The Rockefeller Foundation, The Japanese Public Health Profession, and China, 1914-1938

by Shawn Foster

University of Minnesota

A generous grant-in-aid furnished by the Rockefeller Archive Center (RAC) in the summer of 2014 enabled me to pursue research at the repository on the following questions. The first question is about the interaction of diverse medical cultures with the China Medical Board (CMB), a division of the Rockefeller Foundation (RF). When the CMB formally entered China in 1914, Western medicine had already come to the country through multiple channels. One significant pathway was for Chinese students to receive their training in Japanese medical schools, a pattern begun right after Japan defeated China in 1895. The returning Chinese medical doctors—who had been in some ways influenced by a German medical outlook in Japan—had already occupied important positions in the government medical administration and in various newly built national medical schools. The question I ask is, how did CMB personnel in the field deal with these students and their multiple foreign, but non-American, influences?

The second question concerns the relationship between the medical students who had been trained earlier in Japan and those who had studied more recently in Western countries (mainly Great Britain and the United States). Although both groups were working towards establishing scientific medicine in China, they did not get along well. Japanese-trained Chinese doctors were initially in charge, and they tried to block the efforts of Western-trained Chinese doctors. In the late 1920s, however, the latter gained the upper hand in the medical and public health administrative and educational institutions at both central and local levels. Beyond the political reasons for this development, I ask, how did the differences in medical science and in attention to public health between Japan and in the West affect this change?

My third question is, simply, how did Rockefeller Foundation officials understand Japanese public health professional development?

Probably because the Foundation had never formally entered Japan as a philanthropic organization, references to their Japanese public health-related projects were spread out in different collections at the RAC. I searched through

the records of the CMB (R4) and the Rockefeller Boards records (Series O), as well as the officers' diaries (RG 12). Because some of these materials have been digitized and are available online, during my three-week research at the RAC, I limited my search to otherwise unavailable manuscript records.

The research results I present here are organized chronologically into three parts, respectively covering Rockefeller Foundation officers' views on Japanese medical education, on public health organization structure in Japan, and on the effort of visiting commissions and staff to understand how the prevailing Japanese background of many Chinese scientists might have an impact on medical students in China. The records also highlight the probably inevitable disparity in medical science and in public health practice in particular between the United States and Japan, as well as the Foundation's changing viewpoint on the issue of whether Japan needed outside aid in order to adopt new advancements in the public health practices of the West.

Starting in China: 1914–1915

The Rockefeller Foundation's China Medical Commission (CMC) traveled to China, the Philippines, and Japan in 1914 to investigate the development of medical schools, mission hospitals, and colleges and universities for the Rockefeller Foundation. The Commission published a formal report entitled *Medicine in China*.[1] Archival sources about the CMC's process of investigation in Japan are scattered across several collections at the RAC, but two files of notes do reveal commissioners' views towards Japanese efforts at scientific medicine as it related to the work the CMC intended to undertake in China. These references also display commissioners' anticipation of future conflict between the American medicine they would promote and the German-style medicine the Japanese had been practicing for about fifty years.

The first piece is Francis W. Peabody's note of April 28, 1914, the tenth day after his arrival in Asia, documenting his visit to a Japanese hospital in Peking. He did not give the name of the hospital, but only indicated that it was one of "a series" operated by a Japanese society founded by Count Okuma for philanthropic work in China. Peabody pointed out that this facility was quite small, more like a dispensary than a hospital, and that the one Japanese doctor in residence there had studied the shorter Japanese medical course. The hospital's businesslike appearance and its rather well-equipped laboratory nonetheless impressed him. Peabody specifically noted that this small facility performed the Wassermann reaction, a complicated test he had not seen in the other hospitals he had visited in Peking so far. He further commented that, in contrast with other Peking hospitals, the cleanliness, orderliness, and apparent efficiency of this one was striking. The language and tone of this short note clearly show that the author had respect for this Japanese medical facility.[2]

Another file collected reports, memoranda, and notes the CMC members produced during their fall trip in 1914 to Japan, papers that supplement Peabody's.[3] The notes in the file listed, in the order of the date on which each note was written, the sites the CMC delegation visited. The notes reveal the commissioners calling at the Kyoto Prefectural Medical School and its hospital, at St. Luke's International Hospital, the Imperial Institute for Infectious Diseases, and at the Medical School of the Imperial University of Tokyo and its hospital. In their notes and in a memorandum about the St. Luke's International Hospital's grant application, commissioners expressed clear feelings about the development of modern medicine in Japan and about how the problems derived from the situation in Japan could possibly affect future CMC work in China.

Commissioners evaluated Japanese-trained Chinese medical students mainly through their comments on the prefectural medical schools. They observed that these were the same type of medical schools in which most of Chinese students had been educated in Japan. The best of these schools, they reported, was located in Osaka. The school at Kyoto stood second, while the school at Chiba was

deemed the poorest. Chinese students were accepted without examination at Chiba if they understood the language. They were not, however, given the same degrees as the Japanese, but instead took an examination and received a certificate. Graduates occasionally did well, but most, the reviewers thought, did not amount to much because their preparation had been so inferior.

Commissioners expressed equally critical opinions about other Japanese medical facilities, and their comments showed concern about the possible need of the RF's intervention on medical education. They noted that many professors in the Japanese medical schools were products of German laboratories and that Japanese medical education and hospital practice strictly followed German lines. The Japanese knew little of what was being done medically in the United States and showed little respect for it. Although they found the hospitals they visited sufficiently clean, orderly, and efficient, the commissioners judged the level of practice they witnessed to be far below current Western standards. Commissioners observed, moreover, that the Japanese, though well behind the West in modern medical practice, had the theoretical knowledge of scientific medicine and the economic power to catch up to it. The Commission decided, therefore, that medical work on a large scale in Japan was inadvisable because it would hurt the "amour-propre"—the pride—of the Japanese.

The Commission did, however, strongly recommend a favorable consideration on St. Luke's International Hospital's grant request for a new building. Because the Rockefeller Foundation had previously committed itself to the meeting the overwhelming funding needs of the Belgium Relief during World War I, however, the funds were never granted. The memorandum by the Commission, written primarily by Roger S. Greene, exhibited the strategic concerns of the Foundation personnel in the field for their future work in China.

Dr. Rudolf B. Teusler, an 1894 graduate of the Medical College of Virginia, had founded St. Luke's in 1902 under the auspices of the Domestic and Foreign Missionary Society of the Protestant Episcopal Church in the United States, and

served as its director and chief surgeon. One important reason for the Commission to support the Hospital was its superiority to other hospitals the Commission visited and its positive reputation among many Japanese medical men. Dr. Teusler and his medical staff, moreover, frequently invited leading Japanese physicians and surgeons as consultants to attend cases at the hospital. Developing this hospital further could make it an important vehicle for informing Japanese doctors of the development of medical science in the United States. With improvements, the hospital might serve as a contact zone between the American and Japanese medical professions.

The Commission believed that because more Chinese had studied modern medicine in Japan than in any other country, the Japanese were likely to continue to have considerable influence on the development of medicine in China. Anything that would improve the standing of American medicine in Japan, therefore, would facilitate the China Medical Commission‘s relations with the Japanese-trained men in China who now occupied important positions in the Chinese government. Raising the standard of Japanese hospital practice would also indirectly help to improve the quality of future Chinese graduates of Japanese medical schools. In hopes of enabling the Foundation to exert its influence to raise the standard of Chinese doctors trained in Japan, the commissioners strongly recommended that the grant application be favorably considered.

Extending the Rockefeller Foundation's Interests beyond China: 1921–1923

A key event in Rockefeller Foundation history in the period after World War I was John D. Rockefeller, Jr.'s 1921 "Oriental Trip" and his impressive delegation to China for the Peking Union Medical College's dedication ceremony. This visit marked the Foundation's increasing interest in the broader Far East. Officers conducted surveys on medical service and education in various countries. One report of interest is Dr. Richard M. Pearce's "Medical Education in Japan (with Note on Hospitals and Public health)."[4]

Dr. Pearce's report covered a much wider subject than its title indicated. The parts that would most help scholars understand the Japanese medical education system and public health framework of the time are Dr. Pearce's evaluation of Japanese medical schools and his description of the Japanese public health administrative organization.

Dr. Pearce categorized Japanese medical schools into four groups: central government controlled university rank, non-university special schools, local government prefecture schools, and private schools. All totaled, the doctor counted twenty-five schools. Except for the four schools outside of Japan proper and two service schools, Pearce graded the other nineteen schools into four classes. His criteria roughly correlated with American standards, but he also took into consideration the management of the school, the number of students, how long it had been operating, and admission requirements. The A-plus class included the University Medical Schools of Tokyo, Kyoto, Kyushu, Kohoku, and Hokkaido, and a private one, the Medical College of Keio University. The A-minus class included two prefectural government Medical Colleges, Osaka and Aichi. The grade B class included five imperial government special medical schools, Niigata, Kanazawa, Chiba, Okayama, and Nagasaki, two prefectural

government special Medical Schools, Kyoto and Kumamoto, and a private special school, Tokyo Charity Hospital Medical School; and class C included three private special Medical Schools: Nihon, Tokyo, and Tokyo Women's. This classification is important for understanding the scientific status of Japanese-trained Chinese medical students. Another issue worth noting is that a government-required curriculum list revealed that hygiene was listed, but not public health or preventive medicine.

According to Dr. Pearce, since1875 a public health administrative unit called the Central Sanitary Bureau had been operating as a part of the Ministry of the Interior (Home Affairs). This Bureau had three divisions: 1) a Health Preservation Section, responsible for supervising waterworks, sewage, street cleaning, parks, health resorts, food, and drinks; 2) an Epidemic Prevention Section, responsible for supervising the prevention of infectious and local diseases, quarantine work, vaccine lymph, sera, and vaccination; and 3) a Medical Affairs Section, responsible for supervising physicians, pharmacists, midwives, nurses, hospitals, and the handling of medicines. Personnel of this Bureau consisted of a councilor from the Home Department, and a staff of a director, sixteen subordinates, and four additional sanitary inspection experts. For the central government, the Institute of Infectious Disease did research work in connection with the prevention of epidemics, the preparation and distribution of vaccine lymph and various therapeutic sera, and a three month course for the training of physicians and veterinarians in the handling of infectious diseases.[5] In major cities such as Tokyo, Osaka, and Yokohama, hygienic labs did routine examinations of water, air, soil, and food. At the time the most prevalent diseases were enteric fever, dysentery, diphtheria, smallpox, cholera, and verminosis. While the first governmental hygienic and public health organization in China was modeled after the Japanese system, Dr. Pearce's description provides important references, and a comparison point for organizations of the later national health departments controlled by Chinese doctors trained in the West.

Dr. Pearce's observations on Chinese medical students trained in Japan did not add much that was new in comparison with what his colleagues had written in 1914 and 1915. He claimed that, as a rule, these students were graduates of the poorer schools in Japan and that they normally came back not with a diploma but rather merely a certificate as "listeners." He also stressed again that Chinese students who had returned from Japan now controlled practically all governmental medical schools, such as national medical schools at Peking, Soochow, and Hangchow, and hospitals. Almost all of these facilities were modeled after the Japanese-German system of medical education and administration. Dr. Pearce thought that the German medical system overstressed research and gave little concern to the human aspect of patient care. He predicted that this situation would cause problems for future graduates of the Peking Union Medical College when they were ready to seek jobs.

One file at the RAC pertaining to a Dr. Tang Erho (1878–1940) seem to echo the worries that Dr. Pearce and of his colleagues were expressing.[6] Tang probably belonged to the most pro-Japan Chinese student group trained in Japan. At the end stage of his life, he actually served as a high level official in the puppet regime in Beijing under Japanese rule. This might be the reason for difficulties in finding biographical information about him. Still, several facts became clear. Tang studied medicine in Kanazawa Medical School, (a class B school, according to Dr. Pearce), between 1907 and 1910 during his second time in overseas study in Japan. In the 1910s, he served as the president of the National Peking Medical School for several years. During this period, his most prominent contribution to spreading Western-style medicine was that he single-handedly pushed through a government decree on dissection in 1914 that legalized this practice in medical education in China. In the 1920s, Tang held high-level positions in education in the Beiyang government. During the period I studied, the CMB personnel contacted him and extended several invitations for him to visit the US. Tang, however, made excuses each time for not going.

In his lifetime of work for the development of scientific medicine in China, Dr. Tang said nothing about public health and preventive medicine. When Dr. Tang was working on legalizing dissection for medical education in China in 1914, an American-trained Chinese doctor, Yan Fuqing, who happened to have returned to China in 1910 as well, added preventive medicine to the curriculum of the Xiangya Medical School in Hunan, which was a product of the cooperation between American missionaries and local Chinese.[7] These cases suggest that there were clear differences between the two systems regarding actual public health training.

Dr. Pearce's in-depth survey, however, did not concern the different situation in Japanese medical schools on public health education and the formation of a public health profession. Dr. Pearce believed that Japan had largely succeeded in adapting Western medicine, apart from some difficulties in adjusting Western practices to national habits and customs. He confirmed the recommendations his colleagues had made in 1914: for the development of fundamental principles in laboratory work, in clinical medicine, or in the promotion of public health, Japan did not need aid from outside.

Documents at the RAC indicate that this understanding was changing.[8] In 1922, at Dr. Teusler's initiative, the Foundation began to think about inviting Japanese medical scientists to the US to observe Western advances in scientific medicine, with an emphasis on public health administrative practice. After about a year of back-and-forth correspondence, a commission of six members arrived in New York in March of 1923. According to a later, retrospective account, during their two-month visit, the Japanese "carefully took notes and descriptions of staining methods, technical procedures and new clinical tests, clinic-pathological demonstrations; public health work and broad conception of what hospital could mean in community; social attitude toward disease and cooperation between organizations as life insurance companies, city and federal authorities and private agencies."[9]

Upon the delegation's return to Japan, its leader, Mataro Nagayo, the head of Japan's Institute of Infectious Disease, wrote to Dr. Pearce about how much the experience had influenced him. "What I have experienced personally in the States urges me in many respects to undertake all possible applications here in Japan, and have already set about on my part numbers of improvement in our ordinary administrations etc. Especially those admirable organizations in America on the part of Public Health service were most instructive to us and some of them should be appointed by us at once even in the present state of our country. I am sure that all doctors who have been in the States with me are of the same opinion with myself."[10] This message aroused high hopes among Foundation officers that public health practice would develop in Japan without further outside aid.[11]

Getting Involved: 1923–1938

The Great Kantō earthquake that struck Japan on September 1, 1923 provided an opportunity for the Rockefeller Foundation to get directly involved in the development of the public health profession in the country. Dr. Teusler again played a mediating role in drawing the Foundation's attention to the need for recovering the medical educational and practical facilities damaged by the earthquake.[12]

The earthquake having completely leveled Dr. Teusley's St. Luke's International Hospital, he appealed to the Rockefeller Foundation for funds to rebuild it. Unlike during World War I, however, the Foundation and its subdivisions had decided end further direct involvement in disaster relief. John D. Rockefeller Jr. himself, along with the Laura Spelman Rockefeller Memorial Foundation, contributed a total of $500,000 to the American Red Cross, amounting to one-tenth of the total funds the organization collected from the United States for Tokyo earthquake relief. Despite its reluctance, the Rockefeller Foundation, too, would be persuaded to get involved.

When Dr. Teusley learned that the Foundation was considering extending its help for the reconstruction process but wanted a formal invitation from the Japanese government, he contacted his Japanese friends, some of whom were government officials, and worked out an official invitation for a Foundation commission to survey medical and public health conditions in Japan. In May 1924, a commission consisting of Drs. Frederick F. Russell, Victor G. Heiser, and John B. Grant came to Japan to conduct an investigation. The commission concluded that Japan's bacteriologists were doing first-class work by worldwide standards. Yet their advanced bacteriological work was still failing to help lower the mortality rate to the level of countries that had been moving forward in public health measures. The Japanese had fallen behind in establishing graduate-level public health training, especially public health administration training. They did not have public health nurses. Although their governmental public health system had great potential, it was fragmented. It appeared Japan did need some help from the outside.

The Rockefeller Foundation undertook three initiatives to try to remedy this situation, focusing particularly on the shortage of well-trained, modern public health administrative personnel. First, in hopes of increasing Japanese knowledge about American institutions and methods of medicine and public health, the Foundation began providing postgraduate fellowships to aid Japanese MDs to study in the United States through auspices of the International Health Board. This aid had actually started even before the 1924 RF investigation, but the Foundation began issuing these grants more routinely in its wake. It provided twenty-eight such fellowships between 1922 and 1938.

The Foundation's second initiative was to have its Division of Medical Education assist a private medical school, the Medical School of the Keio University, to establish a preventive medicine department (today the Center for Preventive Medicine of the Keio University School of Medicine). Why was the first independent preventive medicine educational facility in Japan undertaken at a private, rather than a public (or imperial) university? There were several reasons.

First of all, the nature of Japanese medical education system made it difficult to introduce modern trends into imperial universities.[13] The government had less strict control of the private universities. Second, the medical group at the Keio University was considered more aggressive in absorbing Western medical advances. Third, Dr. Yoshio Kusama of the Keio Medical School strongly desired separating the hygiene and parasitology from the existing departments of pathology and bacteriology in order to establish a preventive medicine department that resembled the American system. Taking these factors into consideration, the Rockefeller Foundation granted Keio University $175,000 toward a new building. The new institute's formally opened in 1929.

The Foundation's third post-1924 aim in Japan was to construct a Tokyo Institute of Public Health in cooperation with the Japanese government. This cooperative project proved a long haul. In November 1924 the Foundation decided support this project with a total contribution not to exceed $1,500,000 for the building plus $40,000 a year for three years to underwrite the Institution's urban and rural demonstration units. Further negotiations, however, were hung up by the question of selecting the institute's director. The Japanese government suggested Dr. Mataro Nagayo, but various groups opposed Dr. Nagayo for varying reasons. Two of these reasons would place the Foundation's overall goals for the Far East in particular jeopardy. Dr. Nagayo happened to be the leader of the ultra-pro-German group that exerted the kind of influence the Foundation's medical program was in part directed toward overcoming. More than that, Dr. Nagayo also led a group that backed Japanese medical penetration of China, but for nationalistic rather than scientific purposes. There would be little chance, under his leadership, that the future institution could be utilized to help China develop its public health system. This tension, combined with a lack of local action, led the Foundation to withdraw its support in 1927.

In April 1930, Dr. Miyajima, a member of both the Keio medical group and the Japanese Cabinet, met the Rockefeller Foundation's Dr. Heiser in Geneva, where the two reopened the discussion of the possibility of cooperation toward the

construction of the Tokyo Institute of Public Health. The stated rationale was the promotion of good international relations and humanitarian service to the Japanese people. The Japanese government invited Dr. Heiser to come to Japan. His visit in November 1930 resulted in the organization of a special committee to study needs and conditions and to present a definite project. This committee was also responsible for making grounds and facilities available for construction, for presenting definite numbers for the cost of construction and equipment, for guaranteeing the government's willingness to maintain the plant, and to make arrangements with the local government for demonstration units. The fact that many members of this committee had been International Health Board fellows may have facilitated this arrangement.

Although the Japanese acted much more enthusiastically this time, other hurdles remained. First, it took about a year for the Japanese special committee to resolve the problem of selecting a district for experimental and practical work. It presented this project to the RF's Board in October 1931. At this point, however, the Board decided to cut its financial gift to two-thirds of its 1924 offer in order to adjust for the impact of the worldwide depression on the Foundation's liquidity. The project was further stalled when the League of Nations, in an effort to resolve the international fracas caused by the Manchurian Incident of September 6, 1931, strongly urged the Foundation to postpone.

The project did not move forward until November 1933 with a push by Selskar Gunn. The road to construction, however, remained obstructed. This time, problems again arose in Japan. In the intensified post-Manchuria Incident nationalistic climate, the Japanese military expressed strong opposition to allowing the Foundation's appointed representative, Dr. Charles N. Leach, to reside in Japan, where he was to supervise the construction and direct the urban and rural health center. Opposition to foreigners playing such roles in Tokyo came out most explicitly in the medical press.

Although Dr. Leach and his successor John B. Grant were forced to conduct their work with the Institute from a base in China, construction nonetheless proceeded, if slowly. In 1938, with the building close to completion, a rapid increase in the cost of materials delayed the work again. The Institute's formal opening ceremony took place in 1940. Although the United States and Japan were not yet on an obvious war footing, the only American to attend the event was the secretary of the American ambassador attended.

Conclusion

The slow pace of the Rockefeller Foundation's efforts to advance public health enterprise in Japan provides a very interesting case in terms of knowledge transfer and cultural exchange. Japan had been the first Asian country to industrialize and to be directly influenced by European practices. The Japanese government officially adopted the German medical approach as early as 1870. In 1874, the *Isei* (medical code) decree launched the modern Japanese public health system. In 1893, a reformed central administration placed all public health-related activities under police supervision, a practice that continued until 1942. These changes were all undertaken by the initiative of the Japanese themselves. Yet, despite the passage of many decades, a public health profession had not grown organically out of this environment of adopted Western medicine and industry. Instead, in the government-subsidized medical educational system, public health remained largely disconnected from medicine. The Japanese case thus becomes an interesting point of comparison with other Asian countries, such as China and the Philippines, which adopted Western public health practices in the 1920s and 1930s at a faster rate and with more evident results. Placed in political context, this material also helps explain why the Rockefeller Foundation's prewar investments in Japan remained so limited.

[1] China Medical Commission of the Rockefeller Foundation, *Medicine in China* (New York, 1914), https://archive.org/stream/medicineinchina00rock#page/n3/mode/2up
[2] RF RG4 S1 Box 19 F317.
[3] The following narrative is based on materials in RF RG4 S1.1 B26 F559.
[4] RF, RG1.1, 609A, B5, F33.
[5] Among the materials I examined, Dr. Pearce gave the most detailed account of public health-related training by the Institute of Infectious diseases in his report (RF, RG1.1, 609A, B5, F33). He reports that over two thousand physicians acquired graduate training in bacteriology, immunology, and parasitology at the Institute.
[6] RF, RG4, S1, B85, F1969.
[7] Shawn Foster, "Three Case Studies: The Changing Participation of Chinese Leadership in Modern Medical Education in China, 1879-1937," paper presented at the Conference of History of Western Medicine in China, 1800-1950, Beijing, China, June 22-23, 2013.
[8] RF, RG1.1, 609, B1, F3.
[9] Irvine McQuarrie's 1947 survey, RF, RG1.1, 609, B1, F3.
[10] A letter from Mataro Nagayo to R. M. Pearce on July 16, 1923, RF, RG1.1, 609, B1, F3.
[11] RF, RG1.1, 609, B1, F3.
[12] This section is based on documents in RF, RG1.1, 609 and 609A.
[13] Irvine McQuirrie mentioned the following problems with imperial universities in his notes: "Imperial universities as whole were definitely organized as any department of government, in some respects resembling military system. Number and character of professorships, assistant professorships, and lectureships definitely fixed, as salaries; promotion by seniority. Salary increase solely on length of office had unfortunate effect on productivity. Young men did research and published because higher degrees and University appointments depended on this; output of men after taking university chairs when they should be fruitful, much less satisfactory; equally good opportunities but stimulation lacking." Irvine McQuirrie, 1947, RF, RG1.1, 609, B5, F32.