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Traditional Korean medicine in the modernization process: Institutional and attitudinal changes

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Traditional Korean medicine in the modernization process: Institutional and attitudinal changes

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DEDICATION

To my mother and the memory of my father.

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CHAPTER I. INTRODUCTION

This dissertation is a study of the persistence and change of a traditional institution in a modernizing society. The institution that this study investigates is the traditional medical system, also called East Asian medicine[1], and the society is Korea. The overall themes of the current project are the following.

First, as a rapidly industrializing society, Korea offers a rare opportunity to test various modernization theories that have been developed in the discipline of sociology. By compiling empirical and historical data on Korea's modernization process, we may be able to provide a conclusive case study to support either the unilinear and convergent evolution theory or the multilinear and divergent theory.

Second, by focusing on a specific institution in Korea, this study will be able to pinpoint the strengths and weaknesses of other contesting sociological theories in the

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[1]Following Lock's (1980a) argument, I will use the term East Asian medicine instead of Chinese medicine to refer to the medical beliefs and practices that were dominant among the literate population of East Asian countries until the 19th century.

fields of social change and development, such as structural-functionalism and conflict theory. East Asian medicine is used in this study because it has a long history and clearly defined social organizations and behavioral modes and because it has undergone dramatic change in the last few decades. Documentation of this change will reveal the structural dynamics, functional imperatives, and group conflicts in the modernization process. The fine-tuning of these theories will enable future researchers to identify problem areas and to develop specific methods to cope with them.

The third emphasis of the current research is to identify the sociocultural variables that are associated with the acceptance or rejection of East Asian medicine among contemporary Korean residents. At the individual level, the modernization process involves the subjective acceptance or rejection of the old versus the new. To what extent the individual's predispositions in education, rural-urban experience, income level, age, gender, and nationalistic sentiment affect the selection and rejection of traditional institutions remains a poorly understood and poorly documented issue.

To carry out this research project, we developed a two-pronged approach. The first approach to this research was

to collect historical and statistical documents for a comprehensive understanding of the changing nature of East Asian medicine in Korea. Data was collected in libraries in the United States and in Korea. This research gives us a synoptic view of traditional medicine in Korea, its relationship with the political system, and its transformation under the colonial and post-liberation eras.

The second approach to this research project was to conduct surveys in Korea among certain segments of the population. By using survey questionnaires, we collected a large number of samples that can empirically answer questions regarding the correlations between individual attributes and perceptions and the use of East Asian medicine.

Although this research scheme appears to emphasize the division between institutional change and individual change in the modernization of the traditional Korean medical system, it is important to point out that such a division is used mainly for the purposes of clarity and research logistics. Modernization and social change is a multifaceted process that involves continuous feedback and interaction between the society (i.e., its various organizations, institutions, and accompanying norms and values) and its constituent members (as seen in their

demographic compositions, changing personal propensities in education, income, residence, values, etc.). In the case of Korean traditional medicine, it is inevitable that a comprehensive understanding of this modernization process must investigate both the feedback loops between the macro-sociopolitical change and the adaptational change of the traditional medical system on the one hand, and the micro-individual change vis-a-vis the changing medical environment on the other. This triangular relationship between the sociopolitical environment, the changing traditional institution in health care, and the changing individual propensities can probably be illustrated only with a four-dimensional model. Because such a model is not available in current sociological research, this dissertation will illustrate this study as if it contained two separate dimensions, namely, institutional change and individual change.

Description of the Research Site and the Research Problem

Korea has been a land of two nations since 1948. This research, however, is confined to the Republic of Korea, even though the study includes both sections of Korea through the period before division. The Republic of Korea contains about 98,000 square kilometers. As of 1986, Korea

had a population of 41.5 million (International Bank for Reconstruction and Development, 1988).

Historically, Korea has received Chinese culture and social institutions but has retained its own language and alphabet and developed its own way of life (Lee, 1984). Before contact with Western countries in the late 19th century, Korea maintained remarkably stable political and cultural patterns (McCune, 1983). In 1910, however, Korea was annexed by Japan. Upon liberation from Japanese rule in 1945, Korea was occupied and administered by the Soviet Union in the north and by the United States in the south (Lee, 1984). A war between the north and the south began in 1950 and lasted for three years. In addition to many civilian losses during this period, nearly 2 million soldiers died, and most industrial facilities were destroyed (Wagner, 1983).

After the war, Korean society experienced great change, which involved orientation with Western societies. Economic change since the war has been dramatic. People's values, attitudes, and behavior patterns have also experienced much change. Although traditional social relationships are still strongly emphasized, Western patterns have become the dominant mode of life (Lee, 1984).

It is within this context of dramatic social change

that I have attempted to investigate the persistence and change of the East Asian medical system. It is therefore useful to provide some background information about East Asian medicine in Korea today.

It was about 2,000 years ago that a traditional medical system was developed in China. This medical system has been accepted in neighboring countries since the 5th and 6th centuries (Jingfeng, 1988). Varieties of this medical system have been practiced in China, Korea, Japan, Taiwan, Hong Kong, and Southeast Asian countries where Chinese influence has been significant.

Many traditional institutions in East Asia have disappeared during the past century in the process of modernization, as has happened in most other Third World countries. But East Asian medicine has survived because of its therapeutic or adaptive value, although it lost its official status. In the post-World War II era, with the nationalist movements in Asia, there have been revivals of interest in and/or institutional reforms of East Asian medical systems in countries where it is practiced (Croizier, 1968, 1976; Lee, 1974; Lock, 1980a; Otsuka, 1976).

Today, the dual system of Western and East Asian medicine is a characteristic feature of health care services

among most East Asian countries. Each part of the dual system has its own concepts, diagnoses, and treatment techniques and its own institutions for education, research, and medical practice, even though the status of East Asian medicine is generally inferior to that of Western medicine.

Social scientists have studied East Asian medicine since the 1970s. Changes in the East Asian medical system in the modern era have been very dynamic; many nonmedical factors were related to the changes, including Western medical imperialism, scientism, and nationalism.

A major reason for the increase in the number of recent studies concerns institutional reforms of traditional medical systems in East Asian countries. These studies provide insights into cultural processes and change (Gallin, 1974). Comparative studies in these diverse sociocultural contexts unravel a rich area for the study of development and for the testing of sociological theories (Fabrega and Silver, 1973).

The study of the changing medical system in Korea can answer several questions. How has the Western medical system come to dominate the East Asian medical system, which had been the official medical system for more than 1,000 years? How has the East Asian medical system managed to persist despite the introduction of Western medicine? How

successfully has the East Asian medical system been modernized in contemporary Korea? To what extent can the East Asian medical system and the Western medical system coexist in Korea? To answer these questions, institutional factors related to medicine in East Asia will be examined.

In a society characterized by a market economy, the viability of the East Asian medical system essentially depends on people's attitudes toward and use of East Asian medicine. The following questions can be raised. What are the typical views that people have toward each of the medical systems? To what extent is East Asian medicine used? Is there any consistency between attitudes and behaviors concerning East Asian medicine? Which factors affect people's attitudes toward and their use of East Asian medicine? What are the relationships between sociodemographic variables and the selection of the two medical services? To what extent has nationalistic sentiment contributed to the revival of East Asian medicine? Therefore, an investigation of people's attitudes and behaviors toward East Asian medicine becomes an important research area. Such studies are helpful in understanding the current popularity and raising status of East Asian medicine.

The present research is a study of East Asian medicine in Korea, where such research is relatively rare. The primary objective of the research is to contribute to the sociological understanding of East Asian medicine in Korea. Specifically, at the institutional level, this study will describe changes in the structure and organization of the traditional East Asian medical system, look for some major reasons for these changes, examine the system's developmental process as a social system, and inquire about the system's dynamic relationship with Western medicine. At the individual level, this research will examine Korean people's attitudes and behaviors concerning East Asian medicine in relation to Western medicine; the effects of sociodemographic variables and nationalistic sentiment on attitudes and use of East Asian medicine will be examined.

This dissertation consists of six chapters. Following this introductory chapter, Chapter II reviews existing research and theories and generates research hypotheses at the institutional level. In Chapter III, institutional factors affecting changes in the East Asian medical system are examined. Chapter IV provides the theories and hypotheses concerning individuals' attitudes and behaviors toward East Asian medicine and presents the methods and descriptive findings. In Chapter V, findings from the

hypotheses testing are presented. The last chapter, Chapter VI, discusses the implications of the research results, the limits of this study, and suggestions for future research.

CHAPTER II. MEDICINE AS AN INSTITUTION IN EAST ASIA: LITERATURE REVIEW AND THEORIES

The sociological study of the East Asian medical system lies in the area of the sociology of medicine and is related to developmental studies. Studies of East Asian medicine will be introduced to summarize previous research on institutional changes and research in Korea. Next, general theories in these areas are set forth in this chapter, and research hypotheses are generated concerning changes in medical institutions in Korea.

Research on East Asian Medicine

This section examines the current situation in East Asian medicine and provides the background information necessary for our understanding of East Asian medicine in Korea. To accomplish this, a brief summary of the social scientific research on East Asian medicine will be provided. This summary will be followed by a discussion of the institutional changes and research in Korea. Two related questions about institutional change will be asked. In what way is the East Asian medical system interfaced with the Western medical system? How has the East Asian medical system survived and revived in the modern era? Existing

studies will be used to summarize different perspectives that are used to explain the current situations. Research in Korea will also be discussed.

Summary of research on East Asian medicine

Before the 1970s, except for the works of Croizier (1965, 1966, 1968), there were very few studies of East Asian medicine. In the early 1970s, a series of introductions to Chinese health services, based mainly on short travels to the People's Republic of China (PRC), stimulated the systematic research on East Asian medicine.

Of the studies of East Asian medicine, about three-fourths have been conducted in the PRC (Table 1). There are several reasons for this emphasis. East Asian medicine originated in ancient China, and the PRC possesses the majority of the population who practice this form of medicine. Also, modern China has been successful in preserving and improving its traditional medical system and has been enthusiastically trying to integrate traditional and Western medicine (Croizier, 1968; Cai, 1988). Finally, the attempt at an equitable distribution of medical resources throughout the nation (e.g., via the barefoot doctors) has been considered a possible model of medical development for other Third World countries (Sidel, 1972;

Table 1. Social scientific research on East Asian medicine by country[a]

Source Country	Articles in journals	Articles in books	Books
Hong Kong	3	3	0
Japan	4	3	3
Korea	1	0	0
Malaysia	3	1	0
People's Republic of China	34	41	18
Republic of China	1	5	1
Singapore	2	0	0
Vietnam	2	0	0

[a]The research computed here is limited to studies published in the United States from 1932 through 1988 (Hong, 1988).

Rifkin, 1973).

The major results of these studies can be classified as follow: 1) documentation of the historical and theoretical foundations of East Asian medicine (e.g., Wong and Wu, 1973; Porkert, 1974); 2) exploration of the relationships between East Asian and Western medicine (e.g., Lee, 1982; Unschuld, 1976); 3) explanation of the sustaining and changing aspects of the East Asian medical system (e.g., Leslie, 1974; Lee, 1981); 4) analysis of dynamics of culture and East Asian medicine (e.g., Kleinman, 1980; Emiko, 1984); 5) discussion of political effects on the East Asian medical system (e.g., Esposito, 1972; Lampton, 1977); 6) examination of the relevance of China's medical experience for other developing countries (e.g., Bibeau, 1985; Karefa-Smart, 1978); and 7) investigation of perceptions about and use of East Asian medicine (e.g., Lee, 1980; Gale, 1974).

Contemporary status of East Asian medicine

The current health care situation in East Asian countries is characterized by plural medical systems. Besides folk healing techniques, there exists a dual East Asian and Western medical system. These two medical systems are unequal in terms of power, prestige, and wealth (Lee, 1982). Lee (1982) characterized this situation as a

hierarchical medical pluralism in which Western medicine became structurally superior to East Asian medicine. This hierarchy between the two medical systems is more salient in capitalist countries (e.g., Hong Kong, Japan, Korea, Malaysia, Singapore, and Taiwan) than it is in socialist countries (e.g., PRC and Vietnam).

The subordination of the East Asian medical system to the Western medical system is most prominent in Hong Kong. According to Lee's (1974, 1980, 1982) research, the health care systems in Hong Kong are pluralistic, comprising a variety of medical traditions. However, Western-style medical doctors have dominated the entire system of health care. The status of East Asian medical practitioner is low. The Hong Kong government does not grant licenses to East Asian medical practitioners. Anyone can become an East Asian medical practitioner by making a payment of HK$150 for commercial registration (Lee, 1980). "No traditional practitioner may call himself 'doctor'...(or) may do anything restricted as a privilege to qualified registrable Western-trained doctors" (Topley, 1974:243). For example, the practitioner of East Asian medicine may not issue birth, death, or international inoculation certificates. The government does not provide East Asian medical care, nor do university medical faculties teach East Asian medicine.

There were 20 or more professional associations of East Asian medical practitioners and more than 20 East Asian medical training institutes in 1980. However, these professional associations and training institutes lacked uniform standards and disciplinary procedures (Lee, 1980).

The status of East Asian medicine is somewhat different in Taiwan, Korea, Malaysia, and Singapore. In Taiwan, the Chinese nationalist government grants licenses to East Asian medical practitioners (Gale, 1974). There exists legal competition between East Asian and Western medicine. Both Western-style and East Asian medical doctors have their own organizations, hospitals, and training institutes. Nevertheless, government financial support has been given almost entirely to Western medical systems. All physicians employed in the government are Western-trained. Five Western medical schools and only one East Asian medical school were in operation in 1973 (Gale, 1974).

Quah (1977, 1981) reports that the Western medical system is dominant in Singapore, even though East Asian medical doctors have their own professional organization and educational facility. It has been estimated that nine out of every ten persons seeking health care go to a Western-style medical doctor. Government attitudes toward East Asian medicine are not supportive. Indeed, the government

wants to modernize East Asian medicine through the adoption of the scientific methods and equipment used by Western-style doctors.

In Malaysia, according to a study by Chen (1981), traditional Malaysian, East Asian, and Western medical systems coexist. East Asian medicine was introduced with the rapid immigration of the Chinese population from 1800 onwards. The Chinese people in Malaysia are the principal users of East Asian medicine. East Asian and traditional Malaysian medical practitioners have their own associations, but their general status is lower than practitioners of Western medicine.

The situation in Japan differs greatly from that of other capitalist countries in East Asia. The difference comes from the fact that East Asian medical doctors (not practitioners of acupuncture and moxibustion) are required to receive Western medical education and licensing before they can practice East Asian medicine. This requirement was implemented with the official adoption of the Western medical system during the Meiji Restoration of the 1860s (Lock, 1980b). As a consequence, the number of East Asian medical doctors became very small by the end of the last century, although East Asian medicine was not ruled illegal as such (Lock, 1985).

The dominant medical system in modern Japan is, of course, Western medicine. Even though there is no hierarchical difference between Western-style medical doctors and East Asian medical doctors and each has their own associations and journals, the East Asian medical system is much weaker than the Western system.

The status of East Asian medicine in the PRC and in Vietnam is much higher than that in capitalist countries. East Asian medical doctors enjoy almost the same level of prestige as that enjoyed by Western-style medical doctors (Ladinsky et al., 1987; Cai, 1988). Also, at the institutional level, the East Asian medical system is both a competing and cooperating partner with the Western medical system; it is not subordinate. Lee (1981) reports that, in the PRC, both East Asian and Western-style health services are provided in each level of the health services. Western medicine plays more important roles at the higher-level hospitals. At the local level, however, East Asian medical care is more available than is Western medical care. The choice between East Asian and Western medicine depends on the patient.

The status of East Asian medicine in China before 1949 was not different from that in other East Asian countries (Lee, 1982). In the first part of the 20th century, the

dominant position of East Asian medicine was threatened by Western medicine. After 1949, the new health policy adopted by the Chinese communist government stressed cooperation between East Asian and Western-style doctors (Unschuld, 1976). With strong government support, the status of East Asian medicine has been enhanced. Many East Asian medical schools were established. In 1988, there were 25 East Asian medical colleges in China. The number of East Asian medical doctors and pharmacists had increased from 276,000 in 1949 to 471,774 in 1984 (Cai, 1988). Lee (1981) reports that East Asian and Western-style medical doctors are the same in terms of prestige and income, but in the area of medical administration, Western-style medical doctors are superior to East Asian medical doctors. Rosenthal (1981:612) criticizes this method, asserting that "(s)ome Americans...have romanticized the PRC health care system including traditional medicine and in the process, lost some perspectives on realities." For example, people have failed to make the distinction between stated policy and its actual implementation. Rosental's research (1981:599) concludes that "...traditional medicine is subordinate to a Western medical frame of reference and Western-style practitioners." In general, however, the status of East Asian medicine is much higher in the PRC than it is in other East Asian

countries, but some inequalities still exist.

In Vietnam, according to Ladinsky et al. (1987), the health care delivery system has become highly centralized, emphasizing the provision of health services to the greatest number of people since the reunification of the country in 1976. The identification and utilization of traditional medicine have been emphasized. "The field of traditional medicine is represented at all levels of the health structure" (Ladinsky et al., 1987:1106). There are several research centers of East Asian medicine in Vietnam, and every hospital has an East Asian medicine section. There are 17 East Asian medical hospitals. All students in medical school are required to take courses in traditional medicine, and East Asian medicine is as equally esteemed as Western medicine. Generally, the status of East Asian medicine in Vietnam is similar to that in the PRC.

Factors contributing to Western medical dominance

Why is the status of East Asian medicine lower than that of Western medicine? The efficacy of Western medicine may be an important source of its dominance. However, social scientists have been looking for nonmedical reasons for Western medical dominance in East Asia. Scientism, professionalism, and the role of government have been

suggested as possible explanations.

Lee (1982:637) asserts that Western medicine's dominance in East Asia "...should be understood in the context of modernization." East Asian countries have strived for modernization since the 19th century. The need for modernization was pre-eminent for the nations' power and wealth. In the process of modernization, the application of scientific principles was essential to solving problems. Science became an ideology. Anything that was scientific was respected (Kwok, 1965). "It is generally believed that science is truth and that the application of science will result in progress" (Lee, 1982:636). Western medicine, which was already scientific, quickly won the confidence of the people and thus became superior to East Asian medicine (Lee, 1982).

One supplemental explanation for the dominance of Western medicine in East Asia is that of professional struggle. In the West, medical doctors formed national professional associations. Through these centralized organizations, they acquired the right to monopolize national health care systems (Friedson, 1970). "Many non-Western societies imported from the West not only the technical content but also the organizational content of scientific biomedicine" (Lee, 1982:636). Western-style

doctors in East Asia organized the national professional associations, and these organizations became a powerful force in the promotion of Western medicine and in the introduction of legal measures against traditional medical systems (Lee, 1982).

A second question asks why this inequality differs between the socialist and the capitalist countries. The differential support by socialist governments and capitalist governments has been suggested as an explanation. The communist governments of the PRC and Vietnam were very supportive of East Asian medicine (Croizier, 1968, 1976; Ladinsky et al., 1987; Esposito, 1972; Lampton, 1977). On the other hand, the governments in capitalist countries were not supportive until recent times, even though the governments were not repressive (Lee, 1974, 1980; Lock, 1980b; Quah, 1981; Unschuld, 1976).

The studies on the health policies in the PRC show well the impacts of government policy on the status of East Asian medicine. Sidel and Sidel (1982) argue that, because the health care system in the PRC is closely intertwined with political ideology and practice, the changes in the former reflect the changes of the latter. Before 1949, the Chinese nationalist government was active in the introduction of Western health care and attempted to lessen the use of

traditional medicine (Croizier, 1968). The status of East Asian medicine was low, and its development stagnated. Since 1949, the Communist government has been active in the development of East Asian medicine (Croizier, 1968). Esposito (1972) analyzed the impacts of the Cultural Revolution on the development of East Asian medicine. The positive results of traditional medicine were emphasized, and many short-term trained medical practitioners (i.e., barefoot doctors) were cultivated. After Mao's death in 1976, modernization and economic growth became the new national goals. The emphasis of health policy changed to "...high technology, basic research, and hospital care" (Lampton, 1981:21). As an example, Lampton points out the longer medical education and new hospital construction in urban areas. As a result, the equal distribution of medical services received less emphasis and Western medical research was promoted (Lampton, 1981; New and Cheung, 1983, 1984).

Rosenthal (1981) suggests another reason for the promotion of East Asian medicine in the PRC--the struggle between the government (the Party) and professionals. The party promoted East Asian medicine to assert control over the professionals (Western-style doctors). Rosenthal (1981:600-601) writes that

> as part of "Red versus Expert" battle because of the "unwillingness" of physicians to be guided by party ideology and the accusation that they were clinging to

bourgeois thinking, massive criticism of Western-trained doctors was carried out.

These studies imply that scientism, professionalism, and government policy greatly affect the status and development of East Asian medicine. Scientism and professionalism were important factors for the dominance of Western medicine during the initial introduction of Western medicine. On the other hand, government policy was always critical of the status of East Asian medicine. These factors will be examined in the explanation of Western medical dominance in Korea since the late 19th century.

Survival and revival of East Asian medicine

Even in the capitalist countries of East Asia, East Asian medicine has persisted, despite its low status. More interestingly, it has even revived in recent years. In Hong Kong, the prominence of Western medicine has not driven out the traditional forms of medical care. East Asian medicine survives in the Chinese community of Hong Kong today. Moreover, people's confidence in East Asian medicine has been increasing in recent years (Lee, 1974, 1982). According to a 1969 survey conducted by the Hong Kong Medical Association in cooperation with the government's Census and Statistics Department, there were 4,506 East Asian medical practitioners, compared with 2,317 Western-

style doctors (3,742 in 1976) (Lee, 1974, 1980). Moreover, Lee (1974) mentions a revivalist movement. "Both medical professionals and the lay public have been increasingly interested in re-examining and reviving the use of Chinese medical skills" (Lee, 1974:232). As an example, a group of Western-style medical doctors established the Chinese Medical Research Center, mainly for Western-style doctors training in acupuncture. University students in the medical colleges also asked for a teaching program in East Asian medicine. In recent years, newspapers and magazines have more frequently discussed East Asian medicine.

In Taiwan, the number of licenced Western-style and East Asian medical doctors was 7,724 and 1,592, respectively, in 1974 (Kleinman, 1980). Kleinman (1980:63) observes that, because of the rising interest in East Asian medicine around the world in recent years, "(t)he number of candidates studying for and taking the licensing examinations in Chinese medicine is said to have increased considerably."

Lock (1980b) and Otsuka (1976) report that East Asian medicine in modern Japan is undergoing a popular revival. In 1976, a new law added more than 100 traditional herbal prescriptions to the national health insurance program.

This law is one official response to the revival of interest in East Asian medicine (Lock, 1980b). Another aspect of the revival is East Asian medical research. The number of books and periodicals about this research has increased in this century. And several research institutes of East Asian medicine have been established (Otsuka, 1976).

In Malaysia, as Chen (1981) indicates, East Asian medicine is now more popular. The acceptance and integration of East Asian medicine in China has affected the status of East Asian medicine in Malaysia.

East Asian medicine has survived the modernization process in every East Asian country that has historically used it. More interestingly, it has gained more popularity and government legitimacy in recent years. This general trend is also true in Korea.

Reasons for the survival and revival of East Asian medicine

How has East Asian medicine persisted under the pressure of Western medicine and even managed to stage a comeback in recent years? The medical effectiveness of East Asian medicine may be an important factor in its survival. However, several other factors can be identified.

Guerra (1969) and Lee (1981) point out that many people use traditional medicine chiefly because it is cheaper than

is Western medicine. This argument can be applied to the PRC and Vietnam. The use of acupuncture is cheap, and most East Asian medicinal herbs can be collected or planted locally and are thus inexpensive. Moreover, most of the East Asian patent medicines can be manufactured locally.

In other countries, however, the economic factor is not necessarily a positive indicator of the survival of East Asian medicine. Usually, the cost of using East Asian medicine is higher than or as high as that of using Western medicine. In the case of Hong Kong, "...because of the rising cost of Chinese medical herbs, it has become more expensive to use Chinese than Western services for the treatment of many diseases" (Lee, 1974:233). And in Taiwan, Western and East Asian medicines are about equally expensive (Kleinman, 1980).

The cultural factor is another explanation. The concept of illness is affected by a person's specific culture (Kim, 1973). This concept affects the selection of medical facilities for disease treatment. Unschuld (1976) indicates that health problems in East Asian cultures are frequently conceptualized differently from those in Western cultures. In many cases, Western treatment, non-Western health problems, and the patients' expectations do not fit. Unschuld (1975) called this phenomenon "medico-cultural

conflicts." Therefore, people in these regions do not commit themselves to Western medicine entirely.

Lock (1985) argues that the traditional holistic idea of the human body is socialized and affects the choice of medical system in Japan. Ahern (1974) suggests that the cultural factor is an important ground for the persistence of East Asian medicine in Taiwan. Ahern claims that East Asian medical doctors provide support for people's ideas about diseases. In doctor-patient interactions, East Asian medical doctors utilize concepts and employ terms that are familiar to their patients. But the patients' ideas about disease are often either contradicted or ignored by Western-style doctors.

The holistic approach to the human body was introduced as a factor in the survival of East Asian medicine (Otsuka, 1976). The model of East Asian medicine is holistic, "...considering all the parts of the body to be inter-connected and mutually affecting each other..." (Lock, 1980b:247). On the other hand, Western medical practice has increased its division into specialty areas. This division sometimes bothers a patient who wants to be treated as a whole body (Otsuka, 1976). There is, therefore, an opportunity for traditional medicine to be promoted.

The appearance of fewer side effects is identified as

another factor for the survival of East Asian medicine (Otsuka, 1976). Western medicine has resulted in "...the increasing incidence of serious side-effects from synthetic drugs" (Otsuka, 1976:322). East Asian medicine uses only natural products, and most of them have been used for a long time.

These factors may explain the survival of East Asian medicine, but they do not account for its recent revival. To understand the recent trends in the use of East Asian medicine, the rise of nationalism must be considered.

Croizier (1970) suggests cultural nationalism as one important factor in the revival of East Asian medicine in the PRC. Through modernization processes, China's cultural autonomy and self-assurance have not functioned well because much Western culture has been introduced and has eroded the traditional basis of identity. Croizier (1970:289) analyzes that:

> A new identity has had to be worked out, and this process has been at the heart of modern Asian nationalism. However, the new identity has had to be built out of the old one thus creating a strong basis for cultural nationalism.

Behind the revival of traditional medicine in the PRC, there exists cultural nationalism for creating the new identity.

With the rise of nationalism in Japan, Janzen (1978) found that the government renewed support for traditional

medicine. Lock (1980b) reports various movements in Japan that have reevaluated traditional aspects of Japanese culture. East Asian medicine, traditional art, and "...physical activity which share a philosophy closely linked to that of traditional medicine" has been fostered (Lock, 1980b:250). These movements are the basis of East Asian medicine's revival in Japan.

On the basis of the above literature review, we may conclude with the following general picture on East Asian medicine: In every East Asian country, the Western medical system is dominant, even though the degree of dominance is different. But East Asian medicine was not totally abolished and seems to have revived in recent years. The decisive causes of Western medical dominance seem to be scientism, Western medical imperialism, government policy, and professional struggle. The rise of nationalism and the role of government are important in the revival of East Asian medicine. In this research, we will explore whether these general trends and their causes, observed for much of East Asia, can be applied to the Korean situation.

Research in Korea

The study of East Asian medicine in Korea has been relatively rare. One short paper (Kim, 1987), published in a journal in the United States, presents the current trends in Korea. All other publications in English are confined to short reports published in Korea Journal, which is printed in Korea. In articles in that journal, No (1971a, 1971b) and M. Lee (1972) describe the background of East Asian medicine and its contemporary status; Kim (1962) analyzes the influences of Middle Eastern and Western medicines on the development of East Asian medicine; Kim (1973, 1974) researches the traditional concepts of disease; and Sich (1978) discusses traditional medical practices and illness behavior.

Within Korea, social scientific studies of East Asian medicine are not conducted frequently, although some studies have laid the groundwork for long-term research. The most creative works are two books by Kim (A History of Medicine in Korea, 1981; The Chronology of Medicine in Korea, 1966). These two books describe the history of medicine in Korea from ancient times to the early 20th century. Another historical study of medicine in Korea was conducted by No (1968), and Lee (1977) wrote a modern history of East Asian medicine in Korea.

Besides these historical reports, several studies of East Asian medicine in contemporary Korea have been initiated since 1970. Several master's theses are the richest sources of information about East Asian medicine in contemporary Korea. And there are a limited number of papers published in journals.

Many researchers have attempted to explore attitudes and behaviors toward East Asian medicine. Research on this subject has been completed for city inhabitants (Ahn, 1980; Korean Gallup Research Institute, 1986; S. Lee, 1971, 1972), for high school students (Chae, 1979), and for the clients who visited one East Asian hospital (Kim, 1979). According to these studies, most of the respondents (74.6%) had received East Asian medical cures (Ahn, 1980), 64.2% had had the experience within the last three years (Lee, 1971), and about half of the responding high school students (54%) had visited East Asian medical doctors (Chae, 1979). The survey conducted by the Korean Gallup Research Institute (1986) reports that, during an 18-month period, 20.8% of those polled had used East Asian medical care, with 25.9% taking tonic.[2]

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[2]This is an herbal medicine for the general promotion and maintenance of good health, not for specific disease treatment.

Lee (1971) reports that about three-quarters of the respondents (75.1%) indicated that East Asian medical remedies were effective. About half of the responding high school students (51.6%) recognized East Asian medicine as being effective for energetic restoration (Chae, 1979). Among the responding East Asian medical hospital clients, 59.4% thought that East Asian medicine was more effective than was Western medicine (Kim, 1979). Respondents who visited both the East Asian and the Western-style hospitals were asked about the effectiveness of treatment; many of them answered "good" for East Asian medicine (62%) and also answered "good" for Western medicine (63%) (Korean Gallup Research Institute, 1986).

Two surveys were conducted by Hong (1979) and Lee (1979) among East Asian medical doctors in Seoul. Both researchers attempted to explore the pattern of East Asian medical practice in contemporary Korea. About half of the respondents (53.4%) had more than three specialized fields (Lee, 1979). Internal medicine was the most popular area of practice (Hong, 1979). And the cases most frequently handled by the doctors were "general weakness" for which herbal tonic medicines were prescribed (Lee, 1979).

The diagnostic equipment used for the East Asian medical practice was largely that adopted from Western

medicine (e.g., stethoscope, sphygmomanometer). The equipment for treatment, however, originated from East Asian medicine (Hong, 1979). In their attitudes toward Western medicine, the majority of East Asian medical doctors responded favorably about the use of injections and vaccinations and agreed that Western medicine was more effective in surgery and surgical management than was East Asian medicine. However, they pointed out that Western medicine used too many chemical drugs that may cause many side effects (Hong, 1979).

Lim (1978) approaches East Asian medicine at the institutional level. He documents the current state of the East Asian medical system, including East Asian medical practices, education systems, research facilities, and public policy and indicates the conflicts between traditional medical concepts and medical practices dominated by Western medicine. To improve East Asian medicine, he suggests the modernization of the medical system, including increasing use of scientific equipments in medical practices, the development of folk medicine, and the expansion of East Asian medical education.

Hong (1981) describes the historical change in Korean medical education and concludes that the medical system was greatly affected by the political and cultural changes of

the nation. Moon et al. (1983) investigated the actual condition of inpatients in East Asian hospitals, and Lee and Park (1978) and No (1986) investigated the condition of outpatients. All three report that most of the patients wanted treatment for chronic diseases.

Social scientific studies of East Asian medicine in Korea have been active since the late 1970s. Much of this research has been conducted by applied social scientists and medical practitioners. Despite the increases in research interest, however, few theoretical hypotheses have been advanced and tested. The relationships between East Asian medicine and cultural and political factors have not been explored. It is the purpose of the current research to identify and test modernization theories within the context of Korean medicine.

Theoretical Background

Straus (1957:203) describes the boundaries of the sociology of medicine as follows:

> The sociology of medicine is concerned with studying such factors as the organizational structure, role relationships, value systems, rituals, and functions of medicine as a system of behavior....

Although numerous empirical studies have been conducted in this area and several middle range theories have been proposed, these works usually have not extended to macro

sociological theories (Johnson, 1975). Research on medical problems is usually not accomplished from the perspective of general social theory. Johnson (1975:230) suggests that the stunted growth of theoretical work in the sociology of medicine is caused by the short history of the area, "...financial and professional constraints on research...", and "...disciplinary isolationism."

Two macro sociological theories (functionalism and conflict) are the general background for this research. In these two theories, medical systems are seen from opposite sides, but both theories regard the medical system as a part of the broader social system; thus, general social rules in other social systems can be applied to medical systems.

Parsons (1951) analyzes modern medical practice as a case relevant to his theoretical analysis of social systems. He concentrates on the analysis of the roles of doctors and patients. Parsons's paradigm, especially the interpretation of the sick role, had great impact on empirical studies, but "(t)he focus on the individual replaces that on societal forces" in later studies (Gerhardt, 1979:244).

The major concern over Parsons in this research is not for his actual analysis of medical practice but for his general theory of social systems. The functionalistic

perspective provides the general framework in analyzing the East Asian medical system in Korea as a social system in which various statuses and roles are interlocked. Through socialization (training), the East Asian medical system recruits new members; the cultural system teaches how members of the system will interact with others (Turner, 1986). Functionalism can explain how the medical system operates within the structural framework of a society and how this medical system functions for the entire society.

Field (1976:84) differentiates the elements of the medical system as "...educational and research components that train and equip, and a service component...." The service component includes six types of services: prevention, diagnosis, treatment, rehabilation, custody, and health education. The division of the medical system by Field guides the analysis of the East Asian medical system in Korea.

Another issue of functionalism concerns the idea of social change. The process of social change proposed by Parsons can be summarized as "...increasing differentiation of system units..." which leads to the "...establishment of new principles and mechanisms of integration in differentiating systems, and increasing adaptive capacity of differentiated systems..." (Turner, 1986:75).

Differentiation means "...the ways through which the main social functions or the major institutional spheres of society become disassociated from one another..." (Eisenstadt, 1964:376). The concept of differentiation is applicable to the explanation of the changing process of the East Asian medical system in Korea because the organizational division of labor in the East Asian medical system as a social system has been differentiated in the process of the transition from traditional to modern.

This view of social change was accepted and developed by structural-functional modernization theorists (e.g., Smelser, 1963; Eisenstadt, 1964). For them, the social system is the unit of analysis. To modernize, "...a society must (a) differentiate its social structure--its roles and collectivities and (b) develop new integrative institutions" (Marsh, 1984:96-97). Through the process of differentiation and reintegration of social structure, "...social roles are transformed to approach modern standards of universalism, specificity, and achievement" (Portes, 1976:63). This theoretical perspective will be employed in the analysis of changes of the East Asian medical system in contemporary Korea in terms of modernization.

On the process of modernization, early modernization theorists (e.g., Levy, 1966; Shils, 1963) suggested the

convergence hypothesis. Levy (1966:709) argues that:

> As the level of modernization increases, the level of structural uniformity among relatively modernized societies continually increases regardless of how diverse the original basis from which change took place in the societies may have been.

Lauer (1971) suggests that the convergence hypothesis is basically a kind of technological determinism in which technological changes (industrialization) result in similar economic and social structures. For example, Theodorson (1953) insists that, in any society, some patterns seen in Western societies would appear through the acceptance of Western technology.

This view has been challenged since the 1960s by social scientists labelled as revisionists. Bendix (1967), Eisenstadt (1985), and Gusfield (1967) sought to avoid the convergence hypothesis by viewing the modernization process as multilinear and modern societies as diverse. Although sound in their theoretical orientations, these revisionists have been unable to demonstrate multilinear modernization in their actual research (Marsh, 1984). Most of their studies show how "modern" and "traditional" elements coexist (e.g., Singer, 1959; Whitaker, 1970) but not how traditional elements become modernized. East Asian medicine in Korea may be a good subject for understanding the nature of multilinear and divergent modernization. In recent times,

the East Asian medical system in Korea has changed considerably.

Hypothesis 1 The development of the traditional medical system in Korea rejects the unilinear convergent theory in favor of the multilinear, divergent theory of modernization. As the level of modernization (e.g., industrialization, urbanization) of the entire Korean society increases, the level of modernization of the East Asian medical system also increases and hence strengthens its position.

A competing perspective to structural-functionalism is the Marxist view of medical care. According to this perspective, the origin of ill health lies in societal problems. Marx (1906) saw that illness was the direct outcome of social conditions. Working conditions are "...historically determined...by the nature of social relations..." (Frankenberg, 1974:412). Engels and Marx described "...the dangerous working and housing conditions that created ill health" (Waitzkin, 1978:264). After the defeat of the revolutionary struggles in the mid-19th century, Marxist analysis of health care declined, especially in Western Europe and the United States. It was only during the late 1960s that the Marxist perspective of health care grew rapidly against the conservative

structural-functional paradigm (Waitzkin, 1978). Navarro (1976), Waitzkin (1978), and Krause (1977) represent the Marxist tradition of studies. "They focus mainly on economic and political factors influencing both health care and the etiology of illness, leading to excess mortality and morbidity among the poor and lower-level occupational groups" (Wardwell, 1982:567).

The part of Marxist studies most relevant to the present research is the argument of medical imperialism. Galtung (1971) conceptualized cultural and social imperialism. Cultural imperialism indicates the teacher-learner relations between the center and the periphery. Social imperialism indicates that the center "...imposes a certain social structure on the periphery..." (Galtung, 1976:154). These two kinds of imperialism have been prevalent in Third World countries that were colonialized or influenced by the center countries and are the two main modes of medical imperialism. Elling (1981:94) asserts that "(m)odern medicine and public health have served as instruments of imperialism." Missionary doctors played important roles in exporting Western medicine to Third World countries around the 19th century (Cai, 1988).

Goldstein and Donaldson (1979) analyzed the case of

Thailand, and Brown (1979) analyzed that of China of the process of exporting Western medical education initiated by the Rockefeller Foundation. The primary emphasis of medical education was given to training a relatively small number of highly skilled physicians who were Western-oriented and politically conservative. Based on the analysis of documents, they argue that the program was intended, psychologically, to lead to submission to the authority of Western cultures, and socially "...to shape the recipient country's cultural, political and economic development to meet the needs of Western nations" (Brown, 1979:585). The exporting of Western medicine influenced the direction of medical development in Third World countries. This argument may help in understanding the high status of Western medicine and the inferior status of East Asian medicine in modern Korea, which has experienced Japanese rule and strong American influence.

A related theory that explains the status of traditional medicine is the theory of political impact. Based on this theory, the relative status of traditional and Western medicine is decided by the characteristics of the political system (Elling, 1978, 1981; Janzen, 1978). Janzen (1978) asserts that studies at the micro level (i.e., health beliefs, medical practices, and role relations within local

groups) usually ignore the changing aspects of medical systems. To explain these changes, political economic analysis of medical systems at the macro level must be used. Elling (1978:107) claims that "(c)hanging social systems entail changes in medical systems." He (1981:89) argues that "...a medical public health cultural hegemony is seen as paralleling the overall hegemony which maintains social control and otherwise fosters the interests of the ruling class." Elling (1981) has found that, in socialist countries with low resource levels, mergers of traditional and Western medicine occurred; in capitalist countries with low resource levels, Western medicine served mainly for the ruling class and traditional medicine served mainly for lower classes. Leslie (1974) suggests that the influence of government health policies is an important factor affecting the status of traditional medicine in different situations.

Another theory that explains the status of traditional medicine is the theory of professional struggle, which was affected by conflict theory (Friedson, 1970; Berlant, 1975; Unschuld, 1975). Berlant (1975) criticizes Parsons' depiction of medical professionals as a group performing the function of social control and, based on professional norms, avoiding the exploitation of patients. Friedson (1970) and Berlant (1975) argue instead that medical doctors formed

national professional associations and, through this centralized organization, acquired the right to monopolize national health care systems and tried to increase their group interests rather than the benefits to society or patients.

Following Friedson's and Berlant's arguments, Unschuld (1975:304) defines professionalization in medicine as "...the evidence of the continuing struggle of one or various groups for an ever-increasing share in the control of medical resources available in any given community or society." These arguments suggest that the degree of professionalization affects the status of a specific medical community.

McDonald (1981) has tried to synthesize these two theories. She (1981:106) suggests that "...in centralized governments or in those where action in concerted, the government is able to set priorities; in other situations, such as the United States, health priorities are the outcome of professional struggles."

Hypothesis 2 The status of the traditional medical system is affected by the health policies of a government. The more repressive the health policy to East Asian medicine is, the lower the status of the medical system is.

Hypothesis 3 The position of the traditional medical system in relation to the Western medical system is dependent on professional organization. The more professionalized the traditional medical system is, the higher its status is.

To examine these hypotheses, previously published studies, historical documents, and medical statistics provided by the government and professional associations are organized in a manner by which to test the hypotheses. Korean society has been substantially modernized. Hypothesis 1 will be tested through the systematic comparison between the traditional and the current East Asian medical system in Korea. By examining the general societal changes in the last century, this study will analyze whether corresponding changes have indeed occurred in the East Asian medical system as a response to Korea's modernization process. Hypotheses 2 and 3 will be tested through the study of government health policies toward East Asian medicine under different historical stages and the degree of professionalization of East Asian medicine. The findings should indicate whether corresponding status changes in East Asian medicine had occurred as government policy changed and as professional organizations became better organized. The next chapter deals with these issues.

CHAPTER III. MEDICINE AS AN INSTITUTION IN KOREA: TESTING HYPOTHESES

This chapter examines the transformation of traditional East Asian medicine in Korea under the impact of modernization during this past century. Keeping in mind the three hypotheses raised in the last chapter, we may pose the following questions. How was Western medicine introduced into Korea? What was the relationship between specific government medical policy and the relative status of one or the other medical system? How was the East Asian medical system modernized? And, finally, under what conditions did Western medicine become dominant? The first section will analyze the development of the East Asian medical system from the perspective of the modernization of traditional institutions. The second section is intended to promote the understanding of the relationship between the status of the traditional medical system and the health policies toward East Asian medicine. Finally, the dynamics of the relationship between East Asian and Western medicine will be explored in terms of the theory of professional struggle.

Before 1876, Korea was a highly stratified society. Confucianism shaped political structure and human relations. The economy was based mainly on agriculture, and almost all

the people lived in small villages and worked on farms. Because of its isolationist policies, the Korean government did not open the door to Western countries until 1876 (Lee, 1984). During the Japanese colonial rule, a modern administration and economic system replaced the political structure of the Yi dynasty, but Korean society was still predominantly traditional agrarian until the end of World War II (Macdonald, 1988). In the last several decades, Korean society has experienced tremendous changes from a traditional agricultural society to a modern industrial one.

Economic change during this period has been dramatic. Since the 1960s, Korea has made special efforts to industrialize and has achieved high rates of economic growth. Per capita General National Product (GNP) was $2,370 in 1986. The average annual growth rate of GNP from 1965 to 1986 was 6.7% (International Bank for Reconstruction and Development, 1988).

The structure of the Korean economy also changed radically. Agriculture's share of total domestic product declined from 56.5% in 1963 to 18.1% in 1983, while the industrial sector's share increased from 11.6% to 35.4% (Lee, 1983). Industrialization accelerated urbanization. The urban population was 64% of the total population in 1985 compared with 32% in 1965 (International Bank for

Reconstruction and Development, 1988). With economic development, the political system has also been changing in the direction toward more popular participation. Bureaucratic organizations emerged. Many modern educational facilities were established.

During this period, the East Asian medical system has also been substantially changed. In terms of organizational, normal, and technical aspects, there are tremendous differences between the traditional and the current East Asian medical systems. In comparing the two systems, we may thus test Hypothesis 1.

Modernization of the East Asian Medical System

East Asian medicine was introduced into Korea in about the 6th century (No, 1971a). Around the 13th century, East Asian medicine in Korea underwent unique development through the study and exploitation of its own traditional folk medicine (No, 1968; Kim, 1981).

Korea's East Asian medical system was not primitive before its contact with Western medicine. Its administrative system was well organized. As with other government organizations, the medical administrative system had its unique bureaucratic characteristics. The offices had clearly differentiated functions and were hierarchically

organized. The central administrative office was the Jeon-ui Gam. The Nae-ui Won was specifically instituted to provide medical services for the royal family. The Hae-min Kuk and the Jae-saeng Won, which are comparable to today's medical dispensary, were predominantly responsible for public medical services. The Whal-in Won was the facility for relief assistance to the poor and also provided medical services to them (Kim, 1981; No, 1968). At the local level, a Ui Won (medical clinic) was established in every province, and doctors and medical students were stationed there. A Ui-hak Won (medical school) was installed in every province for medical education. In the army and in prisons, medical facilities and doctors existed (Kim, 1981). The medical staff's number and responsibilities were clearly described. Qualification was required to be a member of the medical offices. Generally, the traditional East Asian medical system was, in comparison with the folk medicine, "...relatively more organized or professionalized (e.g., having a codified body of knowledge, medical ethics, and control over entry to the profession)..." (Lee, 1982:639).

However, the system had many traditional characteristics. Medical services and the recruitment of medical doctors had class restrictions. The medical system was mainly oriented to serving the royal family and the

privileged classes (No, 1968). The assignment to a doctor's position was based on the ascribed properties of an individual (middle class) rather than on a person's ability or performance.

The functional differentiation of the traditional medical system was not so high. The functions of research, education, and medical services were often mixed. The research function was not specialized. The division of labor among medical professionals was not highly developed. Education was not standardized; education through individual apprenticeship was dominant as it was in traditional China (Gale, 1974). The orientation to medical practice was traditionalistic rather than rationalistic. Although it was considerably empirical, traditional East Asian medicine was not scientific (Porkert, 1974).

Modernization of medical education

There were intermittent efforts to establish a modern educational facility for East Asian medicine before Korean liberation from Japan (1945). Because of political oppression, financial difficulties, and the lack of cooperation among East Asian medical doctors, however, the efforts were not successful. Dong-je (1904-1907) and Gong-in (1912-1919), East Asian medical schools, were established

by several East Asian medical doctors but closed because of financial difficulties (Hong, 1981; Lee, 1977). Until 1937, there was no East Asian medicine educational facility. The Kyung-Gee Do-rip East Asian Medical Training School was established in 1937. Its training period was one year. The school trained about 300 East Asian medical doctors until it was closed in 1944 (Lee, 1977). In 1940, the Oriental Medical Training School was founded by the Oriental Medical and Medicine Association (Lee, 1977).

It was not until 1948 that the first East Asian medical college, the Oriental Medical College, was established, succeeding the Oriental Medical Training School founded in 1940 (Lee, 1977). The Oriental Medical College became affiliated with Kyung-Hee University as an East Asian medical college in 1965 (M. Lee, 1972). It was the only East Asian medical college in Korea before 1972 and turned out 60 to 70 graduates a year (No, 1971b). In 1972, a second East Asian medical college was established in Won-Kwang University (Lee, 1977). By 1988, the number of East Asian medical schools had increased to eight (compared to 28 Western medical colleges in 1987) (Korean Oriental Medical Society, 1988; Ministry of Education, 1987).

Most of the existing East Asian medical schools have been established in recent years. All are six-year East

Asian medical colleges with a total of 3,482 students in 1987. The establishment of modern East Asian medical colleges has increased the standardization of educational procedures, and the lengthening of the training period assures the acceptable professional qualification of an East Asian medical doctor.

Education after graduation was also initiated and developed. In 1966, M.A. level courses in East Asian medicine were offered at Kyung-Hee University, and, in 1974, doctoral level courses were approved. By 1988, there were more than 600 master's degrees awarded in East Asian medicine and more than 200 doctoral (Korean Oriental Medical Society, 1988).

The increase in the number of educational facilities meant an increase in the number of East Asian medical doctors. The number of East Asian doctors has slowly increased since 1978, when the total was 2,852 (Korean Oriental Medical Society, 1988). In 1986, there were 4,041 East Asian medical doctors licensed (compared to 31,616 Western-style medical doctors), including 151 women, and there were 2,957 East Asian hospitals and clinics (compared to 6,949 Western-style hospitals and clinics) (Ministry of Health and Social Affairs, 1987). Although these numbers are smaller than are those for Western medicine, with the

rapid increase of East Asian medical colleges, it is expected that the number of East Asian doctors will increase rapidly (by about 500 every year).

Specialization of the research function

East Asian medical circles have met many difficult problems in the modernization process of their research capacity because traditional East Asian medical theories and practices have often been handed down from masters to disciples without formal and institutionalized transition. The readjustment of classical theories, the standardization of medical terms, and the scientific verification of clinical results were some of the imminent issues.

Before 1945, there had been no research institute of East Asian medicine. Today, there are many private research institutes, including the East-West Medicine Research Institute, the Jae-Han East Asian Medicine Academy, and the Oriental Medicine Research Institute (Korean Oriental Medical Society, 1988).

In 1961, a group of East Asian and Western-style doctors established the Korean Oriental Medical Academy for comparative study of East Asian and Western medicine. In 1971, it was renamed the Korean East-West Medicine Research Institute, and many East Asian and Western medical doctors

and pharmacists participated in its research projects. This institute has held several international academic meetings and has published a collection of papers (Lee, 1977).

In 1971, Jung-Han Byun (an East Asian medical doctor) established the Jae-Han East Asian Medicine Academy in the city of Taegu with his own funds. The academy has researched clinical aspects of East Asian medicine and issues a quarterly journal--the Journal of Hwang-jae (Emperor) Medicine (Lee, 1977).

In 1972, the Oriental Medicine Research Institute was founded. This institute has investigated East Asian medical theories, the improvement of medication, and the standardization of medicinal herbs. The institute also publishes a quarterly journal--the Journal of Oriental Medicine (Lee, 1977).

But these institutes are not well organized or well funded. The main places where East Asian medical research occurs are the East Asian medical colleges and their attached hospitals. From 1945 to 1977, about 900 academic papers and 70 books on East Asian medicine were published (Lee, 1977). From 1968 to 1986, the number of degree theses reached 659 (Han, 1987). Research has been concentrated on reexamining old textbooks and investigating existing medical theories by using modern medical research methods. Reports

on clinical results have also increased (Hong et al., 1988)

Clinical development

With all these institutional changes, there have been substantial improvements in East Asian medicine's clinical aspects, including the simplification of medicine taking and preparation and the introduction of new medical equipment. In 1974, the Committee on the Formulation of East Asian Medicinal Stuffs Standards was founded by the Korean Oriental Medical Society. The first step the committee took was to establish 11 standards for about 100 herbs (Lee, 1975). The government also participated in this project. In 1983, 266 East Asian medicines were standardized, and another 81 were standardized in 1985 (Song, 1985).

The changes in medicine taking and preparation are also important. Traditionally, East Asian medicine was packaged in small bags containing various ingredients and was difficult to prepare and use. East Asian medical circles promoted the transformation of East Asian medicinal herbs into liquids or granules. In many cases, they succeeded. They have also researched the effects of powdered medicine (Health and Law, 1987).

Acupuncture is one of the main therapeutic instruments in East Asian medicine. After the liberation, the types of

acupuncture were diversified and their qualities improved (Lee, 1977). The kyung-rak (blood vessel) detector and electromagnetically operating acupuncture were developed to help acupuncture treatment. Physical therapy using electromagnetism was also developed (Lee, 1977).

Some Western diagnostic equipment (i.e., the stethoscope and the tonometer) has been widely used to increase the accuracy of diagnosis. Many East Asian hospitals and clinics have also introduced high-technology facilities for diagnosis, such as diagnostic computers used exclusively for East Asian medicine, supersonic diagnostic machines, X-rays, and clinical pathology tests (Ginseng and Health, 1987b). The application of such equipment and of scientific procedures has increased the accuracy of diagnosis.

With the amendment of the Medical Services Law in 1973, it became possible to establish large-scale East Asian medical hospitals, of which there were 16 by 1986 (Ministry of Health and Social Affairs, 1987). Five East Asian hospitals were built in 1987 alone (Korean Oriental Medical Society, 1988). These hospitals have many modern medical facilities, including wards and physical treatment rooms (Lee, 1977). These clinical developments of East Asian medicine have increased its capacity to adapt to modern

society.

The East Asian medical system in Korea has experienced considerable readjustment and reconstruction. This is remarkable, considering that the changes have been accomplished without active support from the government. In the organizational aspect, the differentiation of the East Asian medical system has been increased, including the specialization of the research function, the development of professional associations, and the standardization and professionalization of the education and training process. In terms of role differentiation of medical personnel, the division of labor in the medical occupation (e.g., the division of medical doctor and nurse) and the division of specialty areas among medical doctors have occurred. And a group of female doctors have appeared with the same prestige as male doctors.

In technical aspects, the integration of scientific methods and technologies for research, education, and health care in the East Asian medical system has occurred. The introduction and development of new equipment and technology have become regular practices. In the recruitment process, the qualification to be a medical student has changed from hereditary inheritance to individual achievement. In terms of the beneficiaries of these changes, medical services are

now oriented to common people and not just to the privileged classes.

Based on these analyses, we may conclude that the East Asian medical system has been considerably modernized in comparison to the traditional East Asian medical system before 1876. These developments were possible specifically by imitating the modernized Western medical system, such as the developments of modern education and research institutions, the bureaucratization of professional organizations, the increased differentiation in specializations, the incorporation of Western technological developments, and normative changes. A new synthesis was developed, which effectively preserves traditional Korean medicine into modern day health care in Korea. Therefore, Hypothesis 1 is generally supported.

Even though the East Asian medical system in Korea does not reach the stage of the Western medical system in terms of modernization, the system provides an example of multilinear and divergent modernization that was hypothetically suggested by revisionists of modernization theory (i.e., Tipps, 1973; Bendix, 1967).

The Impacts of Health Policies

Today, the status of East Asian medicine is lower than that of Western medicine in Korea. Western medical dominance is a common phenomenon among East Asian countries, even though the degree of its dominance varies from country to country. Similarly, the factors contributing to Western medical dominance also differ. This section will analyze the status change of East Asian medicine in relation to different health policies.

Before the late 19th century, East Asian medicine was the official medicine in Korea (No, 1968). The introduction of Western medicine to the general public came with the conclusion of the Korea-Japan treaty of amity in 1876 which brought Japanese Western-style doctors and Western medical doctors to Korea. Even though there was some resistance from the local elites and particularly from indigenous healers, Western medicine rapidly diffused (Lee, 1982).

In the late 19th century, the Japanese government set up hospitals in Seoul and in the ports of Korea for its expatriates (Kim, 1977). These were the earliest Western-style hospitals in Korea. The hospitals were initially built to treat Japanese patients, but they soon admitted Korean patients as well. Besides these official activities, Japanese doctors came to Korea and established private

clinics (Kim, 1977). The number of Japanese doctors reached 282 just before the annexation of Korea (1910) (Kim, 1981).

Western medical missionaries began their work in Korea in the late 19th century. Their objective was to promote evangelism through medical services (Lee, 1962). Through the activities of these missionaries, Western medicine was directly introduced to Koreans. Western-style hospitals and a medical school (Severance Medical College) were established. Later, many American medical missionaries came to Korea and provided Western medical treatment in Seoul and many other cities (Kim, 1977; Lee, 1962). The number of Western doctors before the annexation of Korea reached 19 (Kim, 1981).

External political dominance initially played an important role in the introduction of Western medicine in Korea, but it was not influential enough to lead to Western medical dominance. Korea opened itself to Western countries only in the late 19th century. And when foreign medical influences became active, Korea was annexed by Japan in 1910. Therefore, direct Western medical influence in Korea was weaker than it was in any other East Asian country except Taiwan.

Western-oriented health policy before 1910

In 1894, the pro-Japanese progressive party launched the Kap-o Reform. Wide-ranging reform was carried out to promote Western-oriented modernization (Lee, 1984), and medicine was no exception. A new medical system, based on Western medical knowledge, was established, and the old medical administrative system was abolished. The Bureau of Hygiene was established as the administrative organ for medicine under the Ministry of Internal Affairs (Soh, 1981). The government started to install facilities for the practice of Western medicine, including the building of the Nai-bu Hospital in 1899 (Kim, 1977). In the meantime, the government also founded a public medical school (Kwan-rip Medical School) in 1899. After merging with the Dai-han Hospital in 1907, the school provided, along with the four-year medical course, a three-year pharmaceutical curriculum, a two-year nursing course, and a midwifery course. In 1906, Western medical training schools were established in Taegu and Pyeongyang (Kim, 1981; Lee, 1962).

The new Western-oriented medical policy carried out by the progressive political elites was not strong enough to lead to Western medical dominance because the government at that time was very weak. For example, in the Westernized government medical bureau and hospitals, East Asian medical

doctors were employed equally with Western-style medical doctors (Lee, 1977).

The decline of East Asian medicine in Korea can not be explained solely by the introduction of Western medicine. In fact, East Asian medicine was deteriorating at this juncture because of internal factors. East Asian medicine, before its contact with Western medicine, had not experienced significant changes, as Western medicine did during its scientific revolution in the pre-modern era. In the 19th century, the Yi dynasty became very weak and East Asian medicine also declined. For example, the medical schools in the capital city and in local provinces ceased to operate (Hong, 1981). The introduction of Western medicine in the late 19th century accelerated the decline of East Asian medicine. In 1891, the East Asian medical examination, which had been in practice for about 1,000 years, was abolished. Traditional medical administrative offices were reduced or ceased to function (No, 1968).

This period (1876-1909) can be characterized by the coexistence of both medical systems. The Western medical system had been introduced, but its medical practice did not reach the entire nation. The East Asian medical system lost its official status in national health care and declined. But the majority of the people depended on East Asian

medicine and folk remedies outside of the formal medical establishments (No, 1968). The number of medical doctors before the annexation was 2,659, and most of them were East Asian medical doctors (Kim, 1981).

Impacts of Japanese rule

It was during Japanese rule (1910-1945) that Western medical dominance was established. The health policies toward East Asian medicine were very repressive. The Japanese governor-general intended that a nationwide medical system be operated only by Western medicine (Lee, 1977). Because Japanese colonial rule was autocratic and exercised centralized control, the impacts of health policies were greater than those in earlier times.

During this period, Western medicine had been considerably advanced through the introduction of German medicine, which the Japanese adopted, and of American medicine by missionary medical schools (Kim, 1981; No, 1968). Medical schools founded before 1910 were expanded, and new medical schools were founded. At the end of Japanese rule, the number of Western medical schools in Korea increased to eight, two of which were in what is now North Korea. These schools were supported by the government. The number of students enrolled totaled 2,189;

staff members numbered 855. About half of the students and staff were Japanese (Soh, 1981).

On the other hand, East Asian medicine stagnated. Only the shortage of Western-style medical personnel and facilities protected the extinction of East Asian medicine. The shortage of Western medical personnel was too great to care for the whole population (about 20 million at that time). In 1914, there were 228 Western-style hospitals and 611 Western-style doctors, including 425 Japanese and 22 Western doctors (Lee, 1977). East Asian medical doctors were recognized merely as a stopgap measure to cope with the shortage of Western-style medical personnel. The status of East Asian medical doctors was downgraded. They were officially named ui-saeng, which was not an honorary title. The East Asian medical license was divided into a five-year limited license and a permanent license. No public educational facility for East Asian medicine was provided (Kim, 1981; Lee, 1977). Therefore, East Asian research and practical techniques could not be developed.

During Japanese rule, no technical and organizational development occurred in East Asian medicine, whereas Western medicine was actively promoted and developed. The decline of East Asian medicine and the advancement of Western medicine resulted in a situation in which Western medicine

became dominant in the number of doctors, education, and research. For example, just before the liberation of Korea, the number of Western-style medical doctors was about 4,000; licensed East Asian medical doctors totaled about 1,600 (No, 1968).

The decline of East Asian medicine during this period was not natural. It was mainly caused by the health policies of the Japanese governor-general. The Japanese policies on East Asian medicine were an active repression on educational and professional activities. Similar results of imperialistic Japanese health policies on East Asian medicine were reported in Taiwan by Unschuld (1976). Leslie's (1974) emphasis on the impact of government policy on the medical systems explains well the decline of East Asian medicine during the Japanese colonial rule. The other factors--foreign influence, people's attitudes, or formation of professional organizations--could not be as effective in explaining the relative status between East Asian and Western medical systems as they were in the other East Asian countries, except for Taiwan.

Health policies after 1945

Western medical dominance has continued after the liberation. Strong government support would have been

essential for the revival of East Asian medicine, but no action was taken by the U.S. military government or by succeeding Korean governments after 1948. Instead, East Asian medical doctors were excluded from participation in the medical administration. Nearly all medical support was given to Western medicine (Lee, 1977). However, in the post-liberation period, the health policies toward East Asian medicine were not as repressive as they were under the colonial rule. The policies were closer to noninterference than they were to repression. A National Medical Services Law, enacted in 1952, regulated licenses for East Asian medical doctors (Lee, 1977). This legislation undoubtedly enhanced the legal status of East Asian medical doctors. Under this law, about 3,000 East Asian medical practitioners were licensed through a national qualification examination (No, 1971b).

Government support for the development of East Asian medicine has been limited. In the government health administration system, East Asian medicine occupies only a small fraction. East Asian medicine has been managed by the Medical Office under the Medical Bureau of the Ministry of Health and Social Affairs (Yun, 1985). There is no national or public medical college or research institute of East Asian medicine. And national and public medical centers

don't provide East Asian medical treatments (Suh, 1982). Until 1984, the total government budget assigned to East Asian medicine was only 10 million won (about $13,000) (Yun, 1985).

However, since the early 1980s, the government has become more supportive of East Asian medicine in its policies and legislation, even though the change has not been rapid or consistent (Ahn, 1987). These neutral positions taken by the government were more appropriate for the development of East Asian medicine than the repression in the prior time. Based on East Asian doctors' own efforts and increased use by the people since the 1970s, the status of East Asian medicine has been greatly enhanced, as documented in the prior section, even though it is still lower than that of Western medicine. Therefore, Hypothesis 2 is generally upheld in this analysis.

The Impacts of Professionalization

Before 1945, East Asian medical practitioners were not well organized. The status of East Asian medicine was much lower than that of the Western medical system. After the Korean liberation, this situation continued. The Korean government tried Western-oriented modernization and gave support almost exclusively to Western medicine. As a

result, East Asian medical doctors were denied certain privileges granted to the Western-style medical doctors. East Asian medical doctors were excluded from appointment as government health officials, as practitioners in national and public health centers, and as military doctors. Medical insurance was not applied to East Asian medical practices (Jang, 1983). This situation could be characterized as a hierarchical medical dualism in which Western medicine preserved power, a situation similar to that of Taiwan and Hong Kong (Lee, 1982).

Around 1970, the East Asian medical system began professionalizing its education, research, and clinical techniques. Based on these developments, the professional associations of East Asian medical doctors have been strengthened. The professionalized East Asian medical doctors have striven themselves to lessening these inequalities through competition with Western medical doctors. Therefore, there have been conflicts among various medical groups to expand or maintain their occupational domains. The following analysis reveals the conflicts between the East Asian and Western medical practitioners and the strategies used by professionalized East Asian medical groups to enhance their legal status.

Development of professional associations and journals

During the Japanese rule, some East Asian medical doctors endeavored to organize their profession and published journals. Due to financial difficulties, oppression by the Japanese governor-general, and the lack of cooperation among doctors, however, these attempts were not successful. All the East Asian medical associations, journals, and training schools during Japanese rule were short-lived (Lee, 1977).

The Dae-Han (Korean) Medical Society, founded in 1909, was the first professional association in Korea. Nationwide, about 170 East Asian medical doctors joined this society, but it was dissolved in 1913 (Kim, 1982).

In the early 1910s, some East Asian medical doctors organized the Jo-Seon (Korean) Medical Doctors' Association, issued an East Asian medical journal named Han-bang Ui-hak-gye, and offered public lectures. All these activities were done with their private funds. Their activities, however, did not grow (Lee, 1977). In October of 1915, a nationwide East Asian medical doctors' meeting was convened in Seoul, and 770 doctors participated. In November, the Jeon-Seon (all Korean) Doctors' Association was established. This association proposed to extend their occupational rights, advance academic research, and promote educational

facilities. The academic periodical, Dong-ui Bo-gam, was founded. This association was compulsorily dissolved in May of 1916 by decree from the Japanese governor-general, and all activities ceased (Lee, 1977). The Dong-Suh (East-West) Medical Journal (1916-1917) and Jo-seon Medical World (1918-1919) were also founded but soon discontinued (Lee, 1977).

From 1920 to the mid-1930s, there were only sporadic efforts to revive East Asian medicine. In the 1930s, East Asian medical doctors and Korean people began to realize the limitations of Western medicine and the value of East Asian medicine. Editorials in newspapers suggested the need to revive East Asian medicine (Lee, 1977). The Society for the Study of East-West Medicine became active at this time. Members of this society founded the Journal of Oriental Medicine in 1935 but continued only to the third issue. Financial difficulty and suppression by the Japanese governor-general were too severe to overcome (Lee, 1977).

The Oriental Medical and Medicine Association was established in 1939, and the Journal of Oriental Medicine was reissued (Lee, 1977). In 1942, the Kyung-Gee Province (including Seoul) East Asian Medical Society was organized. It had about 300 members in the Kyung-Gee area. In 1945, they established the East Asian Medical Doctors' Hall (Lee, 1977).

In November of 1945, a nationwide Jo-Seon (Korean) Medical Association was founded, mainly through the efforts of the staff of the Kyung-Gee Province East Asian Medical Society (Lee, 1977). In 1947, another East Asian medical association, the Oriental Medical Society, was organized. The 53 founders of the society included not only East Asian medical doctors but also Western-trained doctors and pharmacists. The main purpose of the society was the promotion of East Asian medicine in academic fields. Society members also published the Journal of Oriental Medical Science, but it was discontinued after just one issue. The occupation government's policy toward East Asian medicine after the liberation was very disappointing in South Korea. As a consequence, some of the young members of the Oriental Medical Society went to North Korea and some older ones retired (Lee, 1977).

After the enactment of the new Medical Services Law in 1952, the Korean Oriental Medical Society was established in October of that year and has continued to the present day. Its membership was 3,263 and it had fourteen provincial branches throughout the nation in 1987. Under each branch, local chapters are organized following the administrative units. The Korean Oriental Medical Society has published its official journal, the Journal of the Korean Oriental

Medical Society, biannually since 1955 (Korean Oriental Medical Society, 1988).

In 1954, an East Asian medical doctor, Won-Sick Bae, with assistance from his fellow doctors, founded the Journal of Dong-bang (Eastern) Medical Society and have issued Ee-lim bimonthly since 1954. The Society for Korean Ginseng has published the Korean Journal of Ginseng Science semiannually since 1977.

Besides those mentioned, there are several other East Asian medical associations based on specialties, such as the Korean East Asian Hospital Association, the Korean Oriental Medicine Saturday Club, the Tuesday East Asian Medical Academic Society, and the Korean Eastern Medicine Academic Meeting (Lee, 1977). There are also more than ten professional journals and newspapers on East Asian medicine.

East Asian medical insurance

Among the many issues, the exclusion of East Asian medicine from medical insurance was the most important to East Asian medical doctors. Without participation in medical insurance programs, East Asian medicine would be severely hampered because of its high costs. According to the results of a survey performed by the Korean Gallup Research Institute (1986), 86.8% of respondents answered

that they would visit East Asian clinics more frequently if insurance covered East Asian medical treatment.

In July of 1977, a medical insurance program was established for laborers in large factories in Korea, but East Asian medicine was excluded from the insurance coverage. By 1982, the insurance was expanded to small enterprises and business. By 1986, 56.3% of the people were covered by medical insurance (Han, 1986b). The government has plans to further expand the medical insurance programs for the agricultural and fishery sectors throughout the nation in 1988 and for the urban poor in 1989 (Ahn, 1987).

Because of the difference in costs between Western and East Asian medicine, many patients avoided visiting East Asian hospitals (Korean Gallup Research Institute, 1986). To participate in medical insurance programs, the East Asian medical doctors tried several strategies. In 1977, the Korean Oriental Medical Society prepared and submitted a pricing proposal for East Asian medical insurance, and published the Collection of East Asian Medicine Standard Prescriptions (Park, 1988). Students and professors of East Asian medical colleges demonstrated and demanded the inclusion of East Asian medicine in the nationwide medical insurance (Ginseng and Health, 1987a).

The East Asian medical profession suggested several

rationales for insurance coverage. First, if the universal medical insurance program is to become a reality, only a few high-income people can afford the noninsured East Asian medicine, and the national (East Asian) medicine would be weakened. Second, nobody could deprive people of their right to be treated with East Asian medicine. Third, to serve the people was the obligation of the medical professions, and East Asian medical doctors could not abandon their duties (Hong, 1987). And, finally, the superiority of East Asian medicine in dealing with chronic diseases strongly argued for its inclusion in insurance (Han, 1986a). Public opinion was another source of strength for East Asian medical insurance. According to the 1986 Gallup survey, 96.2% of the people wanted the inclusion of East Asian medical insurance (Korean Gallup Research Institute, 1986).

In response to these pressures, East Asian medical insurance has been accepted since 1984 in 26 East Asian clinics in a model area. In August 1986, the government organized the East Asian Medical System Council to discuss the nationwide practice of East Asian medical insurance. The Ministry of Health and Social Affairs, on November 28, 1986, announced the inclusion of medical insurance for 26 finished herbal medicine, acupuncture, and moxibustion

practices throughout the country by February of 1987 (Park, 1988).

The association of Western-style doctors demanded that this plan not be adopted. The main objection they raised was that there were insufficient insurance funds to cover both systems. The Western-style doctors also pointed out several administrative problems in the enforcement of East Asian medical insurance, such as the price difference of herbs because of their sources of purchase, the unstandardized prescriptions and drugs, and the difficulty in differentiating drugs for treatment from drugs for restoration (Park, 1987). Furthermore, Kee-Il Park, the public information trustee of the Korean Medical Association, argued that it was meaningless to expand medical insurance to East Asian medicine when modern (Western) medicine alone could provide the best treatment for the people (Park, 1987).

The pharmacists' association also issued a statement against the plan on December 2, 1986. They insisted that the separation of medicine preparation from medical practice was the most imminent task. They argued that the finished products of herbal medicines included in the plan belonged not to the East Asian medical doctors but to pharmacists because they had been developed and sold mainly by the

latter (Ginseng and Health, 1987a). Opposition from the associations of Western medical doctors and pharmacists was apparently caused by the fact that the inclusion of East Asian medicine into medical insurance threatened their group interests. If the plan were practiced, Western-style medical doctors and pharmacists would lose many clients.

Coming from the opposite direction, many East Asian medicine dealers also opposed the plan. Their opposition was not to stall the plan but to expand it to cover East Asian medicine dealers. Soo-Kuen Lee, the president of the Korean Medicine Dealers' Association, based his demand on two arguments. First, during the two-year experimental coverage of East Asian medicine, the medicine dealers in the model area were financially hampered because they were excluded from the medical insurance clinics. Second, considering that 96% of East Asian medical doctors operated their clinics in urban areas, the plan excluded the rural people from insurance coverage by excluding East Asian medicine dealers, many of whom served the rural areas (Lee, 1987).

In spite of the opposition from these medical groups, the East Asian medical insurance was expanded. In April of 1987, 26 prescriptions, which included about 60% of all prescriptions, were added to medical insurance. In

September of 1987, 10 more prescriptions were added (Park, 1988).

The combination of medical systems

In August of 1977, the associations of Western-style doctors and pharmacists agreed to promote a unified medical system for more effective medical services. They suggested organizing a research council that would include Western-style doctors, East Asian doctors, and pharmacists and that would evaluate the current medical education, treatment, and administration systems and suggest reforms (Shin, 1982).

Most East Asian doctors were against this suggestion. They argued that there were fundamental differences between East Asian and Western medicine in medical theory, diagnosis, and therapeutic measures and that Western medicine was dominant in the government administration system and in the number of doctors (Bae, 1987). Therefore, compulsory unification under such a situation would lead to the extinction of the national (East Asian) medicine. They believed that the proposition made by Western-style medical doctors was intended to absorb and obliterate East Asian medicine. To support their allegation, they pointed out that Western-style doctors never really tried to understand East Asian medicine. For example, no Western medical

colleges offered courses on East Asian medicine, whereas East Asian medical colleges offered many courses on Western medicine, including physiology, diagnostics, and clinical pathology (Ginseng and Health, 1987b). Confronting resistance from East Asian medical doctors, the combining of the medical systems did not occur.

Employing medical technicians

According to the current Medical Technician Law, East Asian medical doctors are not allowed to employ medical technicians, including pathological technicians, radiological technicians, physical therapists, and occupational therapists (Korean Oriental Medical Society, 1988). The association of Western-style doctors opposed the use of modern diagnostic facilities by East Asian medical doctors. They argued that, first, East Asian doctors did not have adequate training in operating modern medical equipment and tools, and, second, it was illegal (Ginseng and Health, 1987b). Against these arguments, East Asian doctors insisted that the current laws are inadequate and unjust and that the right to use modern medical equipment and tools should be permitted to East Asian medical doctors for more accurate diagnosis (Ginseng and Health, 1987b). Even though the amendment to the related law was not passed,

many East Asian doctors use modern medical equipment. The government does not actively restrict this use.

Conflicts with pharmacists

Many pharmaceutical companies have been involved in the production of herbal medicines in the forms of extracts or granules. These products have been supplied mainly to pharmacies. Besides the sale of the finished products of East Asian medicine, many pharmacists' shops have processed East Asian medicine. In 1981, 12,865 pharmacists operated shops. Of these, 4,197 (32.6%) processed East Asian medicine (Park, 1982). This practice has led to controversies among medical occupations.

East Asian medical doctors argue that processing East Asian medicine is very complex and needs specialized knowledge that pharmacists lack. Pharmacists study very little East Asian medicine in the pharmaceutical colleges. Therefore, processing of East Asian medicine by pharmacists trained in Western medical colleges should be prohibited (Lee, 1986).

The Research Council of East Asian Medicine was established in the Korean Pharmacists Association and has promoted research of East Asian medicine and education for pharmacists. This council insisted on the pharmacists'

right to prepare medicines, even in the case of East Asian medicine, according to the Drugs, Cosmetics, and Medical Instruments Law (Park, 1982). Park (1982) contests the attempts by East Asian doctors to forbid the processing of East Asian medicine in pharmacists' shops. He insists that the real intention of East Asian doctors was to pursue their clannish interests without national consideration. The debate is in progress, and no action has been taken by the medical administrative office.

Conclusion

The discussion in the previous two chapters provides an interesting case study of the modernization of a traditional institution that lends support to the first three hypotheses. When considering Hypothesis 1, it becomes clear that economic development in Korea in recent years and the urbanization and industrialization in Korea in general has strengthened the traditional medical system. By borrowing modern Western medical technologies and organizations, traditional Asian medicine was able not only to survive but to stage a comeback, competing head-on with Western medicine when the circumstances permitted.

It is within this context that we can examine the second hypothesis, namely, that health policies very much

affect the status of the traditional medical system vis-a-vis the Western medical system. During the entire Japanese colonial period and the early part of the post-liberation period, when the indigenous Korean government exercised limited political authority, the health policies toward East Asian medicine were very repressive and almost no support was given to East Asian medicine. The traditional medical system withered and lingered. It was only when Korea became increasingly industrialized and began to have more political autonomy that the revival of the traditional medicine began to emerge.

When the East Asian medical system was not highly professionalized before the 1970s, it suffered many disadvantages in comparison with Western medicine. Through improved professional organization, the East Asian medical doctors could compete with Western medical professionals, and they began to exercise political pressure through legislation to protect their interests. The formal licensing of traditional medical doctors and the inclusion of traditional medicine into the insurance program attest to the success of this approach, even though Western medicine is still dominant and many issues remain unresolved (partly because of less professionalization). These changes, again, prove the validity of the third hypothesis.

CHAPTER IV. RESIDENTS' VIEWS OF MEDICINE IN EAST ASIA: HYPOTHESES AND DESCRIPTIVE FINDINGS

Theories and Hypotheses

People's attitudes and behaviors regarding medical practices will be explored in this chapter, and the factors affecting these attitudes and behaviors will be examined. Also, the relationship between attitude and behavior will be tested. Studies on individual modernity, nationalism, and the relationship between attitude and behavior provide the theoretical background.

Individual modernity is the critical factor in modernizing a social system (Abraham, 1980). Inkeles (1969) constructed a conceptual model of individual modernity based on research conducted in six developing countries. Inkeles and Smith (1974) identified four major attitudes and values distinguishing modern man; active participation, belief in human and personal efficacy, independence from traditional influence, and readiness for new experiences. In addition, relationships between sociodemographic characteristics and individual modernity have been studied. Individual modernity is positively and significantly related to formal education (Armer and Youtz, 1971), occupational experience in large organizations (Inkeles, 1969), and urban living

experience (Schnaiberg, 1971). Triandis (1972) writes that those people with higher levels of individual modernity would be more inclined toward science and more open to new experiences. Modern Western medicine advanced through scientific research; scientific concepts of disease were developed, and new instruments for diagnosis, treatment, and research were invented (Garrison, 1929). Therefore, the more educated and urban residents would be expected to prefer to consult Western (more modernized) medicine.

But research results don not reveal clear relationships. Lee (1980) summarizes several surveys of attitudes and behaviors toward East Asian medicine in Hong Kong, including a life quality survey, a health attitudes and behavior survey, another health study, a familism survey, and a faculty health survey at a local university. The findings of these surveys are relatively consistent. In behavioral aspects, the respondents visited Western-style hospitals more often than they visited East Asian hospitals, although most respondents consulted both East Asian and Western-style medical doctors. The use of East Asian or Western-style practitioners was not statistically significantly associated with the gender, age, educational level, and income status of the respondents, however.

In attitudinal aspects, respondents generally expressed more confidence in Western-style doctors and Western medicine. However, people tended to make differential evaluations of the various aspects of East Asian and Western medical care. Most people perceived that Western medicine was more effective than East Asian medicine in the prevention of infectious diseases and the treatment of acute diseases and that Western medicine worked faster than did East Asian medicine. However, most people believed that East Asian medicine was better for tonic care and was less likely to produce side-effects than was Western medicine.

Lock (1980b:249), on the basis of interviews with 50 families sampled in urban Japan, reports that "(p)atients of every income group and educational level make use of traditional medicine." Rosenthal (1981:605), based on interviews with 24 informants in the People's Republic of China, reports that "Western medicine was more popular in the cities and among the young." Lee's findings are consistent with Rosenthal's. Among some local families, he (1981:145) observed that "...most peasant families have used Chinese medicine as frequently as, and sometimes even more frequently than, Western medicine."

Ahern (1974) reported a survey of the attitudes toward East Asian medicine of 68 villagers in northern Taiwan. She

(1974:214) found that, "(o)n the whole, women, older people and less well educated people tend to be more inclined toward Chinese-style medicine." But the relationships were relatively weak.

These study results imply that East Asian medicine is generally more popular in rural areas than it is in urban areas and that, in urban areas, the relationships between sociodemographic characteristics and attitudes and behaviors toward East Asian medicine are not significant.

Hypothesis 4 Sociodemographic variables (age, gender, education, rural experience, and income) will not be significantly related to people's attitudes and behaviors concerning East Asian and Western medicine. It is assumed that the lack of significant relationships is caused by the modernization of the East Asian medical system in Korea.

Another variable used in this study is nationalism. In sociology, the main approaches to nationalism are through functionalism and conflict. In the functionalistic approach, when the differentiation of a social system increases, it brings some conflicts or discontinuities. Therefore, "...society must institutionalize new modes of fulfilling the principles and performing the functions with which earlier structures can no longer cope" (Smith, 1983:49). Nationalism is an important mechanism of

integration (Smith, 1983). It is seen to result from "...a search for new common symbols in which various groups of the society could find some sense of personal and collective identity" (Eisenstadt, 1966:15). Therefore, nationalism contributes to the reintegration of a society.

Conflict theory assumes continuous group conflicts for scarce resources. The source of nationalism is the conflict between the more developed countries and the underdeveloped countries (Smith, 1983). Nationalism in Third World countries is not different from anti-imperialism. Nationalism is a natural response to foreign oppression (Lenin, 1917). Nationalistic sentiment based on anti-imperialism is the concept of nationalism used in this research because it indicates people's sentiments, whereas nationalism in functionalistic theory explains the function of nationalistic sentiment in promoting social integration.

Many authors have maintained that nationalistic sentiment based on anti-imperialism is an important factor in the survival and revival of East Asian medicine, although this theory has never been statistically tested (Croizier, 1965, 1968, 1976; Brass, 1972; Kunstadter, 1974; Lee, 1982; Lock, 1980b). Kim (1981:139) argues that Korean nationalism is "...largely a reaction to powerful foreign threats...", appealing to the feeling of racial kinship and

common heritage and "...backward-looking conservatism." Their arguments suggest that the more nationalistic one is, the more favorable one will be to traditional cultural patterns.

Hypothesis 5 Nationalistic sentiment will be positively related to people's attitudes and behaviors concerning East Asian medicine.

Concerning the attitude-behavior relationship, there has been general agreement that a person's attitude toward some object predicts the related behavior (Fishbein and Ajzen, 1974). After reviewing more than 30 studies on the attitude-behavior relationship, however, Wicker (1969) concludes that attitudes do not or only slightly predict overt behaviors.

However, in the area of East Asian medicine, Lee (1980) found that the use of East Asian versus Western-style medical doctors was strongly related to the patients' relative confidence in the two types of practitioners in Hong Kong and was also significantly related to their relative confidence in the two medical systems.

Hypothesis 6 Attitudes toward East Asian and Western medicine will be positively related to medical behaviors.

Sample

To test these hypotheses, a survey was conducted from August 1 to 12, 1988, in Bong-Dug 2 Dong in Taegu, Korea. Taegu is the third largest city in Korea, with a population of 2.03 million in 1985 (National Bureau of Statistics, 1985). Bong-Dug 2 Dong was one of 132 administrative districts of Taegu in 1985. It is located in the southern part of Taegu. A total of 20,292 residents were living in that area in 1985; among them, 12,309 were of age 20 or older (National Bureau of Statistics, 1985). Potential respondents were chosen through random sampling among Bong-Dug 2 Dong residents. The resident registration books kept by the town-block office were used as the sampling frame. They listed all the Bong-Dug 2 Dong residents. A total of 350 residents were sampled to ensure enough cases for several subpopulations to do statistical data analysis; this number was about 3% of the total residents 20 years of age or older in Bong-Dug 2 Dong. To select 350 residents, every 58th resident was selected age 20 or older. If the individual selected was younger than 20, the next listed resident of age 20 or older was chosen.

Collection of Data

A questionnaire was designed for this study, and an interview was conducted with each sampled resident (see Appendix B). The questionnaire, which was originally prepared in English, was translated into Korean, the native and official language of the Republic of Korea.

Before the study began, the wording and ordering of the questions and the subjects' comprehension of the questions were evaluated and modified through a pilot study. The questionnaire was administered to 20 residents who were encouraged to point out any difficulties they experienced in understanding the wording of the questions. They were also asked to indicate which, if any, questions caused embarrassment or distress. Difficulties in comprehension or with the content of the questionnaire were corrected during this stage. Before formal interviews began, letters were sent to each potential respondent on July 15, 1988 (see Appendix A). Of these letters, 43 were sent back because the recipient did not live at the address.

Interviews were attempted with the 307 eligible to respond. Interviewers were employed to administer the questionnaire. The eight interviewers were divided into four teams and visited each house. Subjects were given a questionnaire and were asked to follow along as an

interviewer read each question. If the subjects understood the question, they were asked to choose the appropriate answer from all the possible categories. If the subjects could not grasp what was being asked, the interviewer explained the question. The instructions on the explanations and examples were given before practicing interviews, thereby reducing response bias due to restructuring the questions. Subjects were encouraged to select the response that most closely approximated their understanding of the question. Participants were informed that they could refuse to answer any question and could withdraw from the study at any time.

Among the 307 eligible for the study, four were in foreign countries, thirteen lived outside of Taegu, eight changed their residences, three served in the army outside of Taegu, and six were on summer vacation. Interviews were attempted with the remaining 273. A total of 155 interviews were completed. After the interview period, questionnaires were mailed with return postage and envelopes to those not contacted. Thirty-six mailed questionnaires were returned. Thus, a total of 191 questionnaires was collected; the sex and age distributions of these 191 respondents are not statistically different from those of the population (Table 2). Therefore, the 191 respondents are regarded as

Table 2. Sociodemographic characteristics of the respondents and population from which they were selected

	Sample		Population[a]		Taegu[a]	
	Frequency	%	Frequency	%	Frequency	%
Sex[b]						
Male	92	48.2	5,758	46.8	569,747	47.7
Female	99	51.8	6,551	53.2	625,542	52.3
Total	191	100.0	12,309	100.0	1,195,289	100.0
Age[c]						
20-29	60	31.4	4,680	38.0	460,625	38.5
30-39	54	28.3	2,556	20.8	297,410	24.9
40-49	39	20.4	2,257	18.3	211,107	17.7
50-59	19	10.0	1,629	13.2	126,030	10.5
60-69	12	6.2	726	5.9	64,596	5.4
70 or older	7	3.7	461	3.7	35,512	3.0
Total	191	100.0	12,309	99.9	1,195,289	100.0
Mean	38.7					
S.D.	14.1					
Education[d]						
No schooling	7	3.7			97,337	8.1
1-6 years	24	12.6			245,796	20.6
7-9 years	27	14.1			276,261	23.1
10-12 years	69	36.1			350,742	29.3
13 years or more	61	31.9			225,110	18.8
No response	3	1.6			43	0.0
Total	191	100.0			1,195,289	99.9
Mean	3.8					
S.D.	1.1					

[a]Source: National Bureau of Statistics, 1985 Population and Housing Census Report.

[b]Chi-square of sample vs. population: 0.146, $P > 0.50$. Chi-square of sample vs. Taegu: 0.019, $P > 0.80$.

[c]Chi-square of sample vs. population: 9.288, $P > 0.05$. Chi-square of sample vs. Taegu: 4.859, $P > 0.30$.

[d]Chi-square of sample vs. Taegu: 38.253, $P < 0.001$.

representative of the population from which they were drawn.

Sociodemographic Characteristics of the Respondents

Five sociodemographic variables were measured. The questions used to gather information on the items used in the analysis can be found in the part IV of Appendix B. In addition, summary statistics for the five variables used in the analysis are provided in Tables 2 and 3.

Sex

A total of 92 (48.2%) males and 99 (51.8%) females were interviewed. The sex ratio of the respondents was very similar to that of the population and Taegu residents.

Age

This was measured by age in years given by the respondent at the time of the interview. Age ranged from 20 to 80, with three-fifths (59.7%) under 40 (Table 2) and a mean of 38.7. Again, the distributions of respondents and the population from which they were drawn and Taegu were not statistically different.

Education

Respondents were asked to indicate the number of years of education completed. Responses were classified into five categories from low to high: 1) no formal education (3.7%); 2) from 1 to 6 years (12.6%); 3) from 7 to 9 years (14.1%); 4) from 10 to 12 years (36.1%); and 5) more than 12 years (31.9%) (Table 2). The respondents reported significantly more education than that of all Taegu residents. It could be that educated individuals were more likely to agree to be interviewed; also, it is possible that the respondents reported more years of education than they had actually completed.

Rural experience

During the interview period, all respondents were living in an urban area (Taegu). Rural experience was measured based on their past residences (the number of years the respondent lived in a rural area divided by age). A majority (59.5%) of the respondents answered that they once lived in rural area. Of these residents, a quarter had spent less than 30% of their lives in rural areas, although nearly a third had spent 60% or more of their years in rural places (Table 3).

Table 3. Sociodemographic and socioeconomic characteristics of respondents

	Respondents	
	Frequency	Percent
Rural residence		
Yes	113	59.2
1-5 years	(10)	(8.8)
6-10 years	(18)	(15.9)
11-15 years	(16)	(14.2)
16-20 years	(38)	(33.6)
21-25 years	(6)	(5.3)
26-30 years	(8)	(7.1)
31 or more	(17)	(15.0)
Mean	19.3	
S.D.	11.9	
No	77	40.3
No response	1	0.5
Total	191	100.0
Rural experience		
0% of years lived	77	40.3
1% to 30%	29	15.2
31% to 60%	49	25.7
61% or more	35	18.3
No response	1	0.5
Total	191	100.0
Mean	0.277	
S.D.	0.288	
Family income (per month)		
Less than $500	36	18.8
$500-$749	56	29.3
$750-$999	30	15.7
$1,000-$1,499	39	20.4
$1,500 or more	14	7.3
No response	16	8.4
Total	191	99.9
Mean	$997	
S.D.	1,044	

Table 3. (continued)

	Respondents	
	Frequency	Percent
Family size		
1 person	10	5.2
2 persons	15	7.9
3 persons	23	12.0
4 persons	61	31.9
5 persons	44	23.0
6 persons	26	13.6
7 or more persons	11	5.8
No response	1	0.5
Total	191	99.9
Mean	4.2	
S.D.	1.48	
Per capita family income (per month)		
Less than $100	16	8.4
$100-$199	84	44.0
$200-$299	35	18.3
$300-$399	16	8.4
$400 or more	24	12.6
No response	16	8.4
Total	191	100.1
Mean	$249	
S.D.	251.7	

Family income

Per capita family income was used to measure the living standard of the respondents because it is a better indication of one's living standard than is individual income in Korea. Per capita family income was measured by dividing family income by family size. Family income per month ranged from $139 to more than $10,000, with an average family income of $997 (Table 3). Family size averaged 4.2 residents. The mean per capita family income was $249, with more than half the units (52.4%) below $200, although 21.0% were above $400.

Nationalistic Sentiment

Nationalistic sentiment was measured by asking the respondents to indicate their anti-imperialistic sentiments in cultural, political, and economic affairs. Thirteen questions (Q9-Q22 of part I in Appendix B) were asked (Table 4). A reliability coefficient (alpha) of 0.6905 was obtained across these thirteen items. The nationalistic sentiment score ranged from 2.00 to 4.83, with a mean of 3.46; 16.8% of the respondents scored below 3.0 and 15.7% above 4.0 (Table 4). The higher the score, the higher the respondent's nationalistic sentiment is.

Table 4. Nationalistic sentiment

	Respondents	
	Frequency	Percent
Students' demonstration for the removal of American troops from Korea is reasonable		
Strongly agree	10	5.2
Agree	46	24.1
Undecided	37	19.4
Disagree	65	34.0
Strongly disagree	32	16.8
No response	1	0.5
Total	191	100.0
Mean	2.668	
S.D.	1.169	
It is understandable that the United States presses Korea to import American cigarettes[a]		
Strongly agree	7	3.7
Agree	13	6.8
Undecided	22	11.5
Disagree	62	32.5
Strongly disagree	85	44.5
No response	2	1.0
Total	191	100.0
Mean	4.085	
S.D.	1.083	

[a]Coding of these questions was reversed when scale scores were calculated.

Table 4. (continued)

	Respondents	
	Frequency	Percent
Japanese fishermen should be shot if they fish in Korean waters		
Strongly agree	30	15.7
Agree	61	31.9
Undecided	32	16.8
Disagree	55	28.8
Strongly disagree	11	5.8
No response	2	1.0
Total	191	100.0
Mean	3.233	
S.D.	1.198	
The laborers' right to strike should be guaranteed in the foreign firms in Korea		
Strongly agree	75	39.3
Agree	73	38.2
Undecided	20	10.5
Disagree	17	8.9
Strongly disagree	2	1.0
No response	2	1.0
Total	191	99.9
Mean	4.080	
S.D.	0.983	
It is proper that the students demonstrate to ask that all foreign investors leave Korea		
Strongly agree	12	6.3
Agree	34	17.8
Undecided	44	23.0
Disagree	78	40.8
Strongly disagree	20	10.5
No response	3	1.6
Total	191	100.0
Mean	2.681	
S.D.	1.087	

Table 4. (continued)

	Respondents	
	Frequency	Percent
The Korean government should place a heavy tax on foreign firms in Korea		
Strongly agree	40	20.9
Agree	81	42.4
Undecided	38	19.9
Disagree	25	13.1
Strongly disagree	4	2.1
No response	3	1.6
Total	191	100.0
Mean	3.681	
S.D.	1.021	
American culture is superior to Korean traditional culture[a]		
Strongly agree	4	2.1
Agree	24	12.6
Undecided	35	18.3
Disagree	53	27.7
Strongly disagree	74	38.7
No response	1	0.5
Total	191	99.9
Mean	3.889	
S.D.	1.124	
Japanese culture is superior to Korean traditional culture[a]		
Strongly agree	2	1.0
Agree	24	12.6
Undecided	17	8.9
Disagree	56	29.3
Strongly disagree	91	47.6
No response	1	0.5
Total	191	99.9
Mean	4.105	
S.D.	1.079	

Table 4. (continued)

	Respondents	
	Frequency	Percent
Japan is a good nation to Korea[a]		
Strongly agree	2	1.0
Agree	23	12.0
Undecided	38	19.9
Disagree	68	35.6
Strongly disagree	59	30.9
No response	1	0.5
Total	191	99.9
Mean	3.837	
S.D.	1.034	
The United States is a good nation to Korea[a]		
Strongly agree	14	7.3
Agree	72	37.7
Undecided	49	25.7
Disagree	41	21.5
Strongly disagree	14	7.3
No response	1	0.5
Total	191	100.0
Mean	2.837	
S.D.	1.078	
The Korean government should limit the number of American movie imports		
Strongly agree	20	10.5
Agree	79	41.4
Undecided	44	23.0
Disagree	39	20.4
Strongly disagree	7	3.7
No response	2	1.0
Total	191	100.0
Mean	3.349	
S.D.	1.039	

Table 4. (continued)

	Respondents	
	Frequency	Percent
The Korean government should ban Japanese movie imports		
Strongly agree	30	15.7
Agree	47	24.6
Undecided	39	20.4
Disagree	60	31.4
Strongly disagree	13	6.8
No response	2	1.0
Total	191	99.9
Mean	3.111	
S.D.	1.213	
We should be kind to the Japanese tourists[a]		
Strongly agree	88	46.1
Agree	85	44.5
Undecided	15	7.9
Disagree	2	1.0
Strongly disagree	0	0.0
No response	1	0.5
Total	191	100.0
Mean	1.637	
S.D.	0.674	
We should be kind to the American tourists[a]		
Strongly agree	92	48.2
Agree	84	44.0
Undecided	12	6.3
Disagree	0	0.0
Strongly disagree	1	0.5
No response	2	1.0
Total	191	100.0
Mean	1.593	
S.D.	0.659	

Table 4. (continued)

	Respondents	
	Frequency	Percent
Scale score[b]		
0.0-2.99	32	16.8
3.0-3.49	66	34.6
3.5-3.99	63	33.0
4.0-5.00	30	15.7
Total	191	100.1
Mean	3.455	
S.D.	0.516	

[b]Scale scores were obtained by dividing the total scores of a respondent by the total number of items (13).

Attitude toward East Asian Medicine

A scale of the respondents' attitudes toward East Asian medicine was constructed. Five positive and four negative statements toward East Asian medicine were included (Q23-Q31 of part I in Appendix B). Respondents indicated their degree of agreement on each statement. The reliability coefficient (alpha) of the attitude scale was 0.5880. The mean score on the attitude scale was 3.60, and the range was from 2.33 to 5.00 (Table 5). Only 9.4% of the respondents scored lower than 3.00, and almost a quarter (24.1%) scored higher than 4.00. Higher scores indicated more positive attitudes toward East Asian medicine.

Generally, responses to the individual items are

Table 5. Attitudes toward East Asian medicine

	Respondents	
	Frequency	Percent
Nowadays we don't need East Asian medicine[a]		
Strongly agree	4	2.1
Agree	5	2.6
Undecided	8	4.2
Disagree	80	41.9
Strongly disagree	94	49.2
No response	0	0.0
Total	191	100.0
Mean	4.335	
S.D.	0.848	
Western medicine only cures the superficial syndromes, not root causes		
Strongly agree	16	8.4
Agree	70	36.6
Undecided	29	15.2
Disagree	55	28.8
Strongly disagree	20	10.5
No response	1	0.5
Total	191	100.0
Mean	3.037	
S.D.	1.192	
It is unscientific to diagnose by feeling the pulse[a]		
Strongly agree	1	0.5
Agree	29	15.2
Undecided	27	14.1
Disagree	102	53.4
Strongly disagree	31	16.2
No response	1	0.5
Total	191	99.9
Mean	3.700	
S.D.	0.937	

[a]Coding of these questions was reversed when scale scores were calculated.

Table 5. (continued)

	Respondents	
	Frequency	Percent
East Asian medicine can sometimes deal with diseases that can not be treated by Western medicine		
Strongly agree	65	34.0
Agree	96	50.3
Undecided	18	9.4
Disagree	10	5.2
Strongly disagree	1	0.5
No response	1	0.5
Total	191	99.9
Mean	4.126	
S.D.	0.826	
A Western-style medical doctor's diagnosis is more accurate than that made by an East Asian medical doctor[a]		
Strongly agree	35	18.3
Agree	67	35.1
Undecided	61	31.9
Disagree	24	12.6
Strongly disagree	4	2.1
No response	0	0.0
Total	191	100.0
Mean	2.450	
S.D.	0.998	
Shots make you feel better for only a little while		
Strongly agree	32	16.8
Agree	79	41.4
Undecided	37	19.4
Disagree	34	17.8
Strongly disagree	9	4.7
No response	0	0.0
Total	191	100.1
Mean	3.476	
S.D.	1.109	

Table 5. (continued)

	Respondents	
	Frequency	Percent
East Asian medicine is slow to take effect and hence not practical today[a]		
Strongly agree	3	1.6
Agree	18	9.4
Undecided	17	8.9
Disagree	119	62.3
Strongly disagree	34	17.8
No response	0	0.0
Total	191	100.0
Mean	3.853	
S.D.	0.876	
Western medicine is more likely to produce side-effects than East Asian medicine		
Strongly agree	42	22.0
Agree	80	41.9
Undecided	39	20.4
Disagree	27	14.1
Strongly disagree	3	1.6
No response	0	0.0
Total	191	100.0
Mean	3.686	
S.D.	1.019	
East Asian medicine is more effective than Western medicine in the treatment of chronic diseases		
Strongly agree	48	25.1
Agree	84	44.0
Undecided	34	17.8
Disagree	20	10.5
Strongly disagree	5	2.6
No response	0	0.0
Total	191	100.0
Mean	3.785	
S.D.	1.021	

Table 5. (continued)

	Respondents	
	Frequency	Percent
Scale score[b]		
0.0-2.99	18	9.4
3.0-3.49	56	29.3
3.5-3.99	71	37.2
4.0-5.00	46	24.1
Total	191	100.0
Mean	3.605	
S.D.	0.472	

[b]Scale scores were obtained by dividing the total scores of a respondent by the total number of items (9).

positive. Most respondents felt that East Asian medicine is still needed (91.1%) and practical, despite its slow effects (80.1%) (Table 5). More than two-thirds (69.1%) of the respondents agreed that East Asian medicine is more effective than Western medicine in tonic care. Many (84.7%) of them perceived that East Asian medicine can sometimes deal with diseases that can not be treated by Western medicine.

Respondents generally recognized some negative aspects of Western medicine. Many believed that Western medicine is more likely to produce side-effects than is East Asian medicine (63.9%) and that shots make them feel good for only a little while (58.2%). But on the statement that Western

medicine does not cure root causes, the responses were widely scattered; 45.4% agreed and 39.4% disagreed. And many people thought that a Western doctor's diagnosis is more accurate; more than half (53.4%) agreed with this statement, whereas only 14.7% disagreed.

In addition, respondents were given a list of diseases and were asked to indicate whether treatment by East Asian (herbal medicine or acupuncture) or Western medicine would work better (the part III in Appendix B). Of course, the list did not represent all the diseases. It was included to determine differential preferences between East Asian and Western medicine by the kind of disease. Western medicine was preferred for treatment of infectious diseases (tuberculosis, 91.6%; measles, 88.5%; fever, 71.2%) (Table 6). Respondents also showed a high degree confidence in Western medicine for heart disease (83.8%), fractures (64.4%), and gastroenteric disorders (57.6%). On the other hand, East Asian medicine was frequently chosen for chronic diseases (paralysis, 94.8%; rheumatism, 80.6%; arthritis, 55.6%; women's diseases, 55.0%).

Respondents generally had more confidence in herbal medicine than they had in acupuncture (Table 6). Selection of acupuncture concentrated on several specific diseases, such as fractures, rheumatism, paralysis, and arthritis. On

Table 6. Preference between Western and East Asian medicine for specific diseases

Disease	East Asian medicine			Western medicine	No res.	Total %	Total freq.
	H. M.	Acup.	Total				
Arthritis	33.2%	22.5	55.7	42.7	1.6	100.0%	191
Fever	24.9%	0.5	25.4	71.5	3.1	100.0%	191
Fractures	13.6%	19.4	33.0	64.4	2.6	100.0%	191
Gastroenteric disorder	39.5%	1.0	40.5	57.9	1.6	100.0%	191
Heart disease	12.3%	0.0	12.3	84.0	3.7	100.0%	191
Measles	6.3%	0.5	6.8	88.5	4.7	100.0%	191
Paralysis	67.8%	27.0	94.8	4.2	1.0	100.0%	191
Rheumatism	49.9%	31.3	81.2	16.1	2.6	99.9%	191
Tuberculosis	5.8%	0.0	5.8	91.6	2.6	100.0%	191
Women's disease	52.9%	2.1	55.0	44.0	1.0	100.0%	191

the other hand, herbal medicine was chosen for more diseases, and its selection was widely scattered.

East Asian Medical Behavior

To measure East Asian medical behaviors, two indexes were constructed. The visit index is based on the number of hospital visits. It was computed by dividing the number of visits to East Asian hospitals by the total number of visits to both East Asian and Western hospitals among those who had had hospital visiting experience during the previous two years. The mean of the visit index was 0.396 (Table 7). Nearly a third of the respondents (31.5%) who had visited a hospital had gone only to Western units, although another fifth (27.8%) indicated that at least 70% of their visits were to East Asian hospitals.

The expense index is based on the amount of money spent in East Asian and Western hospitals. It was computed as the total expenses from visits to East Asian hospitals divided by the total expenses from all hospital visits among those who had had hospital visiting experience during the previous two years. A mean of the expense index was 0.424 (Table 7). About a third the respondents (32.9%) had no East Asian hospital expense, whereas another third (34.9%) scored higher than 70%.

Table 7. Visit and expense indexes of those with at least one hospital experience in the last two years

	Respondents	
	Frequency	Percent
Visit index		
0.00	47	31.5
0.01-0.34	28	18.8
0.35-0.69	38	25.5
0.70-1.00	34	22.8
No response	2	1.3
Total	149	99.9
Mean	0.396	
S.D.	0.367	
Expense index		
0.00	49[a]	32.9
0.01-0.34	21	14.1
0.35-0.69	12	8.1
0.70-1.00	52	34.9
No response	15	10.1
Total	149	100.1
Mean	0.424	
S.D.	0.418	

[a]Two respondents who visited East Asian hospitals reported that they paid nothing for treatments because the doctors were close to them.

Concerning the utilization of medical services during the previous two years, respondents were asked to list whether they visited East Asian and/or Western hospitals, the diseases treated, the motives for visiting specific hospitals, and whether medical insurance was applied. If East Asian medicine was used, they were asked to identify the specific East Asian medicines used and the diseases treated.

Respondents were more likely to visit Western hospitals (86.6%) than East Asian hospitals (68.5%). But many respondents (82 of 149) visited both East Asian and Western hospitals (Table 8). The mean number of visits among those who had been to hospitals was statistically similar--6.25 for East Asian hospitals and 6.92 for Western hospitals (Table 9). The mean of total money spent in Western hospitals ($483) was almost two times higher than that spent in East Asian hospitals ($247), although the proportion of visits that required less than $50 was much greater in Western hospitals (45.0%) than it was in East Asian hospital visits (22.5%). Western hospital visits (11.6%) were much more likely than were East Asian hospital visits (3.9%) to result in costs of at least $1,000. Evidently, a few respondents who had been hospitalized for long periods in Western hospitals greatly elevated the mean money spent on

Table 8. Hospital visiting experience during the last two years

	East Asian hospital		Western hospital		Any hospital		Both hospital	
Response	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Yes	102	53.4	129	67.5	149	78.0	82	42.9
No	89	46.6	62	32.5	42	22.0	109	57.1
Total	191	100.0	191	100.0	191	100.0	191	100.0

Table 9. Hospital visits during the previous two years

Response	East Asian hospital	Western hospital
Number of visits among those who have hospital experience[a]		
1-2	41.2%	39.5%
3-5	28.4	24.0
6-10	14.7	19.4
11 or more	13.7	16.3
No response	2.0	0.8
Total percent	100.0%	100.0%
Total frequency	102	129
Mean	6.25	6.92
S.D.	11.59	9.68
Money spent among those who have hospital experience[b]		
Less than $50	22.5%	45.0%
$50-$99	19.6	8.5
$100-$249	17.6	14.0
$250-$499	12.7	11.6
$500-$999	10.8	3.9
$1,000 or more	3.9	11.6
No response	12.7	5.4
Total percent	99.8%	100.0%
Total frequency	102	129
Mean	247	483
S.D.	325	1,266

Motives		
Friends or relatives[c,d] recommendation	32.0%	4.7%
Family recommendation	40.0	14.2
Economic factors	5.0	17.3
Character of illness	63.0	73.2
Familiarity	11.0	37.8
Superiority	48.0	48.8
Proximity	5.0%	23.6%
Total frequency	100	127

[a]T-score of difference in means between East Asian and Western hospital visits: 0.469, $P > 0.60$.

[b]T-score of difference in means between East Asian and Western hospital visits: 2,034, $P < 0.05$.

[c]Chi-square of East Asian vs. Western hospital visit motivation: 75.628, $P < 0.001$.

[d]Respondents could give three motives.

Western hospitals.

When the respondents were asked to identify from among seven choices the three reasons why they had chosen particular types of hospitals, the nature of illness was most frequently mentioned for both East Asian (63.0%) and Western (73.2%) hospital visits (Table 9). Superiority of medical practice was the next most frequently chosen reason in both cases. These results imply that people believe that both types of hospitals have their own merits for specific diseases and that people choose between East Asian and Western hospitals according to the kinds of diseases. On the other items, however, considerably different motives operate in the choice between East Asian and Western hospitals. Recommendations from family members and friends or relatives were much more common among those choosing East Asian hospitals (40.0% and 32.0%, respectively) than those choosing Western hospitals (14.2% and 4.7%, respectively). Familiarity, proximity, and economic factors were much more frequent motives for visiting Western hospitals (37.8%, 23.6%, and 17.3%, respectively) than those for visiting East Asian hospitals (11.0%, 5.0%, and 5.0%, respectively). These results reveal that the use of East Asian hospitals is influenced by one's close surroundings.

Both East Asian and Western hospitals treated almost every disease (Table 10). For physical examinations and the cure of dental diseases, only Western hospitals were used, however. In the cases of rheumatism (81.0%), sprains or fractures (78.6%), and circulation diseases (72.2%), East Asian hospitals were more frequently visited than were Western-style hospitals. On the other hand, for the remedy of colds or headache (71.1%), childbirth (78.6%), skin disease (90.9%), eye disease (87.5%), and nose, ear or throat disease (78.6%), Western hospitals were more popular. For the treatment of internal diseases both hospitals were commonly used.

The proportion of medical visits covered by insurance was much higher in Western hospitals visits (68.2%) than it was in East Asian hospital visits (Table 11). Except for acupuncture (16.3%), the insurance coverage for other East Asian medical treatments were less than 4% of the cases.

Among the 102 respondents who used East Asian medicine, 44.1% used tonic, 62.7% used herbal medicine for disease treatment, 42.2% used acupuncture, and 4.9% used moxibustion (Table 12). Herbal medicine, tonic, and acupuncture are three popular East Asian treatment methods in Korea.

The mean number of visits to East Asian hospitals was highest for acupuncture (7.26), followed by moxibustion

Table 10. Diseases treated during the previous two years

Disease[a]	East Asian hospital	Western hospital	Total percent	Total freq.
Medical examination	0.0%	100.0	100.0%	8
Colds or headache	28.9%	71.1	100.0%	45
Rheumatism	81.0%	19.0	100.0%	42
Arthritis	50.0%	50.0	100.0%	14
Sprains or fractures	78.6%	21.4	100.0%	14
Gastroenteric disorder	44.1%	55.9	100.0%	34
Other internal diseases	31.4%	68.6	100.0%	35
Respiratory ailments	50.0%	50.0	100.0%	6
Circulation disease	72.2%	27.8	100.0%	18
Women's disease	50.0%	50.0	100.0%	10
Childbirth	11.1%	88.9	100.0%	9
Mental disease	42.9%	57.1	100.0%	7
Skin disease	9.1%	90.9	100.0%	11
Eye disease	12.5%	87.5	100.0%	8
Nose, ear, throat D.	21.4%	78.6	100.0%	14
Dental disease	0.0%	100.0	100.0%	17
Other	30.0%	70.0	100.0%	10

[a]Respondents could list all the diseases treated.

Table 11. Medical insurance during the last two years

Insurance	Western hospital	East Asian hospital			
		Tonic	Herbal medicine	Acupuncture	Moxibustion[a]
Yes	68.2%	2.2%	3.1%	16.3%	0.0%
No	24.8	95.6	75.0	62.8	40.0
No response	7.0	2.2	21.9	20.9	60.0
Total percent	100.0%	100.0%	100.0%	100.0%	100.0%
Total freq.	129	45	64	43	5

[a]A therapeutic technique in which small cones of a powdered herb (mugwort) are burned on the body at certain defined points (Lock, 1980a).

(5.00), herbal medicine (2.35), and tonic (1.97). On the other hand, the mean of total money spent for a specific treatment was highest on tonic ($240), next highest on herbal medicine ($233), and lowest on acupuncture ($38) and moxibustion ($9). Tonic is a very expensive medicine that usually costs more than $100 for each preparation. Herbal medicine averages about $70 per treatment. Acupuncture and moxibustion are very cheap therapeutic techniques that usually cost $5 or less per treatment.

Herbal medicine was used to treat almost all diseases, even though the frequencies varied by the type of diseases. On the other hand, acupuncture and moxibustion were used only for specific diseases (e.g., rheumatism, sprains or

Table 12. Measures of East Asian hospital visits during the last two years

Using	Tonic	Herbal medicine	Acupuncture	Moxibustion
Experience				
Yes	44.1%	62.7%	42.2%	4.9%
No	55.9	37.3	57.8	95.1
Total percent	100.0%	100.0%	100.0%	100.0%
Total freq.	102	102	102	102
Number of visits among respondents who have hospital experience				
1	46.7%	23.4%	16.3%	0.0%
2	31.1	31.3	18.6	40.0
3	2.2	12.5	18.6	0.0
4	11.1	4.7	7.0	20.0
5	6.7	12.5	7.0	0.0
6 or more	0.0	14.1	30.2	40.0
No response	2.2	1.6	2.3	0.0
Total percent	100.0%	100.1%	100.0%	100.0%
Total freq.	45	64	43	5
Mean	1.97	3.35	7.26	5.00
S.D.	1.27	2.81	15.03	3.46
Money spent among respondents who have hospital experience				
Less than $50	4.4%	25.0%	74.4%	80.0%
$50-$99	22.2	20.3	14.0	0.0
$100-$249	37.8	14.1	0.0	0.0
$250-$499	20.0	15.6	0.0	0.0
$500 or more	15.6	10.9	2.3	0.0
No response	0.0	14.1	9.3	20.0
Total percent	100.0%	100.0%	100.0%	100.0%
Total freq.	45	64	43	5
Mean	240	233	38	9
S.D.	192.7	345.8	87.8	13.2

fractures, and circulation diseases) (Table 13).

Table 13. Diseases treated in East Asian hospital visits[a,b]

Disease	Herbal medicine	Acu-puncture	Moxi-bustion	Total %	Total freq.
Colds or headache	84.6%	15.4	0.0	100.0%	13
Rheumatism	32.4%	55.9	11.8	100.1%	34
Arthritis	42.9%	42.9	14.3	100.1%	7
Sprains or fractures	11.1%	88.9	0.0	100.0%	9
Gastroenteric D.	80.0%	20.0	0.0	100.0%	15
Other internal D.	90.9%	9.1	0.0	100.0%	11
Respiratory ail.	100.0%	0.0	0.0	100.0%	3
Circulation D.	27.3%	63.6	9.1	100.0%	11
Paralysis	50.0%	50.0	0.0	100.0%	2
Women's disease	80.0%	20.0	0.0	100.0%	5
Childbirth	100.0%	0.0	0.0	100.0%	1
Mental disease	66.7%	33.3	0.0	100.0%	3
Skin disease	100.0%	0.0	0.0	100.0%	1
Eye disease	100.0%	0.0	0.0	100.0%	1
Nose/ear/throat D.	100.0%	0.0	0.0	100.0%	3
Other	33.3%	66.7	0.0	100.0%	3

[a]By definition, tonic is not used to treat specific diseases.

[b]Respondents could give all diseases treated in East Asian hospitals.

CHAPTER V. RESIDENTS' VIEWS OF MEDICINE IN KOREA: TESTING HYPOTHESES

Correlations and regressions among sociodemographic variables, the attitude scale, and the visit and expense indexes were computed to discover whether there are different attitudes and/or behaviors toward East Asian medicine among different segments of the Korean population.

The sociodemographic variables are generally very weakly and inconsistently correlated with the attitude scale and the visit and expense indexes (Table 14). Only the correlation between sex and the visit index is statistically significant. Males visited East Asian hospitals somewhat more frequently than females did. Thus, the fourth hypothesis, which predicted no significant relationships among these variables, is upheld.

To determine the variance explained in the attitude scale and behavior indexes by the sociodemographic variables, regressions were calculated. The standardized regression coefficients are not much different from the correlation coefficients in direction and strength of relationships (Table 15). The r-squares are extremely low (-0.004 for the attitude scale toward East Asian medicine, 0.013 for the visit index, and -0.005 for the expense

Table 14. Zero-order correlation coefficients among variables

Variable	Age	Sex	Education	Rural residence
Age	1.000			
Sex	-.092	1.000		
Education	-.574***	.318***	1.000	
Rural residence	.186**	-.018	-.316***	1.000
Income	-.038	-.085	.236***	-.136*
Nationalistic sentiment	-.178**	-.045	.185**	-.107
Attitude	-.059	.055	-.047	.083
Visit	.102	.149*	-.069	-.050
Expense	.086	.138	.022	.041

*Significant at the 0.05 level.

**Significant at the 0.01 level.

***Significant at the 0.001 level.

Income	Nationalistic sentiment	Attitude	Visit	Expense
1.000				
-.053	1.000			
-.033	.187**	1.000		
-.012	-.107	.177*	1.000	
.041	-.050	.277***	.790***	1.000

Table 15. Multiple regression analyses of attitudes and behaviors towards East Asian medicine without nationalism

Variable	Attitude		Visit		Expense	
	B	Beta	B	Beta	B	Beta
Age	-.005	-.141	.002	.063	.004	.120
Sex	.083	.088	.145	.197**	.116	.139
Education	-.057	-.137	-.043	-.132	.018	.048
Rural residence	.113	.069	-.123	-.096	.063	.043
Income	.000	.010	.000	.026	.000	.052
Intercept	3.847		-.305		.007	
R^2		-.004		.013		-.005

*Significant at .10 level.

**Significant at .05 level.

index). This result implies that the sociodemographic variables do not explain attitudes and behaviors toward East Asian medicine.

The correlation of nationalistic sentiment and the attitude scale is positive and statistically significant (Table 14), while the correlations of nationalistic sentiment and the visit and expense indexes are not statistically significant (Table 14). Therefore, Hypothesis 5 is partly supported in the relationship between nationalistic sentiment and attitudes toward East Asian medicine and is not supported in the relationship between nationalistic sentiment and behaviors toward East Asian medicine.

Correlations between the attitude scale and the visit (0.177) and expense (0.277) indexes are statistically significant (Table 14). Although Hypothesis 6 is supported, attitudes toward East Asian medicine fail to explain much of the visiting or expense pattern.

CHAPTER VI. DISCUSSION

In this chapter, research findings about institutional changes and individual attitudes and behaviors concerning East Asian medicine are summarized first. Second, the implications of the results for the research problems are drawn. Third, the limitations associated with this study are presented. Finally, suggestions for further research are discussed.

Results of the Research

Along with general social changes (e.g., industrialization, urbanization), the East Asian medical system has been substantially modernized in recent years. It is an example of the modernization of traditional institutions, even though the development was not linear. This finding is contradictory to the convergence hypothesis suggested by early modernization theorists (e.g., Levy, 1966; Shils, 1963) and provides a supporting case for the theory of multilinear and divergent modernization (e.g., Bendix, 1967; Gusfield, 1967).

Health policies have clearly affected the status of the traditional medical system. In Korea, repression of East Asian medicine during colonial rule resulted in the

establishment of Western medical dominance. On the other hand, Western medical imperialism and scientism among the people had little effect on the establishment of Western medical dominance. This result is consistent with Leslie's (1974) emphasis on the effects of government health policies on the status of traditional medicine and is also in accordance with Elling's (1978, 1981) and Janzen's (1978) arguments on the political impacts on the relative status of medical systems.

The influences of professionalization on the status of the traditional medical system are generally upheld. Recently, a professionalized East Asian medical group has been successful in enhancing its legal status and in removing some of the inequalities with Western medicine, which was not possible in the past, when East Asian medicine was less professionalized. This circumstance supports Unschuld's (1975) and McDonald's (1981) suggestions that the status of a medical system is decided through professional struggle.

Through this research, three main factors affecting the status and development of the East Asian medical system in Korea are identified--the change of the macro social system, the government health policy, and the degree of professionalization. These three factors combine to affect

the East Asian medical system, and there are relationships among these three independent variables. Korean society had been substantially industrialized and urbanized during Japanese rule, but East Asian medicine stagnated when the government health policy was quite repressive toward East Asian medicine. Before 1876, East Asian medicine had been recognized as the official medicine, but the East Asian medical system had been progressing slowly, as had been societal change. Therefore, general social development and a positive health policy toward East Asian medicine are necessary for the development of the East Asian medical system. However, only when they are combined can the rapid development of East Asian medicine be followed. Professionalization of East Asian medical doctors is an aspect of East Asian medical development. Therefore, it has been affected by the macro social change and the health policy in a certain time period.

At the individual level, people's attitudes and behaviors toward East Asian medicine were explored on the basis of the survey data collected in Korea. The popularity of East Asian medicine has been maintained among the people, regardless of their age, gender, level of education, rural residence experience, and income. This finding is consistent with the report of Lee (1980). Generally, the

respondents in this study recognized the positive aspects of East Asian medicine, and many of them consulted both East Asian and Western-style medical doctors, although the respondents visited Western hospitals more often than they visited East Asian hospitals.

The empirical data in this study indicate that nationalistic sentiment based on anti-imperialism is significantly related to the attitude scale but is not significantly related to the two behavior indexes. Therefore, nationalistic sentiment affects individual attitudes toward East Asian medicine, but it does not significantly affect the real medical choice.

Attitudes and behaviors concerning East Asian medicine are significantly correlated, but the relationships are not as strong as was anticipated. This result is similar to Wicker's (1969) conclusion that there is only a slight relationship at best between attitudes and behaviors. It does not support Lee's (1980) findings, which indicate a strong relationship between attitudes and behavior. The difference between the results of this and Lee's study can be explained by the different statistical procedures that were employed; Lee dichotomized the responses of attitudes and behaviors toward East Asian medicine and applied chi-square test.

This research analyzed the institutional level and the individual level separately. However, these two levels are closely related to each other. The impacts of institutional change of a medical system on individual attitudes and behaviors are partly tested in this research by assuming that the modernized East Asian medical system would affect the Korean people's attitudes and behaviors toward East Asian medicine. This hypothesis was supported. Changing aspects of a medical system (e.g., facility, technique, and education) definitely affect individual perceptions and the utilization of the medical system. Conversely, the people's attitudes and their use of East Asian medicine affect the existence and development of the medical system. It is obvious that a medical system can not exist without utilization. Specifically, in countries based on the market economy, both aspects are closely related.

Implications of the Results

The results of this dissertation have implications for sociological theories and practical uses. The documentation of modernization of the traditional medical system in Korea contributes to modernization theories. This study demonstrates that the traditional medical system is not a separate part of the society. Changes in the traditional

medical system have been closely related to the changing trends in Korean society in recent years. The general change in a society, including technological advancement and the emergence of bureaucratic organizations, affects the traditional medical system. Because many non-Western countries have not been highly modernized, it was difficult to provide evidence of convergent or divergent modernization theories. By providing a conclusive case of the modernization of traditional institutions (the East Asian medical system in Korea), this study contributes to the development of modernization theory.

Another contribution of this investigation is that it provides supporting evidence for theories about political impacts and professional struggle. Although there have been many arguments about the impacts of the political system and professionalization on traditional medicine, empirical studies were seldom completed. This study explores the impacts of these factors on traditional medicine in Korea and finds that these factors influenced the status of East Asian medicine.

At the individual level, the lack of significant relationships between sociodemographic variables and attitudes and behaviors toward East Asian medicine implies that East Asian medicine is not a transient medicine in

Korea that is used only by rural, low income, less educated, and elderly people. The lack of significant relationships between nationalistic sentiment and behaviors toward East Asian medicine suggests that people choose between East Asian and Western medicine based on practical reasons, not on ideological grounds. But the significant relationship between nationalistic and attitudes toward East Asian medicine implies that nationalistic sentiment among the people can affect national health policies toward East Asian medicine.

In addition, the results of this study have practical implications for development in Third World countries. The changing process of the East Asian medical system in Korea gives a clue about how traditional institutions in Third World countries have been changing and about how they can be changed. The modernization processes of Third World countries have been very different from those of Western countries and have been generally related to Western imperialism. Colonial governments introduced Western technologies and social systems. After liberation, the need for quick modernization for national wealth and strength made the political elite in Third World countries select the easy way; they adopted the more modernized Western technologies and social systems (Kothari, 1968; Doob, 1962).

Therefore, many traditional social systems, norms, and life styles disappeared or were considered to be inferior to the Western ones (Kishimoto, 1963; Hoogvelt, 1978; Foster-Carter, 1985). Even though Western-oriented modernization can bring some rapid development, disregard of a society's own traditions lowers the people's self-respect as a nation (Portes, 1973). Therefore, it is necessary to reexamine that society's traditions to understand historical distortions and values in modern society. This study shows how traditional medicine in Korea has been influenced by the political system and how it has been sustained and modernized, thereby giving lessons about why the current status of traditional institutions is low and how traditions can be modernized.

Limitations

Several limitations associated with this research must be noted. The fact that the research site was confined to Korea limits the generalization of the findings. For the institutional hypotheses, the study can only provide supporting or conflicting cases. Therefore, the findings at the institutional level are unlikely to be generalized. In addition, the research objective was confined to a traditional medical system, which makes it difficult to

argue that the modernization of traditional institutions is a general trend in Korea. Another problem is that the analysis mainly depended on documents. Information about historical private medical practices and education was especially limited.

Next, the survey data were collected in only one administrative district of the city of Taegu and did not contain any data from rural people. Thus, the findings cannot be generalized to the entire Korean population. To understand Koreans' attitudes and behaviors toward East Asian medicine fully, data for rural people should be gathered.

Finally, the low reliability of the nationalism and attitude scales is another problem. These low reliabilities mean high measurement error and decrease the accuracy of the tests of the hypotheses.

Suggestions for Further Research

Comparative studies of East Asian medicine among several countries will provide a better setting for the testing of modernization theories, the impacts of socioeconomic systems, and the theory of professional struggle. East Asian countries share traditional East Asian medicine, but their modern national development processes

are diverse.

Therefore, East Asian countries can provide an ideal setting to test the impacts of political systems on traditional medical systems.

The traditional medical system was the focus of this study. The study of changes in other traditional institutions, norms, and ways of life in relation to social and political changes will increase sociological knowledge of the dynamics of traditions in the modernization process in Third World countries.

In the future, a study of East Asian medical attitudes and behaviors that includes both urban and rural residents is desired. Nationwide sampling will be helpful. And in the process of constructing a questionnaire, reliability of scales should be considered. A pretest to those who share similar sociodemographic characteristics within the study population is recommended.

The inclusion of several other variables, such as traditionalism, individual modernity, and traditional medical beliefs, could provide valuable information in understanding East Asian medicine in Korea. The inter-relationships among sociodemographic variables, individual modernity, traditionalism, and nationalism and the effects of these factors on traditional medical beliefs and

attitudes and behaviors toward East Asian medicine will increase sociological knowledge about who uses East Asian medicine and why they use it. Adopting other methods and studying other aspects are other suggestions. Observation of real medical practices and facilities and interviews with medical doctors and patients, which were not attempted in this study, will provide valuable information in understanding the current East Asian medical system in Korea.

This study reveals that the changes in the East Asian medical system in Korea were closely related to the changes in society and in the political system. The subjects in this study maintained positive attitudes toward East Asian medicine and used East Asian medicine, regardless of their sociodemographic variables. This study implies that traditional institutions and some traditional beliefs can be sustained at the same time that modernization occurs at a rapid pace.

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APPENDIX A: INFORMING LETTER MAILED TO THE RESPONDENTS

Iowa State University
Ph.D. Candidate in Sociology
Seung-Pyo Hong
Address: 905 Ho 6 Dong
Mirinae A.P.T.
Bong-Dug 3 Dong
Nam-Gu Taegu
Telephone: 622-2939

Dear Respondent,

My name is Seung-Pyo Hong. I graduated from the Sociology Department of Korea University, where I got B.A. and M.A. degrees, and am working toward a Ph.D. degree at the Department of Sociology at Iowa State University. The topic of my dissertation is "Traditional Korean Medicine in the Modernization Process: Institutional and Attitudinal Changes."

This survey is a necessary process so that I can write the thesis. You were randomly selected from the resident registration books in Bong-Dug 2 Dong. Your cooperation will provide useful information regarding the sociological study of East Asian medicine in Korea.

The interview method will be that one of the interviewers will visit your house to interview you on one day, from __day __month to __day __month. The main content of the interview will be to determine your attitudes toward and use of East Asian and Western medicine. The interview

will take about fifteen minutes.

Your responses will be used only to derive some academic information and will remain confidential. Then, requesting your cooperative responses, I sincerely wish good luck to you and your family.

Sincerely,

APPENDIX B: INTERVIEW SCHEDULE

I.D. No.: (do not record)

1. Interviewer:

2. Date Sending Informing Letter: 88/ / (year/month/day)

3. Interview Date: 88/ / (year/month/day)

4. Length of Interview: minutes

5. Respondent's Name:

6. Respondent's Address: _____ Street Bong-Dug 2
Dong Nam-Gu Taegu, Korea

7. Place of Interview: __ Home __ Place of Work
__ Other ( )

8. Atmosphere of Interview: __ with nobody else at interview place
__ with someone else
Who? (relationship to respondent)
_____

9. Comments of Interviewer:

Interview Schedule
For
The Study of East Asian Medicine in Korea

I. Would you please tell me what you think of the following statement. Please indicate whether you strongly agree, agree, are neutral, disagree, or strongly disagree with the statements made below.

	Strongly Disagree	Dis-Agree	Neutral	Agree	Strongly Agree
1. Marriage without the permission of parents should be strongly discouraged.	( )	( )	( )	( )	( )
2. A high school student should be allowed to decide most things for himself or herself.	( )	( )	( )	( )	( )
3. There should be a separation of men's and women's work.	( )	( )	( )	( )	( )
4. Women should take an active interest in politics.	( )	( )	( )	( )	( )
5. It's good to have as many children as possible.	( )	( )	( )	( )	( )
6. Whatever one does, the "tried and true" ways are always the best.	( )	( )	( )	( )	( )

	Strongly Disagree	Dis-Agree	Neutral	Agree	Strongly Agree
7. Older people's opinions and experiences need not always be respected by everybody.	( )	( )	( )	( )	( )
8. Society should be quicker to throw out old ideas and traditions and to adopt new thinking and customs.	( )	( )	( )	( )	( )
9. Students' demonstration for the removal of American troops from Korea is reasonable.	( )	( )	( )	( )	( )
10. It's understandable that the United States presses Korea to import American cigarettes.	( )	( )	( )	( )	( )
11. Japanese fishermen should be shot if they fish in Korean waters.	( )	( )	( )	( )	( )
12. The laborers' right to strike should be guaranteed in the foreign firms in Korea.	( )	( )	( )	( )	( )

	Strongly Disagree	Dis-Agree	Neutral	Agree	Strongly Agree
13. It's proper that the students demonstrate to ask that all foreign investors leave Korea.	( )	( )	( )	( )	( )
14. The Korean government should place a heavy tax on foreign firms in Korea.	( )	( )	( )	( )	( )
15. American culture is superior to traditional Korean culture.	( )	( )	( )	( )	( )
16. Japanese culture is superior to traditional Korean culture.	( )	( )	( )	( )	( )
17. Japan is a good nation to Korea.	( )	( )	( )	( )	( )
18. The United States is a good nation to Korea.	( )	( )	( )	( )	( )
19. The Korean government should limit the number of American movie imports.	( )	( )	( )	( )	( )
20. The Korean government should ban Japanese movie imports.	( )	( )	( )	( )	( )
21. We should be kind to Japanese tourists.	( )	( )	( )	( )	( )

	Strongly Disagree	Dis-Agree	Neutral	Agree	Strongly Agree
22. We should be kind to American tourists.	( )	( )	( )	( )	( )
23. Nowadays we don't need East Asian medicine.	( )	( )	( )	( )	( )
24. Western medicine only cures the superficial syndromes, not root causes.	( )	( )	( )	( )	( )
25. It's unscientific to diagnose by feeling the pulse.	( )	( )	( )	( )	( )
26. East Asian medicine can sometimes deal with diseases that can't be treated by Western medicine.	( )	( )	( )	( )	( )
27. A Western-style medical doctor's diagnosis is more accurate than that made by an East Asian medical doctor.	( )	( )	( )	( )	( )
28. Shots make you feel better for a little while.	( )	( )	( )	( )	( )
29. East Asian medicine is slow to take effect and hence not practical today.	( )	( )	( )	( )	( )

	Strongly Disagree	Dis-Agree	Neutral	Agree	Strongly Agree
30. Western medicine is more likely to produce side-effects than East Asian medicine.	( )	( )	( )	( )	( )
31. East Asian medicine is more effective than Western medicine in the treatment of chronic diseases.	( )	( )	( )	( )	( )

II. Did you go to any medical facilities during the previous 2 years?

1) Yes __ (Go to A and B)
2) No __ (Go to III)

A. Did you consult Western-style doctors during the previous 2 years?

1) Yes __ (Go to A-1/A-4)
2) No __ (Go to B)

A-1. How many times did you consult Western-style doctors during the previous 2 years? ___ times

A-2. What kinds of disorders did you want to be treated for by Western-style doctors? Please describe all disorders you can remember.

_____

A-3. Approximately how much money did you spend to receive medical care in the Western-style hospitals during the previous two years?
$_____ (insurance, non-insurance)

A-4. Please indicate the influential factors in visiting Western-style hospital. Please rank the priority.

1) Family recommendation __
2) Economic factor __
3) Character of illness __
4) Familiarity __
5) Superiority __
6) Proximity __
7) Friend's or relative's recommendation __

B. Did you go to East Asian clinics or take East Asian medicine during the previous 2 years?

1) Yes __ (Go to B-1)
2) No __ (Go to III)

B-1. What kinds of treatment did you receive in the East Asian hospitals? Please check all the appropriate boxes.

1) Tonic __ (Go to B-2/B-3)
2) Herbal medicine __ (Go to B-4/B-6)
3) Acupuncture __ (Go to B-7/B-9)
4) Moxibustion __ (Go to B-10/B-12)

B-2. How many times did you have tonic during previous 2 years? ___ times

B-3. Approximately how much money did you spend in taking tonic during the previous 2 years?
$_____ (insurance, non-insurance)

B-4. How many times did you visit the East Asian hospitals to receive herbal medicine during the previous 2 years? ___ times

B-5. What kinds of disorders did you want to be treated for by herbal medicine during the previous two years? Please describe all disorders you can remember.

_____

B-6. Approximately how much money did you spend in taking herbal medicine during the previous 2 years?
$_____ (insurance, non-insurance)

B-7. How many times did you visit the East Asian hospitals or the houses of acupuncturists to be treated with acupuncture during the previous 2 years? ___ times

B-8. What kinds of disorders did you want to be treated for by acupuncture during the previous two years? Please describe all disorders you can remember.

_____

B-9. Approximately how much money did you spend to get acupunctured during the previous 2 years?
$_____ (insurance, non-insurance)

B-10. How many times did you cauterize with moxa during the previous 2 years? ___ times

B-11. What kinds of disorders did you want to be treated for by moxibustion during the previous two years? Please describe all disorders you can remember.

_____

B-12. Approximately how much money did you spend to be treated by moxibustion during the previous 2 years?
$_____ (insurance, non-insurance)

B-13. Please indicate the influential factors in visiting an East Asian hospital. Please rank the priority.

1) Family recommendation __
2) Economic factor __
3) Character of illness __
4) Familiarity __
5) Superiority __
6) Proximity __
7) Friend's or relative's recommendation __

III. Which treatment will work best for the following diseases? Please mark the relevant box.

	Western medicine	Herbal medicine	Acupuncture
Gastroenteric disorder	( )	( )	( )
Tuberculosis	( )	( )	( )
Paralysis	( )	( )	( )
Fever	( )	( )	( )
Heart disease	( )	( )	( )
Measles	( )	( )	( )
Rheumatism	( )	( )	( )
Fractures	( )	( )	( )
Women's disease	( )	( )	( )
Arthritis	( )	( )	( )

IV. Please answer in the appropriate blank.

1. Respondent's sex: 1) Male __ 2) Female __

2. May I ask your birthday?
   Birth date: __ (month) __ (date) __ (year)

3. What is your last formal schooling?
   (Please indicate graduation or leaving in mid-course of the last formal school)

   _____

4. What is your religion?

   1) Buddhism __ 2) Protestantism __
   3) Catholicism __ 4) Confucianism __
   5) Other __ 6) No religion __

5. Have you ever lived in a rural area (not city)?

   1) No __ 2) Yes __ (go to 5-A/5-B)

   5-A. When was the last year you lived in a rural area?
   year _____

   5-B. How long did you live in a rural area?
   ___ years

6. Do you have a job that provides a regular income?

   1) No __ 2) Yes __ (go to 6-A)

   6-A. What kind of occupation do you have?

   Occupation (concretely): _____

   Position: _____

   Monthly income: $_____

7. What is the approximate total family income per month?

   $_____

8. How many people are living together in your household, including yourself?

   ____ persons

9. How is your health status in general?

   1) Very good __ 2) Good __ 3) Fair __
   4) Poor __ 5) Very poor __