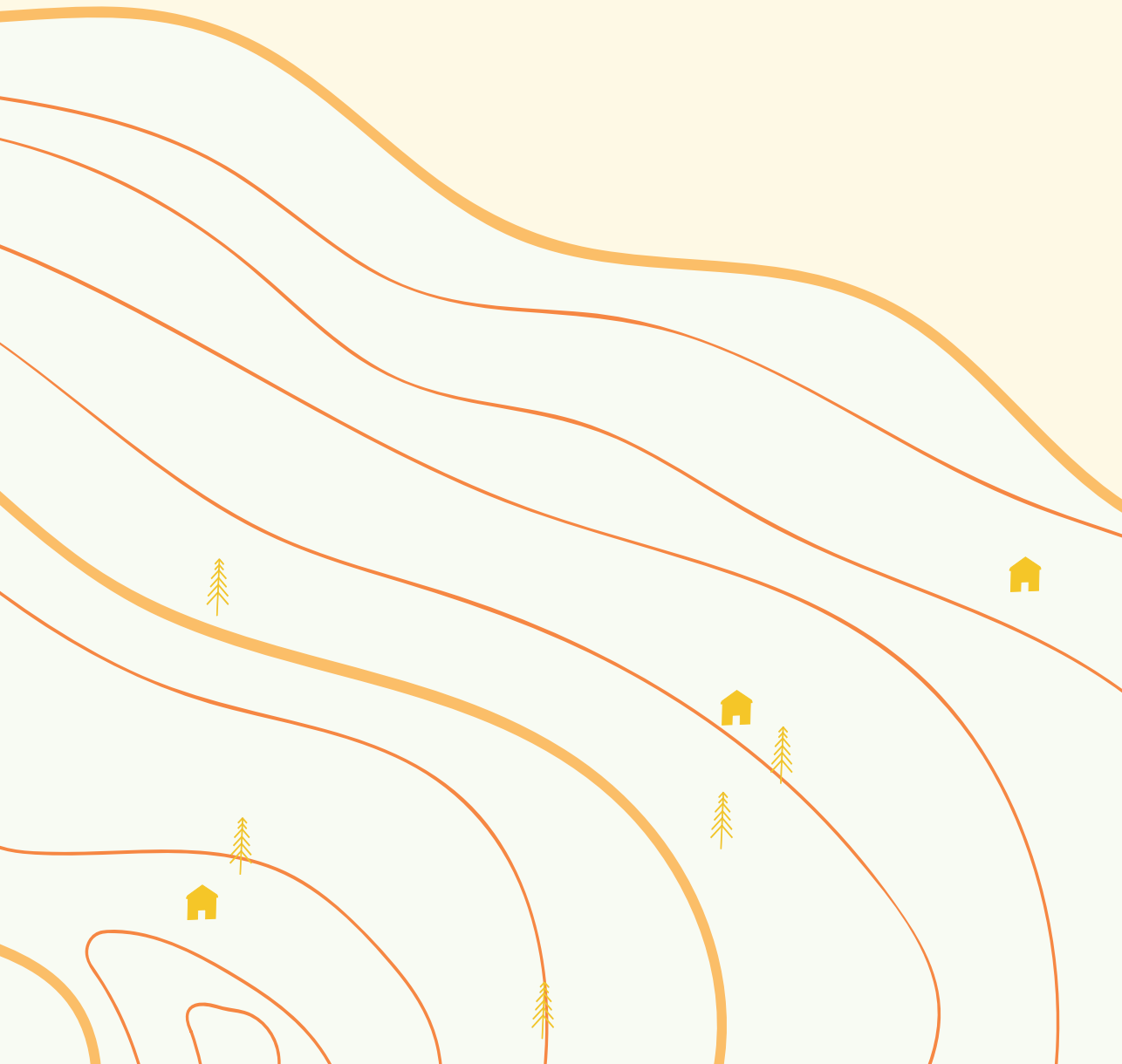
A Century of Global Medical Engagements



A Physician in Beijing

Photo of Tang Erhe (1878–1940). Source: Wikimedia Commons (CC).

Taking a Moderate Path: Tang Erhe, Colonial Korea, and the Formation of a Dual Medical System in 1910s China

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In 1922, the Chinese Government took a moderate path in regulating medical doctors by issuing parallel decrees to separately legalise traditional Chinese medicine and Western medicine. This became the starting point of China's dual medical system that exists to this day. By tracing the formation of this important policy, this essay shows the central role played by a Japanese-trained Chinese physician named Tang Erhe in persuading the Chinese authorities to learn from colonial Korea's medical model.

In China today, patients can choose between traditional Chinese medicine (TCM) and Western medicine as alternative, equally legitimate treatments. Often overlooked is the fact that the roots of this system can be found in the Republican era. As early as 1922, the Beiyang Government (1912–28) enacted regulations that granted TCM and Western medicine equal legal status. Albeit short-lived and seemingly inconsequential for medical practitioners at the time (Andrews 2014: 150), these regulations survived the many political upheavals of the Republican period and even shaped the dual system in existence in China today.

This contradicts the classical narratives that we encounter in the literature on the medical history of modern China, which portray China's Republican period as something of a 'dark age' for indigenous medical practitioners as Chinese progressives sought to ban their practices. These modernisers invoked the precedent of Japan in the Meiji era (1868–1912), when traditional Japanese medicine was prohibited from being taught at government-run medical schools. From its founding, the Chinese Republican Government allegedly held an equally negative attitude towards TCM. In particular, the Nationalist Government in Nanking (1928–37) several times proposed abolishing TCM (Lei 2014: 101–5). If attitudes were so critical, why did Chinese authorities legalise TCM in 1922?

In this essay, I examine how a prominent Japanese-trained Chinese physician based in Beijing, Tang Erhe (汤尔和), played a crucial role in the birth of this system, and contend that the legalisation of indigenous medicine in 1922 was inspired by Japanese

colonial medical policy in Korea. It was colonial Korea rather than Meiji Japan that exerted the greater influence on China's Republican Government in the Beiyang period. This was because Chinese policymakers at that time did not think the radical model of Meiji Japan was transplantable to the Chinese context, while colonial Korea's dual system of medical services was more practical and workable for China.

Attempts to Wipe Out TCM in the 1910s

After the new Chinese republic was founded in 1912, many radical intellectuals who returned from overseas saw the need for a scientific revolution to accompany the political one (Elman 2005: 418). Occupying many essential government posts, such as at the ministries of education and interior, they strove to introduce Western learning (西学), including science and technology, to China, while many of the indigenous scholarly classics were either adjusted to Western frames or omitted altogether from the new school system. In this context, Western medicine replaced TCM to become the only authorised medicine taught in government medical institutions. In 1913, then Minister of Education Wang Daxie publicly announced that he had 'decided to abolish Chinese medicine and the use of Chinese drugs in the future' (Andrews 2014: 169).

Nevertheless, TCM was still the leading healthcare service most Chinese people could afford. Western medicine was an 'enclave' medicine, and its use was concentrated in a few metropolitan cities. And there were only a couple of Japanised national Western medical schools across the country, which produced fewer than 100 graduates in total each year. With China's population of about 400 million, it seemed impossible to produce enough Western medical doctors to meet the growing demand in the short term. For this reason, the government had to tolerate the existence of TCM, while attempting to put its distribution and use under intense police surveillance.

Around the 1910s, several local police offices announced their own regulations regarding medical registries. An example is the Peking Municipal Police (京师警察厅, PMP). Based on the Japanese experience, the PMP set up a special medical branch called the Hygiene Division (卫生处) to supervise all medical practitioners. In 1913, the police released a provisional regulation according to which anyone who wanted to be a doctor had to obtain a licence by passing written examinations administered by the police. Medical degree–holders and TCM doctors who enjoyed a high reputation were exempted from the tests (PMP 1913). By 1918, 989 Chinese-style practitioners and 109 Western-style practitioners had received their licences in Peking (now Beijing) (Gamble 1921: 118–19). However, despite these attempts to police TCM, at the local level, the practice was widely accepted, and complaints about it were rarely heard. Moreover, in the countryside, the police were largely absent.

In 1917, the National Medical and Pharmaceutical Association of China (中华民国医药学会, NMPAC), the leading association of medical professionals (most of whom had studied in Japan), submitted a memorandum to the Ministry of Education requesting that it establish a national examination system for medical practitioners. It proposed testing medical candidates by scientific standards rather than the traditional way of writing essays, in the hope of excluding TCM practitioners from registration. The association claimed that relying on medical police to regulate the profession was only a provisional solution. The Ministry of Education, it proposed, should assume regulatory responsibility and establish these exams for medical candidates, as Japan and Western powers had done before (Tang 1917b: 5). Since the registered members of the association included teachers in various government and military medical schools as well as state officials, the memorandum signalled a consensus among Chinese practitioners of Western medicine: the central government must ban TCM.

Tang Erhe's 1917 Survey in Korea

Tang Erhe, the president of the NMPAC and an eminent physician who had studied Western medicine in Japan from 1906 to 1910, founded and ran the first Chinese national medical school, Peking Medical College, from 1912. He had significant influence over healthcare politics in Peking, partly due to his extensive connections with higher-level officials. He not only successfully persuaded the government to sanction China's first *Anatomy Act*, in 1913—which allowed human dissection in medical schools and hospitals (Luesink 2017: 7–12)—but also formed the NMPAC, the most prominent Chinese medical association at that time and a key player in standardising medical terminology.

Tang was also known for his stance against TCM. In his correspondence with the Ministry of Education in 1912, he argued that TCM depended on experience and had nothing to do with scientific research. In a letter published in the progressive *New Youth* (新青年) magazine, Tang Erhe claimed that the core concepts of TCM were 'nonsense' and 'even ridiculous' (Tang 1918c). In the preface to his translation of a Japanese medical book of modern diagnostics, he proclaimed that 'according to the world trend, Chinese medicine is destined to perish' (Tang 1918b).

But his stance against TCM was an idealised vision of a future China rather than a political aim to be achieved within a short time. Tang suspected that banning TCM in a society that could not afford Western medicine was all but impossible. In March 1917, he wrote to the ministry again, proposing to visit Japanese-occupied Korea in the coming months. The purpose of the trip was to 'study the Japanese compromise on Old Medicine [旧医] in Korea'. Clearly, he was fully aware of Japanese colonial medicine in Korea and eager to find out about the conditions there. The ministry approved his application and appointed him an official delegate to Korea on 7 April 1917.

By the turn of the twentieth century, Korea was also a country with a very limited number of practitioners of Western medicine, with most Koreans relying on the Korean version of Chinese medicine, which Japanese colonisers called *Kampo* medicine (汉医, hereinafter KCM). When Japan annexed Korea in 1910, it promised to bring 'civilisation' to the peninsula's 'backward' indigenous people. However, instead of founding new schools of biomedicine, the Governor-General of Korea (GGK) legalised Korean medicine as a remedy for the shortage of Western-style doctors in 1913. At that time, the mild way the Japanese Empire dealt with KCM surprised reform-minded Chinese intellectuals, who knew that there were tough restrictions on traditional medicine in metropolitan Japan. For context, it is worth noting that even British India—another colony with a long history of indigenous healing traditions—was able to establish a similar registry for indigenous doctors only 25 years later, in 1938 (Park 2006: 212).

Tang set out from Beijing by train on 12 April 1917, crossed Manchuria, and arrived in Seoul on 15 April. He stayed there for five days. His report to the Ministry of Education resembled a personal diary. It was published in the government journal *Education Bulletin* (教育公报) and the journal of the NMPAC. At the same time, a concise version was posted in one of the most influential magazines of the Republican period, *The Eastern Miscellany* (东方杂志).

Tang was not someone who could be manipulated easily by Japanese colonial propaganda. On the contrary, he appeared to be very sensitive to the racial inequality caused by Japanese colonialism. On the way to Korea on the Japanese South Manchuria Railway, he witnessed many cases of racial discrimination against Chinese and Koreans. He was angry when he saw Japanese teachers in Seoul mocking their Korean students. 'Japanese do not even try to hide their arrogance in front of foreign visitors,' wrote Tang in his diary, 'one can imagine how much worse it could be when there are no outsiders' (Tang 1917a: 11–12).

Health chief Yoshio Bando from the Police Department of the GGK received Tang in Seoul on 17 April. Their two-hour conversation was quite intense. Bando explained the colonial medical policy to Tang. The Japanese regulations named local healers who passed the written test 'medical students' and graduates of colleges of Western medicine 'medical teachers'. By so doing, the colonisers attempted to inflict a sense of inferiority on the former. Moreover, qualified 'medical students' were required by the government to receive yearly training from 'medical teachers' in Seoul on anatomy, physiology, and infectious diseases.

For Tang, the written examinations for indigenous practitioners had nothing to do with clinical skills and were thereby meaningless. He was also sceptical of the re-education program for KCM practitioners. When he expressed his concerns, Bando defended the colonial policy by admitting that there were no other options, and explained that KCM was indispensable to contemporary Koreans. The principle of the colonial medical

administration was to gradually eliminate KCM and recruit established indigenous practitioners for re-education on the one hand, while strengthening regular medical education on the other.

Instead of praising Japanese colonial medicine in Korea, Tang Erhe could see the limitations of the GGK's policy. Tang did not conceal his disappointment with Bando in his report to the ministry. He pointed out incisively that Bando was not trained in medicine, that his responses were incoherent and he failed to grasp the main points. But at the same time, he recognised that the value of the Korean case lay exactly in the inability of the Japanese Empire to suppress traditional medicine in Korea. Tang (1917a: 7–8) subsequently became pessimistic about the future of Western medicine in China. If a strong empire like Japan, equipped with a modern police force, could not realise its civilising mission in a colony as small as one Chinese province, how could a weak Chinese government have its decrees obeyed? How could it motivate thousands of Chinese doctors to abandon their life-long careers?

The Legalisation of Chinese Medicine

Tang returned to Beijing on 31 May 1917. On 19 May, the Ministry of the Interior had urged the Ministry of Education to develop systems to grant 'practice licences' to qualified physicians and to conduct 'medical examinations' to prospective doctors (Ministry of the Interior 1917). It appears that at that time the head of the Department of Health of the Ministry of the Interior, Liu Daoren, who had studied police administration in Meiji Japan, still wanted to prohibit TCM. The Ministry of Education then asked Tang for advice. Tang presented his diary to the ministry on 2 June, replying in a pessimistic tone:

> Unfortunately, the conditions in China are similar to Korea. Its people are so poorly educated, and the number of normal physicians of Western medicine is so small that medicine and medical instruments can only be available in metropolitan cities. Even if someone who practices Kampo medicine would like to make a fresh start [to learn Western medicine], there will be few [Western] medical books written in Chinese … Moreover, the [national] household registration system has not been established. The police have neither the power outside the capital nor the specialised knowledge [required to regulate local physicians]. All these weaknesses may lead to the conclusion that [the conditions in China] are worse than Korea. (Tang 1918a: 3)

After this meticulous comparison between China and Korea, Tang advised against banning TCM and suggested adopting Japanese colonial medical policy and allowing Chinese medicine to exist. He also forwarded three translated documents of Korea's medical registration law to the ministry for reference.

The Ministry of Education took Tang's opinion seriously. It appointed him its representative to the Ministry of the Interior in September 1917. The representative from the Ministry of the Interior to the Ministry of Education was also a Japanese-trained Chinese medical student, Wang Huanwen, who was a member of NMPAC and a researcher of Chinese medicine. We do not know the exact details of their discussions, but after two months, they achieved consensus. Wang accepted Tang's suggestion. In his report to the Ministry of the Interior, he wrote that he agreed with Tang that China was not ready for a wholesale ban on TCM. He suggested following Korea's example and proceeding gradually. This way, the population would not feel sudden policy changes (Ministry of Education 1918).

In 1922, the Ministry of the Interior announced the establishment of a dual medical system based on the Korean model. This system distinguished between the two different titles of 'medical teacher' (医师) and 'medical professional' (医士), which have similar pronounciation in the Chinese language and were interchangeable in daily use. However, the title of medical professional was granted to: those who had passed the examinations held by local police; those who had graduated from TCM training schools; those who had worked as a medical doctor (医员) in public hospitals with an outstanding record, and had been recommended by three 'medical teachers' or 'medical professionals'; and those who had medical knowledge and skills and had practised medicine for at least five years, demonstrated through references from three medical teachers or professionals. It is worth noting that the regulation also legitimised schools of TCM. It essentially legalised the status quo of TCM (Ministry of the Interior 1922).

The Legacies of Colonial Medical Policy

Colonial Korea played a crucial role in shaping modern Chinese medical policy. It was Tang Erhe, the prominent leader of an association of Japan-trained Chinese physicians, who introduced Korean dual medical services to the central government. But he did not use it as a positive example to laud Japanese colonial medicine in Korea, and instead expressed scepticism about its effectiveness. Along with his suspicions about Japanese colonialism more generally, Tang felt pessimistic about China's conditions at the time. In this way, he shared a similar type of anxiety as the Japanese colonisers in Korea. The sense of fatalism among Japanese medical modernisers he witnessed in Korea was a shock to him, so much so that as a medical revolutionary he had to attenuate his stance in support of the coexistence of Western and Chinese medicine.

Tang's modest agenda persuaded the central government to adopt a middle ground in medical policy—one that did not favour either kind of medicine publicly and granted Chinese medicine equal legal status to Western medicine. Although the 1922 regulation was abandoned before it was formally put into force, the dual system was inherited by subsequent governments at both the central and the local levels. It laid the foundations for the treatment of Chinese medicine as both unique and equal to Western medicine. From colonial fatalism to modernity in nation-building, the 1922 dual system heralded a new era in which Chinese medicine could now be used in national health programs.