

A Rebellion in the Korean Medicine Community:

An Ethnography of Healthcare Politics in Contemporary South Korea



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Abstract

This thesis explores South Korean healthcare politics based on a series of intergenerational conflicts that occurred in a medical community in 2012. The conflicts broke out among ‘doctors of Korean medicine’, a medical profession unique to Korea practicing a form of medicine of East Asian origin that has recently undergone significant ‘bio-medicalization’. Doctors of Korean medicine have the same status as doctors of Western medicine in the country’s mainstream healthcare system, although the purview of their practice is legally demarcated. Government policies aimed at the industrialization of pharmaceuticals and the promotion of health among Korea’s elderly population were the source of the conflicts that escalated into a group of junior doctors leading to what could be considered a ‘rebellion’ against the community leaders.

The thesis investigates first the socio-economic and political backgrounds of the conflict. It proposes that elements of intra-and inter-professional politics and the aftermath of the country’s re-democratization, economic shock and demographic transition were all important factors. Second, it explores the nature of the rebellion itself by focusing on the emergence of a set of norms and values and on the ‘ritual-like’ interactions observed during the event. The analysis reveals that during the conflicts the actors referenced certain values and ideologies underpinning their everyday lives and, in doing so, were effectively engaged in the strengthening, rather than the weakening, of existing social structures.

This thesis contributes to the study of Korean medicine by revealing the features of its integration into the country’s healthcare system and the effects of its bio-medicalization. By describing the process by which new online-based agents of a social movement emerged, it also contributes to the study of hyper-connectivity in Korean society. Finally, the ethnography contributes to the anthropological study of East Asian medicine by illustrating the importance of institutional factors such as politics and the economy in capturing the modes of its contemporary presence.

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A List of Organizations and Institutions

AKOM (Daehanhanŭsahyŏphoe, The Association of Korean Medicine): the professional association for doctors of Korean medicine

Ch'amsillyŏn (Ch'amŭryosilch'ŏnyŏnhaphoe, The Association for True Healthcare): the young doctors' association in the Korean Medicine community formed in 2011

Ch'ŏnghan (Ch'ŏnyonhanŭsahoe, The Young Doctors' Association for True Healthcare): the association of doctors of Korean medicine who used to be actively involved in the country's pro-democratic social movements

Chŏnŭch'ong (Chŏngukŭsach'ongyŏnhap, The National Union of Medical Doctors): the young doctors' association in the Western medicine community formed in 2009

HIRA (Gŏng'angbohŏmsimsapyŏngg'awŏn, The Health Insurance Review and Assessment Agency): the quasi-state organization responsible for the assessment of reimbursement claims in national health insurance

KIOM (Hangukhanŭhakyonguwŏn, The Korea Institute of Oriental Medicine): the national research institute on Korean medicine

KMA (Daehanŭsahyŏphoe, The Korean Medical Association): the official organization for the doctors of Western medicine

MOHW (Bogŏnbokjibu, The Ministry of Health and Welfare): the Korean government ministry responsible for matters of health and welfare

NHIC (Gŏng'angbohŏmgongdan, The National Health Insurance Corporation): the quasi-state organization that is responsible for the management of financial and administrative aspects of national health insurance

NHI Committee (Gŏng'angbohŏmjŏngch'aeksimŭwiwŏnhoe, The National Health Insurance Policy Deliberation Committee): A supreme decision-making body regarding the issues of national health insurance

PNU (Pusandaehakgyo, Pusan National University): the national university located in Pusan, the country's second largest city located at the Southeastern tip of the Korean peninsula

A List of Key Terms and Abbreviations

CAM (complementary and alternative medicine): treatments and medical practices that have non-biomedical origins

Ch'ŏbyak: a type of *hanyak* dispensed, generally in the form of liquid extracts, in clinics of Korean medicine

CPG (clinical practice guidelines): a standardized manual for clinical practice that is developed by medical societies or governmental organizations

DRG (diagnosis related group)-based payment: a method of reimbursements used in national health insurance in which medical services are paid according to the diagnosis-based, pre-set fee schedule regardless of the frequency and nature of treatments offered to the patients

EAM (*tongyangŭhak*, East Asian medicine): an indigenous medicine popular in East Asia that has its origin in Chinese *Han* Dynasty (206 BCE-220 CE)

Hanyak: medicines used in Korean medicine

ICD (the international classification of diseases): the disease classification system developed by the World Health Organization

KCD (the Korean classification of diseases): the Korean version of ICD

KM (*hanŭhak*): Korean medicine

KMD (*hanŭsa*): doctors practicing Korean medicine

KOPG-OM (Korean out-patients group-Oriental Medicine): the outpatient classification system in Korean medicine used by HIRA

SPD (the separation of prescription and distribution of drugs): the legal institution where doctors and pharmacists have a division of labor in which doctors prescribe drugs and pharmacists dispense them to the patients

WM (*sŏyangŭhak*): Western medicine

WMD (*yangŭsa*): doctors practicing Western medicine

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Chapter I Introduction

1. Main Themes of the Thesis

This ethnography deals with a series of conflicts that occurred in a medical community in South Korea. It is an event where junior members of the community attempted to overthrow the leadership of their professional association. By exploring deeply the structural conditions behind the young doctors' discontent, this thesis provides a comprehensive picture of healthcare politics in contemporary South Korea. Through an extensive analysis of the nature of the conflict and its progression, as well as the patterns of the actors' behavior, this thesis also reveals how actors come to reenact, not destroy, existing social structures through their engagements in the conflict.

2. The Dual Medical License System

To understand Korean healthcare politics, a unique Korean system of medical licensing called the *dual healthcare or medical license system* (*ũryo yiwŏnhwajedo*) should be explained. It is one of South Korea's fundamental healthcare institutions under which the state recognizes *two mainstream medical doctors*, Doctors of Western Medicine (*yangŭsa*, WMD)¹ and Doctors of Korean Medicine (*hanŭsa*, KMD). While WMDs are similar to MDs in Western countries, KMDs are different from East Asian medical practitioners in

¹ The legal term for this profession, however, is 'Doctor of Medicine (ŭsa)'. To avoid confusion, I will use the WMD throughout to designate this profession.

Western countries as they are closer, identity-wise, to conventional MDs than to other alternative medical practitioners. The only exception to this pattern is American Doctors of Osteopathic Medicine (DO) whose identity is also more similar to that of MDs than to alternative medical practitioners.²

Under the dual medical license system, WMDs are not allowed to engage in *therapeutic* Korean Medicine (KM) practices originating from East Asian medicine (EAM) that utilize, for example, acupuncture. Also, KMDs who are legally qualified to practice Korean Medicine under the system are not allowed to engage in *therapeutic* Western Medicine (WM) practices such as surgery. However, KMDs are given liberal access to WM diagnostics. Although WMDs significantly outnumber KMDs at the ratio of four to one, KMDs and WMDs enjoy the same socio-economic and legal status.

3. Fieldwork

Fieldwork was conducted in South Korea, from February 2012 to January 2013, in a community of doctors of Korean Medicine. I gained access to this community by working as a full-time health policy researcher in the Korean Medicine Policy Research Unit at the Pusan National University School of Korean Medicine. Over the course of one year, I participated in various national-level policy projects. Also at the School of Korean Medicine, I worked as an adjunct lecturer, through which I gained additional insights. As a KMD myself with a successful clinical career, I have extensive connections in the Korean

² The process of professionalization of KMDs and American DOs is very similar. What distinguishes Korean Medicine from US osteopathy is that Korean Medicine is more socially, culturally and institutionally integrated into the country's health system than US osteopathy. Clinically, however, osteopathy has been much more deeply integrated into the biomedical framework than has Korean Medicine.

Medicine community, and it provided me with further access to group events and meetings. The KMDs' digital communities to which I had full access also offered key insights.

4. Methodology

4.1 The Bridge Method

As a central methodology of this thesis, I employed what is called 'the Extended Case Method'. It is an analytical framework that was proposed by Max Gluckman (1961:16) who stated that 'one good case can illuminate the working of *a social system* in a way that a series of morphological statements cannot achieve'. Scholars in the Manchester School³ called this case-based ethnographic approach 'the Bridge Method'. It is referred to as 'the Bridge method' because Gluckman (1958) utilized the descriptions of a series of events leading to a bridge opening as an analytical platform to identify the structural conditions underpinning the workings of the South African society in the 1930s.

I employ Gluckman's method firstly to explore healthcare politics in contemporary South Korea, and secondly to investigate its social structure, or the norms and values underpinning everyday lives. The analytical platform of my ethnography, or the 'Bridge', is an intergenerational conflict that broke out in the Korean Medicine community. This

³ According to Evens and Helman (2006a, IX), the 'Manchester School' initiated the third major anthropological innovation in the modern development of British social anthropology after the initial innovations by Malinowski (methodology) and Radcliffe-Brown (theory). The authors state that the scholars belonging to this tradition did not lose sight of 'the complexities of social life through time' while 'recognizing the importance of theorizing them' at the same time. The school was named after Manchester University in which Max Gluckman worked for most of his life.

conflict, which resulted from contrasting opinions on governmental policies, serves as 'a good case' to illuminate the workings of 'a social system' and its expression in contemporary Korea. The utility of this case stems from the fact that the conflict involved, either directly or indirectly, most of the country's major healthcare actors and stakeholders, such as the state, the public, doctors and public professionals.

Conflicts emerge when the existing system does not function. As a result, they provide valuable opportunities to study societal changes. As Victor Turner (1996, 91,162) asserted, 'norms are frequently breached' in conflict situations, and depending upon the extent to which this breach is manifested, these situations would often become 'an index or vehicle of change'. This means that through the investigation of the 'changes' that occur in the wake of conflicts, the nature of the conflicts could be ascertained. This organic relation existing between conflict and social change is one of the themes that I explore through my ethnographic analysis.

4.2 Data Sources and Triangulation

Data from various sources were used in this ethnography. Policy-related meetings where I regularly encountered AKOM directors and government officials were an important source of information. During these meetings, I was able to observe various features of the country's healthcare provision at close quarters. They also provided me with good opportunities where I could look at the reactions of the AKOM directors and state officials to the conflict in the KM community. In addition, I was also able to obtain a significant amount of data by carrying out participant observation at various academic

and the community-wide activities. In order to get insider information such as the organizational details of Ch'amsillyŏn or Ch'ŏngha, the two organizations which directly opposed to each other, I had sometimes to rely on personal contacts whom I had known before during my clinical career.

Much information was also obtained from Korean Medicine online communities such as Swimtŏ, Facebook Hanŭsadang and AKOM. Swimtŏ where the young doctors openly, often in real-time, discussed their actions was a particularly useful source of information. Facebook Hanŭsadang was also a good venue for me to observe the general opinions of those who did not pledge themselves to either of the conflicting parties. In later stages of the campaign, however, the AKOM homepage became an important source of information as it came to function as the biggest battle field.

As the strength of the argument presented in the thesis will be ultimately dependent upon the validity of my account of the three-month long conflict itself, much attention has been given to secure its integrity, both during the fieldwork and in the writing-up stage. The 'intentional anonymity' and secrecy that was sustained throughout the conflict and associated campaign made my investigation truly challenging. However, thanks to the multiple sources I had access to, I could ensure the quality of my research by utilizing various ethnographic methods such as interviews, participant-observation and document review. To enhance the integrity of the data gathered in the online communities, I also used the method of 'triangulation' (Kilker and Kleinman 1997, 79).

I adopted 'triangulation' in two major ways. Firstly, I triangulated the data gathered from the online communities with what I observed in offline encounters. Many key figures of the conflict, for example, not only were my informants in real-life encounters but also

they were participants in online communities. Secondly, I triangulated the data across the three KM online communities, or performed 'context triangulation' (Kilker and Kleinman 1997, 79). By comparing three online communities, I could eventually index user cultures characterizing each community, and cross-examine the data gathered in one online community in the light of practices and norms characterizing other online communities.

5. The Event

A series of inter-generational conflicts occurred in the Korean Medicine community, lasting about three months from early September to late November, 2012. Sparks for this conflict were created in a dispute between a group of young doctors and executive directors of the Association of Korean Medicine (AKOM), the professional organization representing the KM community. This dispute was over how the community should respond to a series of approvals by the Ministry of Health and Welfare for a new class of Western Medicine drugs called 'natural substance novel drugs (*ch'önyönmulshinyak*)' or botanical drugs.

The young doctors argued for an anti-state stance as they thought that the state was taking away their professional rights by classifying these drugs as Western Medicine drugs, while in fact they were *hanyak*, or traditional East Asian medicine prescriptions, which they believed should be solely under KMDs' control under the dual medical license system. The AKOM executives, however, trivialized the young doctors' concerns and continued to 'work with' the state as they believed doing so would accelerate Korean

Medicine's integration into the country's healthcare system for the benefit of the community.

As neither side compromised, their differences soon escalated into a major confrontation which developed into a full-scale rebellion by the young doctors. The young doctors mobilized supporters aggressively in online communities to compensate for their weak political power. They started to pressurize the senior members of the community. Furthermore, while calling for the resignation of the President of the AKOM, they requested the complete reform of its bureaucratic structure, claiming that the establishment was obstructing the profession's future through its authoritarianism, socialism, incompetency and lack of loyalty to *authentic* Korean Medicine. In an action they proudly termed '*the KM community's Jasmine Revolution (hanŭgyeŭ jasmin hyŏkmyŏng)*', the young doctors even broke into the AKOM headquarters and occupied them for several days. This action aimed to demonstrate the young doctors' collective strength and to show their determination to bring 'revolutionary changes' into the community.

Despite their continued pressure, however, the young doctors failed repeatedly to get the resignation of the AKOM president. Even through a face-to-face encounter in which the young doctors showed complete dominance over the president, they still could not force his resignation. After a formal AKOM meeting that occurred at the end of November, however, the young doctors' campaign suddenly lost its momentum. No substantial ground was laid for the significant reforms that the young doctors had envisaged, and the campaign ended soon after and the quick normalization of the KM community followed.

In the sections below, I will break down the event into four distinctive stages and describe each in more detail.

5.1 Contestation and Mobilization

Contestation began between a young doctors' organization called Ch'amsillyŏn and the AKOM executive members over how the KM community should react to the Ministry of Health and Welfare (MOHW)'s classification of botanical drugs as Western medicine drugs. These drugs had also been given the status of a 'novel drug' by the Korean Food and Drug Administration (KFDA) to incentivise pharmaceutical companies to develop them. Many of these drugs, however, originated from traditional East Asian medical formulas and had been developed in collaboration with KMD researchers.

The Ch'amsillyŏn requested the AKOM to protest against the pharmaceutical policy and to try to reinstate the prescriptive rights to those drugs to KMDs as specified under the dual medical license system. They claimed that the state was unjustly favouring WMDs and the pharmaceutical industry, and called for an immediate community-wide action that would target the stripping of the WMD's prescriptive rights and a revision of the pharmaceutical law. The young doctors argued that unless the community rectified this situation of injustice, the profession would become extinct after surrendering all of its professional rights to others.

Reactions from the AKOM executives, however, were lukewarm as they thought that the best way to secure their professional interests was to collaborate with the state. They said that it was a perfect time for the KM community to 'negotiate' with the state as

WMDs, the KMDs' main opponents, were absent in the negotiating scene following their clash with the MOHW the previous year. The AKOM executives believed that their chances of influencing the governmental health policies so that the KMDs' rights could expand were higher than ever before.

The young doctors, however, failed to change the AKOM's official policy stance despite their repeated attempts, and it magnified their frustration. They began to get actively engaged with online KM communities in order to expand their support base. Before long, the efforts paid dividends as the young doctors were able to mobilize 'ordinary members (*pyŏnghoewŏn*)', around their pledged loyalty to 'authentic Korean Medicine', openly against the 'incapable, authoritarian and half-baked socialist (*munŭnghago gwŏnwijŏkigo ōsŏlp'un sahoejuŭja*)' AKOM leaders.

5.2 Attacks on Social Hierarchy

The young doctors' movement soon turned into a full blown anti-establishment action in which they came to ask for the overhaul of the entire bureaucratic structure of the community. The young doctors soon realized, however, that without squarely facing the age-based social hierarchy, the establishment's biggest bulwark, their campaign would have no future. The young doctors decided to turn the central Confucian value of the age-based social ordering on its head by adopting another Confucian value of 'meritocracy', namely the prioritisation of one's educational attainment. Through campaigns of blame, the young doctors started to criticize their seniors by stating that

with better educational credentials, they were more eligible members of the community to lead the community than the seniors.

The young doctors' verbal abuse included their university professors whom the young doctors branded as 'turncoats (*baesinja*)' in reference to their collaboration with botanical drug developments and their lack of regard for the purist form of Korean Medicine. The extent to which the young doctors defied linguistic convention in doing so, even towards their teachers, the most revered profession in the Confucian social worlds, was conspicuous. Though softened to an extent, the social etiquette had been relatively well kept in the online communities where all the users were confirmed members of the KM community.

Emotions intensified and as if in a state free of constraints, the rebellious doctors soon persecuted anyone challenging them with violent abusive language as if they wished to introduce an atmosphere of 'terror'.

5.3 Occupation of the AKOM Headquarters

With the successful mobilization of online-communities, in addition to confidence gained from such 'offline' activities as collective protests, negative public-relation actions against AKOM and the manipulation of the electoral processes, the young doctors felt greatly empowered. At this time, the government added fuel to the already fiery situations by announcing a plan to expand national health insurance (NHI) coverage in elderly care through the inclusion of *ch'öbyak*, the EAM formula-based *hanyak*

prescriptions,⁴ in the NHI reimbursement scheme. Though its role was compared to some decades earlier, *ch'öbyak* still played some roles in the economy of KM clinics.

For the young doctors, the AKOM's public endorsement of this governmental policy concerning the elderly turned out to be the last straw. Demanding the immediate scrapping of the plan, they occupied the AKOM headquarters to express their wish to end the AKOM's 'authoritarianism' (*gwönwijuŭ*), or to prevent 'further havoc to be wreaked by its incapacity', and called their action 'the KM community's Jasmine Revolution (*hanŭgyeŭ jasmin hyökmŏng*)'. The young doctors claimed that the AKOM leaders had no intention of protecting their livelihood and preserve 'authentic Korean Medicine' by acquiescing to the scheme that would eventually put every source of their income under state control.

5.4 Face-to- Face Encounter and the Ending

Despite this, however, the young doctors could not still obtain the resignation of the AKOM president, the symbol of the old order. The establishment was rather resilient, reflecting its position of influence in the nation's health care governance wherein the state delegates most of its policymaking responsibilities to medical associations. This meant the young doctors were not just fighting against the establishment of their own community but also against one that was intricately linked with state power.

A few days after the occupation, another chance came for the young doctors to mount an assault on the establishment when a meeting was held to discuss the inclusion

⁴ See Table V-4 and Picture III-10 for pictures of *ch'öbyak*.

of *ch'ōbyak* in NHI. This time they were determined to get resignations from AKOM leaders. Forcing resignations, particularly from the AKOM president, was the central objective around which the young doctors had been organizing their entire campaign. In a situation where the remaining terms of the president and the executives had been about to finish anyway, it served to legitimize their 'revolutionary' motives. Utilizing real-time smartphone connections to their fullest, the young doctors kept the AKOM executives hostage. A radical young doctor even performed pseudo-ideological assessments on them. Verbal abuses that appeared earlier in online communities came into the offline world, while a high level of harassment was also inflicted on the AKOM leaders, particularly on the AKOM president. However, the young doctors still could not force the resignation of the president.

Then in mid-November, an AKOM councillors' meeting occurred where a measure allowing for the direct AKOM presidential election was passed along with other measures that could placate the young doctors to some degree. At this point, a serious loss of momentum started to occur in the young doctors' campaign, although no foundations were laid for the 'radical changes' in the social and political structure of the community. The 'revolutionary' fervour fizzled out quickly and the KM community quickly returned to normality as if nothing had happened in the past three months.

6. Structural Conditions

According to what was at stake in the event, I explore in later parts of the thesis the various structural conditions behind the young doctors' unusually vitriolic campaign against their own professional association. I divided a constellation of conditions into two categories, namely the professional and the politico-economic.

In terms of professional conditions, I explore the background of the 'discursive divide' that was manifested in the event, and attempt to contextualize it within the country's intra-and inter-professional healthcare politics that is largely underpinned by the dual medical license system. Emphasis is placed particularly on *the KM community's relationship with the WM community*. With regards to politico-economic conditions, I explore a group of factors that might have affected the economic livelihood of the junior doctors. The factors explored range from changes in business environments affecting the economy of the KM community to changes in political circumstances that affected the economy of the country's medical communities in general. In analysing the political economy behind healthcare provision, I particularly focus on *the state-doctor relationship*.

6.1. The Professional Conditions

In the rebellion, the young doctors resorted to 'fundamentalist' ideology as manifested in their professed allegiance to 'authentic Korean Medicine' while the senior leaders of the community have shown a strong 'integrationist' stance. In an institutional context, the source of this 'discursive divide' can be found in the country's dual medical license system, a system under which KMDs are expected to carry out biomedicine-based

healthcare duties in diagnosis and in public health, while they practice a medicine different from Western Medicine. The uncertainty around the KMDs' role in the nation's healthcare further complicated conceptualizations of KMDs' professional identity both by KMDs and by other healthcare stakeholders.

In the language of the KM school curriculum, the ideological division within the community could be summarized as the division between 'classics and science'. The classics-based thinking represented by the young doctors' fundamentalist orientation prioritizes the discipline's emphasis on theories and concepts of East Asian medicine that are described in classical medical texts. The ultimate aim of this camp within the community is *to pursue the 'authentic and untainted practices of East Asian Medicine'* which are believed to be the key identity-markers of the profession. In economic terms, this classics-based thinking has a strong correlation with the espousal of the *hanyak*-based model for KM clinic business.

The 'science'-based thinking, in contrast, prioritizes the community's proactive involvement with 'scientific' or biomedical practices, so that *the territory of the KM practice could be broadened*. This priority was exemplified during the conflict through the AKOM executives' efforts to expand KMDs' rights to modern biomedical technologies. The 'integrationist' camp has been empowered by the state's increasing investments in the field of Korean Medicine. Although a large part of this investment has been aimed at pharmaceutical industrialization, it also led to the growth of scientific activities in the community.

My analysis of the professional conditions underpinning the conflict also involves looking at the wider inter-professional healthcare politics, or how the issues within the

KM community are affected by external forces, such as the WM community. By exploring WMDs' challenges to the KM community in particular, I attempt to contextualize the intra-professional division in the KM community within the wider inter-professional political landscape. I highlight elements of WMDs' challenges in which WMDs subtly yet systematically carried out interventions that negatively impacted on KMDs in general and the young KMDs' aspirations in particular.

Although an intra-professional schism was entrenched in the community and inter-professional politics such as the WMD's challenges affected the young doctors' subjectivity and conditions substantially, it is important to recognize that the conflict could not be entirely characterized in terms of intra or inter-professional struggles. Firstly, not all young doctors shared a fundamentalist orientation and divergent opinions were often held among them. Secondly, in the course of the rebellion, the hardliner WMDs actually endorsed the young KMDs' action and even indicated to the KMDs the possibility of a solidarity front against the government, which they believed was exploiting the labour of all the country's private medical providers.

6.2. The Politico-Economic Conditions

In addition to exploring the professional conditions behind the conflict, it is necessary to investigate the *political conditions* shaping it. Political conditions have an impact on the economy of the country's medical communities. The main element constituting these political conditions is the strained relationship forged between the state and doctors in which the power balance between these two actors has been

radically changed in the past several decades due to the expansion of National Health Insurance.

I explore, firstly, the generation- and profession-specific economic conditions affecting the young doctors in the KM community. Although the young doctors' grievances started from worries about their economic conditions, the investigation reveals that their economic livelihood is still relatively bright. The young doctors earn substantially more than graduates of prestigious universities in Seoul. And the positions of the schools of Korean Medicine in university-entrance league tables were still solid, although some drop occurred in comparison with the period when they entered college. The changes in market environments related with KM clinics, however, turned out to have some negative effects on the young doctors' long-term prospect of achieving affluence. The stagnation found in the careers of specialist license holders also provides them with some causes for concern.

These factors were not, however, sufficient to prompt the violent uprising of the young doctors who were mostly employed at primary care-level clinics. What, then, were the factors that triggered the young doctors' anger?

As mentioned, the state's interference in the doctors' practice has increased substantially over the past several decades, and the recent anti-state actions by the medical communities showed that the doctors were not happy about the state's control. Simply put, the young doctors' rebellion could be read as an anti-state statement from young doctors expressing their grudges against the state's interference into the practice of the country's private medical service providers.

On the part of the state, however, the interference is justified as the state needs to constantly address the rising healthcare expenditure in NHI. This need is felt strongly due to such factors as the country's sluggish economic growth, the financial shock of the IMF crisis in the late 1990s and the country's demographic transition characterized by the aging population. The unexpected increase in drug expenses in NHI expenditure also increased the need to control rising healthcare expenditure through measures aimed at controlling the doctors' clinical practice.

To achieve this objective, the Korean state applies political pressures on the doctors in the session of the National Health Insurance Policy Deliberation Committee where important decisions are made. The Korean state fully utilizes, to rein in the doctors, the moral high ground it assumes since the country's re-democratization in late 1980s, benefiting from having the support of civil society. The doctors, on the other hand, attempt to resist the state's pressures through collective action. The actions carried out by both medical communities in which young doctors rose against the leaders of professional associations criticizing their pro-state stance, testifies to the presence of the strained relationship that has developed between the state and the country's private practitioners.

7. Anthropological Reflections

The event can be defined, first and foremost, as a conflict. It is an inter-generational conflict while it is also a status-based one as the young doctors revolted with the consciousness of their 'inferior statuses' in an age-based social hierarchy dominating the

community. At the same time, it was a conflict between Western and Eastern medicine. Notably, a dispute of this scale no longer occurs in the contemporary world except in South Korea. It was also a conflict between the state and doctors as the conflict was motivated by the young KMDs' grudge against the state's actions affecting them.

The event was not a 'revolution' as the young doctors liked to term it as ultimately no major changes occurred in the social structure of the community. It was an act of 'rebellion'. It means that despite intentions for 'radical changes', the essential nature of the event was *conservative* as it led to 'corrective' changes in the system, such as amending organizational weaknesses present in the professional association, rather than its destruction. Through the process of the rebellion, the existing social structure came to be solidified and reinforced.

This is where an anthropological interpretation of the event as 'rituals of rebellion' (Gluckman 1954; 1955) is relevant. This theory proposes that rebellions have the function of stabilizing the society by creating opportunities among its members to channel their discontents positively for the benefits of the community. Indeed, throughout the course of the young doctors' rebellion, ritualistic interactions were observed among most actors involved, not least among the junior and senior members of the community.

Focusing on the 'ritualistic' aspect of the event then opens up additional possibilities for anthropological interpretations. Firstly, the conflict period can be conceptualized as a 'liminal period' in which hidden social norms and values appear and the everyday social structure does not function (Turner 1969). Such liminal-period attributes such as acts of status reversal, the presence of an ideational sense of 'togetherness', and clashes between values governing the actors' lives all appeared during

the three month-long event. Particularly, the emergence of the conflict between the Confucian norm of gerontocracy and the principles of democracy, and of the actors' positive assessment of the norms of nationalism was conspicuous. In other words, it was a period when these norms were made visible for all the community members to see so that they could reassess or reaffirm them in light of their specific social, political and economic conditions.

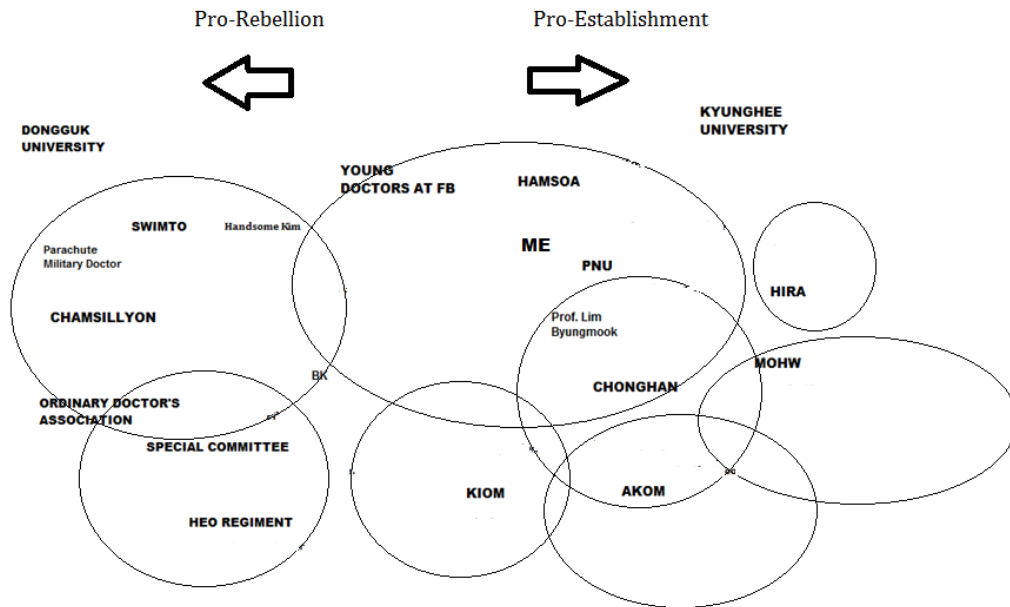
Secondly, patterns of ritualistic interaction observed between the junior and senior members of the KM community suggest that the rebellion could be interpreted as an exercise aimed at collective-identity building. In other words, the conflict might have operated as 'social glue' that actually improves the social bonding among the members of the community, rather than weakening it. By taking part in shared experiences of strong emotional intensity through which the enmeshing of personal and social identities commonly occurs, the event may have worked to facilitate the formation of a strong group identity which will eventually help the community out-compete its rivals (Whitehouse 2004; Swann et al. 2009; Whitehouse 2012; Whitehouse and Lanman 2014). This interpretation is particularly relevant in the analysis of Korean healthcare politics that is characterized by frequent conflicts and collective actions.

8. Positionality and Ethics

8.1 Positionality

Some words on positionality are necessary before I finish this introduction. In an article titled 'Suffering and its professional transformation', Kleinman et.al (1996, 170) argued that one way that anthropological analysis can overcome the 'risk of de-legitimizing their subject matter's human conditions' or of 'being experience-distant', is to open the central enquiry with the question '*what is at stake?*'. This notion is particularly relevant here because not only the actors discussed in the ethnography, but *I also had things at stake*. As a Korean, I shared with the actors a nationalistic sentiment in that I valued my own cultural and historical heritage. As a KMD, I shared with the young doctors the hope for the advancement of the profession and grudges towards the WM community. At the same time, I sympathized with the AKOM directors because I was part of the establishment of the community by virtue of being senior in age, having lectured in a KM school, and having had a successful clinical career during which I employed many junior doctors (see Figure I-1).

Figure I-1 A Map of Relations in the Field



As an anthropologist researching his own community, reconciling these various positionalities with my research objective was the hard methodological problem that I had to continuously address both in the field and during the writing-up period. In the initial stage of the fieldwork, I tried to solve this issue by identifying through the young doctors, or by fully empathizing with them via an ‘intense kind of identification that does not allow for any separation’ (Hage 2009, 71).⁵ I believed it was the only way I could reconcile my contrasting sentiments toward them as I found myself often strongly disliking the actions of the young doctors and their ‘unfair’ treatment of the older generation while I also shared some of their progressive ideals expressed during the campaign.

⁵ Gassan Hage distinguishes ‘identity with’ from ‘identity through’, the latter being a more intense than the former.

As the fieldwork continued, however, I realized that this way of engaging with my informants posed risks to my research, particularly when the confrontation between the generations became intense and violent. And as my understanding of the conflicts deepened, I discovered that my liminal presence in the field neither entitled nor empowered me to affect, in any meaningful way, the actors as well as the country's healthcare politics. This realization reduced moral burdens I was feeling toward my informants to a certain extent, and subsequently made my fieldwork objectives clearer. I could then concentrate on 'listening to what is unsaid' (Dresch 2000, 122) amidst the sound and fury the young doctors' rebellion was creating around me.

In the writing-up stage, I attempted to create a 'reflective distance' from my field material as much as possible. When analysing the data, I constantly worked to understand how my background and positionality influenced my interpretation or description of events. Although I monitored the situations in the KM community regularly after I came back from the field, I tried to reduce my contacts with the informants as much as possible. In presenting my research materials to academic audience, I also tried to contextualize my understanding of those materials in the process. In other words, by exposing myself to the situations that is alien to the environments into which my informants and I had been entrenched in the field, I attempted to create my 'self-contemplation' on the situations I was analysing so that the reflexive interplay between mine and those of my informants could lead to the creation of the 'final ethnography' (Goodman 2000, 163).

8.2 Research Ethics

Before I embarked on the fieldwork, my proposal for doctoral research successfully passed the Oxford University's Central University Research Ethics Committee (CUREC), a university-wide ethical clearance scheme that is applied to all research involving human subjects. Before fieldwork, I contacted my potential field sites with clear explanations of my research objectives. During fieldwork, I attempted to gain informed consent before every formal interview and participant observation. In situations where gaining consent was challenging, as during policy-making activities where doing so could risk hampering the flow of things, I used common sense approaches such as distributing my university name card at the beginning of meetings with a brief explanation of my research. When occasions arose, I did my best to make my objectives clear to those around me. For those belonging to the KM community, gaining consent was less challenging, partly because many already had been informed of my research either directly by me or indirectly through several news articles published in the community-wide newspapers on my research activities.

As for the materials gathered in online communities, I used only those for analysis that are academic in nature or those that are critical to my arguments. As many of these materials were written anonymously, getting informed consent from the authors of those statements was not only difficult considering the large number of posts uploaded daily,⁶ but also deemed inappropriate because many of them chose to hide their identities when they wrote them. But I did retain the original usernames of many of the authors of the online posts because those usernames were, so to speak, in the public domain due to the

⁶ Particularly at Swimtö, close to 1,500 to 2,000 posts are uploaded every day.

active roles of those authors in the ‘rebellion’. I feel that keeping them as they are represents the reality of their online presence more faithfully than anonymising them. All the policy documents mentioned are published reports that are available to the public on request.

For ‘offline’ informants, I used pseudonyms when necessary, although I left some names, such as the presidents of public organizations such as that of AKOM, Ch’amsillyŏn and Chŏnŭch’ong, as they are because their activities were in the public domain. I also used real names for those who consented to appear that way in the thesis.

9. Transcriptions for Korean and Classical Chinese

Following academic conventions in Korea-related studies, I have used the McCune-Reischauer Romanization system for the transcription of Korean words. As people’s surnames come first in the Korean custom, I have used surnames first for designation. However, for those figures whose names appeared frequently in the English-based literature, I have used the known forms of designation.

For the sake of clarity, I have used translated English words mainly and put the Romanized Korean words in parenthesis. However, I used important Korean words such as *hanyak* in Romanized form without English translation. As for Koreanized classical Chinese characters, or *hanja*, I have tried not to use them in the main text unless their parallel transcription is absolutely necessary. As for classical Chinese words used in Japan and in China, I have transcribed the words using the local forms of pronunciations. In the

Appendix, I have collated all the linguistic elements including the original Chinese characters of the words mentioned in the text.

In most quoted statements and sentences, italics and emphasis were added by me, unless specified otherwise. Generally, I used () in places where I inserted classical Chinese characters or Romanized Korean for additional information, although in some cases, () was in the original sentences. I used [] when I needed to put some additional words or phrases into the sentences to clarify meanings.

Chapter II Korean Medicine: an Overview⁷

1. Introduction

In this chapter, I aim to present the widest possible overview of Korean Medicine to enable readers to understand the various situations that will be investigated in later chapters of this thesis. I will discuss its history from pre-modern times to the post-Korean War period developments before I explore the institutional, clinical and sociological features of contemporary Korean Medicine in detail.

1.1 The Distinction between Korean Medicine and East Asian medicine

First and foremost, it is important to note that I am distinguishing ‘Korean Medicine’ from ‘traditional East Asian Medicine in Korea’ in this thesis.⁸ Thus, henceforth, I will use the term ‘doctors of Korean Medicine’,⁹ not ‘doctors of traditional East Asian medicine’ nor ‘traditional East Asian medical practitioners’. These are crucial distinctions to be made because, despite the seeming overlap between traditional East Asian Medicine and Korean Medicine, particularly in the realm of therapeutics, Korean Medicine is not traditional East Asian Medicine, nor its extension. While I give an overview of Korean

⁷ Many parts of this chapter contain contents contained in my previous publication “East Asian Medicine in South Korea.” *Harvard Asia Quarterly* 14 (4): 44–56 (2012). However, the arguments presented here are based upon much richer fieldwork and historical data than those included in my published article.

⁸ Though the terms ‘Korean Medicine’ and ‘East Asian Medicine’ were used interchangeably in my HAQ article, the two terms are separated in this thesis. The published article, however, also subtly conveys the idea that Korean Medicine is different from East Asian medicine *per se*, despite its title. That distinction is made more explicit here. I will also use the term East Asian Medicine, or EAM as an acronym, where relevant, to refer to traditional East Asian medicine.

⁹ I will mainly use, throughout the thesis, the acronym ‘KMD’ to designate Doctors of Korean Medicine, and use ‘WMD’ to refer to Doctors of Western Medicine.

Medicine in this chapter, I will also make this point explicit in the course of my arguments. And that is actually where my account of Korean Medicine diverges from the accounts presented by previous scholars (Hyo-je Cho 1999; Hyunji Lee 2000; Baker 2003; Jongyoung Kim 2005; B.-H. Cho 2009; Taewoo Kim 2011) who assumed Korean Medicine and traditional East Asian Medicine essentially to be the same thing.

The root of Korean Medicine is undeniably traditional East Asian Medicine. And many ‘therapeutic’ modalities of Korean Medicine are indeed the kinds of therapy that typically characterize traditional East Asian medical practice which includes acupuncture (*ch’im*), cauterization (*gu*) and herbal medicines (*hanyak*). Even terms used by doctors of Korean Medicine are exactly the same as those used in traditional East Asian medical practices such as qi (*gi*), blood (*hyŏl*), yin (*ŭm*), yang (*yang*), and meridians (*gyŏngrak*).

What are the elements then that differentiate Korean Medicine from traditional East Asian medicine? I argue that it is *everything except the therapeutic modalities symbolic of traditional East Asian medical practices that are currently utilized in clinics of Korean Medicine*. In this chapter, I will show the readers how Korean Medicine has been intensely ‘*bio-medicalized*’ over the past sixty years such that contemporary Korean Medicine has come to have more similarity than difference with Western Medicine. In other words, I will argue through various ethnographic data that Korean Medicine could no longer be considered as ‘an extension of East Asian Medicine’ due to its deep social and institutional integration into the country’s mainstream healthcare system which transformed it into something that is closer to biomedicine in nature than to the medicine of its origin.

Logically, this argument leads to another central argument of this chapter, which is that practitioners of Korean Medicine are ‘bio-medicalized’ professionals. It is important to understand their identity and role as they are the main actors of the situations to be described in the thesis. The main point of my arguments, as mentioned, is that Korean Medicine’s professionalization process over six decades during which it had been enjoying the status of mainstream medicine has exerted a unidirectional pressure on its practitioners, and has provided them with institutional and social legitimacy, and has enabled them to be fully integrated into the country’s biomedicine-based healthcare system. I will follow this argument up with detailed explanations in later sections of this chapter. It is important to note at this juncture, however, that this process of professionalization also took place under the country’s unusual legal framework of healthcare where practices of Korean and Western Medicine have been ‘legally defined’ on a separatist basis, though in reality, the boundary between professional territories has never been clear-cut, and is increasingly blurred.

In this introduction, I will firstly describe briefly how my views on Korean Medicine and its practitioners diverge from those of previous scholars. Then, I will present some critical reviews of their works in the next section.

1.1.1 The Practice: Similarity in Names but Are They the Same Thing?

Although some terms and concepts are used in both practices of Korean Medicine and in East Asian medical practices, it is important to understand that they might mean entirely different things. As mentioned, it is mainly because the nomenclature in Korean Medicine is as much *a legal construct* as a clinical or epistemological endeavor.

In Korean Medicine, there is a therapy called *Ch'una* which is a legally defined Korean Medicine therapy which due to its name would remind us of the traditional East Asian manual therapy of *Tuina*. The *Ch'una* therapy, however, was developed more on the basis of American chiropractic and osteopathic medicine than traditional East Asian manual therapies despite their namesake similarity. KMDs simply gave it a similar name in order to legally 'own' this new Complementary and Alternative (CAM) therapy that has been increasingly popular in the West.¹⁰

It is the same with the *Jangbuhyŏngsang* diagnostic technique used by KMDs wherein they employ the diagnostic ultrasonography. Again, despite its namesake similarity with the East Asian medical principle of *Zang Xiang*, a EAM concept that designates the correspondence or consonance existing between internal organs and the outer surface of the body (Porkert 1974, 107–114), it is not hard to determine that these two diagnostic techniques are based upon entirely different set of perspectives and knowledge so that in real terms, it is not an exaggeration to say that they have no similarity whatsoever.

There is another therapy called *Ch'imdoyobbŏp* that is gaining popularity among KMDs, and despite its name signifying a connection to acupuncture (*ch'im*), it is actually a minor surgery that is being conducted by the practitioners with the help of extensive MRI and CT scans on the conditions of the patients' vertebral column. KMDs simply use the word '*ch'im*' to show that it is part of the acupuncture therapies that belong in their professional territory.

¹⁰ See Picture II-12.

Assuming Korean Medicine is an extension of East Asian medicine simply on the basis of these similarities of terms presents the risk not only of misrepresenting Korean Medicine, but also of ‘buying into’ the discourse of medical professions aimed at guarding their own professional interests.

1.1.2 The Sociological Dimension: The ‘Bio-Medicalized’ Profession

In explicating sociological features related with Korean Medicine, we also need to demarcate between Korean Medicine and traditional East Asian medicine. As I argue throughout this thesis, unless we break away from the habit of employing the perspectives applied in the study of traditional East Asian medical practitioners in the study on KMDs, we would not be able to grasp the role the KMDs play in healthcare provision in contemporary South Korea, and in the political dynamics among various healthcare stakeholders of the country.

Chapter III, for example, describes how young doctors in the Korean Medicine community vehemently opposed the governmental plan to include *hanyak*, or herbal decoctions, into the national health insurance. We will also see, near the end of Chapter V, WMDs’ implicit call for solidarity directed at the KM community to form a united front against the state. If KMDs are indeed conceptualized as practitioners of ‘traditional medicine’, we will not be able to fully understand, for example, the situation where the supposedly ‘weaker’ and ‘marginalized’ practitioners of traditional medicine were mobilizing their forces to actively thwart a governmental policy initiative to integrate their ‘traditional medical’ practice into the state-run national health insurance.

In the same vein, how one could understand the situation where all-powerful elitist WMDs have troubled themselves to issue a public statement endorsing 'traditional practitioners' with language indicating their inter-professional solidarity on the assumption of equal status? And most important of all, why is it that the Korean Medicine community has been opposing, for most of post-Korean war history, the pressure from the Western Medicine community to unify the medical licenses, which essentially means allowing 'traditional practitioners' to become WMDs?

If we stick to the formula of equating Korean Medicine with traditional East Asian medicine, these all become 'puzzles' to which only partial and elusive answers could be given. However, once we break away from the equation and begin to accept that we find 'medical practitioners' or 'medical doctors' in KMDs, and '(bio) medicine' in Korean Medicine, these no longer become puzzles but incidences of social phenomena that no longer surprise us because these are the events that occur to medical professions and (bio) medicine in any part of the world where there exist medical professions.

1.2 Critical Literature Review

Due to this narrow methodological framework adopted by prior scholars, existing research has been limited in scope and partial. I will critically review six prior works on Korean Medicine below.

The central research question Hyoje Cho (1999) put forth in his seminal work on Korean Medicine *The Quest for Professional Status: a Social and Sociological Study of Korean Traditional Medicine in the 20th Century* was how these 'traditional practitioners'

have gained professional recognition in the nation's healthcare system. At the outset, he defines practitioners of Korean Medicine as 'traditional practitioners', complicating the otherwise shrewd sociological analysis of the professionalization process of Korean Medicine. His provisional answer to what he implied to be *an unusual ascent of Korean Medicine* is the KMDs' wise use of a 'legalist strategy' which allowed them to use the legal apparatus to their advantage.

His work was limited by the fact that it created a dichotomy between the modern, subjugating, and powerful Western Medicine, and the traditional, subjugated, and weak non-biomedicine. Thus he was not able to provide convincing explanations as to why KMDs alone, not even powerful Korean pharmacists, were eventually able to attain the status. I think he failed to give notice to other wider, potentially more important, *structural factors* that underpinned the professionalization of Korean Medicine by focusing on those formalized distinctions between the Western and other medicines. The consideration of these factors could have equipped him with a better informed analytical position with which he could have viewed the professionalization of Korean Medicine in the context of the overall development of the country's healthcare system in modern times.

Jongyoung Kim (2005) also tried to tackle the issue in similar vein in his doctoral thesis *Hybrid Modernity: the Scientific Construction of Korean Medicine in a Global Age*. In this work, he focused more on the novel ways in which enterprising KM clinicians actively forge connections with the scientific community with the aim of targeting the global market with their cosmetic products. It is an interesting case of 'alternative modernity' for him as 'traditional medicine' is seen there to have successfully

transformed itself into a form that defies the pre-destined path of modernity. Within the frame of his conceptualization where Korean Medicine is equated with traditional East Asian medicine, it is indeed 'unusual' to see how 'traditional doctors' garner a significant amount of social and economic capital, and concoct an active global commercial agenda from it. However, his way of framing the 'puzzle' and the partial answers coming from the investigation do not provide us with enough sense as to how Korean Medicine as a whole operates in contemporary South Korea. It seems that there are too many stones unturned to reveal the full sociological landscape concerning the practice of Korean Medicine as well as the ways in which its practitioners were pursuing capitalistic objectives at the global scale.

Eunjeong Ma (2008) who explored the 'incommensurability' present in political and professional discourses used by WMDs and KMDs in her doctoral thesis *Medicine in the Making in Post-colonial Korea (1948-2006)* does not depart much from this research trend. In her research, the need to make some distinctions between Western and Korean Medicine, and subsequently, to equalize Korean Medicine with EAM, seemed to have been stronger than the previous works on the subject because the claims made by the WMDs and KMDs she was analyzing had been already fashioned upon the country's separatist-based dual medical license system. Contradictions were found in both practitioners' changing claim that the system of Western and Korean Medicine is compatible depending upon the specific contexts within which their claims were advanced. For example, KMDs claimed for the compatibility, or commensurability, of these two systems when they asked for the wider use of modern biomedical technology, an argument they willingly discarded in favor of an 'incommensurability' argument in

other contexts. Similar contradictions were found on the WMDs' discourse in their claims for and against the commensurability between the systems depending on contexts.

However, as mentioned, these claims are fundamentally predicated upon the *institutional conditions* within which KM and WM are situated, namely the dual medical license system. So analyzing the discourse without specifying its fundamental context would be aiming for moving targets. In other words, the analysis she had embarked with regards to the 'problems' of contradictions in discourse, on the basis of epistemological distinction between KM and WM as well as of the conflation of KM with EAM, would then become matters of everyday healthcare politics under the dual medical system, rather than an interesting Korean case of dispute between western medicine and traditional medicine as she intended to conceptualize it in her thesis.

Byounghee Cho (2009)'s article 'Two Paths for Alternative Medicine: professionalization of Oriental Medicine and the growth of lay acupuncturists in Korea' is no exception in that he conceptualizes Korean Medicine as an 'alternative medicine'. It would be analytically compromising, however, to compare KMDs and lay acupuncturists on the same plane simply on the basis of their occupational heritage. In other words, my question is whether it is methodologically sound to compare the twenty-thousand strong practitioners who play a mainstream medical role in the country's healthcare system with a group of forty-odd alternative practitioners who have marginal social and economic presence on the basis of a supposed epistemological similarity.

From a users' perspective, the distinction between non-licensed practitioners and medical practitioners might not be so significant. However, the problem underlying this 'sociological' analysis of the pattern of the collective behavior of these two practitioner

groups over the decades is that the analysis runs a risk of ‘blinding’ the *vastly different socio-political and economic conditions* under which these two groups operate in contemporary Korean society. This analysis places too much emphasis on the assumption that a ‘strong’ continuity exists between these two groups of people. In other words, this approach, by taking the epistemology-based distinction as *a priori*, is unintentionally blurring obvious institutional boundaries existing between these two groups, and ends up jeopardizing the clear understanding of the social and political dynamics existing among various healthcare stakeholders of the country that include not only the medical practitioners like KMDs but also the unlicensed practitioners like lay acupuncturists.

Taewoo Kim's (2011) exploration of the clinical practice of Korean Medicine in his doctoral thesis *Medicine Without the Medical Gaze: Theory, Practice and Phenomenology in Korean Medicine* is also based upon the assumption that Korean Medicine is a local, ‘traditional medicine’. He described the treatment rationale shared by a certain group of doctors in the Korean Medicine community that relies on the practice of the time-bounded acupuncture therapy called *paekgak ch’imbŏp*. But just like prior authors in the field, he misses the contexts within which the specific acupuncture practice is situated, namely *the legal environments* which actually regulate the clinical practices of which the very ‘Korean’ style of acupuncture is part. To be specific, they include, among other things, the doctors’ daily practices of diagnosing patients based upon their biomedical disease categories, providing bio-medically informed instructions in the managements of patient, writing referrals to secondary or tertiary hospitals, and sending reimbursement claims on the basis of the regulations set by the authorities. What should be important for anthropologists are ‘all these other things’ surrounding the unique acupuncture

technique. Just like other research before his, however, Kim seemed to have been so much conditioned by this epistemologically bounded concern that his investigation did not go beyond the premise of this epistemologically pre-defined boundaries he set out in the beginning, and thus failed to grasp the comprehensive landscape of the social and moral universe these doctors were inhabiting in their professional lives.

1.2.1 The Korean Exception or the Epistemic Bias

All these ‘exceptions’ and ‘unusual cases’ highlighted in the existing research with regards to Korean Medicine do not have to be conceptualized as such, if it were distinguished from traditional East Asian medicine. Once we accept this preposition, shedding the emphasis on epistemology-based distinction, many ‘puzzles’ then become non-puzzles and also become a simple issue to be addressed.

As for Hyoje Cho’s concern to explicate the ‘unique’ ascendancy of KMDs’ status, for example, we could argue that KMDs’ status had been already pre-determined in 1951 when they were given the medical license. It is not hard to imagine that with this strong legal backing, their professionalization becomes accelerated during the period of the country’s rapid economic developments over the next six decades. Jongyoung Kim’s view on enterprising KMDs should be also seen as the product of capitalist economies in which Korean healthcare market operates, rather than as an interesting case of ‘traditional practitioners proactively targeting global market’, because in these economies, it would not be surprising to find some medical practitioners pursuing some industrial opportunities on the basis of their clinical expertise.

The contradiction in professional discourse whose nature was explored by Eunjeong Ma simply reflects the fact that the medical professions are powerful interest groups who like to twist and turn various conditions to maximize their interests. In this perspective, the fact that the Korean healthcare system has a dual medical license system is none other than institutional specifics within which these inter-professional politics operate. As for Taewoo Kim's case of doctors promoting a special acupuncture technique, it should be taken as a case where doctors attempt to promote their 'novel' therapies in order to widen their client base. As their aim is to publicize the therapies, it seems that the doctors did not feel the need to reveal to the social scientist, who was only interested in the novelty of *their epistemologically distinct* EAM acupuncture therapies, various other activities they were engaged in practice such as their use of the ICD-based unified disease classification system and the fact that they are using this therapy, fundamentally, within the frame of biomedicine, possibly with a partial objective of safeguarding themselves from potential malpractice claims.¹¹

These arguments will foreground the debates that will be presented in later chapters of the thesis, and will contribute to an understanding of the events and situations that will be extensively explored.

In the next two sections of this chapter, I will now describe historical developments of Korean Medicine. The first part will focus on developments of East Asian Medicine in Korea from its introduction from China around 5th century A.D. to the end of Chosŏn

¹¹ One of the key figures in Banryong Academic Society, the academic society for KMDs using *paekgakch'imbŏp*, also tried to contact me while I was doing fieldwork to publicize their newly invented clock which they can use in applying their esoteric acupuncture treatments. I was also sent unsolicited lecture material from the head of the society who is a KMD specialist in pediatrics at a university hospital. The biomedical frame within which the therapy is clinically situated was also obvious in the contents of the lecture material.

Dynasty in the early 20th century. The second part will explore the path Korean Medicine travelled in the last century until the contemporary Korea period during which East Asian medicine has transformed itself into biomedicine-friendly Korean Medicine. Then in the following section, I will describe contemporary features of Korean Medicine in its social, legal, clinical and institutional specifics before I conclude the chapter with a brief elaboration of the domestic and international implications of the country's dual medical license system.

2. The History of East Asian Medicine in Korea

The historical developments of East Asian medicine in China, Korea and Japan followed diversified paths. The table below summarizes them in each country, illustrating that major breakthroughs occurred near 17th century across the three countries in the form of the publication of key medical texts (see Table II-1).¹²

Table II-1 Historical Developments of East Asian Medicine in China, Korea and Japan

China	The publications of Han medical classics . <i>Yellow Emperor's Classic on internal medicine, Treatise on Cold Disorder and the Classic of Difficult Issues</i> published circa BCE 206-CE 220	The Tang era: many prescription books were published during 7 th to 9 th cent. The Sung/Jin/Yuan era: Neo-Confucian Medical Revolution took place during 12th and 14th cent.	<i>Warm Factor (溫病)</i> school developed during 16 th -19 th cent. TCM: new tradition of Chinese medicine that was actively combined with Western medicine
Korea	Records of prescription style books in 3-6 th cent such as 高麗老師方, 百濟新集方. 新羅法師方. Yellow Emperor's classic reimported to China in 11 th cent. Emphasis on local medicine and the publication of 鄉藥救急方 in 13th cent.	Theories and practices of East Asian medicine were systematized and compiled in the easy-to-use format in Precious Mirror of Eastern Medicine (<i>Donguibogam</i>) that was published in 17 th cent.	The publication of <i>Dongususebowon</i> : the birth of Sasang Constitutional Medicine (SCM) in late 19 th cent. Korean EAM: Faithful to classical ideas and strong preference for Neo-Confucian medical tradition
Japan	Records of the invitation of doctors to Japan from Shilla in 5 th cent. Books imported through Korea in 6 th cent along with Buddhism. The contry's first collection of prescriptions 醫心方 was published in 10 th cent	Emphasis on local medicine developed in 17 th cent. typified by the emergence of Old Prescription School (古方派). The publication of 藥徵 is an example and it provides a new interpretation of <i>Treatise on Cold Disorders</i> . Also the Sung/Jin/Won streams (後世方派) was present alongside. The introduction of Dutch medicine.	Kanpo: Emphasis on abdominal diagnosis 氣血水 theory. Aversion to classical theorizing.

Looking more closely, the historical development of East Asian medicine in Korea can be characterized by three major elements.

Firstly, it is characterized by the publication of Precious Mirror of Eastern Medicine (*Donguibogam*), a medical encyclopedia compiled by Hŏ Jun in 17th century which

¹² Also, in East Asian Medicine, classical texts are much closer to those who practice it (Farquhar 1996, 28).

provided a systematic account of East Asian Medicine that had been developed by that time. Just as the development of the Old Formula Style (*Kohoha*) faction in the 17th century characterizes later developments of East Asian Medicine in Japan (Otsuka 1976, 328–330), the publication of this book in Chosŏn Dynasty is important simply because all major textbooks on medicine afterwards were based upon the contents published in this 17th century classic.

Secondly, the *Warm Factor School* (Wenbingshue) tradition which prospered in the continent during Qing period, and thus has become the major source of prescriptive rationale since 18th century all the way to contemporary China, had minimal influence on practices in the Korean peninsula. Therefore, in contemporary practices of Korean Medicine, the *Four Sector Analysis* that is the central diagnostic and treatment logic in the Warm Factor School and subsequently in TCM (Farquhar 1996, 107–108) is rarely used.

Finally, in Korea there is Sasang Constitutional medicine that emerged in late 19th century wherein prescriptions for each condition are fundamentally decided on differentiations of people's innate constitutions which are divided into the four types of Greater-Yang, Lesser-Yang, Greater-Yin and Lesser-Yin.

I will present this development of East Asian medicine in Korea a bit more closely below.

2.1. Three Kingdom Period (108 BCE-668 CE) to Koryŏ Dynasty (918 -1392)

The scholarly medical tradition in the Korean peninsula seems to have started in the Three Kingdom Period. Books published in China and Japan from 8th to 10th century such as Secret Formulas in the Outer Fortress (*Waitaibiyao*), Comprehensively Categorized Prescriptions (*Taidoruijupo*), and Medically Central Formulas (*Ishimpo*) recorded formulas that were believed to be contained in the texts that could have been originated or circulated in the three countries (Hyunsook Lee 2012, 50–66; Dujong Kim 1981, 48–50). This is the time when medicine, along with Buddhism, was exported to Japan through Paekje Kingdom (18 BCE-660 CE), one of the three kingdoms that had the closest relationship with Japan (Hyunsook Lee 2001). The story of Kim Moo, for example, who was invited from Shilla Kingdom (57 BCE–935 CE) to treat an illness of a Japanese king in 414, shows the extent to which the medicine from the Korean peninsula was received in those days (Hyunsook Lee 2001).

The full-scale import of Chinese medicine, however, started during Unified Shilla Period (668 CE-918 CE) when Shilla borrowed the military force of Tang Dynasty in China (618-907 CE) in its campaign to unify the territory within the Korean peninsula through wars staged between years 660 CE and 668 CE, pushing the defeated Koguryŏ Kingdom (37 BCE –668 CE), another party that had been constituting the three kingdoms in the Korean peninsula, further north eventually to establish its own country of Palhae (698 CE-926 CE) in 698. Classical books such as Book of Pulse (*Maijing*) and Treatise on Cold Disorders (*Shanghanlun*) from Han Dynasty in China (206 BCE –220 CE) along with more recent books such as Causes and Symptoms of Various Diseases (*Zhubingyuanhoulun*) and

A Thousand Precious Prescriptions (*Qianjinfang*) of Shui Dynasty in China (581-618 CE) and Tang Dynasty were imported into the country in this period (Dujong Kim 1981, 101).

Developments in Koryŏ Dynasty (918-1392) which succeeded the Unified Shilla can be characterized by the continuous import of Chinese medicine, namely Neo-Confucianism-based Song Dynasty (960-1279) medicine in mid-era and that of the Yuan Dynasty (1271-1368) in later periods, and by its interest in local medicines and subsequent publications of *materia medica* near the end (Dujong Kim 1981, 117–124). It is well known that The Canon of Acupuncture (*Ch'imgyŏng*) was sent back to Song Dynasty in 1091 to be used as a platform in China for later royal publications of Divine Pivot (*Lingshu*) (Dujong Kim 1981, 118; Chin 2003), the text that is considered to be one of the two most fundamental classics of East Asian medicine along with Yellow Emperor's Classic on Internal Medicine (*Hwandineijing*).

The dependence on imported Chinese medical books, however, caused concerns as the medicines from China, or *Tangjae*, were expensive and not easily available, and it prompted a need to compile local *materia medica*. Locally Available Emergency Formulas (*Hyangyakgugŭbbang*), the first medical book in Korea, thus came to be published under the auspice of King Kojong's in 1236. *Hyangyak* in the title of the book meant local medicines in contrast to *Tangyak*, or medicines from China, and the book contained descriptions of about one hundred and eighty different types of local medicines with explanations of their botanical characteristics, methods of cultivation and medicinal

effects (Dujong Kim 1981, 141). The publication of this book started the *Hyangyak* tradition in the peninsula.¹³

2.2. Chosŏn Dynasty (1392-1910) to Port Opening (1876)

The Chosŏn Dynasty saw the indigenization process of medicine accelerated. Locally Available Emergency Formulas was upgraded to contain more than nine hundred and sixty formulas in the newly expanded volume of Comprehensive Selection of Local Medicines (*Hyangyakjipsŏngbang*) published in 1431 during the reign of King Sejong (reign. 1418-1450). The king also ordered the compilation of various formulas in accordance with their applications to disease conditions, and it led to the publication of Categorized Compilation of Various Medical Prescriptions (*Ŭbangryuch'ui*) in 1445 (Sungsoo Kim 2012, 108–113).

The knowledge gained with the publication of these two projects in the early period of Chosŏn Dynasty contributed significantly to the birth of the symbol of Korean Medicine in 1679, namely Precious Mirror of Eastern Medicine (*Dongŭbogam*). The book compiled by Hŏ Jun (1539- 1615) at the behest of King Sŏnjo (reign. 1567-1608) for distribution to his people after six years of war with Japan, the Precious Mirror, offered a faithful and systematic arrangement of contemporary medical achievements in an easy-to-use format complete with descriptions of various folk therapies utilizing locally grown herbs and medicines for those who did not have access to expensive medicines (D. Shin, Kim, and Yeo 1999; H. Kim 2000).

¹³ More books of this kind such as *Samwhaja's Local Medicines* (Samhwajahanyakbbang), *Old Formulas using Local Medicines* (Hyangyakgobang), and *Empirically Proved Beneficial Formulas using Local Medicines* (Hyangyakhymembang) were published near the end of the Koryŏ period (Dujong Kim 1981, 141).

In the middle of the five hindered year-long existence of Chosŏn dynasty in the Korean peninsula, the Qing Dynasty replaced the Ming Dynasty (1368-1644) in China in 1644. With the interruption of Confucian Chosŏn's diplomatic relationship with Qing, a corresponding break in the exchange of medical ideas followed, resulting in a gap in the Korean medical discourse where Warm Factor School (*Wenbingshue*) which was developed in southern China in 17th and 18th century is not present (Samsup Choi and Hong 1987). As exchange between Europe and China increased through missionaries, small scale introduction of knowledge of Western medicine also occurred In the 18th century in Korea, mainly through the Practical Learning School (*Shirak*) scholars such as Chŏngyagyong (1762-1836) and Choi Hanki (1803-1877) (D. Shin 2004, 296).

3. East Asian Medicine to Korean Medicine

The period from the country's opening in 1876 to the Japanese annexation of the country in 1910 is important in understanding the transition that East Asian Medicine underwent, in terms of its adaptive changes, in response to Western medicine. As mentioned, Western medicine was introduced from China in a piecemeal fashion in late 18th and early 19th century and more directly, by American missionaries and Japanese doctors in late 19th century. It is important to note that vaccination, a cutting edge technique at that time, was introduced into the country through traditional doctors during this period.

Western medicine was fully introduced during the Japanese colonial period (1910-1945), albeit in the form of colonial medicine. More importantly, during this period, the institutional platform for the transformation of East Asian medicine into biomedicine-friendly Korean Medicine was established, notably through the institution of *licensure*. The establishment of medical licensure in both fields of Western Medicine and of East Asian Medicine during this period - or the establishment of a formal contract between the practitioners and the Korean peninsula's 'first modern and centralized state' (Robinson 1991, 215), namely Japanese Government General of Korea (*Chosŏn Ch'ongdokbu*) - practically meant the beginning of the professionalization process for both practitioners. Coupled with social and economic capital accrued in the traditional medicine community, this act of entering into a social contract with the state has become the important basis on which the recognition of the medical status of traditional practitioners in the nation's first medical law in 1951 was granted, which again ushered in the era of the dual medical license system.

In the postwar period, Korean Medicine's integration into the state's mainstream healthcare system has been unidirectional to reach a point where the practice of Korean Medicine is now fully integrated into the country's healthcare system so that virtually no difference exists in its official position as compared with those of Western Medicine and Dentistry.

What follows is the detailed account of its development from the time when the country was exposed to the Western influence in 1876, to the period of the transformation during the colonial period and finally to the period of its extensive integration into the country's mainstream healthcare in post-war South Korea.

3.1. Exposure to Western Medicine: From the Port Opening (1876) to the End of the Korean Empire (1897-1907)

Unable to retain its policy of isolation in the context of rapid imperial expansion, the country of *Chosŏn* signed an agreement in 1876 with Japan to open its ports to Japanese commercial activity (The Korean Society for Modern History 2007, 75–76). In the field of healthcare, this period is characterized as a time of piecemeal changes both in the introduction of Western medicine and in the adaptation to it by traditional physicians. The country's first Western hospital *Chejungwŏn* and a medical school affiliated with it were briefly in operation (D. Shin 1997, 84–106; 2004, 226). Vaccination measures were propagated by Ji Sŏgyŏng (1855-1935), a traditional physician who accompanied the country's learning mission to Japan following the opening of the port, and also were implemented quite successfully nationwide by 1900 (D. Shin 1997, 320–321). The first

governmental Western medical school *Ŭhaggyo* was established in 1899 where many teachers were traditional physicians. The court hospital *Nebubyŏngwŏn* affiliated with this school was also mostly staffed by traditional doctors who have mastered vaccination techniques (D. Shin 1997, 279–280).

A decree promulgated by King Kojong (reign. 1897-1907) in 1901 shows the ways in which the ‘medicine’ was conceived by the establishment of the day, possibly foreshadowing its later developments in post-colonial Korea. This first modern decree on ‘Doctor (*ŭsa* 醫士), meaning ‘medical scholar’,¹⁴ defined the profession as :

Those who, after having mastered medicine, are well versed in transformative orders in nature (*ch’ŏnjang’i*), diagnostic methods including pulsation (*maekhujinch’al*), internal and external bodily landscapes (*naeogyŏng*), big and small formulas (*daesobang*), qualities of warm and cold in drugs (*yakp’umonryang*), methods of supplementing and leaking (*ch’imgubosa*), and therefore, are able to give prescriptions according to the characteristics of the patient’s pathological symptoms (*daejjŭngt’uje*).

And it continues to state that those who want to qualify as doctor

...shall be required to obtain the license of medical practice through the examination of the Ministry after the acquisition of certificates of graduation from the college of medicine and pharmacy (The Ministry of Home Affairs, Korean Empire. 1900. “Ordinance No. 27”)

Considering the developments of Korean Medicine in post-war South Korea, this event, though the decree could not be implemented, holds considerable significance as it seemed to foretell the interesting amalgamation of Western and East Asian medicine in

¹⁴ Please pay particular attention to the character ‘士’, a term that has been traditionally used to designate scholars who do not have official governmental positions. Hence, the term ‘醫士’ reflects the mediocre prestige accorded to the occupation. In comparison, the later and now current usage of ‘醫師’ reflects the more dignified nature of the profession as the term ‘師’ has traditionally been used for those who have governmental posts.

Korean Medicine. Though we do not know yet whether the decree was the outcome of the effort by traditional doctors who envisaged the system of education that embraced Western medicine, or if it was simply the product of the state's policy to combine old virtues with new ideas (*gubonsinch'am*),¹⁵ the contents of the decree convincingly shows the ways in which East Asian medicine was conceived by leaders of the country to be a medical system that can comfortably embrace institutional framework of Western medicine.

3.2. The Japanese Colonial Period (1910-1945): The Beginning of Professionalization

As mentioned, it is in the Japanese colonial period when Western Medicine was properly introduced into the country¹⁶ and an official relationship between the state and any medical system, whether it is Korean Medicine or Western Medicine, started. This was a time when medical practice was bifurcated in a way that Japanese doctors and a few Korean biomedical doctors were catering mostly to the needs of the Japanese residents and a handful of the upper-class Koreans (DiMoia 2007, 89) while traditional doctors were serving the majority of the population. The number of Korean doctors practicing Western Medicine in 1914, for example, was 144 and traditional doctors

¹⁵ For explanations of *Gubonsinch'am*, see The Korean Society for Modern History (2007, 215)

¹⁶ The impact of western medicine just before the colonial period seemed to have been limited or isolated at best. The story, or myth as a Korean medical historian (D. Shin 2004, 225–226) calls it, of *Chejungwŏn* and Allen, the American missionary physician who cured the Prince Min's stab wound suffered during a *coup d'état* in 1884, is a relevant case in point. The fact that it is only after 1903 when the first properly trained Korean doctors practicing Western medicine began to be produced (D. Shin 1997, 412) would probably tell the whole story with regards to the situation of Western medicine during that period.

numbered at 5,827 in the same year, outnumbering WMD significantly (GM Lee 2008, 142).

Western medicine was introduced in large scale to the public mainly through such personnel as public doctors (*gongŭ*) and public hygiene police officers while the propaganda-oriented 'Clinics of Benevolence' (*jahyeŭwŏn*) established across the country by the Government General also facilitated the use of Western medicine (Suh 2006, 113–115). Though Western missionary-based medical education facilities existed with some autonomy from the Government General's rule, it seems that they ended up educating an extremely small number of Koreans many of whom eventually went overseas to practice (DiMoia 2007, 91).

Traditional doctors were disallowed to increase their number as the colonial government prohibited licensing new traditional medicine practitioners, an action that the Meiji government in Japan took in 1874 following the Meiji Reform in 1868 (D. Shin 1997, 410–414; Ma 2008, 90). Also they were given the name 'medical apprentice' (*Ŭsaeng* 醫生) in 1913 when the colonial government introduced measures of regulation on medical practitioners, and this title was of lower legal recognition than that given to Western medical doctors and dentists who were referred to respectively as 'doctor' (*Ŭsa* 醫師) and 'dental doctor' (*Chi'ggaŭsa* 齒科醫師), the suffix *Sa* (師) meaning 'teacher' (Y. Park 2008, 41).

3.2.1 *Was it the Dark Age for Korean Medicine?*

On the basis of these measures, many historians and social scientists seem to hold a view that the Japanese colonial period was the Dark Age for Korean Medicine (N. Kim 2008; Jongyoung Kim 2005, 44–45; Ma 2008, 55–58; D. Shin 1997, 250, 410–411; Y. Park 2008, 40–43). However, there is an alternative explanation if we take into account the broader picture and the ways in which traditional East Asian medicine functioned during this period, moving away from focusing on the denigration of title and cessation of education.

Firstly, it is obvious that degradation in status affected only a small number of elite doctors who had governmental or court posts. For the majority of traditional practitioners who did not have high status in the traditional Confucian social order in the first place, those measures might not have affected them much. Conversely, with the installation of the licensure system, many local practitioners must have been quite pleased to get official recognition, which is demonstrated by the steep rise in the number of license holders in the first few years after the implementation of the license policy (Hyo-je Cho 1999, 147).

A comparison with Taiwan would throw a particularly illuminating light on the significance of the colonial period for the practitioners of traditional East Asian medicine. It is important to note that unlike their counterparts in Japan and in Taiwan, traditional practitioners in Korea were at least allowed to continue to practice with added requirements of Western medicine-based public health knowledge.¹⁷ The ban on the establishment of educational institutions teaching traditional medicine did indeed reduce

¹⁷ You needed to pass the tests containing public health knowledge to be qualified as *Ŭsaeng* (In-seok Yeo et al. 2012, 271–287; Ma 2008, 53–54).

the number of traditional doctors over the years which was 3,604 in 1940 down from 5,827 in 1914 (D. Shin 1997, 410–414). However, when compared with Taiwan where only 30 to 40 traditional doctors remained after the country's independence due to the authorities' active persecution of its practice (Unschuld 1976, 301), the number of overall practitioners who remained in Korea after independence is still substantial.

Statistics collated near the end of the period give us a good idea of the situation of healthcare during the period, and the roles traditional doctors played in the system. In 1943, two years before the country's liberation from Japan, for example, the number of doctors in the Ch'ungbuk province with the population of one million was reported to be 263 which included 74 Western medicine doctors, 48 western medicine doctors with limited area licenses, and 30 traditional doctors, and 111 traditional doctors with limited area licenses (DiMoia 2007, 108–109). We could see that even near the end of the colonial period, traditional doctors still outnumbered Western medicine doctors. The statistics testify not only to the legally regulated status of traditional doctors but also to the possibility that they were operating quite actively, particularly in rural regions (GM Lee 2008). Considering that this was a time when the number of Korean western doctors had increased substantially (see Table II-2), the extended role traditional doctors must have played in catering to needs of the populace in early and middle parts of the colonial period is imaginable.

Table II-2 The Number of Western Medicine and Traditional Medicine Doctors During the Japanese Colonial Period

Year	1915	1920	1930	1940
WM doctors	954	1111	1972	3660
traditional doctors	5804	5376	4594	3604

Source: J Park (1994)

This situation makes us think that during the colonial period, the traditional practitioners actually consolidated the social and economic client base by playing an official role with added knowledge of Western medicine¹⁸ to the extent that their expanded client base could have compensated for the loss suffered in number of practitioners over the years. In that sense, the paradoxical solidification of traditional medicine during the colonial period was an important foothold for later developments of Korean Medicine.

Social and economic opportunities created for traditional practitioners seems to have arisen from the Japanese colonial government's ambivalent attitude toward traditional medicine (DiMoia 2007, 98–99) in which it showed leniency in its control despite its official policy of promoting Western medicine as the state medicine. The laxity in control of traditional medicine, differently from what Japanese governments both in Japan and Taiwan did,¹⁹ might have been motivated by the lack of healthcare resources in the peninsula initially, and later by industrial opportunities envisaged in areas of

¹⁸ As some traditional doctors were interested too much in Western drugs, the Government General had to devise an measure to thwart their activities (Gyuhwan Shin 2008, 135).

¹⁹ According to Unschuld (1976, 302), in Taiwan, the Japanese colonial government was said to employ spies and use other means to detect the 'illegal activities' of practicing traditional medicine.

pharmaceutical development, and in late 1930s by the needs for medicinal resources on war fronts during the second Sino-Japanese War (Gyuhwan Shin 2008, 114).²⁰

3.2.2 A Comparison of Politico-Legal contexts in Korea and Taiwan

The politico-legal context of this relative lack of policing in the use of traditional medicine in Korea²¹ might be found in difference in the Japanese government's legal stance toward its colonies. The Korean Government General was entirely independent of the metro-pole Japanese cabinet as he was given the autonomy of making and implementing civil laws (*Jeryŏng*), independently from the Japanese domestic law. On the other hand, the colony of Taiwan, though its Government-General had similar rights, was fundamentally subjected under the principle of 'simultaneous application of the Japanese domestic law' (*Naejibŏpyŏnjangjuŭ*) in 1921 (C. Kim 2008, 150–154), which subjected the Taiwanese under the same law as applied to the people in Japan. However, this type of legal arrangement was not in place in Korea until the end of the colonial regime. Only in the late 1930s, a similar assimilationist policy scheme called 'Japan-Chosŏn Residing within One Body (*Naesŏnilch'e*)' focusing mainly on cultural elements appeared.²² Overall, it seems that the difference in politico-legal arrangements in two countries have affected the ways that practice of traditional medicine was regulated, which might have allowed the Korean practitioners to have more leeway during this period.

²⁰ This was also the time when series of high profile debates between the supporters and sceptics of traditional medicine occurred through the columns of a daily newspaper in Korea (Hunyoung Cho 1997) .

²¹ In other parts of the regime, policing in Korea was extreme to the extent that the whole country was said to be under surveillance. The number of policemen per capita in 1925 amounted to 9 in 10,000, a rate which surpassed the number of policemen in Britain at that time (C. Lee 2008, 9).

²² Under this scheme, the use of Korean language and text were banned, and the majority of Koreans had to adopt Japanese names under the Name Order (*Ch'angssigaemyŏng*) (Buzo 2007, 35,41).

Consequently, after the defeat of Japan in the Pacific War, Korea turned out to be the only country among the three East Asian countries of Japan, Taiwan and Korea, where the status of traditional medicine came out quite strongly in terms both of its formal relationship with the state and the degree of its adaptation to Western Medicine. If we consider the ‘public’ and ‘semi-official’ role that traditional medicine in Korea played during this period, we could even argue that in Korea, *the formal state-doctor relationship was forged simultaneously both in Western medicine and Eastern medicine fields*, unlike in Japan and Taiwan where due to thorough crackdown on traditional medicine, the state-medicine relationship was established only in the area of Western Medicine. After the country’s liberation, therefore, traditional medicine communities were able to push the professionalization agenda forward, establishing their own organization called KOMA (the Korean Oriental Medical Association) in 1947 (DiMoia 2007, 119), and mobilizing support in the enactment of the country’s first national healthcare law in 1951 which became a crucial step in ushering in the era of the dual medical license system.

3.3 Integration into the Country’s Healthcare System (1951) and Post-War Developments

Some developments of significance in healthcare occurred during the period after Japan’s withdrawal from Korea in August, 1945 and before the breakout of the Korean War in June, 1950. This was the time when the peninsula was divided and, in the American supported South, a free market-based healthcare system, namely a system where the role of government in healthcare provision was minimized, was instituted (In-sok Yeo 2008, 81). The Western medicine community adopted a professional educational

system based on the American model during this time (Ma 2008, 54) whose shape, both in research and clinical practice, had just been completed after decades of reform since the publication of the Flexner's report in 1910 (Gevitz 2004, 86–87, 94, 99). As mentioned, East Asian medical practitioners formed their own professional association KOMA in 1947. The policy of non-interference in matters of traditional medicine continued during the interim American government United States Army Military Government in Korea (USAMGIK), though the USAMGIK officially adopted, just like the Japanese colonial government, the policy of disallowing the licensing of traditional doctors (DiMoia 2007, 106).

In 1951, in the midst of the Korean War, the National Assembly convened to draft the country's first healthcare law (*Kungminŭryopŏb*)²³ where after fiery discussions, the lawmakers eventually decided to give traditional doctors the title of 'medical doctor (*Ŭsa* 醫師)', not 'medical scholar (*Ŭsa* 醫士)', and gave their practice the name of 'medical clinic (*Ŭwŏn* 醫院)', not 'consulting room (*Jinryŏso* 診療所)' (Hyunji Lee 2008, 116–121), an event of prime significance which formed the basis of the dual medical license system (Hyo-je Cho 1999, 157; Jongyoung Kim 2005, 50; Ma 2008, 86; Hyunji Lee 2008, 120).

Being officially recognized as 'Doctor 醫師'²⁴ in the medical law, which later became the most important arbiter of determining professional boundaries in healthcare,

²³ This law was modeled upon Chosŏn Law of Medical Practice (*Chosŏnŭryŏryŏng*) (朝鮮醫療令), the law which was drafted in 1944 under the Japanese colonial rule (Y. Park 2008, 40–43).

²⁴ Their official name given was '*Hanŭsa* 漢醫師'. To avoid confusion, however, I will consistently use the term 'Doctor of Korean Medicine' to refer to the practitioners after the 1951, ignoring the detailed designation of the title which might be more strictly translated into Doctors of Oriental Medicine or Doctors of Chinese Medicine.

meant that doctors of Korean Medicine were officially operating under the same duties and rights as doctors of Western Medicine and dentists. Particularly after the full establishment of the dual medical license system in 1963 following a significant revision of the medical law (Hyunji Lee 2008, 121; Y. Park 2008, 49; Ma 2008, 100), the KM community could have more legitimacy and stake in the country's healthcare system. The revised law granted colleges of Korean Medicine the six year curriculum,²⁵ which was the same length of the Western medicine and dentistry.²⁶ Soon, the former four-year college called Seoul College of Oriental Medicine (*Sŏulhanŭggwadaehak*) that was established in 1953 expanded to become the six-year Tongyang College of Medical Science (*Toyangŭggwadehak*).²⁷ Two years later, it was acquired by Kyunghee University. The revision of the law in 1963 also solidified KMDs' monopoly over the healthcare market as the revision made it practically impossible for other non-regular practitioners in the field of East Asian medicine such as acupuncturists to achieve any degree of professionalization at all (Hyunji Lee 2008, 121; Y. Park 2008, 49; Ma 2008, 100).

The economic development of the country in the 1970s and 1980²⁸ raised the people's awareness in health and it led to the expansion of the medical market, which

²⁵ The first four-year college of Korean Medicine (Oriental Medicine) was established in 1952.

²⁶ Only medical schools were allowed to have six year curriculum and it still is the case now.

²⁷ It is noteworthy that the name of this school is not the College of *Eastern Medicine*, but it is Tongyang (meaning Eastern) College of *Medical Science*. Cho (1999, 164–165) argues that this naming is the KMDs' strategy, in their attempt to keep their identity, of thwarting the military junta's plan to completely absorb Korean Medicine into the framework of Western Medicine after the General Park Chunghee's military coup of 1961. However, considering the legal status the community already has and the biomedical orientation it continuously showed, the naming may also reflect the general orientation of the community with regards to its professional identity.

²⁸ From late 1970s, the investment in heavy and chemical industries (HCI) made in early 1970s started to pay dividends in the form of increased exports. The economic development of this period was coupled with increased remittances from the workers in the Middle East who had been dispatched to the area following the construction boom in the region in the 1970s and the soldiers who returned from the Vietnam War.

again led to the establishment of more medical colleges across Korean Medicine and Western Medicine.²⁹ Though treatments in Korean Medicine clinics had been already regarded highly in the 1950s (Hyo-je Cho 1999) and 60s,³⁰ the trend was visible in the area of Korean Medicine, particularly in the growing demand for *chöbyak*, or individually prepared herbal prescriptions. For example, entry achievements of students entering Kyunghee University Department of Korean Medicine in the 1970s already were at the same level with those of other Western Medicine schools in the capital.³¹

With the expansion of the national healthcare insurance coverage to include the entire population in 1987 during which the treatment modalities of Korean Medicine such as acupuncture and herbal medicine extract granules were also included in the scheme (Hyo-je Cho 1999, 187–198),³² more people started to use private clinics in their neighbourhood, which also increased the prestige of medical careers. Particularly, the lack of several years of the post-graduate clinical training and comparatively less-demanding workload coupled with the profession's longevity boosted the popularity of

²⁹ Twenty-seven of the country's forty-four Western Medicine colleges and ten of the current twelve colleges of Korean Medicine were established after late 1970s, the period when the country's economy took off.

³⁰ There are recorded case histories that signified the ways in which East Asian Medicine clinics were received by the public in the 1960s. There is, for example, a case description in a monthly magazine published in the Korean Medicine community (W. Pae 1964) in which a Korean Harvard University undergraduate student came all the way from the US to visit a Korean Medicine clinic to get consultation on his bowel problem. This is the time when the nation's GDP was one of the lowest in the world.

³¹ Yearly league tables called *Paech'ip'yo* can be found in past Korean newspapers. Major internet portals in Korea such as Naver and Daum offer this search service. However, it should be remembered that the medicine major was not the most favorite major for high-flying students at that time. Reflecting the country's industrial emphasis on engineering and the growth of domestic firms, the science-track students rather chose basic science and engineering majors in good universities in Seoul rather than medical majors in provincial universities. This trend, however, entirely changed in late 1990s.

³² This is also a significant turning-point in Korea's modern political history. After decades of military dictatorship, this is the year in which the public put enough pressure on the authoritarian government to accept the direct elections to choose the country's president.

the career as doctor of Korean Medicine. That year, the government also changed the official designation of the medicine from Oriental Medicine (漢醫學) to Korean Medicine (韓醫學).

The establishment of the comprehensive national health insurance, however, also meant the beginning of the state's direct control over the free market-based healthcare sector as medical providers were now controlled through the measures of reimbursement payments (Hyo-je Cho 1999, 185). Healthcare practitioners were now required to line up in the state's three-step healthcare delivery system that was composed of the primary, the secondary and the tertiary care sectors, and doctors had to take part in the insurance system on a compulsory basis (Hyo-je Cho 1999, 201–205).³³ Reflecting the growing state's interest in Korean Medicine, the country's only national general hospital, the National Medical Center established the department of Korean Medicine in 1991.

Then in 1993, a major event occurred that had major repercussions on the later developments of Korean Medicine and on the country's healthcare in general. It happened shortly after President Kim Youngsam (in office 1993-1997), the civilian president elected after decades of military rule, was inaugurated. It was the event where the outgoing Minister of Health deleted a sentence in the Pharmaceutical Act, following in the spirit of the new governmental motto of 'internationalization of the nation', in order to streamline domestic regulations to fit the international standards (Ma 2008, 143). The deleted sentence was '*Pharmacists should keep a medicine cabinet other than the*

³³ This is the time when the country was still ruled by military general-turned presidents. Chun Doowhan was the president at that time.

traditional one and keep it clean'.³⁴ This action, however, caused a great stir and resentment among KMDs who argued that with the deletion of the sentence that had been operating as a legal apparatus prohibiting pharmacists from handling East Asian medicines, or *hanyak*, the state was now actually endorsing pharmacists' right to handle them. On the other hand, the pharmacists provided a different interpretation in which they claimed that because the clause just meant that pharmacists should keep their medicine cabinet as 'hygienic' as possible, the deletion of the clause was not in any way related with their rights to handle *hanyak* because they had been already legally entitled to deal with them.

After this event, many pharmacists indeed began to install traditional medicine cabinets in their dispensaries, and KMDs strongly protested against the pharmacists and the government which they thought was colluding with the pharmacists. Pharmacists also reacted strongly to the charges directed against them with collective actions. The dispute escalated until the inter-professional conflicts involved the parents of students at both schools of Korean Medicine and of pharmacy. As the students boycotted their classes in protest to the situation for a long time, the possibility of the suspension of their studies was raised so the Ministry of Education also had to intervene, putting a substantial burden on the government (Ma 2008, 160–162).

The authority of the state was severely challenged during the event because at the end of the dispute which continued until 1996 while putting Korean Medicine at the center of national concern, four ministers of health and four deputy health ministers were sacked, leaving the state deeply embarrassed as it was forced, at one point, to hand over

³⁴ It was Article 11, Clause 1, paragraph 7 in the Enforcement Decree of the Pharmaceutical Act.

the mediation right to a civil rights group called Citizen's Coalition for Economic Justice (CCEJ) (Hyo-je Cho 1999, 276). Eventually pharmacists won the battle as they were able to deal with *hanyak*, though in a limited range of one hundred formulas, with the compromise reached between both groups that the Korean Medicine community would institute the policy of separation of prescription and distribution of medicines (SPD) in the near future.³⁵ Many pharmacists with a temporary license to dispense *hanyak* were produced at this time.³⁶

Two major outcomes came out of this event. The first was the stakeholders' agreement to implement the policy of separation of dispensing and prescription (SPD) among healthcare provider groups including Korean Medicine so that no further conflict of this kind would ever happen. This agreement then became the rationale for the state's implementation of the SPD in the Western Medicine community in 2000 which caused major protests from the WM community.³⁷ The second was the state's institutional support for the KM community as the prolonged conflict became an occasion for the nation-wide publicity event wherein many issues related to Korean Medicine came to be publicized. As a result, the Korean Institute of Oriental Medicine (KIOM) was established in 1994, and the governmental bureau dealing exclusively with matters of Korean Medicine was established in 1997 within the Ministry of Health and Welfare (Hyo-je Cho

³⁵ This compromise was negotiated through the collaboration of three social activist healthcare provider groups, namely Doctors for Humanitarian Practice (*Inŭhyŏp*, WMD), Young Doctors for a Healthy Society (*Ch'ŏngha*, KMD) and Pharmacists for a Healthy Society (*Kŏnyak*, pharmacists). The Ch'ŏngha group will appear repeatedly throughout the thesis.

³⁶ The group categorized as 'seniors' in the KM community - who featured in the rebellion described in the next chapter- participated actively in these protests that formed part of the conflict between KMDs and pharmacists. The 'young' doctors who are the protagonists of the rebellion, however, do not have the direct experience of this event that took place twenty years ago. The head of the Association of Korean Oriental Medicine (AKOM) at this time was Dr. Hŏ Ch'anghoe.

³⁷ See Picture V-6 for details.

1999, 265). Male graduates of the Korean Medicine colleges were now given rights to finish their mandatory military service as military physicians.

A serious economic crisis hit the country in 1997 and job security became the most important concern for the public. The popularity of a medical career sky-rocketed as many science and engineering college graduates re-entered medical schools as their employment prospect dwindled in the struggling economy. When compared to being WMD, choosing to become KMD comes with considerable benefits such as being subjected to less risk of malpractice-related legal accidents, the shorter training necessary to be in practice³⁸ and its professional longevity.³⁹ Various recent state-level institutional changes that occurred in favour of the KM community also improved the KMDs' profile. As a result, popularity of the colleges of Korean Medicine greatly increased to the extent that in the late 1990s and most of the 2000s, the nation's eleven schools of Korean Medicine, in terms of the student achievements, maintained higher spots in the ranking tables for college major choice than most of the country's Western medical schools.

³⁸ To open a local WM clinic, most have to complete lengthy post-graduate clinical training whereas the notion of specialism was relatively new in the KM field at that time.

³⁹ Many KMDs practice past their 80s while dentists, for example, due to the physical strength needed to work, often retire in their 50s and early 60s. In general, WMDs who passed their prime age are not engaged in high-risk procedures such as surgery.

Table II-3 A College Application Guidelines According to SAT Grades in 2008

Grade	Applicable Schools and Subjects
1.00	SNU (WMD), Catholic (wMD), Kyunghee (KMD) , Sungyugwan(WMD), Yonsei (WMD, DDS), Korea (WMD), Ulsan (WMD), Chunang(WMD) Ajou (WMD)
1.08	Yonsei, wonju (WMD) Wonkwang (KMD) , SNU (Pharma), Danguk, Chonan(WMD), Donguk, Kyungjoo (KMD) , Hallym (WMD), Kyungwon (KMD) , Youngnam (WMD), Chungbook (WMD), Taejon (KMD)
1.17	Postech, Seimyung (KMD) , Sunchunghyang (WMD), Eulji (WMD), Daegu Catholic (WMD), Inje (WMD), Dongah (WMD), Sangji (KMD) , Wongwang (WMD, DDS), Woosuk (KMD) , Kangrung (DDS), Dongguk, Kyungjoo (WMD), SNU Mechanical and Aeronautics, Math education, Chemical-biology,
1.25	Dangook, Chonan (DDS), Dongueui (KMD) , Dongshin (KMD) , Gunyang (WMD), Gwandong (WMD), Kyemyung (WMD), Daegu (KMD) , SNU Electrical and computer science, SNU Veterinarian, Statistics, Materials, Ehwa (Pharma), Chooang (Pharma), Sungyungwan (Pharma), Kyunghee (Pharma)
1.42	SNU construction, Physics, Choongbook (Pharma), Kangwon (pharma), PNU (Pharma), Chonnam (Pharma), Seonam (WMD), Goshin (Pharma)

Note: This table shows the top-most 0.42 grade in the total of the 9 grade system. For example, the top section of this table 'Grade 1.00' refers to a cohort of applicants whose exam scores belong to the top 0.08 percentile in the entire range of scores produced that year. The 'applicable' schools and subjects befitting each band of applicants are written in the next column.

Source: Daum Communications (2008)

The period after 2000 is characterized by the state's active intervention. A specialist qualification was introduced in seven subfields of Korean Medicine in 2000 (Hyunji Lee

2008, 113–114), though as in the dentist community, its full implementation at the primary care level has not been resolved yet. The National Assembly passed the Korean Medicine Promotion Law in 2003 that specified the duty of the state and provincial governments to draft and sustain KM promotional policies every five years.⁴⁰ Since then, the state's research and development expenditure in Korean Medicine increased continuously so that the total spending in the area reached 521 billion Korean won (48.5 million USD) in 2010 (B. Lim, Ryu, and Na 2012, 25).⁴¹

And in 2008, the government established the first national school of Korean Medicine at Pusan National University that was modelled on the American-style graduate-entry medical school system.⁴² To push the medical licenses unification agenda (*ŭryoirwŏhwa*) forward, the government revised the healthcare law in 2010 to allow doctors, regardless of their licenses (WMDs, KMDs and dentists), to employ each other in hospital-level facilities,⁴³ a scheme which is being discussed by lawmakers to be extended to the primary care clinic level (Gyubok Lee 2011). Now there is a plan by the state to establish the country's first national hospital of Korean Medicine once the old National Medical Centre, currently situated at the centre of Seoul, is relocated in a few years' time (Jihyun Lee 2012a).

⁴⁰ The details of the Second Phase plan can be found in Ministry of Education and Resources et al. (2008, 8). The expansion of the global market for botanical drugs and herbal supplements during this period seemed to have motivated the state action. See Section 2, Chapter III and Section 2.2, Chapter IV for more discussions on this subject.

⁴¹ The government's total spending in Healthcare Technology R&D also increased during this period. See Figures IV-2, 3 and 4 for details.

⁴² See Pictures II-1 and III-1 for details.

⁴³ This law is called Cooperative Medical Law (*hyŏppjinbŏp*).

3.4. Summary

As we have seen, the enactment of the medical law in 1951 was a crucial point in developments of Korean Medicine because the law gave legal status to KMDs as mainstream doctors whose professionalization could be legitimized on this basis. In addition, the legal entitlement acted as a mechanism by which the place of Korean Medicine could be secured safely within the country's healthcare system so that its parallel development with Western Medicine and Dentistry could proceed at the time of the country's economic ascent in later periods.

As I have covered the historical developments of East Asian medicine and Korean Medicine since antiquity to the modern period thus far, I will explore the features of contemporary Korean Medicine in its various details in the next section.

4. Contemporary Korean Medicine under the Dual Medical License System

As mentioned in previous sections, Korea's healthcare is predicated upon the dual medical system, or *Yiwŏnwha* system, where Western Medicine coexists with Korean Medicine. Korean Medicine has the same legal, institutional, economic and social recognition as Western medicine, and it creates a unique situation where two legitimate kinds of medical doctors, WMDs and KMDs,⁴⁴ operate in the country's healthcare system. I will start with a description of various institutional aspects of Korean Medicine before I present an overview of its clinical practices and characterize the styles of clinical reasoning underpinning those practices. Perceptions of Korean Medicine by WMDs and the public will also be briefly reviewed before I elaborate on KMDs' socio-economic status. Subsequently, I will present a short cross-country comparison of the Korean healthcare system to contextualize globally this unique system. I will conclude the section with a brief description of the ways in which the dual medical system responds to the global trend in healthcare. It will highlight not only the workings of the domestic system but also some features of the domestic healthcare politics.

⁴⁴ The designation of Korean Medicine physician is still not standardized, reflecting its category-straddling status. Recently, the Association of Korean Medicine (AKOM) changed the official title of its members to 'MD (DKM)'. In the meantime, the Korean Medical Association, the association for the country's WMDs, filed a lawsuit against the AKOM's use of 'Korean Medicine' in its title but its attempt was foiled by the court at an early legal stage (B. Song 2012b).

4.1 Law, Licensing and Education in Korean Medicine

4.1.1 *Legal and Institutional features*

In all the country's healthcare laws, KMDs are subject to the same legal duties and rights as WMDs and dentists.⁴⁵ The *Yiwonwha* system, however, separates two official healthcare systems in practice by allowing WMDs to practice '(Western) medicine'⁴⁶ and allowing KMDs to practice 'Korean Medicine', despite the fact that there is no definition whatsoever regarding what constitutes '(Western) Medicine' and 'Korean Medicine' in the medical law itself.⁴⁷

Therefore, it is fair to argue that Korean Medicine can best be defined as '*what KMDs are practicing*'. Recent legal proceedings also show that, despite the fundamental premise of the bipartite license system, the firm, legal line demarcating these two practices has become increasingly difficult to draw as expressed in the following court statement.

Though in our country where Western and Korean medicine are completely legally separated, with the development of technology in diagnosis and treatment method, and with the increasing narrowing of the gap between the two medicines, *it is very difficult to distinguish the area of expertise between MDs and KMDs...*' (Court ruling on the case of a

⁴⁵ In the Medical Act, for example, you could see these three doctors grouped in almost all articles. An electronic version of the Act is available at <http://likms.assembly.go.kr>.

⁴⁶ As the official legal term is 'medicine (*ŭhak*)' although it does mean 'Western medicine', I put the word 'Western' in parenthesis.

⁴⁷ A definition of Korean Medicine, however, was attempted with the installation of the Korean Medicine Promotion Law in 2003 where Korean Medicine was defined as 'medical practice and medicinal affairs based upon the Korean Medicine (*Hanŭhak*) that has been handed down to us from our ancestors'. Its new revision which was effected in 2012 modified its definition by adding 'scientifically developed medical practice and medicinal affairs based upon Korean Medicine' to the existing definition. However, in the Medical Law itself, there is still no definition as to what constitutes '(Western) Medicine' or 'Korean Medicine.'

neurologist using acupuncture as a part of nerve stimulation therapy. 31002-2707,85.3.19)

(Y. Park 2008, 84) (Text translation and addition of italics by author)

Two types of medical schools exist in the country: forty-one Western Medicine schools and twelve Korean Medicine schools. The Korean Medicine school curriculum has the contents of East Asian Medicine, though the learning is couched in the framework of bio-medical education. Curriculums of these schools share 80% of their content with that of Western Medical schools (H.-S. Lim, Ahn, Ahn 2007).⁴⁸ In the school league tables, these medical schools generally hold top positions in terms of entry difficulties. It should also be noted that KMDs, WMDs and dentist have similar income levels (see Table II-4).

⁴⁸ The exact quote from this paper 'A Comparative study of Medical Education Systems in Korea, China and Japan' published by researchers at Department of Medical Education, Korea University School of Medicine is as follows: 'Korea distinguishes medical licenses (*ŭsamyŏnhŏ* 醫師免許) between WMDs and KMDs, and operates different medical schools (*ŭggwadaehak* 醫科大學), but *in fact they share 80% of the curriculum*' (H.-S. Lim, Ahn, and Ahn 2007) (Italics added by author).

Table II-4 A Comparison of Legal Rights and Status Among Doctors in Korea

	WMD	DDS	KMD
Education	6 and 4 year (41 schools)	6 and 4 year (15 schools)	6 and 4 year (12 schools)
Specialist training	Since 1950s	In place but the specialization is not advertisable in clinics	In place but the specialization is not advertisable in clinics
Rights to Issue Certificates	medical/birth/death	medical/death	medical/birth/death
Hospital	hospital/clinic/long-term care hospital	dental clinic/dental hospital	KM clinic/KM hospital/long-term care hospital
Alternative Military service	Military physician/Public Health	Military physician/Public Health	Military/Public Health (after 1 year of clinical training)
Employment in public sector	professional license holder (as Medical Officer in WHO or in Korea International Cooperation Agency)		
Practice	Cross-employable among each other (hospital level)		
Physician Number (2012)	104397	26098	19192
NHI reimbursement (2012)	Hospitals (42.2%) Clinic (22%)	2.9%	3.7%
Monthly Income (average worker's income: 2,030 USD) (2010)*	Median income among doctors 5,560 USD		
	9278 USD (Plastic surgeon)/6401 USD (Gynecologist)/5545 USD (Family medicine)/5127 USD (internal medicine)	5649	6105

*The statistics are from Korean Employment Information Service (KEIS).

In terms of National Health Insurance expenditure, Korean Medicine occupies a small part of the overall finance at around four percent of annual reimbursements, partly because some popular therapies in KM clinics such as *chŏbyak* prescriptions are not reimbursed in the current scheme. Dentists also register very low reimbursement rate similarly because popular treatments such as dental implants are not covered by NHI. In fact these KM and dental therapies, which have become the major sources of the public's out-of-pocket payments, have been argued by civil groups that they should be covered by national health insurance.⁴⁹ As shown in the table below, the government's NHI reimbursements now take up about 60 to 70% of most doctors' income in the country.⁵⁰ The table demonstrates that Western Medicine clinics and hospitals are a primary source of governmental expenditure (see Table II-5).

⁴⁹ In an attempt to meet this public need, the government issued a plan to reimburse Chŏpyak in October, 2012, and the decision sparked a large-scale internal conflict within the KM community. This conflict is the main subject of Chapter III. See also Jihyun Lee (2012b) for a brief press coverage of the event.

⁵⁰ This is called *the coverage rate* of the national health insurance which is defined by the rate of the money the NHIC, the financial center of the national health insurance, account for in the overall healthcare expenditure of the public. As of 2012 it now covers 62.5% of the total healthcare spending which means NHI reimbursements are responsible for around 60% of the doctors' income (Juyeoun Lee 2014). As the patient's co-payment is estimated at 20% of the interventions covered by NHI, it can be said that the NHI-related finance could account for approximately 70% of doctors' overall income.

Table II-5 Reimbursement Statistics of National Health Insurance in 2012

Types of institutions	Reimbursements Amount (million Korean Won)	Percentage of total NHI expenditure
Tertiary General Hospital	58800	16.5
General Hospital	52743	14.8
Hospital	35505	9.9
Long-term care hospital	19695	5.5
Dental Hospital	603	0.2
KM Hospital	1254	0.4
Clinic	78334	21.9
Dental Clinic	10528	<u>2.9</u>
KM Clinic	13221	<u>3.7</u>
Health institutions	1357	0.4
Midwifery	8	0.0
Pharmacy	85098	23.8

Note: The portion of reimbursements to dental and KM clinics out of overall NHI expenditure do not exceed four percent.

Source: NHIC

4.1.2 The State's Engagement with Korean Medicine

The Korean state has had and continues to have a hard time in accommodating this two-tiered healthcare system as there are no comparable cases for consultation in other technologically developed countries. Most government officials that I met while working on various governmental policy projects during the fieldwork mentioned the difficulties they face in coping with this distinctive *Yiwŏnhwa* system, and strongly expressed their wish to make the policy products as comparable as possible, in style and content, to the situations in the WM community or what they called *Ŭggwa*. Recently, to their great relief, an advance in this direction was made when the Korean Medicine community finally agreed to use the newly updated ICD (The International Classification of Disease)-10

based version of the KCD (The Korean Classification of Disease), discarding their independent disease classification called the KCD-OM that had been in use.

The governmental bureau that deals with matters of Korean Medicine in the Ministry of Health and Welfare (MOHW) has two subdivisions: the Bureau of Korean Medicine and Pharmaceutical Policy, and the Bureau of Korean Medicine and Pharmaceutical Industry. Though the Ministry of Education is responsible for regulating nationwide medical schools, the opening of the national Korean Medicine medical school at Pusan National University seems to put officials at the Bureaus of Korean Medicine at MOHW in frequent talking terms with the staff at PNU. The head of the Korea Medicine Bureau at MOHW and representatives from the PNU school of Korean Medicine, for example, sit together on the state-level committee established to facilitate the exchange of information between China and South Korea, signifying the role of the PNU KM School in governmental policymaking.

For the establishment of Pusan National University School of Korean Medicine, the government spent 50 billion Korean won (47 million USD) in building an institution where the student staff ratio is about five to one, with a state-of-the-art lab, library and other educational facilities such as the Problem-Based Learning quarter and venues reserved only for practical clinical training and tests. The on-site clinical research center affiliated with the school's Hospital of Korean Medicine is one of the biggest clinical research centers in the country where all the high-level clinical research activities can be performed. The main mottos of the school are the standardization, scientization, globalization and industrialization of Korean Medicine and they correspond squarely with governmental initiatives on Korean Medicine (see Picture II-1).

Picture II-1 Pusan National University School of Korean Medicine



Note: a) The author is modulating a debate class in the module ‘Korean Medicine and Contemporary Society’ among second-year Korean Medicine school students at PNU. b) The clinical research center affiliated with the school.

Source: Author

The Korean Institute of Oriental Medicine (KIOM), one of approximately twenty national research institutes under the Ministry of Education and Science, conducts basic science research and a significant portion of the government’s annual funding in Korean Medicine goes to this institute. The 21st Donggubogam Project is one of the main research projects that the KIOM is pursuing today as the project aims to create a twenty-first century version of Donggubogam by incorporating into one publication all of the scientific advances and textual research outcomes the Institute has produced so far (see Picture II-2).

Picture II-2 The Korea Institute of Oriental Medicine (KIOM) in Taejeon, South Korea



Note: a) b) KIOM buildings c) the newly established Center for Standardization for Korean Medicine at KIOM

Source: Author

4.1.3 Education in Schools of Korean Medicine

As mentioned, schools of Korean Medicine follow the rules and regulations set by the Ministry of Education which controls minute changes in the curriculum so that they conform to the standard of ‘medical education’.⁵¹ My fieldwork at PNU also confirmed that the Korean Medical education is subject to this framework, though in this school, an ‘outcome-based’ curriculum that includes such elements as OSCE (Objective Structured Clinical Examination)⁵² and CPX (Clinical Performance Examination),⁵³ and PBL (Problem-based learning)⁵⁴ were being implemented (see Table II-6).

Table II-6 Educational Facilities of the PNU School of Korean Medicine

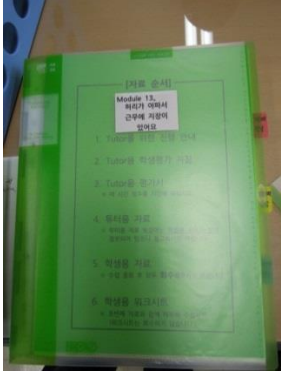
a. OSCE (Objectively Structured Clinical Examination)		

⁵¹ Actually, the school curriculum in Korean Medicine is assessed by the Institute of Korean Medicine Education and Assessment (<http://www.ikmee.or.kr/>) that was established in 2004, an independent organization that is delegated by the state to supervise the education of the schools of Korean Medicine in the country. For the same purpose, the Korean Institute of Medical Education and Evaluation (<http://www.kimee.or.kr/eng/main.html>) was established a year early in 2003 for the evaluation of the curriculum in the schools of Western Medicine. These independent organizations, however, are still under direct control from the Ministry of Education and do not have the degree of autonomy that institutions like General Medical Council (GMC) has in the UK, due to the short period of medical professionalization in the country.

⁵² It is a new type of clinical examination testing the clinical competency of candidates in an objectified way. The students go around designated rooms occupied by simulated patients and independent examiners within a specified time limit in order to complete tasks mimicking real-life clinical situations.

⁵³ This is a clinical examination performed on standardized patients.

⁵⁴ PBL is an educational method in which students proactively work together to solve certain problems with minimal intervention from teachers. The teachers generally evaluate students on the basis of their performance in each session.

b. CPX (Clinical Performance Examination)		
c. PBL (Problem- based Learning)		
d. Biomedical science (equipment for practical)		

Note: a) In this OSCE practical, the students perform the instructed treatments in the room. I observed a test on the cauterization technique. b) In the CPX practical, the students should develop a rule-out diagnosis on a fake patient whose symptoms are shown briefly on the door before the student enters the room. c) PBL classes are student-led. Teachers intervened very rarely and used pre-written instructions to facilitate students' discussion. d) Selection of biomedical equipment is stored in a room for clinical practical.

Source: Author

What distinguishes the PNU curriculum from other schools is the fact that the PNU is not following the conventional subject progression in which the students learn basic sciences in the first two pre-medical years (*yeggwa*) before they are exposed to clinical subjects in the later four years (*bong'gwa*). Instead, subjects are categorized into six different themes which are Recognition and Interpretation of Human Pathology; Studies on Meridian and Acupoints; Herbology and Formularies; Principles of Human Body's Responses and Principles of Disease; Electives; Contemporary Society and Korean Medicine; and Research on Korean Medicine. It is structured in a way that within each stream, various elements of basic and clinical science subjects are incorporated without artificially dividing the pre-medical and the medical as in the conventional Kyung Hee University-based curriculum which most KM schools still follow (see Picture II-3).

Picture II-3 Curriculum for 2nd Year Students at the PNU School of Korean Medicine in 1st Semester 2011

2011학년도 한의학전문대학원 2학년 1학기 수업시간표														
	11주	월(5/2)	화(5/3)	수(5/4)	목(5/5)	금(5/6)	토(6/7)	18주	월(6/6)	화(6/7)	수(6/8)	목(6/9)	금(6/10)	토(6/11)
2)	1교시 (8~10시)	초급안문 3 집합수	초급안문 4 집합수	초급안문 5 집합수		죽림경법 (허기태)	한자 사상	1교시 (8~10시)		초급의론 1 이강현	초급의론 1 이강현	병문심기시험(4차) (김기환·심상우· 하기태)	피부경계질환을 초·중급론 중급	
	2교시 (10~11시)							2교시 (10~11시)						
	3교시 (11~12시)	중급론심상(2) (김기환)	기원경법 초급심 변수 (하기태)	피질학2 (정환철)	어른이발	위·십장경, 세로보인 (홍학호)		3교시 (11~12시)	한글 수업	임도학/BAV 중급 수업 (김기환)	병 심론 (김기환)	생식기계 및 후방질환1 (정환철)	중급질환 (홍학호)	
	4교시 (12~1시)	병문 심기시험 (1차)						4교시 (12~1시)						
	5교시 (1~2시)	죽림경법2 수업 (김기환)	기원경법 (구소현)	피질학2 병문심판 (김기환)		초급안문 6 집합수		5교시 (1~2시)			참마 부합 (김기환)	임구부합, 보전집합 문 (김기환)	초급의론 2 이강현	초급의론 3 이강현
	6교시 (2~3시)							6교시 (2~3시)						
	7교시 (3~4시)		001후반 자소요법 (심기욱)	002후반 중급학, 반사학 (심기욱)				7교시 (3~4시)			001후반 카이포르학 (홍학호)	001후반 복합요법 (홍학호)	002후반 비파리독, 마사지 (심기욱)	
	8교시 (4~5시)							8교시 (4~5시)						
	9교시 (5~6시)							9교시 (5~6시)						
	10교시 (6~7시)							10교시 (6~7시)						
11교시 (7~8시)							11교시 (7~8시)							
3)	1교시 (8~10시)	초급의론 1 이강현	초급의론 2 이강현	상조변론 (심상우)	치질론 (심상우)		한자 제후 대회	1교시 (8~10시)	이론병기 3 이강현, 조수민, 김 철우	비파리독 1 조수민	제후 진단 조수민	병문심기시험(4차) (김기환·심상우· 하기태)	외경도, 주진도, 금강도 (김기환)	
	2교시 (10~11시)							2교시 (10~11시)						
	3교시 (11~12시)	초급안문심론 (하기태)	심기환심문	심상질환1 (정환철)	Ecosanoids NO/ 한식 약물 1 (홍학호)	4교시 (12~1시)		중급생체물질학 (김기환)	약상 속증 및 정신약제학진단 수업 (김기환)	한약 연구방법 (정환철)	생식기계 및 후방질환2 (정환철)	내분비계 질환 (정환철)		
	4교시 (12~1시)							4교시 (12~1시)						
	5교시 (1~2시)	경구약물 1 (구소현)		초급안문심론 1 조수민, 김철우	초급안문심론 2 조수민, 김철우	초급진단제후1 (정환철)		5교시 (1~2시)	한약 연구방법 1 (구소현)	한약 연구방법 2 (구소현)	허그로전, 장신보전 문 (김기환)	중급약이완술1 조수민, 김철우	중급약이완술2 조수민, 김철우	
	6교시 (2~3시)							6교시 (2~3시)						
	7교시 (3~4시)	경구약물 수업 1 (구소현)		001후반 한식, 복합요법 (심기욱)	002후반 후가소요법 (심기욱)			7교시 (3~4시)		신약제학1 001후반 장신보전 1 (심기욱)	신약제학1 002후반 가소요법 1 (홍학호)	신약제학1 002후반 장신보전 2 (심기욱)		
	8교시 (4~5시)							8교시 (4~5시)						
	9교시 (5~6시)							9교시 (5~6시)						
	10교시 (6~7시)							10교시 (6~7시)						
11교시 (7~8시)							11교시 (7~8시)							
4)	1교시 (8~10시)	제후질환 1 김기환	제후질환 2 김기환	중급약이완술 1 김기환	경구약물 수업에서 서포 변론 및 독문 (김기환)	병문 심문 심론(1) (심상우)	18주	1교시 (8~10시)	외경도 및 금강도, 심상도 중급 수업 (김기환)	제후 진단/비파 리독 (김기환)	한약의론/중급/생리 학에 의한 연구 방법 (김기환)	한약의론/중급/심신 통증/심신 (김기환)	병기시험(4차) 및 심문심판 (심기환·심상우· 하기태)	한자· 영어
	2교시 (10~11시)							2교시 (10~11시)						
	3교시 (11~12시)	초급안문 심문 심판 (김기환)	명사특강	제후질환제후2 (정환철)	Ecosanoids NO/ 한식 약물 2 (홍학호)	3교시 (11~12시)		001후반 중급학 조수민, 김철우	001후반 장신보전2 (정환철)	중급약제 및 심신질환1 (정환철)	중급약제 및 심신질환2 (정환철)	심기시험 (심기환)		
	4교시 (12~1시)					4교시 (12~1시)								
	5교시 (1~2시)					5교시 (1~2시)								
	6교시 (2~3시)					6교시 (2~3시)								
	7교시 (3~4시)					7교시 (3~4시)								
	8교시 (4~5시)					8교시 (4~5시)								
	9교시 (5~6시)					9교시 (5~6시)								
	10교시 (6~7시)					10교시 (6~7시)								
11교시 (7~8시)					11교시 (7~8시)									
5)	1교시 (8~10시)	제후질환 1 김기환	제후질환 2 김기환	중급약이완술 1 김기환	경구약물 수업에서 서포 변론 및 독문 (김기환)	병문 심문 심론(1) (심상우)	18주	1교시 (8~10시)	외경도 및 금강도, 심상도 중급 수업 (김기환)	제후 진단/비파 리독 (김기환)	한약의론/중급/생리 학에 의한 연구 방법 (김기환)	한약의론/중급/심신 통증/심신 (김기환)	병기시험(4차) 및 심문심판 (심기환·심상우· 하기태)	한자· 영어
	2교시 (10~11시)							2교시 (10~11시)						
	3교시 (11~12시)	초급안문 심문 심판 (김기환)	명사특강	제후질환제후2 (정환철)	Ecosanoids NO/ 한식 약물 2 (홍학호)	3교시 (11~12시)		001후반 중급학 조수민, 김철우	001후반 장신보전2 (정환철)	중급약제 및 심신질환1 (정환철)	중급약제 및 심신질환2 (정환철)	심기시험 (심기환)		
	4교시 (12~1시)					4교시 (12~1시)								
	5교시 (1~2시)					5교시 (1~2시)								
	6교시 (2~3시)					6교시 (2~3시)								
	7교시 (3~4시)					7교시 (3~4시)								
	8교시 (4~5시)					8교시 (4~5시)								
	9교시 (5~6시)					9교시 (5~6시)								
	10교시 (6~7시)					10교시 (6~7시)								
11교시 (7~8시)					11교시 (7~8시)									

What the PNU curriculum shares with the traditional curriculum, however, is the fact that the study of biomedical science, particularly anatomy, occupies a central place.⁵⁵ According to Prof. Shin who teaches anatomy at PNU, for example, the school was using five cadavers for dissection for the education of about fifty students, a substantial number considering the nationwide lack of cadavers for educational purposes (Kiwon Kim 2011).⁵⁶ While I was doing the fieldwork, I witnessed first-year students at PNU working very hard not to fail the anatomy course, and it reminded me of an ‘osteology’ course, a branch of anatomy that focuses on the study of the skeletal bones, that I took at the end of my first year when I was a student more than twenty years ago.⁵⁷ The attention paid to this subject still seems to be the same at PNU as I witnessed two students fail the anatomy class in the first semester of PNU, and subsequently were suspended for the remainder of their first year.

In most schools of Korean Medicine, the portion of biomedical elements in the curriculum generally increases as the year progresses. Clinical subjects are divided according to the *Dongŭibogam*-based categorization such as Liver, Heart, Spleen, Lung, and Kidney in the case of internal medicine, though many parts of what is actually being

⁵⁵ At PNU, typical WM subjects such as forensic medicine was taught by professors from WM schools, and some applied medical science such as pharmacology was taught by a professor with double medical licenses (KMD and WMD) at the KM school. Many KM school professors, however, had advanced research training in biomedical sciences.

⁵⁶ At PNU, it seems that anatomy professors at three medical schools (WMD, KMD, and dental) collaborate to get a good number of cadavers available for each school.

⁵⁷ Passing the ‘osteology’ course during winter vacation where second-year students taught the basics of osteology in two weeks’ of confinement was a rite of passage every first-year medical school student had to go through at the end of their first year, whether they were in Western Medicine, Korean Medicine or Dentistry schools. It was a preventive measure to successfully prepare the students for the toughness of the anatomy course in their second year.

taught within those subjects are the biomedicine-based clinical knowledge. For example, circulatory tract disorders are taught in Heart Internal Medicine (*simgyenaeggwa*) classes, and gastro-intestinal pathologies are taught in Spleen Internal Medicine (*bigyenaeggwa*) classes, and the hormonal metabolism in the Kidney Internal Medicine (*singyenaeggwa*) classes, etc. because the KM-based categorization is considered to correspond to those WM areas.

What distinguishes the classes in higher years from those in lower years is that biomedical content is taught under the Korean Medicine subject heading in higher years whereas it is taught under Western Medicine subject headings such as Western Medicine Pathology (*yangbang byŏngrihak*) and Western Medicine Physiology (*yangbang saengrihak*) in the lower years.⁵⁸ This emphasis on biomedical science was so comprehensive at the school that I was shocked to find out, in our fifth year, that many parts of the Kidney Korean Medical Internal Medicine textbook were exact Korean translations of the famous biomedical text on internal medicine Cecil Textbook of Medicine.⁵⁹ According to my explorations of the KM school homepages, it seems that the overall structure of the school curriculum is quite similar to the one I received at Kyung Hee University.

⁵⁸ Also there are KM-related subjects such as Korean Medicine Pathology (*hanbang byŏngrihak*) and Korean Medicine Physiology (*hanbang saengrihak*) in the lower years.

⁵⁹ Many WMD school students used to purchase the Korean Medical Kidney Internal Medicine textbook to use as supplementary material for their study. It was a time when the idea of intellectual property rights was scant and pirate copying of the foreign texts was common practice.

4.1.4. Summary

So far we have looked at the ways in which Korean Medicine is integrated into the country's legal and institutional framework under the *Yiwŏnhwa* system. We explored how Korean Medicine operates in the state's legal system in parallel with Western Medicine and Dentistry. The state's engagement with matters of Korean Medicine under the *Yiwŏnhwa* system was also described. Education in schools of Korean Medicine was then explored and it was found out that strong emphasis was given to biomedical elements in the curriculum.

In the following section, I will deal with the clinical practice of Korean Medicine to provide an understanding of the medicine which is being framed within the various institutional and structural conditions thus far described.

4.2 Clinical Practice

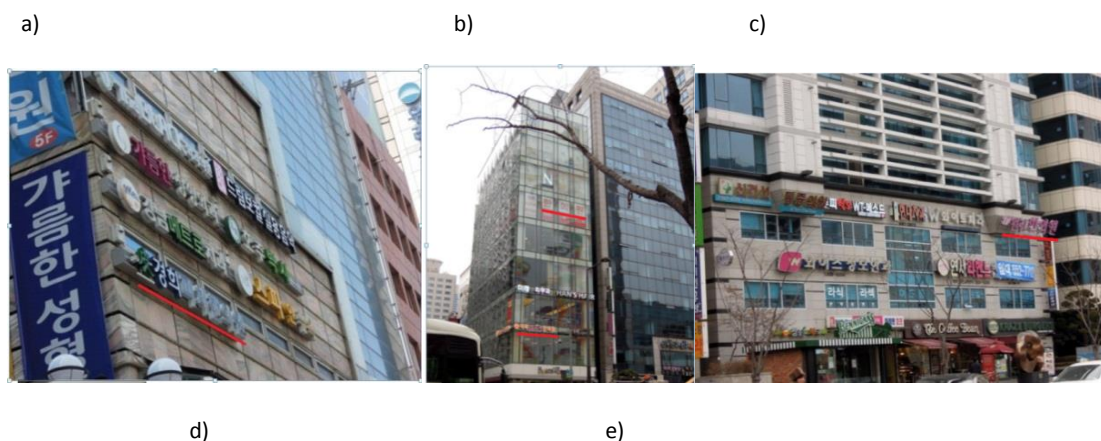
The practice of Korean Medicine should be seen against this institutional backdrop wherein its practice, as mainstream medicine, is subject to extensive legal regulations and to other institutional arrangements. It is important here to note that Korean Medicine is not complementary and alternative Medicine (CAM). The following quote by a member of academic staff at a WM medical school shows well how Korean Medicine is differentiated from CAM in the Korean context.

As the only country in the world where the medical practice is divided into two, this situation causes problems... In the situation where *orthodox medicine is dualized*, CAM practices are also expanding their territories (Byun 2009).

It is clear that the author considers CAM practices as ‘the therapies other than Korean Medicine’, a point that was frequently passed over in previous works on the subject. This situation also means that when a new CAM practice is introduced, a conflict arises between WMDs and KMDs who want to register the new therapy as their own.

Like the most medical practices in Korea, practice of Korean Medicine is also urban-based. Most KMDs prefer to open clinics in cities either individually or in a group of two or three. They are stationed in big and clean buildings at busy street junctions where easy access is provided to potential clients. These clinics are frequently found in large buildings that are commonly called ‘clinic buildings’ in which various types of specialty clinics are gathered to maximize their publicity. Some well-known Korean Medicine clinics spend much money in advertisements in subway trains and busy corridors of underground shopping malls, though the form and content of the advertisements are subjected to strict legal regulation (see Picture II-4).

Picture II-4 Korean Medicine Clinics in ‘Clinic Buildings’





Note: a) b) c) Korean Medicine clinics in Seoul. They are underlined in red colour. d) A KM clinic's advert on subway platform in Seoul advertising treatments for allergic rhinitis. e) An advert inside the train by a Korean Medicine clinic specializing in atopic dermatitis.

Source: Author

Due to the success of so-called 'networked' clinics and as a result of tough competition, many Korean Medicine clinics tend to specialize in fields such as pediatrics, gynecology, dermatology, or ENT (Ear-Nose-Throat) while others specialize even further in disease-specific conditions such as atopic dermatitis, acne, hair loss, obesity, hypertension, diabetes, and cancer. In these networked or franchised clinics, the central office owned and headed by doctors⁶⁰ provides administrative support for their branches (see Picture II-5).⁶¹ Due to the fact that many elderly patients prefer Korean Medicine treatments, another rising trend is that many KMDs and WMDs establish and/or work together in long-term care hospitals, the hospitals for the elderly.

⁶⁰ Under the Korean law, you cannot open and run a clinic if you are not a medical doctor. Also one doctor cannot run multiple clinics.

⁶¹ Since the law specifies that doctors are ultimately responsible for their patients, the treatment decisions are made individually by doctors running the clinic. However, some borderline cases do exist where local branch doctors do not seem to have full control over the treatment decisions due to strong intervention from the central office. See Rho (2012) for clashes that occurred between franchised UD Dental clinic network and the Korean Dental Association over the UD clinic's supposedly unlawful control over its branches.

Picture II-5 The Korean Network Hospital Association

a)



b)



Note: a) KNHA is the organization that represents interests of various networked clinics. Links to MOHW and KMA, AKOM and KDA are visible on the right. b) Various medical subjects in which its member clinics are specializing are listed in the chart. They are Internal Medicine, Plastic Surgery, Gynecologist, Urologist, ENT, Dermatology, Ophthalmology, Men's Conditions, Obesity, Korean Medicine, and Dentistry.

Source: KNHA

Most KMDs working in hospital-level facilities technically have free access to various major WM diagnostic equipment such as MRI (Magnetic Resonance Imaging) and CT (Computed Tomography), albeit through the orders of WMDs employed in the hospitals. Locally-based KM physicians also virtually have free access to WM diagnostic equipment and tests through nearby WM radiologists who regularly post-dispatch diagnostic referral sheets to nearby KM clinics.⁶²

Given access to comprehensive rights in the system, KMDs utilize a multitude of treatment modalities which could largely be divided into two groups: the treatments that are based upon East Asian Medicine, and those that are based upon biomedicine or CAM.

⁶² The full use of all major diagnostic and treatment apparatuses within the KM clinic, which could only be mediated through the employment of medical technicians, however, is not yet granted to KMDs.

4.2.1 East Asian Medicine-based Treatments

For treatments using medicines either in granule, pill or decoction form, the most frequently utilized style of treatments is that based upon the treatment rationale expressed in *Dongŭbogam*, which is the standard form of practice where various East Asian medical theories such as Yinyang and Five Phases (*ŭmyangohaeng*), Theories of Meridian (*gyŏngrakiron*), Zhang Xiang (*jangsang*), Eight Rubrics Diagnosis (*p'algangjindan*) and Theory of Qi and Taste (*Kimiron*) are applied according to disease conditions under consultation.⁶³ Another form derived from this and used by many doctors are treatments based upon the Medicine of Outer Appearance (*Hyŏngsangŭhak*), where the choice of formulas is based upon four key elements of essence (*chŏng*), qi (*ki*), shen (*sin*) and blood (*hyŏl*) which were described in *Dongŭbogam* to be the fundamental attributes of life. The treatment targets the regulation of imbalance in each of these four attributes that are believed to underline the patients' pathophysiology.⁶⁴

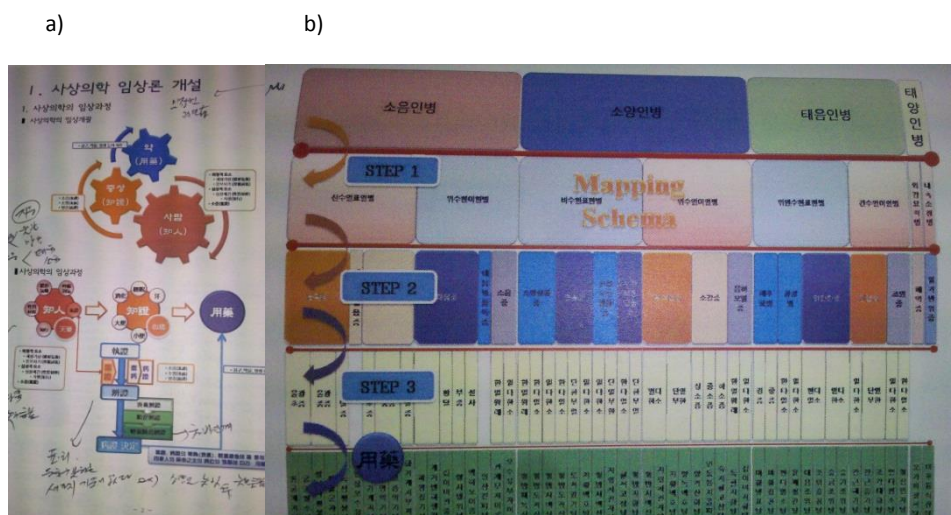
Another defining feature of practices of Korean Medicine is Sasang Constitutional Medicine (*sasangŭhak*) according to which human constitution is divided into four types. In Sasang, the consultation crucially starts with an identification of the patients' innate constitution. This is the stage of Knowing Person (*Chiin*). Then the consultation proceeds to identify symptomatic patterns, or to the stage of Knowing Symptom (*Chijjŭng*) before it

⁶³ These are the basic theories of East Asian medicine. See Farquhar (1996), particularly Chapter 4, for detailed discussion of each concept.

⁶⁴ The Hyŏngsang Society is the officially registered academic group within the Korean Medical Society. See its homepage at <http://www.hyungsang.or.kr>.

is wrapped up with the determination of appropriate formulas, namely the stage of Using Medicines (*Yongyak*) (Hwang 2012) (see Picture II-6).

Picture II-6 A Sasang Constitutional Medicine (SCM)-based Clinical Diagram



Note: a) The diagram shows the process of the Sasang-based consultation that proceeds from identification of the constitution finally to the choice of formulas. b) Another diagram that maps the three step process.

Source: The Sasang Medicine Education Centre (2012)

Sanghanlon-based practices are also an established practice of Korean Medicine.

The stream can generally be divided into two groups. One group follows the classical interpretation of the original text wherein six meridian-based interpretations (*yukgyŏngbyŏnjŭng*) of the symptoms described in the classical Sanghanlon text are acknowledged. The other follows a form of practice inspired by the Japanese style *Kobangp'a*⁶⁵ or *Kohoha* whose famous protagonist is 18th century Japanese scholar Yoshimasūdodo who argued that classical theories such as the Five Phases and Theories

⁶⁵ It is a Korean way of reading Japanese word 'Kohoha' 古方派.

of Meridians should be discarded in favor of the knowledge he gained on the basis of empirical testing.⁶⁶

The *Onbyŏnghak*⁶⁷ or *Wenbingshue* which refers to the warm factor stream, wherein the use of cold, and heat-scattering medicines are frequently used in treatments of the *warmth*-induced conditions, in contrast to *coldness*-induced ones, is also used by some doctors who work on such ailments as atopic dermatitis and psoriasis. As mentioned, the introduction of *Wenbingshue* into the country is very recent, only after the opening up of People's Republic of China in the 1970s. Raising Yang therapy (*Buyangbŏb*) is another therapy that has a distinctive group of supporters, and those belonging to this group rely on the use of formulas that contain a small amount of heat-inducing and potentially toxic elements such as the root of *Aconitum Carmichaeli* DEBX. (buja).⁶⁸

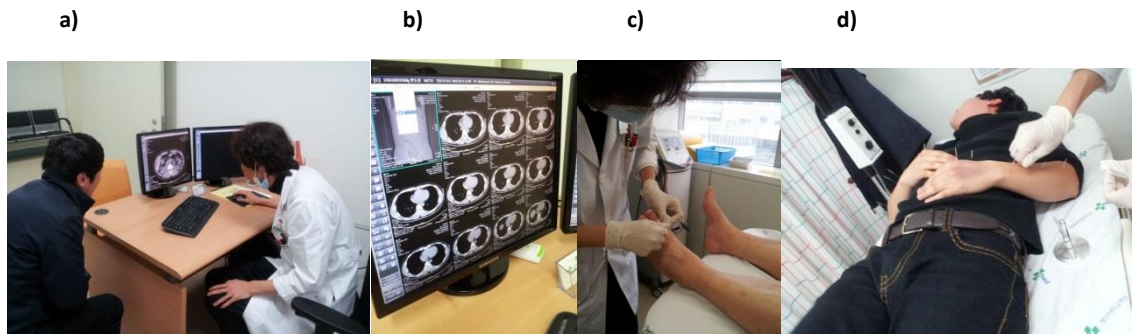
With regard to acupuncture and moxibustion (*Ch'imgu*), the majority of physicians apply the classical style of needling that adheres to the theory of Twelve Meridians. Various classical needling techniques such as Supplementation and Leaking based upon Greet and Follow (*Yŏngsubosa*), Supplementation and Leaking by Twisting (*Yŏmjŏnbosa*), Opposite-side Needling (*Mujabŏp*), Pain-spot Needling (*Ashihyŏlbŏp*) are used (see Pictures II-7 and 8).

⁶⁶ The Korean Society for Abdominal Treatment Society (*Daehanbokchi'ŭhakhoe*) is the academic society which follows this style of Sanghanlon-based practice (<http://www.bokchi.com>).

⁶⁷ '*Onbyŏnghak*' is a Korean way of reading Chinese '*Wenbingshue* 溫病學'.

⁶⁸ The Somunhakhoe is the center for exchange of information in the Korean Medicine community (<http://www.somun.or.kr>).

Picture II-7 Prof. Yang Giyoung at PNU Hospital of Korean Medicine Is Consulting with His Patient



Note: a) b) Prof. Yang is discussing the patient's condition showing him an MRI scan of the condition of his inter-vertebral disc-herniation. c) Acupuncture needling is applied in the patient's foot. d) Prof. Yang is applying Supplementation and Leaking by Twisting (*Yömjönbosa*). Actually, this technique of using thick needles that is accompanied with twisting, causes a lot of pain to the patient.

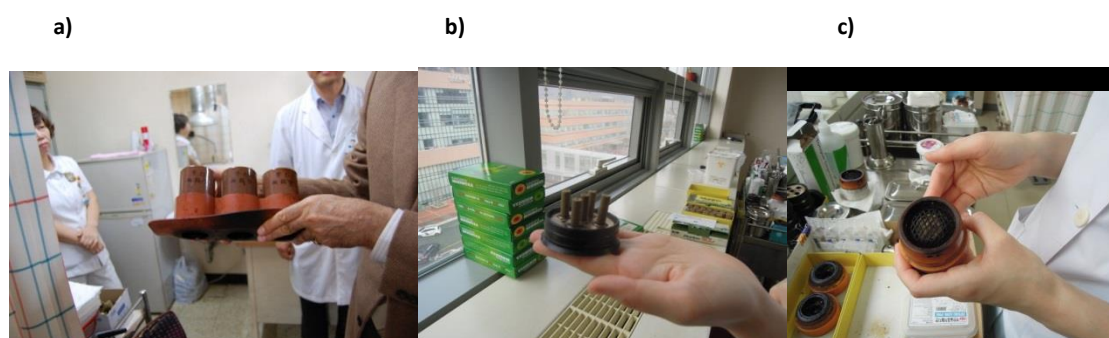
Picture II-8 Prof. Yang's Specially-made Long and Thick Needles



Note: He calls this very old-style acupuncture technique '*Chosŏn* Acupuncture'.

For moxibustion, techniques such as Indirect Moxibustion (*Kyögggu*), Ginger Moxibustion (*Kang'gu*) and cupping techniques such as Wet Cupping (*Sŭpbuhang*) which were aimed either to extract bad qi (*Sagi*) or to replenish right qi (*Chöngg'i*) are all also widely utilized (see Pictures II-9 and 10).

Picture II-9 Moxibustion Devices Used in Korean Medicine



Note: a) Moxibustion devices used in the Hospital of Korean Medicine, Wonkwang University, Chonju. b) c) Moxibustion devices used at PNU Hospital of Korean Medicine

Source: Author

Picture II-10 Cupping Devices Used at PNU Hospital of Korean Medicine



Note: a) Common cup used in cupping therapy. b) The suction gun that pulls the air inside out of the cup. c) Small flexible cups that could be attached to the body are contained with wrapped paper. They are sterilized before use. d) Patient with low back pain is undergoing cupping treatment using small flexible cups. Infra-red light was also applied. e) Lancets used in wet cupping in which small amount of blood is taken out.

Source: Author

A key difference from Chinese acupuncture practice is that many Korean doctors who use thin needles for surface stimulation (see Pictures II-11) do not take *Dŭggi*⁶⁹ or *Deqi*, which refers to the sensation felt by the patient that differentiates various efficacy of the needling, as reported among Chinese doctors in Hsu (2005, 78–79).⁷⁰ This classical acupuncture that is called Whole Body Acupuncture (*Ch'ech'im*) is based upon the concept of Zhang Xiang under which it is believed that troubles at the level of internal organs manifest on corresponding body surfaces.

Picture II-11 Thin Acupuncture Needles Used by Most KMDs



Note: The use of these thin needles prevents doctors from applying an extensive array of techniques that were used by Prof. Yang. And that is why *deqi* is not invoked in patients in local clinics of Korean Medicine. Also, applying painful acupuncture is not considered to an effective way of attracting patients.

Source: Author

One of the acupuncture techniques popular among most Korean doctors is Sa Am Acupuncture (*Sa Am Ch'imböp*) whose methods require practitioners to utilize only five acupuncture points on forearms and lower legs according to Five Phase attributes of each point. Eight Constitutional Acupuncture (*P'alche'jilch'im*) is also commonly used among doctors, and practitioners of this therapy divide the Sasang constitution into two more

⁶⁹ It is a Korean reading of the word '得氣' which is read Deqi in Chinese.

⁷⁰ There are some doctors of Korean Medicine, however, who consider Deqi more seriously. Prof. Yang in Picture II-9 is one of those.

sub-types using hot and yang on the one hand, and cold and yin attributes on the other, making it eight constitutions in total. Needling in this technique is implemented first for the purpose of identifying the constitution and then proper needle insertions take place on the points that have been already set for the conditions of each of the eight constitutional types.⁷¹ One Acupuncture Therapy (*Ilch'imyobŏp*) was formerly very popular among practitioners. In this practice, extreme care is given to diagnosing the patient's pathological conditions to find the single most important needling point.⁷² A newly emerging acupuncture technique is One Hundred Time Unit Acupuncture (*Paeggak Ch'imbŏp*) in which the circulation of *qi* is calculated to find right meridians and right points for the conditions under consultation so that a specific acupoint on a specific meridian can be needled.⁷³

4.2.2 The Biomedicine- and CAM-based Treatments

Chuna Therapy (*Ch'unayobŏp*) which manipulates mainly the spinal column is also a popular therapy among Korean Medicine physicians. According to executive directors of the Korean Medicine Ch'una Society, the society is set to start its professional training program at the College of Osteopathic Medicine at the Michigan State University soon (see Picture II-12).⁷⁴

⁷¹ See D. Kwon (1965) for details.

⁷² The name of the academic society for this therapy is Kim's One Acupuncture Academic Society (Kim's Ilchim Hakhoe).

⁷³ See Taewoo Kim (2011, 137–170) for details of this therapy. This therapy is similar to classical Phase Acupuncture Therapy (*Jaoyujuch'imbŏp*) in that the circulation of *qi* during the day is calculated to find right acupoints to tackle. The difference is that Time unit Acupuncture considers constitutional elements.

⁷⁴ They completed their first batch of training mission in July, 2013. See Park (2013) for details.

Picture II-12 Ch'una Treatments



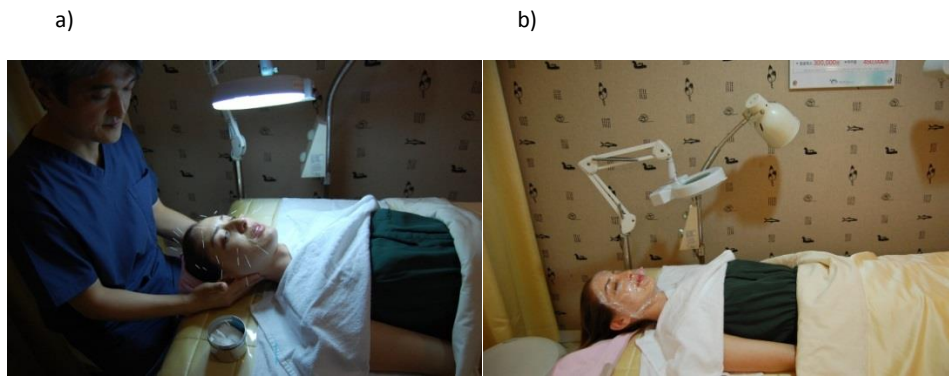
Note: a) Dr. Royer, originally from Austria, is the country's only Westerner qualified as KMD, and works in an international clinic at Jaseng Hospital of Korean Medicine. He is checking the length of the feet of a patient who suffers a severe back pain following multiple surgeries. b) Dr. Royer is applying manual pressure on the patient's spinal column. Both are the standard techniques applied in American chiropractic. c) The head of Jasaeng Korean Medicine Hospital Dr. Junshik Shin is treating a patient with a severe acute spinal incident admitted to the hospital's emergency department of the hospital. Staff from Rush Medical School from Chicago are observing the treatments.

Source: Author (a, b) and Jasaeng Korean Medicine Hospital (c)

Line-insertion Treatment (*maesŏnyobŏp*) during which thin autolytic filament-like materials are inserted under the skin is another popular emerging therapy among doctors, and it is mainly used for aesthetic purposes and pain relief.⁷⁵ Smile in Face Acupuncture (*anmyŏnmisochi'm*) is another therapy applied for clients who have aesthetic concerns on their face. Needling is aimed to affect muscular structures underneath the skin (see Picture II-13). For dermatological treatments, various techniques of peeling medicines are also commonly utilized.

⁷⁵ This therapy started in KM clinics and now it seems that WM clinics have adopted the technique in the name of 'lifting'.

Picture II-13 Smile in Face Acupuncture



Note: a) Dr. Kim Jinhyong, the head of Myungokhŏn Korean Medicine clinic applies acupuncture on a Canadian travel journalist. b) After the acupuncture treatment, the patient receives stabilization treatment where a mixture of therapeutic cream is applied on the skin to sustain the effect of the stimulation.

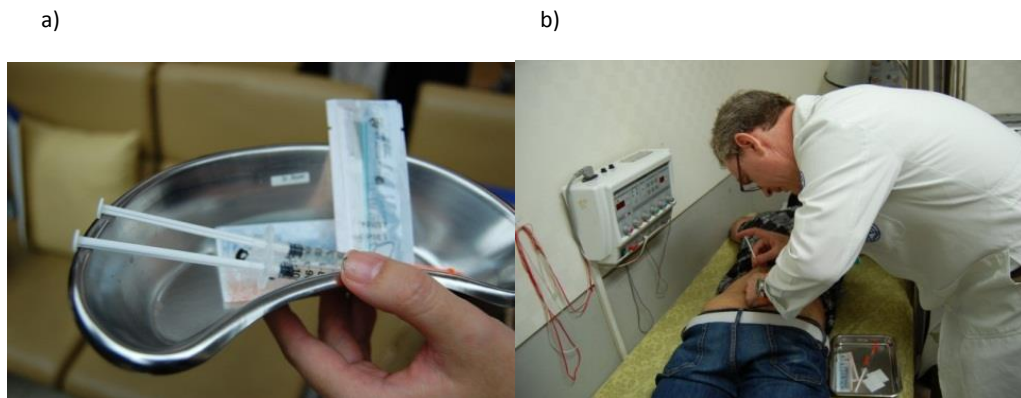
Source: Author

Other biomedicine-based treatments include Acupuncture Surgery therapy (*Ch'imdo-yobŏp*) in which a certain part of the patient's intervertebral tissues is removed using a thin knife on the basis of real-time readings of multi-dimensional CT and MRI pictures on the patient.⁷⁶ The Pharmaco-acupuncture therapy (*yakch'im-yobbŏp*) could also be said to be derived from biomedicine as it is mainly used for pain relief and its effect on the regulation of the immune system.⁷⁷ The points to be chosen by the doctors, however, are traditional acupoints which are close to the location of the pathological conditions (see Picture II-14). Sports medicine has been incorporated in Korean Medicine a long time ago, and team doctor training is done collectively among WMDs and KMDs through various academic societies.

⁷⁶ This technique seems to have been imported from mainland China in recent years.

⁷⁷ The Pharmaco-Acupuncture Society publishes an international peer-reviewed journal called the *Journal of Acupuncture and Meridian Studies* (<http://www.jams-kpi.com/>). Most of the contents of the published articles are on the immuno-regulatory functions involved in the therapy. This society happens to be implicated in the conflict to be dealt with in the next chapter. See particularly the end of Section 3.3, Chapter III for details.

Picture II-14 Pharmaco-acupuncture Therapy



Note: a) acupuncture needles or syringes. b) Dr. Royer at Jaseng Hospital is applying pharmaco-acupuncture treatment.

Source: Author

Other CAM-based therapies include such therapies as iridology in which the shape of the patient's iris is utilized as one of the diagnostic criteria, the Moira treatment wherein diagnosis is made on the basis of an unnatural curvature of the spine, and Ayurveda-based aroma therapies utilized as supplementary measures in treating various conditions.

4.2.3. Summary

So far we have briefly covered the treatments performed in KM clinics. The list is not exhaustive as new techniques are continuously introduced. It is important to remember that all of these therapies belong to the purview of Korean Medicine. It is also important to recognize that despite the obvious use of modern technology and biomedicine-based clinical judgments, the doctors attempt to explain the rationale of using these techniques in East Asian medical terms. This is due to the fact that their practice is under strong influence from the country's dual medical license system and related healthcare politics.

In the next section, I will explore the KMDs' clinical reasoning that underscores the clinical practice described above. I will show the pattern of their reasoning by analyzing conversations between KMDs in a venue where they do not have to worry about the wider professional or political implications of their remarks. At the end of the section, I will also briefly introduce some ethnographic anecdotes where WMDs' individual perceptions on biomedical orientation underlying KMDs' clinical reasoning can be observed.

4.3. Clinical Reasoning: a Discussion of Two Cases

The following are excerpts of two clinical case discussions that I gathered from a KMD-only internet community called Swimtõ that I followed during my fieldwork. As the membership of this online community is strictly confined to KMDs,⁷⁸ it is very hard to get access to the contents of the site if you are not a member of the KM community. Though many functions exist in this online community, exchanging information on difficult clinical cases is one of the popular activities. Also as this site takes a great care in anonymizing the users, the venue is also well utilized as a venue for straightforward discussions on many issues. I found discussions of two clinical cases among the users, and I present them below to illustrate how KMDs' clinical judgments are being performed in their day-to-day practice.

The first case regards post-stroke care and it demonstrates the ways KMDs approached a cerebrovascular condition that affected an old lady. The second is the case

⁷⁸ To apply for a membership, you have to fax a copy of your medical license certificate to the main operator of the site. See Table III-3 for details on the online-communities for KMDs.

that involves a patient with indigestion where doctors discuss how to choose correct East Asian medical formulas for the patient. Although both cases are different in that the first one is about a bio-medically defined condition and the second is about traditional medical regimen, these cases will show the kinds of conceptual framework on which KMDs' clinical judgments are based in practice. And as mentioned, they will be shown to be based upon a very strong 'bio-medical' or 'scientific' orientation that must have been acquired in the course of the KMDs' professionalization.

4.3.1. A Case of Post-stroke Management⁷⁹

A 64-year-old female patient visited a doctor's clinic suspecting that she had an impending stroke. The lady had visited the doctor some months previously for treatment for an ankle sprain. Suspecting that stroke was indeed impending, the doctor K referred the patient to a nearby university hospital, and now the patient came back in a wheelchair following hemiplegia, or paralysis on one side of her body, that occurred a few days after his referral. The doctor posted the case in the online community.

Dr. K⁸⁰ started,

....I checked the Babinski's sign and checked her blood pressure, but as I checked her pupil reflex, it seemed to be a bit slow so I sent her to a big hospital for detailed check-up. But four months later, she came in on a wheel chair with a left hemiplegia. She was ... told she had a light infarction in her brain, but ... after three days of linger injection, she couldn't

⁷⁹ This case was uploaded at Swimtõ on 31st August, 2012.

⁸⁰ * () was in the original writing; the sign (-word-) indicates the original Korean words used in the writing; [] is what the author inserted for clarification; bold type emphasis was added by author

raise her hand and got the paralysis...They must have prescribed thrombolytic agents. Might her condition be exacerbated after she got admitted and treated? It's been three months [since she visited my clinic again] but she still can't use her arms at all...I'd like to see some pictures (MRI, or CT) but her son has some disabilities as well so the communication is very hard...What do you think? Is it the natural course of the condition [of those kinds?] or is it drug adverse reaction (haemorrhage or drug resistance)?

....She said she had discharged herself from the mid-size hospital because nothing of merit was done to her for the improvement of her condition. She had been referred to that [mid-size] hospital from the university hospital I had originally referred her to with an assurance that the condition would be better in six months. I don't know if I don't have enough knowledge [about this issue] or if those who don't know are actually those [WMDs who treated her].

Dr. X replied,

You've made a right decision. It might have been a disaster for you [in liability aspect] had it been a bit late. For those cases who were admitted in the early phase where the affected region could be identified with [brain] imaging, it is generally the case that the staff explains all possible symptoms, and the course the condition might take [in the near future]. In acute cases, it's common that the condition deteriorates on the first day. Hemiplegia is the most common, and in the case you described it seems the deterioration started rather slowly over three days [since admission]. *For CVA patients, during the initial three months, the phase of recovery is the fastest, and they are checked at 6 months and 9 months* [intervals], and when the period passes over three months, the prognosis is generally getting worse...

...Whether thrombolytic agents were administered is unclear (from your descriptions, and I don't know what kind of medication was administered through injection)... [The effectiveness of] *linger* [for this type of condition] *is not evidence-based but that's part of a routine treatment*...The nature of condition is like that...the possibility of adverse reaction?...I don't know...and, even in WM hospitals (-Yangbang byungwon-) there is nothing much to do [for the patient] except for the rehabilitation which is done under the assumption that the patients have a very strong will. Every time the patients come, they check various internal medical conditions such as HTN [Hypertension], DM [Diabetes Mellitus], and see if the condition is being stabilized. It is not an exaggeration to say that

all that they can provide is just physical and rehabilitative interventions. The patients will be extremely dissatisfied [with the ways that the treatment regime is being administered] *but that's the nature of the recovery of the disease...*

Dr. X continued his or her recommendations,

...if you want to treat CVA patients '*locally*' [or on a primary care basis], you should do the treatments focusing on the '*teaching*' with regard to the prevention of subsequent attacks (it would be almost impossible for you to do it alone without employing someone who will be solely responsible for the rehabilitation of the patients). *The most sensible option would be to focus on treating CVA induced complaints (such as pain in the affected and unaffected limb, and neuralgia, or another internal medical conditions like thalamic pain etc...')*...And the mentioning of six months...is something that doctors say to their patients [of these kinds of condition] rather than saying that "your condition will never be improved..." ...I think that's a customary statement...But there seem to be cases where the patients got a dramatic recovery from hemiplegia with a strong will...Of course, *it all depends upon which area was affected in the brain by the accidents*...Generally, however, it's quite uncommon for the patient to do [rehabilitative exercises] by himself.

(() in original. Italics, (- -) and [] added by author)

The clinical case discussion was conducted here on an entirely biomedical basis.

The use of jargons such as 'routine treatment' 'teaching' 'progression' 'local' 'management' implies bio-medicalized aspects of KMDs' professionalization process. The way the discussion is being conducted, with hints of caution against potential malpractice claim from the patient's part, also signifies the fact that KMDs are under a legal pressure to properly inform the patients of their conditions on a biomedical basis with regards to the management of the conditions.

4.3.2. Determining Formulas: Banhasasingt'ang or Gwakhayangjongg'isan?'⁸¹

In the second case, doctors conduct discussions on how to choose the right East Asian medical formulas for a patient suffering from indigestion. The subject of discussion in this case is classical traditional East Asian medical practice, thus, this case is different from the first case where the boundary of the discussion was limited due to the fundamentally biomedical nature of the condition.

Doctor W was faced with a problem of choosing between two classical formulas for acute indigestion (Sikch'e).

The signs and symptoms [presented in the patient] include discomfort below the heart (-*Shimhabi*-) and vomit and diarrhoea. According to Dr. Kwon Sunchong [who is a famous KMD Sanghanlon scholar], Bahansasimt'ang (半夏瀉心湯) is used for Yang Overflow (-*Yangsil*-), or and Gwakhayangchongg'isan (藿香正氣散) is used for Eum Overflow (-*Eumsil*-), what kind of differential criteria do you use in prescribing these two formulas?

Doctor B replied then, "If the condition has accompanying Surface Symptoms (*P'yojjŭng*), Gwakhayangchŏngg'isan is better, if not, it would be Bahansasimt'ang'." And Doctor W asked again for clarification, "By 'surface symptoms', do you mean shivering and fever?" To which Doctor A replied with an indication of disappointment for the lack of basic knowledge on principles of East Asian medicine by saying, "Well...headache, body ache, aversion to cold, and fever. Aren't they the basics?" Then, Doctor B provided a bit more detailed explanation,

⁸¹ This case was uploaded at Swimtŏ on 27th August, 2012 and was accessed by the author on 28th August, 2012.

Gwakhayngchongg'isan is for pressed pain (-*apt'ong*-) in the region of Chungwan [中腕], and Bahansasimt'ang is for the pressed pain for below the heart or sense of discomfort there. Strictly speaking, *the target place* of the formulas is different and the aim [for these two formulas] is also very different.

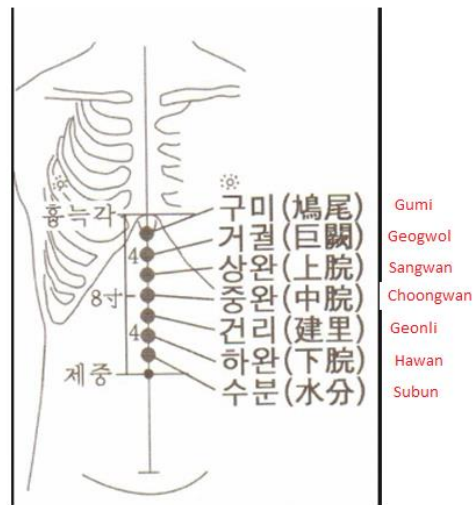
Doctor W followed up,

When you mentioned 'below the heart', *did you mean 'sternum' or the region in the upper Sangwan [上腕] just below the inferno sternal angle* or did you mean Chungwan [中腕]? I think that for acute indigestion, pressed pain for Sangwan and Chungwan is the necessary condition (-P'ilbal symptom 必發症-). Or, despite the fact the patients have discomfort below the heart, is it possible that they could or could not have pain at Sangwan or Chungwan or both?

Doctor B replied,

Below the heart is near Gögwöl (巨關) and Gumi (鳩尾) point which reflects the heat in the heart. *Pressed pain at Chungwan reflects the stagnation in the motility of gastro-intestinal tract* (see Picture II-15). If the indigestion comes from stress, it's most likely that there is no accompanying pressed pain in Chungwan region, and that's when the Bahansasimt'ang works well, but in the case of pressed pain at Chungwan it's better to start with Pyöngwisan...

Picture II-15 The Location of the *Gumi* Acu-point



Note: This diagram is from Daum Blog 'Gyŏnghyŏlch'aggi' (<http://blog.naver.com/imbjwoo/60058047605>). English names were added additionally by author.

Then Doctor W wanted a further clarification of Gumi and Gŏgwŏl acupoints with regards to the region below the heart by asking,

Does 'below the heart' designate the infra-sternal angle or xiphoid process? And is there any case where the region of xiphoid process shows pressing pain while the Chungwan and Sangwan does not show any sign of pressed pain [as they are so close]?

And Doctor B confirmed by saying,

Chungwan is where the stomach and duodenum meet, and there is no organ below the xiphoid process, which means pain in this region should be differentiated from pain in Chungwan and Sangwan. (Italics, (- -) and [] added by author)

Despite the nature of the subject under discussion that is based in East Asian medical practice, the frame of clinical reference the doctors were resorting to is unquestionably 'anatomical' or 'scientific'. The language they use such as '*target place*', and the '*first and second choice*' formulas also show that their professionalization has

been conducted in a bio-medicalized form. Specifically, the use of the word *p'ilbal* symptom (必發症) that indicates the presence of 'necessary conditions' for specific interventions, strike a strong note of similarity to the use of the term 'indications of surgery' in the explications of various pathological conditions in WM textbooks, despite the fact that the word *p'ilbal* itself, as it sounds, carries significant connotations of East Asian medical heritage. Overall, this case discussion also shows that KMDs' clinical rationale is firmly underpinned by WM practices and concepts.

Although KMDs' convictions on principles of East Asian medicine were able to be confirmed in the two case discussions explored, it is also clear that paradoxically, their clinical reasoning, whether it is related to biomedical conditions or to EAM concepts, is seen to be firmly couched in 'bio-medical' terms and concepts. The cases exemplifies on the ground level how KMDs' professional identities have been formed and are being played out in their day-to day clinical practice within the country's healthcare system.

4.3.3. WMDs on KMDs: 'Clinician' and 'Stethoscope'

Before I explore the public perceptions of KM and KMDs in the next section, I will introduce two short ethnographic cases in which WMDs' recognition of the bio-medicalized aspect obtaining in the practice of Korean Medicine can be observed. The discussions will not only concretize the ways in which clinical practice of Korean Medicine

is perceived by other medical practitioners, but also served to provide a snippet of healthcare politics that will be extensively discussed in later chapters of this thesis.⁸²

At least on an individual basis, WMDs do acknowledge KMDs' biomedical competency. In other words, they share the public's view of KMDs' professional identity, namely as 'medical doctors who have sufficient biomedical knowledge with an added understanding of East Asian medicine', although as collectivity, they do not officially acknowledge the 'bio-medicalized' elements utilized in Korean Medicine.

During the fieldwork, I had a chance to observe the WMDs' view of KMDs when I delivered a lecture to a mixed group of clinical professors based within three medical schools (WM, KM and dentistry) of a university. It was a monthly gathering of the school faculty who had interest in medical humanities, and I was asked to present an overview of medical anthropology. After an hour during which I discussed many concepts that might have been new to the audience, a WMD clinical professor said the following to me

... [you] as a KMD who *worked as a clinician* (*Yimsanga* 臨床家) before, and now studies a subject like anthropology, which I think, is very *special* (*Aju T'ukbyŏlhan Keissŭsijanayo*).⁸³ (Italics and () added by author)

It was a compliment and an expression of appreciation for my lecture but what struck me in her remark was her choice of words like *Yimsanga*, or 'clinician', and *T'ukbyŏlhan* 'special' in reference to my profession and to my career. Firstly, *Yimsanga* means literally those who practice *medicine*.⁸⁴ However, in the context of her utterance,

⁸² Particularly, Section 3, Chapter IV deals with inter-professional politics between KMDs and WMDs intensely.

⁸³ She emphasized the word 'special' (*T'ukbyŏlhan*).

⁸⁴ The literal translation of the word on the basis of Chinese characters is 'those who serve at the bedside'.

the word designates the local practitioners in these three medical professions of KMDs, WMDs, and dentists, and implies the fact that they share an assumption that local practitioners of these three medical professions have a similar outlook on clinical practice and life. What might have been the elements that became the basis of her grouping these practitioners in terms of their shared outlook on their clinical practice? The only element that I can think of is the ‘competent knowledge in biomedicine’. Her, rather unconscious intention to group these three professions on the basis of their competency in biomedicine was betrayed by her use of the suffix ‘*ga* (家)’, which is a more respectful form than the neutrally sounding suffix ‘*in* (人)’.⁸⁵ So in a nutshell, by uttering the word ‘Yimsanga’ in the presence of other medical practitioners, she was actually expressing her endorsement of the biomedical competency of KMDs.

Her use of the word ‘special’ (*T’ukbyŏlhan*) can also be understood along the similar line. The choice of the word ‘special’ (*T’ŭkbyŏl*), not the words like ‘unusual’ (*Tŭgihan*), or ‘rare’ (*Dŭmun*), was particularly significant as the word subtly designates another assumption supposedly shared among medical practitioners that ‘the medical professionals’ have hard time in getting out of ‘their medical career track’ to embark upon a completely different career. And it then again presupposes that the medical professionals including my own profession of KMD are effectively following the same career paths. What made these three groups similar in terms of their life-trajectory then? Again, it would be the ‘bio-medicalized’ framework of their professionalization.

⁸⁵ They are collectively called ‘*ŭsa* (醫師)’ or medical doctor, by the public. But this word has an important implication in Korea’s healthcare politics which will be dealt with briefly in the next section of this chapter and extensively in Section 3, Chapter IV.

A conversation I once had with some parents in my clinic, well before my career as an anthropologist, might also merit attention in this regard. A husband and wife visited my clinic, which was well-known for paediatric conditions, with their twelve-month-old baby boy for a prescription for '*dolboyak*', a small amount of immune-boosting Korean Medicine customarily given to babies on their first birthday.⁸⁶ I performed a routine check-up on the baby, listening to his heartbeat and lung sounds with my stethoscope to make sure the baby was healthy enough to take a small amount of *ch'ŏbyak*. The mother told me that she was worried whether the baby had fully recovered from the cold he had had a week before. As I was unable to find any adverse signs, I comforted her by saying that the baby looked fine.

It was then the father who has been silent all the time holding the baby in his lap started to entreat to his wife, shrugging his shoulders as if to defend himself, "I said he had no problem, and now you just heard what the doctor said." I was then informed by the mother that the father is the professor of surgery in the country's biggest hospital nearby. The mother showed an exaggerated expression indicating that she did not seem to be entirely convinced of his husband's opinion.⁸⁷ What this anecdote shows is the fact that one of the nation's most sought-after surgeons acknowledged the KMD's skill of using the stethoscope, the hallmark of biomedicine. And this signifies the extent to which WMDs, at least on the personal level, give recognition to KMDs' biomedical competency.

⁸⁶ The famous one serving that function is a formula called *Gwiryongt'ang* (歸茸湯) whose name is derived from two main ingredients in the formula: *angelica gigas nakai* (當歸) and deer horn(鹿茸).

⁸⁷ The public show of the wife's authority is quite typical of Korean middle-class families.

4.4. Public Perceptions

This section focuses now on the public perceptions both of Korean Medicine and KMDs. In the first part of this section, I will illustrate how the public views KMDs as medical practitioners who are competent in biomedicine with additional EAM knowledge. Then I will elaborate in the next part on the consequence of their perceptions, namely the ‘bio-medicalized’ socio-economic status of KMDs, not that of ‘traditional medical practitioners’, a point which I have continuously emphasized throughout this chapter.

4.4.1. Doctors Competent in Biomedicine with an Additional EAM Knowledge

As mentioned, KMDs are considered as ‘doctors competent in biomedicine with an additional East Asian medical knowledge’. Reflecting high public trust toward the profession, KMDs appear frequently in TV programs and provide health information on the basis of a mix of biomedical and East Asian medical knowledge. Almost without exception, KMDs are introduced and referred to as ‘*medical doctors (ŭsa 醫師)*’ in those programs. Occasionally, KMDs and WMDs appear together in order to provide a ‘balanced’ view to the public.

During the hot summer during my fieldwork, I saw a program on one of the major economic news channels called MBN, which featured a health information session with an invited Korean Medicine school professor. The professor had a specialty in Sasang Constitutional Medicine, and he provided advice on various diseases such as metabolic syndrome.⁸⁸ On the basis of Sasang principles, he also provided advice on how to take

⁸⁸ It is a mixture of borderline conditions of diabetes and hypertension.

‘healthy holidays’ on the basis of each person’s different constitutions, recommending, for example, going to mountains for some and the sea for others, and suggesting that some eat watermelon, while others eat pears (see Picture II-16).

Picture II-16 A KMD Sasang Constitution Specialist Giving Advice on ‘Good Holidays’



Note: This program was aired on MBN on 28 July, 2012.

Source: Author

Some TV programs actively exploit the antagonistic attitude existing between WMDs and KMDs and made an entire program out of this antagonism. The Han-Yang Scandal⁸⁹ is one of those programs where KMDs and WMDs appear on panels and debate various disease conditions, sometimes to the fury of the other party through blatant trivialization of the other’s expertise. One very popular talk show called The Three Rounds (*Sebaqwi*) also features rivalry between a WMD rehabilitative specialist and a KMD generalist as its main source of entertainment as they argue over almost every health-related matter. One drama series titled The Third Hospital (*jesambyŏngwŏn*) where top TV actors and actresses assumed title roles also took rivalry between a WMD and a KMD as the central element around which intrigue and jealousy between these two doctors

⁸⁹ It is written as 韓洋, ‘韓’ meaning KMD (韓醫師) and ‘洋’ meaning WMD (洋醫師).

within the hospital develops in their attempts to win the heart of a heroine (see Picture II-17).

Picture II-17 Homepages of the Program The Hanyang Scandal and The Third Hospital



Note: a) The caption on the Hanyang Scandal says ‘Korean vs Western Medicine Talk show clash’. b) The caption on the poster for The Third Hospital is ‘The Ultimate Clash between Two Geniuses of Korean Medicine and Western Medicine’.

Source: Channel A and TvN homepages

Recently the MBC, the main TV channel of the country, aired a remake of the drama *Huh Joon*, the author of the *Donguibogam*, with the title of *Gu-am Huhjoon* with an expectation that it might garner the viewing rating that would match its original version in 1999 which had a 63.5% rating, putting it as the fourth most popular TV programs in the country’s broadcasting history (Kyunggwon Lee 2013).

During my fieldwork, I also had frequent opportunities to observe the public’s attitude towards KMDs as I was repeatedly asked to give bio-medically informed advice. On one occasion, the wife of the owner of a pub I used to visit asked me to provide advice on her husband’s *herpes zoster* that affected his right thigh. After I highlighted the immunological basis of the condition and the nature of the accompanying pain, I recommended him to stop playing golf for some time. He replied to me that he would surely stick to my recommendation because my advice was identical to that given by a

WMD he visited recently. He seemed to be happy because the nature of his condition and its management were doubly confirmed by two doctors.

4.4.2. The Status

With this popularity and trust in the profession, and most importantly, the public's conceptualization of KMDs as the profession competent both in WM and EAM, it is no wonder that the KMDs assume an upper-middle class position in Korean society, just like WMDs and dentists, and as an elite group, command considerable political influence. In the Korean Medicine General Convention that took place in February, 2012, for example, nineteen members of National Assembly were present while the country's President Lee Myungbak sent a wreath of flowers to congratulate them on the event. Three presidential hopefuls, one former prime minister, and three former health ministers also appeared. During the opening, the deputy health minister delivered an apologetically long message of congratulations from the Health Minister who could not attend the event (see Picture II-18).

Picture II-18 KMDs' Socio-economic Status



Note: a) A session of the Korean Medicine Forum, an informal forum discussing various socio-political issues facing the Korean Medicine community. The place for the meeting is a living room of a KMD in a high-security apartment in one of the most expensive districts in Seoul. b) Politicians are lined up for photo-op in the Korean Medicine General convention. c) One of my university alumni, Dr. Chung Hyungseok is treating me to a dinner at a fancy Italian restaurant in Gangnam. The way he dresses and talks is that of typically upper-middle class professionals in Korea.

Source: Author

The high prestige accorded to the profession, however, put me in awkward situations many times in the field and I had to somehow conceal my professional identity in my daily life to get around unnoticed. The situation was worse in my case as I was also a lecturer in a university, or *gyosu*, another profession considered to be among the most prestigious callings in the country, not to mention my Oxford affiliation⁹⁰ and my past as the owner of a Seoul branch of one of the country's most famous KM clinics.

Some occasions arose, however, when I had to reveal my identity. One of those inevitable moments came when I had to sign a rental contract in a real-estate agency for my studio apartment in the beginning of my fieldwork. I was about to sign the paper, the only remaining step and I could sense the overflowing curiosity about me from the real-estate agent and the landlord who was an old man in his 70s. The lady in the real estate agency returned my driver's license after checking my identity and said, with a look of

⁹⁰ School names of prestigious universities carry enormous social capital with them in Korean society.

surprise on her face, “I just found out that you were the same age as me. But you look like a *Gosiwŏnsaeng*.”⁹¹

The lady seemed to be unsure of my profession because although I had told my landlord that I was going to teach at the School of Korean Medicine, I did not specifically tell the landlord I was a KMD. After signing the form, however, I had to call a utility company, and it was then that the real estate lady and the landlord started to have a conversation *about me* as if I was not listening to them.

The landlord: He came to teach at Korean Medicine Hospital. He is a person of high status (*nop'unbun*).

The estate lady: I could see at first glance that he is not a commoner (*bot'ongsaram*).⁹²

That afternoon after I moved into my studio, a person from an internet company came to install a broadband connection. As the broadband package purchased also contained an option to watch TV, the person from the service company asked me if I would buy a TV set. I hesitated a bit as I was debating with myself briefly whether buying a TV might be a good idea. The landlord suddenly intervened at this point, interpreting my hesitation as the sign of embarrassment caused by the technician's rather 'rude' question, and said with a dismissive gesture, “He is a professor so he is not interested in silly TV programs.”

⁹¹ They are those who prepare for national bar exams.

⁹² She said “*Ddakbomyŏn arayo Bot'ongsarami Aninji.*”

4.5. A Comparison with Other Non-biomedicines

The public's trust in KMDs, and the social and cultural capital associated with them is not surprising when considering their 'bio-medicalized' status. As I highlighted in the introduction of this thesis, the only similar medical profession might be osteopathic doctors in the US.⁹³ As no proper comparison across the countries has been made yet in the literature, I will provide below some cross-country comparisons that can contextualize the role and status of Korean Medicine in the country's unique dual medical license system.

In China, despite the state's active promotion of TCM, young aspiring high school graduates do not seem to choose TCM colleges as their destination,⁹⁴ partly because career prospects of TCM practitioners are not so bright (Hsu 1999, 147). In Japan, Western medicine has been the only legitimate medicine since the Meiji Reformation, and there is no official medical doctor license for East Asian medicine ever since. East Asian medical practice is, therefore, shared by a small group of *Kampo* physicians, acupuncturists and allied health professionals who graduated from junior college-level educational institutions (Otsuka 1976, 334; Lock 1980, 62; Ohnuki-Tierney 1984, 91). In Taiwan, a system similar to that in Korea exists but despite the state's aspiration to enhance the profile of Chinese Medicine, it seems that the public's preference for Western medicine still persists (Unschuld 1976; Wiseman 2000, 6–7) and Chinese

⁹³ Though further research is necessary, the similarity exists in that both KMDs and American doctors of osteopathic medicine are institutionally in the periphery of the country's mainstream healthcare, and both of them, despite their integration into the biomedical healthcare, still aim to preserve, at least in surface discourse, their professional identities that they think are distinct from biomedicine.

⁹⁴ On the internet, there are sites such as Netbig (<http://rank2010.netbig.com>) where college rankings are put up for the Chinese high school graduates. In 2005, for example, Beijing TCM College, one of the country's most revered TCM institution, ranked below 100th place in university-level league table. Subject-based ranking as in Korea's case would put those colleges well under five hundredth position.

medicine does not seem to have been fully integrated into the system, socially and institutionally, as observed in the Korean case.

According to Charles Leslie, efforts of Ayurvedic physicians to gain status in India ended in failure already in the 1970s, making Ayurveda fall into the status of para-professionals to biomedicine (Leslie 1976, 365). It seems, therefore, that osteopathic medicine in the US is the only medical system of non-biomedical origin that has survived to achieve the status that is comparable to KMDs (see Table II-7).

Table II-7 A Comparison of the Status of Korean Medicine with Other Traditional Medicines and CAM

	Names	Healthcare system	History	Social Recognition	Professionalization
Korea	Korean Medicine	Dualized	-Port-opening (1876) -Japan's annexation (1910-1945) -Korean War (1950-1953) -Military Rule (1961-1992)	Equal or comparable to biomedicine	Private sector led
China	Traditional Chinese Medicine	Dualized	- Communist takeover (1945) - Great Leap Forward (1958-61) - Cultural Revolution (1966-76)	Low in recognition (Not favored by students. Lesser career prospects)	State (all the way through)
Taiwan	Chinese Medicine	Dualized	- Japanese colony (1895-1945) - Nationalist government (1945-)	Four CM College (less favored than MD schools)	Special Exam (popular sector-led)

Japan	Kampo	Unitary	- Meiji Restoration (1868) - Integration into National Insurance (1976)	CAM (Junior-level colleges or pharmacies)	Small number of Kampo MDs, acupuncturists and pharmacists
India	Ayurvedic (Sidda) and Yunani Tibb	Unitary (Pluralistic)	- Independence (1947)	Para-professional	Some States involved, but mostly private
US	Osteopathy	Unitary	- WWII (1943-1945) - Merger between CMA and COA (1961)	Mainstream and almost equal to MDs (slightly lower MCAT scores)	Well-organized AOA. Free market based competition
UK	Homeopathy	Unitary	- Establishment of NHS in 1948	CAM (mainly vocational)	Organization exists but not powerful

The central argument of this chapter is that contemporary Korean Medicine cannot be understood simply as an extension of East Asian medicine. As was emphasized, the unusual ways in which Korean Medicine has been integrated into mainstream healthcare has transformed its practices to have not only a strong biomedical orientation but also a strong 'bio-medicalized' presence as seen cross-culturally in this section. In that regard, it would be not be an exaggeration to argue that in Korea, the biomedical healthcare system in its modern and institutionalized form exists in the heterogeneous dispersal of Western and Korean Medicine practitioners.

In the next section, I will explore the ways in which this unique healthcare system responds to the global trends in healthcare. The explorations will highlight again the nature of the domestic healthcare system that has been investigated so far in this chapter. They will also reveal the features of healthcare politics of the country as the local institutions meet global forces.

4.6. Cooperation or Integration?: The Impact of the Global on the Local

One case in point is the advent of integrative medicine in the West. Integrative medicine is generally defined as a new paradigm of medicine that is characterized by patient-centered care and a team approach in which diverse complementary and alternative medicine therapies are actively applied to improve treatment outcomes (Maizes, Rakel, and Niemiec 2009). In this framework, the medical practitioners (MDs) are generally in charge in effecting best possible treatment outcomes in cooperation with other CAM practitioners. This trend has already arrived in the Korean medical fields as several medical societies aiming for this integrative approach have already been established.⁹⁵

The trouble for Korean healthcare is the fact that there are two medical doctors in the system. The state's many healthcare policies had been, therefore, focused on facilitating the cooperation between these two doctors in the name of 'cooperative treatment (*Hyöppjin*)', not the patient-centered amalgamation of practices that this 'integrative' approach aims to achieve. In the Korean context, these two concepts have

⁹⁵ There are three medical societies which have 'integrative medicine' in their names. One consists mainly of WMDs, another mixture of WMDs and KMDs, and another mainly of KMDs.

contrasting implications as, while the ‘cooperation’ recognizes the worth of the current dual medical license system, ‘integration’ practically means its denial by indicating the discarding of one in favor of the other.

A remark made by the longtime head of a Western and Korean medicine cooperative hospital, when he was asked to comment on the approaches of ‘integrative medicine’ in a workshop for cooperative medical care, indicates the subtleties of these concepts. He said,

I was talking in terms of *the cooperative care* utilizing both doctors, but *if you talk about ‘integrative medicine’ it’s a completely different matter* [hence my statements should be entirely re-evaluated in different terms or my statements do not help in the discussion] (Ryu 2012). (Italics added by author)

The controversy surrounding the ‘Botanical Drug’ (*Chōnyōnmulshinyak*) (Hanwool Lee 2012; S. Hong 2012) which will be extensively explored in the next chapter is also mainly related with the advance of the global forces on the local, although in this case, the sphere of interactions between the forces is in the field of pharmaceuticals. It is a case where the local-global interaction had an effect on local healthcare politics in the complex intersection of the industrial and professional interests. At the heart of this politics also lies the dual medical license system.

5. Conclusion

In this chapter I attempted to provide the most comprehensive account of Korean Medicine by focusing on the ways in which it has been transformed under the country's institutional framework. I first described the ways in which traditional East Asian medicine has developed in the country from ancient times to the end of the Chosŏn Dynasty. Then I explored the times after the country's exposure to Western medicine in late 19th century to the end of the Japanese colonial regime in 1945, the period which I argued has set the platform for post-war professionalization of Korean Medicine.

Korean Medicine's unidirectional developments towards full integration into the system after 1951 were then described to provide background to the contemporary situation where 'bio-medicalized' KMDs have not only the same legal and economic recognition with WMDs and dentists but also share very similar styles of clinical reasoning with them. I presented two ethnographic cases where this could be observed. I introduced also cases where WMD's recognition of KMDs' biomedical competency was attested to.

I then explored the ways the public conceptualizes KMDs as 'medical doctors having biomedical competency with additional EAM knowledge' before I presented their 'bio-medicalized' socio-economic class. I corroborated this argument through the presentation of various ethnographic cases including my own experience where the public's perception on KMDs could be ascertained.

Then, I presented a brief cross-country comparison to contextualize the unique dual medical license system within the health systems of other countries. Finally, in the context

of the advance of integrative medicine in the West, I highlighted how it affects the Korean healthcare system in an interesting way. I emphasized that in accommodating the global forces, the structure of the domestic dual medical license system-based healthcare politics manifested an interesting pattern of the global and local interactions.

In the next chapter, I will deal with a set of events that occurred in the KM community the analysis of which will reveal, among other things, the fine-grained details of the country's healthcare politics as well as the political economy of healthcare provision. For a full understanding of the process and implications of the event, however, the knowledge of the fully-integrated features of Korean Medicine which I have laid out in this chapter is crucial. What has been described thus far will serve to foreground the discussions in the later chapters of this thesis.

Chapter III A Rebellion in the Korean Medicine community

This chapter will concern itself with a series of events that occurred in the Korean Medicine community during my fieldwork. It describes a three-month long event sparked by a controversy surrounding 'Botanical Drug (*Chŏnyŏnmulshinyak*)'. This new category of drugs is, in essence, *hanyak* (韓藥) that is prescribed in KM clinics. The difference lies only in the fact that unlike *hanyak*, these botanical drugs have been developed by pharmaceutical companies and passed some safety and efficacy assessments. The country's obscure regulations on natural substance-based pharmaceuticals, corporate interests and the dual medical license system, however, all contributed to the classification of the drugs as WM medications which belong to WMDs, not KM medications, despite the fact that developments of many of these drugs had been funded by Korean Medicine Promotion Law.

The 'young' doctors in the KM community were very unhappy about the situation and tried to elicit the help of AKOM to rectify this situation. That attempt, however, was unsuccessful, and in the process both parties came to realize that their policy goals were incompatible. This conflict in policy goals soon escalated into an intergenerational confrontation in which the young doctors eventually staged a rebellion against the AKOM, their own professional organization.

This chapter deals with the story of the young doctors' rebellion in Korean Medicine community, and I will present the ethnography of the event by providing information in four different sections. As a way of introduction, in Section 1, I will explain the norm of age-hierarchy dominating interactions in Korean society as it plays an important role in

the rebellion. Section 2 will focus on explorations of various background issues such as the online community culture and the controversy over botanical drugs. Section 3 will then be devoted to the description of the process of young doctors' collective actions that occurred in the KM community in 2012. In conclusion, I will provide a brief analysis of the event and indicate the directions of the arguments that will be laid out in the remaining chapters of the thesis.

1. Introduction

1.1 Age as Index of Social Hierarchy

Age plays an important role in social interactions in contemporary Korea. That is why I used the expression ‘young’ doctors rather than ‘junior’ or ‘younger’ doctors. It is to convey the deep-seated age-consciousness that has become the grammar of social interaction, or the platform of societal rank-ordering, in Korean society (Brandt 1971, 20,35,67,91,93–94,113,117; Robinson 1991, 225; Janelli 1993, 168; Kendall 1996, 4,39,96; Koo 2001, 129).

Being a popularized offshoot of the kin-based Confucian political ideology that dominated the ruling elites during Chosŏn Dynasty (Brandt 1971, 116; Robinson 1991, 221; Haboush 1991, 100–110), the age-based social rank ordering seems to have been fortified during the period of military dictatorship when vertical organizational cultures were also produced with pervasive influence on every sector of Korean society (Janelli 1993, 141,220; Koo 2001, 66,140; Nelson 2000, 69–70).⁹⁶

For college students, this rank ordering is magnified through the school entry-year (*hakbŏn*) hierarchy by which the seniors (*sŏnbae*) and juniors (*hubae*) are divided. Juniors were ordered to address their seniors as ‘sŏnbaenim’ with honorific suffix ‘nim’ attached. Among students in medical schools where respect for seniority in terms of clinical experience is considered very important (Freidson 1988, 166), the school year hierarchy carried additional weights in social interactions.

⁹⁶ It is also because every men in the country is bound to experience military culture through their compulsory military services (C. S. Kim 1992, 126).

Generally, this school year-based hierarchy works well with age-based hierarchy because people's life-course events such as university entry and employment into companies occur roughly at a similar period in life.

1.2 Aged-based Rank-Ordering and 'Traffic Management'

This age-based rank and use of appropriate terms of address was something I had to continuously deal with in the field. As mentioned, deference to elders is quite a well-established feature of everyday life in Korea (Brandt 1971, 117; Janelli 1993, 168). At PNU, my presence caused awkwardness among some academic staff because I was a Kyunghee University senior to many of them while my role as an adjunct lecturer was lower than them in the school's official hierarchy.

Some academics, however, made the situation more palatable by addressing me directly as '*sŏnbaenim*' with an honorific suffix '*nim*' attached, or even used more intimate terms like 'elder brother (*hyŏngnim*)', though I decided to use the title of 'professor (*gyosunim*)' to address them out of courtesy. To professor Lim, my boss at the KM policy unit who was three years my senior at Kyung Hee University, I occasionally used the word '*hyŏngnim*', instead of the official designation of '*gyosunim*', in informal situations.

Addressing people in non-academic informal settings was a bit more difficult as people like to be lax on workplace-related social rules in informal settings simply by sticking to age-rank. At the table tennis club I frequented in Seoul, the eldest member was called 'the big brother (*k'ŭnhyŏngnim*)', and in the club in Yangsan, the first serious

question directed at me from a coach was “how old are you?”.⁹⁷ The female coach explained to me the motive behind the question as follows:

You are five years younger than me and the chap you played with today is three years younger than me [which means you are two years younger than him]. We need to do the *traffic management* [regarding social hierarchy] so that there won't be any confusion in order and I am the one who is responsible for it.⁹⁸ (Italics added by author)

In the table tennis club in Seoul, the ‘big brother’ who was in his 50s was commanding the deference and authority corresponding to his age. I had a chance to observe the way in which he was received by others on one occasion. In a post-match social, the owner of the club who was in his late 30s was complaining about his younger brother who did not reveal to him the source of the money used in the purchase of his new apartment in Seoul, despite the fact that he could guess that his brother had been aided by his wife’s family. It was a tricky matter for others to intervene in the first place as they did not seem to know the details of the club owner’s family. Even if they did, I did not feel it was a situation for an outsider to provide opinions on. Without the time to ruminate on the situation, however, a straightforward response which was almost like the ‘verdict’ came from the ‘big brother’ who seemed to have interpreted it to be an issue of morality as he strongly endorsed the club owner by saying with a tone of authority in his voice, “What kind of bastard is he, not revealing the true information to his elder brother!”⁹⁹

⁹⁷ Laurell Kendall (1996, 4) reports a similar experience.

⁹⁸ She said ‘*Gyot’ongjŏngrir ŭl Haeyahgŏdŭnyo*’. The conversation occurred on 18 April, 2012.

⁹⁹ The Korean sentence used was ‘*Gŭrŏnnomi dainnya? Hyŏngege Soljjiki Yaegi Hajiant’ani!*’

People frequently use the slang '*minjjŭng gganda*', which literally means revealing to others one's national residential card where one's date of birth is printed. This also shows the ways in which a person's age is considered an important element in determining interpersonal social hierarchy in Korean society.

1.3 The 'Young'

Though the age rank is relative to the people interacting, certain lines of demarcation exist and being 'young' is one of them. The age of 40 is the line of demarcation and along that line, one's maturity is also determined (Brandt 1971, 20; Janelli 1982, 21,149).¹⁰⁰ Maturity means whether one is capable to assume positions of responsibility in the Korean society. In Table III-1 below, one can see that the title 'young' is attached to most age-categories below 40.

¹⁰⁰ Roger Janelli (1982, 21) specifically pointed out in his ethnography that the word 'young people (*Jŏlmŭnsaram*)' generally refers to those 'under 40'.

Table III-1 Korean Age Categorization

Age	Category	Description
0 to 7	Infants	Useless toys; irresponsible; not really human
8 to 14	School children	Useful for errands, messages
15 to 25	Youth	Full-time workers; frivolous and irresponsible; docile labor
25 to 30	Mature youth or young married man	Begin to assert selves; still little influence or respect
30 to 35	Young head of household with children	More dignified; but real status and respect only in exceptional cases
35 to 40	Young mature adults	Begin to be solid citizens
40 to 55	Men of influence	Authority, leadership, respect
55 to 60	Young old	Less heavy work; lose some of authority
Over 60	Old	Mostly respect

Note: Although this table of age-categorization is based upon the fieldwork conducted in a village setting in the 1960s, it still reflects the general sensibility surrounding age-related rank ordering in contemporary Korean society. It is partly because Confucian social ethics which underpins this categorization is still strongly present (Robinson 1991).

Source: Brandt (1971, 93)

Some anthropologists who have worked on Korea seemed to have also benefited from being over 40, or being 'mature' enough to be treated well. Roger Janelli who was 43 at the time of his field research in one of the big companies in Seoul in late 1980s reported that he was assigned a desk occupying a middle space between the seniors and the subordinates, although his administrative work in the office was rather inconsequential (Janelli 1993, 7,17).¹⁰¹ Vincent Brandt who was 42 was also allowed to hang around with influential people in the village, despite his visitor status (Brandt 1971).

¹⁰¹ Considering the organizational culture of the company where 'not just the layouts of the office, but also the size the desk reflects the hierarchical order', it seems obvious that his age played an important role in the assignment of his desk space (Janelli 1993, 166).

At my own field site, the majority of the ‘young’ doctors were in their late 20s to early 30s, or the category of being ‘immature’, while all executive directors of the Association of Korean Medicine against which those ‘young’ doctors revolted belonged to 40 to 55 category, or the category of being ‘men of influence’. I was 41 in the field and was treated respectfully, with added social weight accorded by the fact that I was an insider.¹⁰²

¹⁰² The origin of age categorization expressed here could be traced to the writings of Confucius, particularly the Doing Politics(爲政篇) in Analects (論語) where he recounts his life experiences according to his age. He says that ‘I had a passion for learning at the age of fifteen, and at the age of thirty, my conviction [in the learning] was firm. *At the age of forty, I had no doubt [about my way]*, and by the time I reached the age of fifty, I knew what my life has been ordained to. At the age of sixty, my receptivity [of other’s opinion] was unhindered and natural. At the age of seventy, I had no problem worrying about breaking the ethical codes even as I acted as I liked (吾十有五而志于學 三十而立 四十而不惑 五十而知天命 六十而耳順 七十而從心所欲不踰矩) (The original sentence is from B. Sung (2011). Translation by author, and Italics and [] added by author). Here you can see that the age 40 is the line demarcating the responsibility of one’s life.

2. The Korean Medicine community and the Botanical Drug Controversy

So far, we have discussed the ‘socio-cultural’ background necessary to understand the event to be soon discussed, namely the age-based social hierarchy. In this section, I will focus on elucidating the sociological and policy backgrounds necessary to understand the event. Firstly, I will explore the characteristics of the Korean Medicine community after I present briefly how my policymaking fieldwork led to the investigation of the community itself. I will focus particularly on the ways in which KM community members engaged with their online-communities. Then I will provide background with regard to the botanical drug policy, the initial source of conflict, before I highlight the KM community’s reaction to it which eventually led to a major inter-generational confrontation.

2.1 Fieldwork and the Korean Medicine community

2.1.1 Settling in at Pusan National University

My fieldwork started in February 2012 in Seoul and I aimed to conduct research on health policymaking in Korea. This initial plan of mine was motivated by my interests both in KMDs’ professional identity¹⁰³ and in the country’s healthcare politics which is characterized by continuous disputes among healthcare provider groups. I felt that getting a grasp on the Korean state’s perspective on Korean Medicine would not only allow me to explore issues of professional identity but also provide me with a vantage point from which to look at the country’s healthcare politics more broadly.

¹⁰³ This interest of mine was covered in my interview with *Minjok Medicine Weekly* (Eunkyung Kim 2012), and in an essay ‘Scarlet letter’ (Na 2012b) published in the PNU student magazine *Hansodam* in 2012.

My bid to have a work placement at the Korean Ministry of Health and Welfare (MOHW), however, failed.¹⁰⁴ Fortunately, with the help of Professor Lim Byungmook who was heading the Korean Medicine Policy Unit at the Pusan National University School of Korean Medicine in Yangsan,¹⁰⁵ I was able to achieve my fieldwork objective as I had originally planned. It was possible because the Korean Medicine Policy Unit at PNU was acting as the hub of the country's Korean Medicine policies where all major KM-related policies were commissioned directly or consulted upon. The school's position as the country's only state-funded school of Korean Medicine¹⁰⁶ and Prof. Lim's expertise¹⁰⁷ contributed to the unit's successful functioning (see Picture III-1).

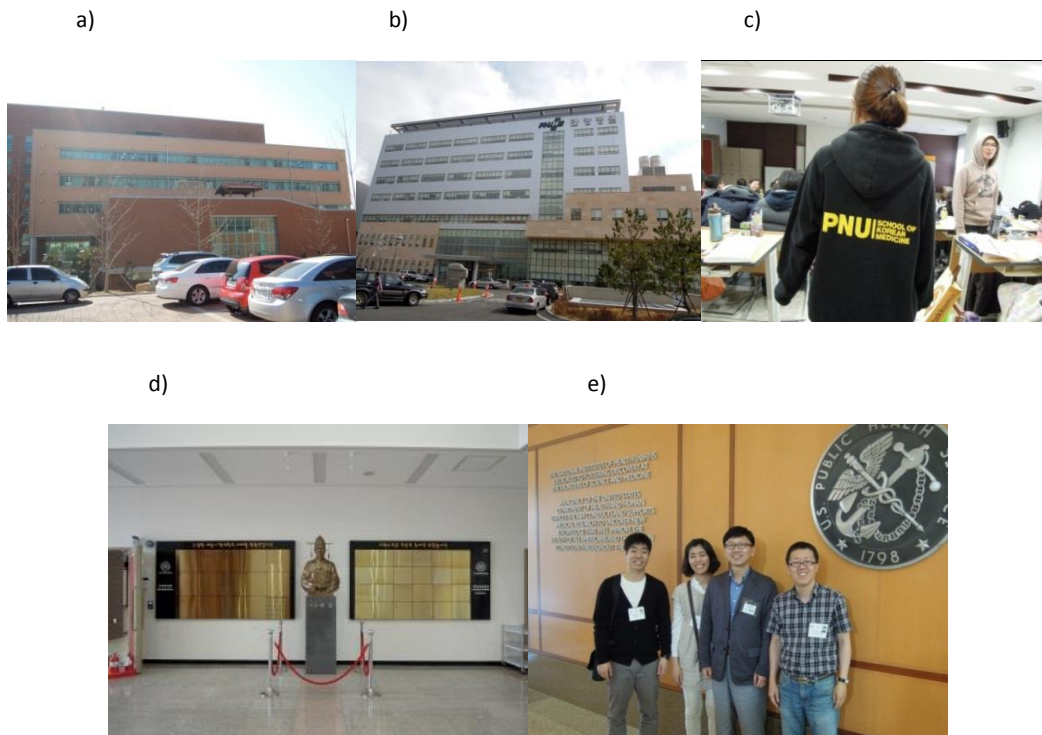
¹⁰⁴ When I was negotiating my access with the Ministry, a major reshuffle took place in the Ministry, and I ended up losing all the major connections in the Ministry who were sympathetic to my research.

¹⁰⁵ Yangsan is a satellite city of Pusan that is located north-west end of the Pusan city. The PNU built a massive medical school-hospital complex in the city in 2008 and all the healthcare related departments such as WM, KM, dentistry and nursing, except for the department of pharmacy, were relocated from Pusan to the new site.

¹⁰⁶ Employees at national universities are regarded as civil servants in Korea so it is quite common for government officials to favor academics at national schools when they commission policy projects.

¹⁰⁷ For a long time, Prof. Lim was the only policy expert in the KM community. In addition to numerous academic and social activist connections, he has a good track record of policy research, which made him a much-sought-after figure among government officials.

Picture III-1 The PNU School of Korean Medicine and its Korean Medicine Policy Unit



Note: a) PNU School of Korean Medicine b) PNU Hospital of Korean Medicine c) A 2nd year KM school student wearing a school jumper d) The bust of Heo Joon, the author of *Dongŭbogam*, in the lobby of the school e) The PNU KM Policy team on a visit to the NIH, Bethesda, US. From left, stand Mr. Choi Byunghee, Dr. Ryu Jiseon, Prof. Lim Byungmook, and the author.

Source: Author

The Unit was already conducting many policy projects when I arrived. Projects related to national-level policy and national health insurance (NHI) were being conducted in close collaboration with or under the close monitoring by The Association of Korean Medicine (AKOM), the representative body of the nation's 20,000-odd KMDs. Even before I got myself adjusted to the rhythm of policy research, I was allocated a role in an ongoing project commissioned by the Basic Research Council under the Ministry of Science and Technology. It was to draft an overview of the global research trends in the field of traditional and complementary medicine (TCAM) for the purpose of assessing the

feasibility of setting up an overseas branch of the Korea Institute of Oriental Medicine (KIOM) for international research collaboration.

For a person like me without any prior policy research experience, adapting to the fast-paced policy research practice itself was enough of a challenge at the outset.¹⁰⁸

What was more challenging, however, was the sheer workload imposed upon us. The unit was swamped with deadlines, urgent policy meetings which were held either in Seoul or Taejon,¹⁰⁹ institutional reviews, proposal writing and preparation of financial statements. In July, for example, effectively a four-man team at the unit was handling five different projects simultaneously (see Table III-2).

¹⁰⁸ There were some practices which I had to make myself familiar with. First of all, all researchers used Korean word processing program called 'Hangul' or 'HWP', not Microsoft Word. And, the style of sentence endings in the main texts of the most policy reports was what is called '*ŭmssŭmch'e*', the style by which the sentence ends with '*ŭm*' or '*ssŭm*' rather than proper ending of '*da*'. The paragraph in the text was generally shorter than academic writings. In discussions, many Koreanized English loan words and acronyms were used among researchers. 'Chaptering', for example, means to come up with the ways to divide chapters in the policy report. And acronyms like 'CFP' or 'call for proposal' or 'KIOM' (Korea Institute of Oriental Medicine), was used as they are. Reflecting the nature of the policy projects which had to be evaluated at some points, the words like '*jöngsöng pyöngg'a*', or the assessment based upon 'quality', and '*jöngryang pyöngg'a*', the assessment based upon 'quantity', were also frequently used.

¹⁰⁹ At least for one day per week, two of the unit's researchers, on average, were away for meetings. Taejon is the place where KIOM is located.

Table III-2 Policy Projects Conducted at the PNU Korean Medicine Policy Unit in 2012

Project name	Commissioning body	Project period											
		Feb. 2012	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan. 2013
World TCAM	Basic Research council												
KM R&D	MOHW												
KOPG-OM	HIRA												
Chronic Disease	MOHW												
KM-CPG	KIOM												
NHI-Payment *	NHIC												
Year Book*	AKOM												

Note: Projects with * are the ones which were conducted at the unit but I was not involved in. See the glossary in the beginning for acronyms.

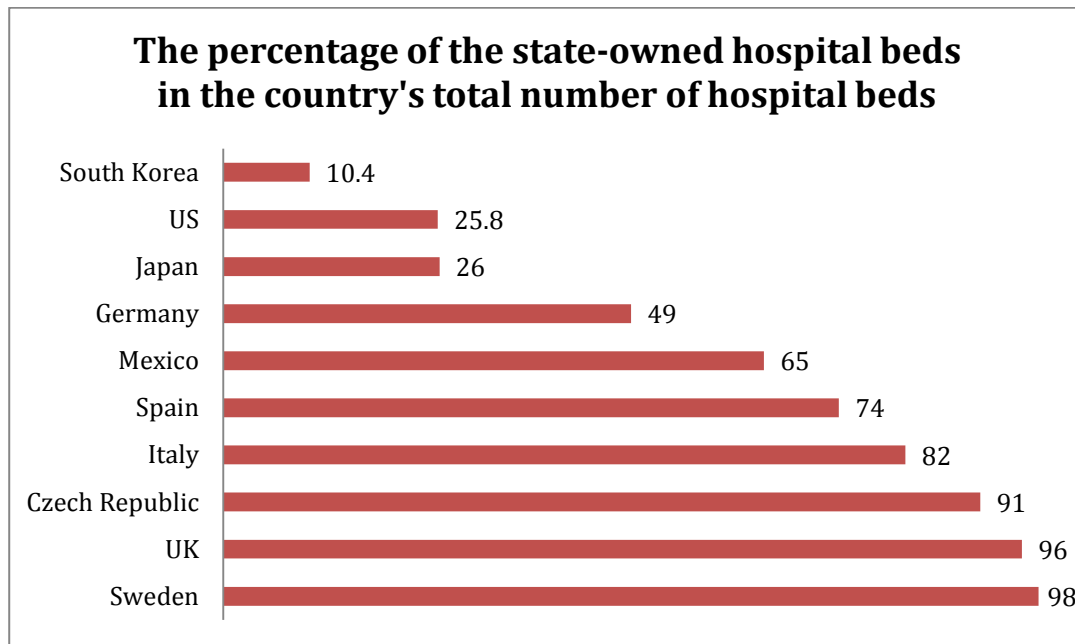
The situation got worse as Mr. Choi, the doctoral student under Prof. Lim, left for the Korea Institute of Oriental Medicine (KIOM) in August, leaving only me and Dr. Ryu at the unit. In this busy policy research schedule, I had numerous chances to work with government officials, and it meant that my original research aim of getting ‘the state’s perspective’ was being well achieved. However, at the same time, I was not sure whether the views of a very small group of officials represented the perspectives of ‘the state’. In this dry, policy-mediated engagement with the field, it seemed that my objectives of investigating the KMDs’ identity and of exploring the country’s healthcare politics were practically being abandoned. Also, in my capacity as a policy researcher, I felt I needed to know more about KMDs to better inform my research outputs.

As a matter of fact, many projects I participated in were directly related with local practices of Korean Medicine. The making of the manual for the development of clinical practice guidelines in Korean Medicine (KM) commissioned by KIOM was to achieve standardization through evidence-based approaches in clinical practice of Korean Medicine. The chronic disease management project commissioned by the Ministry of Health and Welfare (MOHW) was to install a system with which to effectively utilize KM physicians for the control of hypertension and diabetes. Another project commissioned by Health Insurance Review Agency (HIRA) served to update the Korean Outpatient Group Manual in Korean Medicine (KOPG-OM) and to devise a classificatory system by which KM clinical practices could be more efficiently categorized.

Even in exploring state-level health policymaking, it was true that I was not covering the entire policymaking space. I was ignoring the Korean Medicine community, the biggest stakeholder in Korean Medicine-related policymaking. In this private-sector-dominated healthcare economy, where three private medical practitioner groups collectively provide 90 percent of the nation's total healthcare (Soonman Kwon 2009, 66; Y. Song 2013), it is impossible to avoid the conclusion that the medical communities are an integral part of any state-level health policymaking (see Figure III-1).¹¹⁰

¹¹⁰ Even that 10 percent is far from being general care provision to the public as the state's hospitals are few and far between, with only one general hospital in Seoul. Many state-run hospitals focus on providing specialized care for those who have such conditions as mental health, tuberculosis and leprosy. As for primary care, the nationwide 254 public health offices are all that the state can offer. It is not an exaggeration to say that the country's entire healthcare is undertaken by private practitioners.

Figure III-1 Comparisons of the Number of Public Hospital Beds among OECD Nations in 2008 and 2009



Note: All country statistics except US and South Korea are based upon 2008-2009 data. The US data which is based upon 2010 statistics and South Korea's is based upon 2011 statistics.

Source: Y. Song (2013)

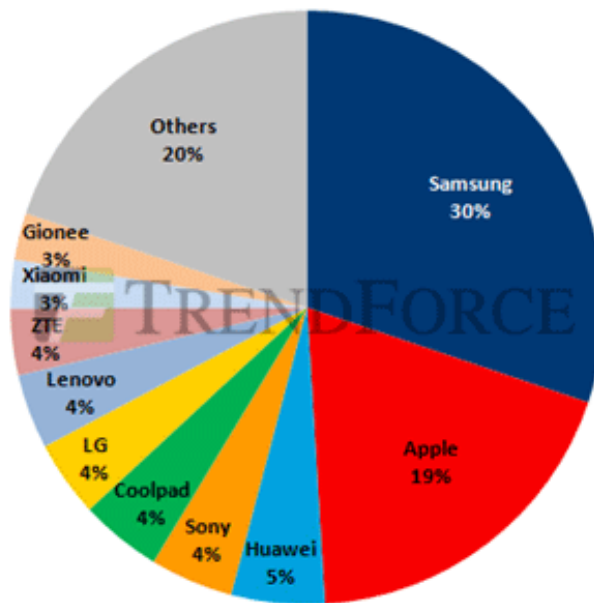
2.1.2 *An Encounter with the Korean Medicine community*

The only way for me to expand my ethnographic coverage into the Korean Medicine community while still being based at PNU, was through the internet. I soon enrolled at the KMD-only online-communities. Indeed, South Korea is renowned for its hyper-connectivity, thanks to the extensive state-led investments in information technology infrastructure since 1995.¹¹¹ In 2012, for example, it was estimated that 97.5 % percent of the country's households had broadband connections (Tencer 2013). Also, as home to

¹¹¹ The first phase of the plan called KII (Korea Information Infrastructure) lasted from 1995 to 2005 with the investment of public funds of 6.2 billion USD with an additional 16.5 billion USD from private sectors. The successful completion of the first phase led to the more extensive second phase developments afterwards (K.-S. Lee 2012, 5,45).

the company that has the largest share of the world's smartphone market, namely Samsung, and to another mobile phone giant LG, the people in the country never lack new smartphone models on offer to try (see Figure III-2).

Figure III-2 The World's Top 10 Smartphone Market Share in the Third Quarter of 2013



Note: This diagram is from “Analyst Predicts Smartphone Sales Will Slump in Q1, First Time in Two Years.” by Alex Colon. It was posted in Gigaom on January 17, 2014 (<http://gigaom.com/2014/01/17/analyst-predicts-smartphone-sales-will-slump-in-q1-first-time-in-two-years/>).

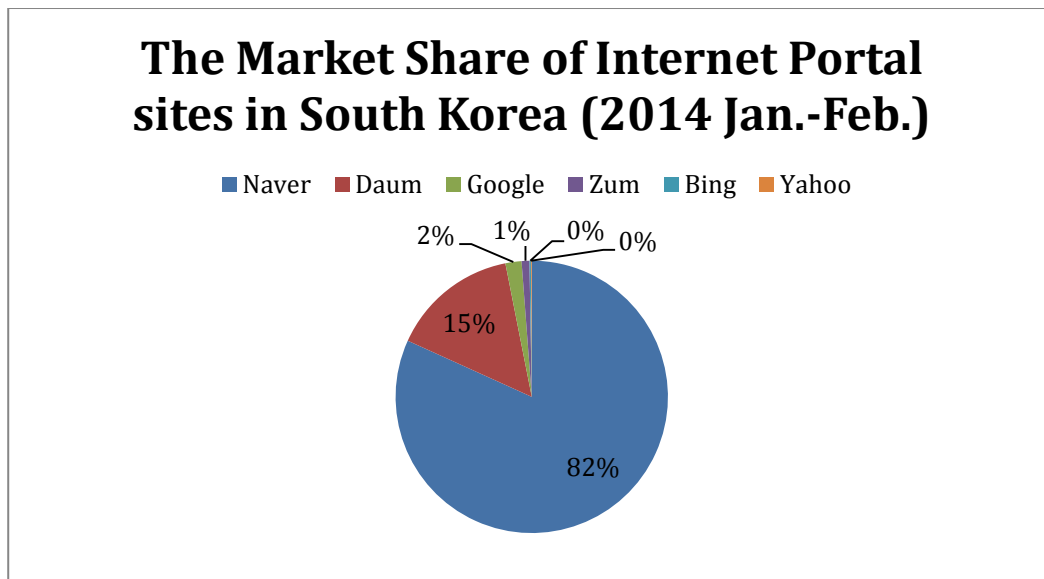
In fact, in 2013, 73% of the country's population used smartphones, the second highest rating in the world.¹¹² The robust broadband infrastructure combined with the high rate of smartphone use provides an optimum condition for the country to have a reputation as a country of ‘the internet’ (PBS 2009; Kovach 2014).¹¹³

¹¹² Fox, Zoe. 2013. “The 15 Countries with the Highest Smartphone Penetration.” August 27. <http://mashable.com/2013/08/27/global-smartphone-penetration/>.

¹¹³ See also Hornayk, Tim. 2012. “Getting Online in Super-Wired South Korea.” CNET. July 17. <http://www.cnet.com/news/getting-online-in-super-wired-south-korea/>

It is also important to note that the Internet for Koreans is more than just information gathering. Actually, the idea of the internet solely as an information provider or a venue for ‘Googling’ seems to have been alien to many Koreans as seen in the low use rate of Google among Korean users (see Figure III-3).

Figure III-3 The Market Share of Internet Portal Sites in South Korea in 2014



Note: Google has only 1% of the market share, which shows that the pattern of internet use among Korean users focuses more on ‘socializing’ than on ‘googling’. The data is from BizSpring and Logger (<http://internettrend.co.kr/trendForward.tsp>)

Instead, the majority of the internet use in Korea is mediated through mega-portal sites like Naver and Daum which have multiple interface features that generally include internet forums where people with similar interests gather. These forums are typically the most popular areas of the site.

The social, or ‘relational’, reasons behind internet use among Koreans (Sangbae Kim 2010, 72–73) have been pointed out by several scholars. Some have argued that this tendency was observed more highly among Koreans than Japanese users despite their similar cultural backgrounds (Bae 2004, 248). A recent study comparing the behavioral

patterns of college students in the US and Korea also reported that Korean users tended to spend the majority of their time in fortifying their ties with a select number of ‘socially close others’ in the SNS or online communities¹¹⁴ while US students used the services mainly to create new connections (Yoojung Kim, Sohn, and Choi 2011, 370–371). The exchanges in online-communities were also seen to be typically mediated through ‘replies (*daeggŭl*)’, or through ‘online deliberations’ (J.-Y. Kim 2006), which allow deeper social connections to develop between users as they are engaged in discussing specific issues.

A. Real-life effects of the internet in Korea

This ‘intimate’ use of online communities, or its real-life effects, sometimes make the division between online and offline worlds meaningless. It is said that the defeat of a presidential candidate backed by the young generation in the election held in 2012 that was characterized by the generational divide can even be explained by the greater efficiency shown by the Katakalk-based messaging system¹¹⁵ favored by the older generation than the Facebook-mediated messaging service favored by the younger generation. In previous elections, it used to be the case that when the voter turnout is as high as 75.8%, this generally meant that more tech-driven and fast-acting young voters went to polling stations than older people. Not in this election, however, as it turned out

¹¹⁴ The proportion of the socially close others (e.g. families and close friends) in Korean respondents’ network reached almost 70% (Yoojung Kim, Sohn, and Choi 2011, 371).

¹¹⁵ Katakalk is a smartphone based messenger that is installed on 73% of all the country’s smartphones and the number of users passed 40 million mark in 2012 (H. Chung 2012). As it is easy to be installed, many old people also use the application. When I wrapped up my stay at Yangsan at the end of the fieldwork, for example, I was asked for my Katakalk ID for later communication by the landlord who was in his 70s.

that Katalink-messaging encouraged more voting among the older generation (Sejin Kwon 2013).

My ignorance of this 'real-life' effect of the internet was revealed when I delivered lectures to second-year students at PNU School of Korean Medicine. It was two-hour-long lecture and we had a ten-minute break in the middle, but due to time constraints, I had to summon the students earlier rather than allowing them to take the full ten-minute break. I asked the class representative who was sitting in the front row to go out and summon the students. He acknowledged my request, but he didn't budge. I told him, with a bit more authority in my voice, to go out and summon the students as I was thinking that my authority as a teacher was being challenged. Once again, he acknowledged the request, but he still did not show any sign of moving, and was just looking downward towards his palm. That is when I realized that he was actually summoning the students through Katalink-messaging! Following my repeated orders, he sent a second message to all the students who soon came back to the classroom.

B. High trust in online communities

Generally, Koreans' trust in information coming from well-known online communities and internet-based media is high. In the initial stage of my fieldwork, table tennis club members in Seoul used to have a suspicion of me that I was working for the Korean CIA when I questioned the credibility of an internet-based talk show called Naggomsu on the basis of its format and styles of commentaries. To me, the talk show sounded more like entertainment than a serious political discussion. However, all members who were in their 40s and 50s with a middle-class background defended

strongly the integrity of the talk show on the basis of the freedom the newscast has, in contrast to the mainstream media which is subjected to bureaucratic structures, and of the vast amount of news sources available through connections made through the internet. Essentially, they were debunking my argument against the talk-show through the argument that it has their trust *precisely because* it is based in the internet.¹¹⁶ In the course of the year, I could observe all the effects of the newscast's commentaries not just on mainstream media but also on the country's politics.¹¹⁷

Dr. Ryu Jiseon, a KMD fellow researcher at PNU Korean Medicine Policy Unit, also once expressed her trust in the Swimtö, one of the Korean Medicine online-communities based at Daum when she said, "I can learn about almost everything that is going on in the country by looking at Swimtö".¹¹⁸ Near the end of my fieldwork, when the country's presidential election was in full swing, I also had a chance to observe the internet 'intimacy' in action while monitoring Swimtö. For example, among many replies attached to the news article uploaded regarding the personal life of the strongest presidential contender Dr. Ahn Cheol-soo, I could recognize a few comments which could not have been made unless the replier had some personal connections to Dr. Ahn. I also experienced many cases during the fieldwork where internet related social interactions came to be 'actualized' in the off-line world.

¹¹⁶ That explains why a live political debate between two famous debaters in an internet-based channel Gom TV that was aired one week before the presidential election was viewed in real time by almost a million people, despite technical glitches the Gom TV server experienced (Kevin Lee 2012).

¹¹⁷ Later, I found out that one year prior the newscast was awarded the 'Democratic media of the year' prize given by the Korean Press Workers' Association.

¹¹⁸ She said, "*Swimtö bomyön sesangdoraganŭngö da alssu issöyo.*"

C. Three Korean Medicine online-communities

Three online-communities that are visited regularly by almost all the country's active KMDs are Swimtö, AKOM and Hanŭsadang. Swimtö is one of 'cafes' or small online communities at Daum, the second most popular portal site in the country (see Figure III-3). The AKOM refers to the bulletin boards on the Association of Korean Medicine (AKOM) official internet site, and the Hanŭsadang is a closed Facebook group.

Generally speaking, users in these communities share the same behavioral patterns as general Korean internet users with added features of privacy and community. These KM communities could be said to be all based upon existing relationships as all members are KMDs.¹¹⁹ Contents uploaded are strictly controlled so that the quality of information, particularly those regarding business transactions or employment, can be sustained. Due to their 'primary group' nature (Ito 1993; Sangbae Kim 2010, 74), the practice of flame-baiting,¹²⁰ trolling¹²¹ or gender-bending (Kilker and Kleinman 1997) that do appear in public online communities do not appear in these three communities.¹²² The 'online deliberations' also occur through replies attached to main posts.

Each community has its own characteristics and rules depending upon various factors such as the style of main operators, user preferences, and the regulations on which those online communities are based.

¹¹⁹ Some bulletin boards at AKOM, however, can be visited by students or AKOM administrative staff working.

¹²⁰ It is called '*ddökpab*' in Korea.

¹²¹ This is a practice of causing controversy intentionally for the purpose of stimulating people.

¹²² At AKOM, however, due to the members' low trust in the membership control of the site, 'flaming' occasionally takes place.

a. *Swimtö*

Swimtö is mainly used by young doctors and local clinic owners and is operated on an anonymous basis. To register, one must reveal oneself fully to the main operator by sending him or her a faxed copy of one's medical license certificate. Although in principle it is possible for the main operator to shut down the community at any time, in daily operations of the community, the site is operated on a democratic basis with each board having an operator responsible for the contents uploaded. As the number of visits to the site is high with almost 2,000 users always being logged into the community, the task of each operator is demanding considering that they are also local clinicians managing their offices. Important decisions are made through collaborative online committee meetings.

At Swimtö, user anonymity is considered to be fundamental so a great care is given to protect the members' anonymity. User names can be changed indefinitely, although some users seem to stick to one username so that they can create an identity of their own. When members upload sensitive materials and information, or make remarks that could cause controversy, they opt to not to use username at all and instead use a series of dots such as '...'.¹²³ On Saturday mornings, the level of anonymity is pushed to an extreme as the moderators designate a bulletin board as an 'anonymous username board (*ikmyönggesip'an* or *ikge*)'. During these three- to four-hour periods, members can upload

¹²³ This is called '*jjömnik*' at Swimtö.

any posts with virtually no concern of their identity being exposed as during this time the username do not even appear on screen.¹²⁴

Due to the high level of anonymity granted and the high number of young doctors involved in this community, the way Swimtö is used very much ties in with the general user culture observed in the country's major online communities, for example in ways of addressing each other and of using a variety of jargon.¹²⁵ Various online practices such as cueing¹²⁶ and number-related rituals¹²⁷ take place and the communication among the members is more direct and straightforward.

b. Hanüsadang

FB Hanüsadang is relatively small compared with Swimtö in user numbers and is mainly used by academics and those who use Facebook. To become a member, you need to reveal your personal information on your Facebook homepage and get the endorsement of the school representatives designated by the community committee. Unlike Swimtö, it is operated on a real name basis.

¹²⁴ During this time, only blank space appears in the place where the usernames are written on weekdays. Some censorship still seems to be in operation though, as members occasionally complain that some posts caused the *Ikge* time to close earlier than usual.

¹²⁵ Typical internet jargon across Korean internet users, mainly online-game related jargon, are used at Swimtö and they include words like '*Ppakch'im*' (very angry), '*Sildch'inda*' (defensive of someone), 'Team Kill' (massive group attack), '*Öke*' instead of the proper '*Öddökhæ*' (how), and '*ddökch'inda*' (sex). The intentional use of improper sentence endings such as '*im*' rather than '*yo*' or '*da*', is also used on Swimtö.

¹²⁶ I am not sure whether this ritual of 'cueing' is only on Swimtö. It is a practice of placing a short reply to a writing which reports a great business or personal fortune in the hope that the same fortune falls on to them.

¹²⁷ There are various number-related rituals in Swimtö. First is a 'first one game'. Though the format of the game looks childish, it has cult following. It is a race to upload the first writing when the anonymous nickname time finishes so that the first person who uploads the writing with their nickname gets some recognition.

It is also operated democratically. Regular main operators meetings are live-cast to other members of the group, and they have their own constitutions which are regularly amended when issues arise. While Swimtŏ shows a very distinctive ‘online user’ culture, FB Hanusadang is more like an online extension of offline meetings due to the real-name policy. Here, users rarely use internet jargon, and when they notice they have used them inappropriately, they self-censor the post and delete the jargon terms.

c. *AKOM*

AKOM is a set of connected multi-functional bulletin boards created by the AKOM. As soon as you are qualified as a KMD, you are given password and login details of the site. Administrative staff at the AKOM as well as Korean Medicine college students are given access to some boards. Using usernames is optional, but the user anonymity is not as highly protected as in Swimtŏ. Possibly due to its official characteristics, or to the cumbersome structure of the site, it is the most under-utilized site in the Korean Medicine community, and its use is generally limited to browsing job postings and to reading official announcements from the AKOM. This site is mainly used by those who have some official connections with the AKOM administration, i.e. former or current executive directors (*isa*), council members (*daeŭwŏn*), or those in various committees at the AKOM (see Table III-3).

Table III-3 Three Major Korean Medicine Online-communities

	Swimt'ō (Daum Café)	Hanūsadang (Facebook)	AKOM
Creator	A KMD nicknamed 'Soyoyu'	A group of FB-using KMDs	AKOM
Structure	Various boards divided according to the nature of content shared by members	One big Facebook wall.; search function inept	A big site containing different boards. Proper portal site with emailing function
Contents	Gossip, entertainment, lecture advertisements, jobs, academic materials, political discussions, KM-related discussions, clinic management	Academic, political and legal issues concerning KM	Mainly used for AKOM official notices, job adverts, and some academic content
History	Ten years	Several years	More than twenty years
Membership registration	By faxing the medical license certificate to the main system operator	By recommendations from members representing each school. Being a KMD should be specified on their FB wall	Automatic registration after being qualified as a KMD
User activity	Anonymity basis	Real-name basis	Anonymity based (mixed with real-name basis)
Main users	Young doctors with local clinic owners are active users	Younger and older age groups; many academics.	Active users being former or current AKOM-related figures
Approx. number of users	12,000	1,500	20,000
Regulator	The creator has the most authority; moderators responsible for the content management of each board	Rules documented and revised through a steering committee whose sessions are generally live broadcast	IT Executive (KMD) at AKOM
Popularity	Very high; more than 10,000 daily visits (stats are official-recorded). 2,000 users online	Well utilized; new posts uploaded constantly	Under-utilized
Political affiliation within KM community	Many Ch'amsillyōn supporters but also many silent users	A Mix of AKOM and Ch'amsillyōn supporters, many being neutral	Large number of AKOM supporters
Styles of expressions used	Direct, straightforward and internet parlance being standard	Refined and generally respectful	Internet jargon used only for certain bulletins

User loyalty	Strong	Neutral	Not strong
Characteristic features	Many popular internet rituals developed from <i>DC Inside</i> communities (Number games, cueing ritual, and the order game) anonymous username time when the username itself is blanked	Detailed discussions through a series of long replies	Official functions mixed with some informal discussions

2.2 Controversy over Botanical Drugs or Ch'önyönmulshinyak

After years of absence, it took some time for me to be acclimatized to Korean online communication culture. However, I was soon able to recognize that a central agenda was being hotly discussed, with particular vigor from young doctors. It was the situation regarding botanical drugs or *Ch'öyönmulshinak*. As mentioned in the beginning of this chapter, they were arguing that prescriptive rights for this category of drugs should belong to KMDs, not to WMDs as it is currently the case because they are a form of herbal decoction (*hanyak*) and are not Western drugs. Particularly at Swimtö, the young doctors were prodding their professional organization AKOM to take some substantive actions to rectify the situation.

2.2.1 The Background

What is important in the word *Ch'önyönmulshinyak* (天然物新藥) which is literally translated as a 'natural substance-based novel drug' or 'botanical drug' in common parlance, is its reference to being a 'novel drug (*shinyak*)'. The young doctors' argument was that this category of pharmaceuticals are not 'novel drugs' because these drugs did not undergo any substantial chemical transformation in the development process, despite

their industrial packaging on the surface.¹²⁸ They further claimed that these drugs are essentially *hanyak* (韓藥) prescribed by KMDs, which was manufactured on the basis of either whole *hanyak* formulas or of *hanyak*-related elements. They warned the KM community that if unhindered, more drugs of these kinds will be soon released so that many formula-based decoctions currently prescribed only by KMDs would soon be replaced by these easy-to-consume ‘Western-packaged’ medications.

Most of these young doctors belonged to a group called Ch’amsillyŏn, and they criticized not only the AKOM administration’s lukewarm attitude on this issue, but also its subservient attitude to the government when it had been supposedly ‘asking for the rights’ to prescribe these drugs. Dr. Lee Jinwook, the Ch’amsillyŏn Chairman even staged a hunger strike at the AKOM headquarters asking for stronger action by AKOM (see Picture III-2).

Picture III-2 The Ch’amsillyŏn Chairman’s Hunger Strike at AKOM



Note: His hunger strike staged in protest to the AKOM’s ambiguous stance on botanical policy lasted 12 days from 3 August, 2012 before he was given a promise to open an AKOM Councilor’s meeting on the issue.

Source: Yejong Lee (2012)

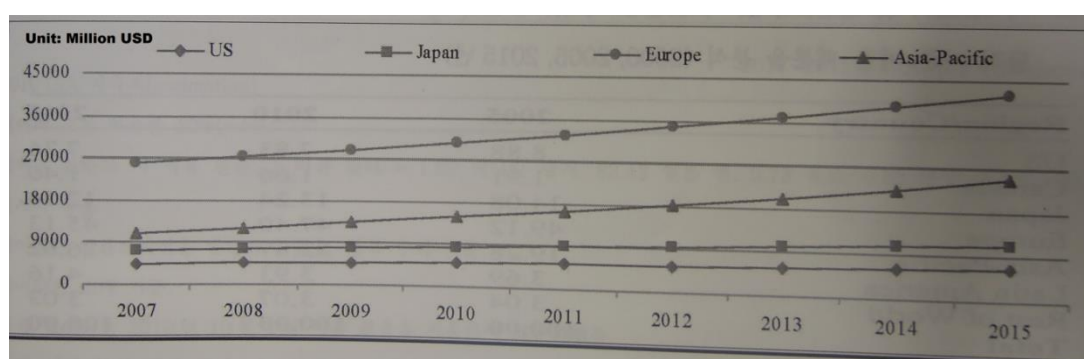
¹²⁸ According to Section 8, Article 2 in the Law of the Pharmaceutical Affairs, the Novel Drug (*shinak* 新藥) is defined as a ‘new drug that has different chemical structure or an entirely different substrate formation from the drugs that were previously approved, or as a synthetic chemical drug that contains new materials with efficacy’. See the governmental website <http://www.law.go.kr/%EB%B2%95%EB%A0%B9/%EC%95%BD%EC%82%AC%EB%B2%95> for details.

A. Changing Domestic and International Industrial Environments

Prior to the year 2000 when the Botanical Drug Research and Development (R&D) Promotion Law¹²⁹ was enacted, however, the development of this type of drug had not been a favorable option for domestic pharmaceutical companies because the products, even if they were successfully developed, could not be qualified, both domestically and internationally, as ‘novel drugs (*shinyak*)’.¹³⁰ But there have been some changes in industrial environments since then.

First, the international market for ‘botanical drugs’ or ‘herbal supplements’ started to expand, possibly due to increasing interest in self-help and the use of CAM modalities in the West (see Figure III-4).

Figure III-4 Projections for the International Market for Botanical Drugs



Note: The graph demonstrates a clear upward from 2007 and in particular, an increase in demand in the Europe and US regions after 2010.

Source: Global Industry Analysts (2011, 89)

Most importantly, since the country’s implementation of the policy of the separation of prescription and diagnosis (SPD) in 2000 by which only pharmacists, not

¹²⁹ It is called ‘*Ch’önyönmulshinakgaebalch’okjjin’pöb.*’

¹³⁰ Korean pharmaceutical companies who had been maintaining their business by developing functional drinks such as *Bachus*, could not venture into drug developments unless the outcome of their investments are promised with an appropriate title such as ‘*shinyak*’ or novel drug, that comes with kudos, hence a hefty marketing potential.

physicians, were allowed to dispense drugs, the domestic drug market expanded substantially (see Figure III-5).

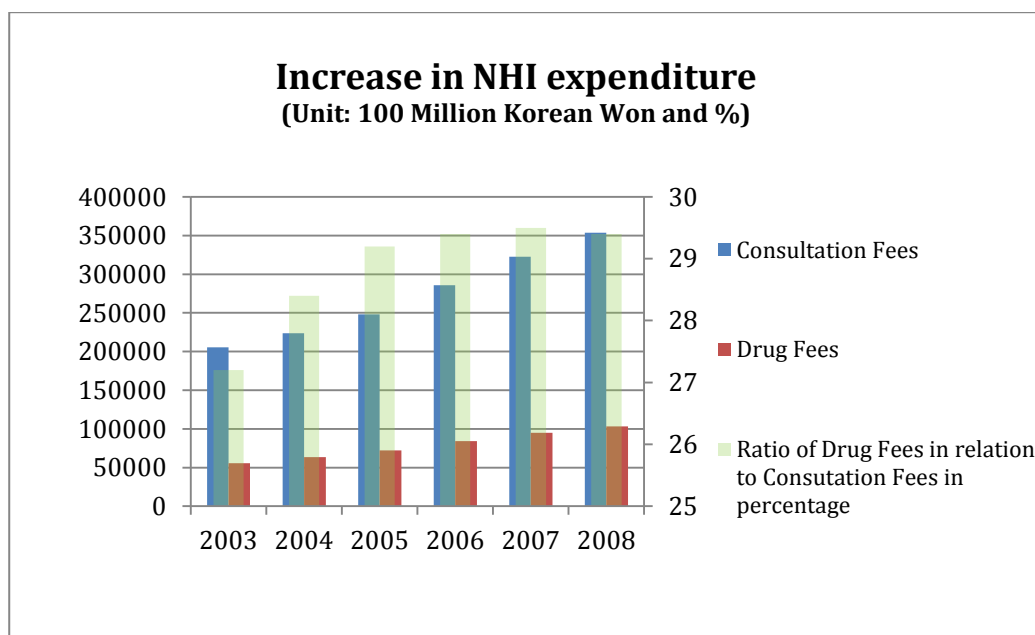
Figure III-5 Domestic Pharmaceuticals Production in South Korea from 2004 to 2011



Source: KFDA from S. Hong (2013)

Subsequently, governmental expenditures on drug NHI reimbursements increased substantially to the extent that during a five year period between 2003 and 2008, the amount of reimbursements almost doubled (see Figure III-6).

Figure III-6 NHI Expenditure Broken Down into Consultation Fees and Drug Fees from 2003 to 2008



Source: Statistics from MOHW (re-quoted from J. Shin (2010))

B. The State's Promotion of Botanical Drug developments

Stimulated by these external and internal factors, the government started to promote the development of these pharmaceutical products in the 2000s actively, revising the original Botanical Drug R&D Promotion Law several times, most significantly in 2008. This final revision led to the situation where the Korea Food and Drug Administration (KFDA) would now be able to exempt pharmaceutical companies from their obligations to present extensive biochemical data in the drug approval process.¹³¹ The inherent lack of clarity in the regulations regarding natural substance-oriented medicines to which *hanyak* (韓藥) and *saengyak* (生藥)¹³² belong also favored further the development of those drugs. According to these regulations, pharmaceuticals produced from *hanyak* or *saengyak*, were exempt from the safety and efficacy assessment,¹³³ if formulas used in the production of the pharmaceutical products are listed in eleven specified classical medical texts.¹³⁴ This is unlike the approval process for the drugs made from chemical compounds where every new chemical or biological agent produced has to pass a safety and efficacy assessment.

¹³¹ In contrast to the usual 'novel' drug approval process, the approval of botanical drugs could follow the regulations of Drugs Needing to Supply Data (*Jaryöjech'ulüyakp'um*), a category of drugs that are not classified as novel drugs but that should meet efficacy and safety requirements.

¹³² *Saengyak* is the category of the medicines which are practically the same as *hanyak* except for the fact that these are in the pharmacists' professional territory.

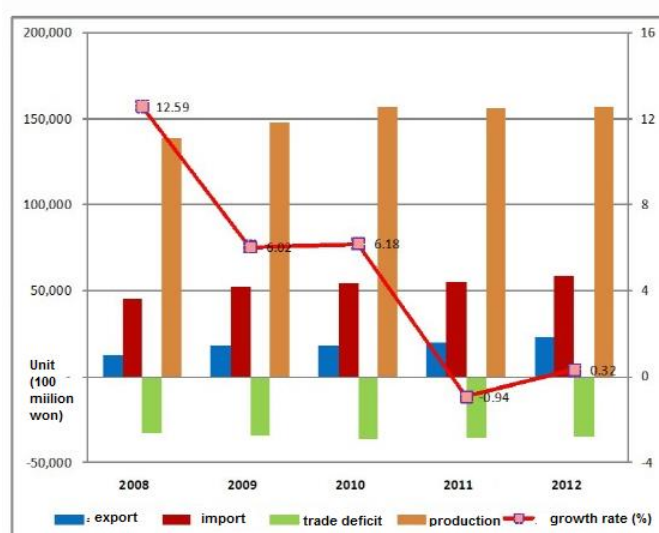
¹³³ It is called '*Anjönsöngyuhyosöngg'ömsa* (安全性有効性検査).

¹³⁴ The eleven Korean Medicine classical texts that were listed in 'the regulation regarding the kinds of *hanyak* prescriptions and their methods of formulations' (the MOHW official notice 1995-15 notified on 15 March, 1995) are *Bangyakhapyon*(方藥合編), *Dongubogam*(東醫寶鑑), *Hyangyakhgipsungbang*(鄉藥集成方), *Gwangjebigup*(廣濟秘笈), *Jejungsinpyun*(濟衆新編), *Yaksongga* (藥性歌), *Sasanguhak*(四象醫學), *Euhakipmun*(醫學入門), *Kyungakjonso*(景岳全書), *Ponchogangmok*(本草綱目), and *Susebowon*(壽世保元).

The new category *Ch'önyönmulshinyak* could, therefore, be said to sit somewhere between the category of *hanyak* or *saengyak*, and that of a novel drug. It is because to qualify for this category, the companies need only to demonstrate safety and efficacy, through clinical trials, of the products developed, but do not have to present extensive evidence on the bio-chemical characteristics of their products, nor to prove their 'novelty' in terms of the chemical structure or clinical indications of the products, if the original formula had been listed in eleven medical classics.

This is how a new category of 'novel drug' called '*Ch'önyönmulshinyak*' was created. Considering the low expense for their development and handsome outputs (Jaehoon Song 2013), and the good country-wide knowledge base regarding natural plant resources, the state's interest in this field is not surprising. Successful developments of botanical drugs and subsequent success in both domestic and international markets, also means a reduction in the trade deficit in pharmaceuticals in the long term (Figure III-7).

Figure III-7 The Size of Domestic Pharmaceutical Productions and the Volume of Trade in Pharmaceuticals from 2008 to 2012



Note: The graph shows that trade deficit in pharmaceuticals is constant over the years.

Source: M. Chon (2013)

Some botanical drugs performed very well in the domestic market. STYREN, a mugwort (艾葉)-based drug developed for gastrointestinal problems by the Donga Pharmaceuticals in 2002, for example, earned an impressive revenue of 80 billion won in 2011 alone. JOINS tablet, a drug developed for the treatment of arthritis and associated joint ailments by SK Chemicals whose main compounds include *wiryōngsŏn* (威靈仙), *hagoch'o* (夏枯草), and *gwallugŭn* (栝樓根) that are common in *hanyak* prescriptions used for joints problems, also recorded a sale of 27 billion won in 2011 (see Table III-4).

Table III-4 Annual Turnouts and Development Costs of Botanical Drugs

Products (Company)	2011	2012	Development cost (Unit: 100 million Won)
Apitoxin injection (Guju Pharmaceutical)	6	7	150
Joins Tablet (SK chemicals)	276	238	60 (in year 2002)
Styren Tablet (Donga Pharmaceuticals)	809	558	180 (in year 2002)
Shinbaro Capsule (Noksipja)	4.7	30.4	-
Sinechura Syrup (Ankuk)	78	246	-
Motiliton Tablet (Donga Pharmaceuticals)	2	81	500
Total	1175.7	1160.4	

Source: Sunghan Kim (2012b)

The state also had another reason to encourage domestic pharmaceutical companies. It is because the country's first, 'real' novel drug Sunplazu¹³⁵ was developed by the domestic company SK Chemicals in 1997, putting the country as the world's 11th country producing synthetic novel drugs. Boosting the state's confidence in the growth potentials of the domestic pharmaceutical industry, the country's second novel drug was

¹³⁵ It is a heptaplatin-based anti-cancer drug. It was developed in cooperation with the Seoul National University hospital and was approved by the KFDA in 1999.

developed in 2003 (H. Kang 2013).¹³⁶ With the newly gained confidence in the sector, the government launched an ambitious scheme called ‘The Columbus Project’ in 2011 in an attempt to boost the strength of the under-developed domestic pharmaceutical industry.

Some domestic pharmaceutical and healthcare technology (HT) companies would take part in the government-sponsored scheme to encourage the developments of new drugs and healthcare technology. The aim is to drive up market share of Korean pharmaceutical products in North America from 1.1% as of 2010 to 3.4% in 2015 (Sanghoon Kim 2011). The government has already put up 10 billion won for its implementation, and pledged to create a 100 billion won fund solely in order to support this project (Sungho Lee 2011). The Korean state has decided that Korea must be part of the global drug developments race. The development of botanical drugs is an essential part of this process (see Table III-5; Picture III-4).¹³⁷

¹³⁶ This novel drug was developed by the LG Biotechnology. It is an antibiotic called ‘Factive’ and it received US FDA approval (H. Kang 2013).

¹³⁷ This project, however, does not seem to be pursued as energetically as in the initial phase. A recent news article mentions that the momentum of the project has been entirely lost with the change of government in 2013 (Eutae Kim 2013).

Table III-5 Pharmaceutical and Health Technology Companies Participating in the Columbus Project

Pharmaceuticals	Medical Device	Cosmetics
*Noksipja Pharmaceuticals	Nano and Tech	Naduri Cosmetics
Daewon Pharmaceuticals	Lutronic	Amore Pacific Cosmetics
Daewoong Pharmaceuticals	Listem	LG Everyday Health
*Donga Pharmaceuticals	Medison	
Biomed	Mediana	
Boryung Pharmaceuticals	Medi Future	
*Seoul Pharmaceuticals	Bionet	
Seltrion	Batech	
Nengicam	Cymedics	
Yuhanyanghaeng	Sewoncelon Tech	
*Chonggundang	CU medical	
Choongoe Pharmaceuticals	*Anguk Pharmaceuticals	
Cha Bio and Biotech	Ostem Implant	
Crystal Genomics	U and I	
Taejoon Pharmaceuticals	Intro Medic	
Hanguk United	Infinite Healthcare	
*Hanmi Pharmaceuticals	Taewoong Medical	
Hanol biopharma		
Hyuons		
*SK Chemicals		

Note: * indicate the companies that have developed or are in the process of developing botanical drugs.

Source: Sanghoon Kim (2011)

Picture III-3 The Official Blog of the Columbus Project



Note: In this blog, the Anguk Chemical's *Sinechura*, the botanical drug is being showcased as one of the successful examples of the project. The picture is from HT Korea Blog (http://blog.naver.com/columbus_pro/150129612117.)

These industrial initiatives seemed to have a knock-on effect on the country's private practitioners as the end product of those initiatives came to affect KMDs, as we could witness in Ch'amsillyon's arguments for these types of drugs.

2.2.2 The Ch'amsillyŏn

The Association for Sincere Healthcare Practice or Ch'amsillyŏn¹³⁸ was founded in 2011 by 'young doctors who voluntarily gathered in an online community to protect the public from illegal practices by non-licensed practitioners, and to rectify the current healthcare environment where the public were made to distrust orthodox Korean Medicine' (Eunkyung Kim 2011) (see Picture III-5).¹³⁹

Picture III-4 The Launch of the Ch'amsillyŏn



Note: It will be seen that most members present are in their late 20s and early-to-mid 30s. The young man in the middle of the first row, wearing a pink tie, is Dr. Lee Jinwook, the second president of the organization.

Source: E. Kim (2011)

From the time when Dr. Lee Jinwook was elected as its second chairman, the Ch'amsillyŏn took up an increasingly militant stance against those who were believed to have impinged upon KMDs' professional licensure rights. Ch'amsillyŏn conducted an

¹³⁸ It is a short form for Ch'amŭryosilch'ŏnyŏnhaphoe.

¹³⁹ This is the expression used by them and the newspaper '*Jŏlmŭn hanŭsa*', which literally means 'young KMDs'.

active negative campaign against the products based upon *hongsam*, or the steamed *Ginseng Panax*, on the grounds that the public was under grave health risk due to side-effects that could be caused by the consumption of those products without doctors' proper guidance. It also staged strong publicity assaults against the Korean Medical Association (KMA), the professional organization of the country's WMDs, which had been conducting an organized anti-KM campaign for a decade through its License Unitarization Special Sub-Committee.¹⁴⁰ It also acted against the Chönüch'ong¹⁴¹ or The National Doctor's Association, the WMD group which was founded by young members of the WM community. True to its mission, the Ch'amsillyon systematically searched for non-licensed practitioners and, when it found them, reported them to the police.

Considering its mission statements and its members' activities so far, the Ch'amsillyön's full-on stance against the botanical drug policy might not be surprising. The problem, however, was the fact that executive directors of the AKOM were not interested.

A. The AKOM's disinterest and Young Doctors' Growing Resentment

AKOM executives were busy with other matters. They were occupied in pushing legislation whereby KMDs could be granted rights to employ medical technicians, which would give them almost unlimited access to modern biomedical equipment.¹⁴² They also

¹⁴⁰ It reads in Korean 'üryoiröwnhwatükbyölwiwöñhoi'.

¹⁴¹ It is a short form for Chöng'uküsach'ongyöñhap.

¹⁴² Many believed that this legislation would have a similar effect as that the Medical License Unitarization policy that is aimed at unifying KMD and WMD licenses, would have. The difference would be, when the 'medical technician law' goes through, that the AKOM would have more political power than the KMA who had been unsuccessfully seeking license unitarization for long time.

thought that a brief window of opportunity was created as KMA representatives, the AKOM's biggest enemy, had been absent in almost all key negotiating scenes. This began after KMA had opted, or 'stormed', out of the sessions of the National Health Insurance Policy Deliberation Committee.¹⁴³ Some AKOM executive even said to me that the KMA's relationship with the MOHW was said to have been so sour that the Minister of Health had refused to meet the KMA president for almost a year.¹⁴⁴

Indeed, the state started to show a favorable attitude towards the AKOM. As a result, the policy of the chronic disease management system was agreed to be implemented in KM clinics, upon AKOM's request. Also, from my observations, the fact that the AKOM health insurance executive director had meetings with various high-ranking officials at the Ministry and representatives from various organizations seemed to signify that some progress in favor of the KM community was under way.

In this atmosphere where pro-governmental and pro-negotiation mentality was pervasive, there was no place for grudges against the governmental policies, whatever they were, certainly not the blanket anti-state stance that was taken up by Ch'amsillyŏn. The following is what a policy expert in the KM community told me regarding the botanical drug issue in a lunchtime conversation.

As they [Ch'amsillyŏn] make a big fuss about the botanical drug issue, I even visited the AKOM while Dr. Lee Jinwook was staging the hunger strike in order to find out what he was trying to say. To me, however, accusations and arguments against the AKOM president seemed all trivial. Though I am not entirely supporting AKOM president myself, revising the Korean Medicine and Pharmaceuticals Promotion Law was itself a great

¹⁴³ See section 2.1.3, Chapter V for details on this committee.

¹⁴⁴ The new KMA president is the former head of the Chŏnŭch'ong. The AKOM Public Relations Director told me this story.

achievement.¹⁴⁵ There is nothing to gain for us just by staging fights against WMDs. See what we got when we went into a full-scale battle with the KMA over the ‘common cold’ a few years ago?¹⁴⁶ I think the the AKOM president Kim is doing a good job taking a practical and sensible route rather than an ideological one.

Here, his stance was straightforward: It is not time for a fight, but for a negotiation.

Also in the KM R&D meetings which I participated in, the general consensus reached among experts in the KM community, was that they should deliver the best outcomes to the state, whether they were botanical drugs or new medical technology, in order to secure the state’s continued trust in the KM field. It was highly unlikely that anybody there would mention potentially ‘harmful effects’ on the Korean Medicine community from any R&D projects just as in the case of botanical drugs that had indeed been a product of KM-related projects.

Precisely because of this collaborative stance by AKOM, the Ch’amsillyŏn had given the current AKOM administration a score of minus 320 in its own assessments (Ch’amsillyŏn Medicine and Drug Committee 2012, 7–30).¹⁴⁷ Antipathy toward the incumbent administration started to grow, firstly because their voice was being ignored and secondly because AKOM was not taking a large-scale anti-governmental stance.

¹⁴⁵ He is referring to those amendments made in the law in 2011 where the purview of Korean Medicine was extended to justify KMDs’ use of modern technologies.

¹⁴⁶ Massive public exchanges of criticism, and eventually legal fights, broke out between KMDs and WMDs in 2005 when KMDs actively promoted the treatments of the common cold in KM clinics, and campaigned against the unnecessary use of antibiotics by WMDs, to which the KMA, particularly WM pediatricians and family medicine specialists, reacted with a large-scale anti-KM campaign. See Taehyung Kim (2005) and section 3.1.1, Chapter IV for details.

¹⁴⁷ The points of the prior administrations ranged from plus 40 to plus 70.

B. Ch'amsillyŏn and Chŏnŭch'ong: Two Young Doctors' Groups

It is interesting to note, at this point, that these young KMDs were showing a great resemblance to Chŏnŭch'ong, the young WMD group.

First of all, both are militant in protecting the professional interests with their policy stances being tougher than their official representative bodies. We have seen Ch'amsillyŏn pressurizing AKOM for stronger actions now, and Chŏnŭch'ong acted in a similar way earlier when it challenged the KMA's decision to implement 'designated clinic systems (*Sŏnt'aekŭwŏnje*)'.¹⁴⁸ Their opposition stemmed from the fact that the policy would not only interfere in the doctor's rights but also would favor the already established members of the WM community over young ones who had yet to come onto the market (Eum 2011). Their opposition to KMA's pro-governmental stance resulted in altercations in which the Head of Chŏnŭch'ong, Dr. Nho Hwangyu, threw eggs in the face of the KMA president (Picture III-6).

Picture III-5 Egg Throwing at the KMA General Council Meeting



Note: Dr. Noh Whangyu, then president of the Chŏnŭch'ong and the current KMA president, is throwing an egg at the KMA president Kyungman Ho in protest to the introduction of the designated clinic system during the KMA General Council held on 10th December 2011.

Source: S. Shin (2011)

¹⁴⁸ See Section 2.2.3, Chapter VI for details on this policy.

Just like Ch'amsillion, members of which systematically reported non-license practitioners to the police, Chŏnŭch'ong also reported to the police pharmacists who they believed had dispensed medicines without doctors' orders. They did this on the basis of evidence collected covertly through video-recording (Sunghan Kim 2012a).

Secondly, both organizations sprang from popular doctors-only online communities consisting mainly of local clinic owners. The Chŏnŭch'ong's base was the Doctors Plaza, or Docple which has more than 25,000 active members while the Ch'amsillyŏn's base is Swimtŏ, the popular online KM community.¹⁴⁹

Thirdly, both groups use very strong expressions in their rallies against each other's community. The Chŏnŭch'ong call KMDs '*hanbangsa*'¹⁵⁰ (Sangyong Yun 2012), taking off 'the medical doctor' at the end of their title, or 'shaman' (*mudang*), in order to degrade the integrity of KMDs' medical expertise. Particularly, in reference to KMDs' move to pass the law on medical technicians, the Chŏnŭch'ong frequently accused them of being 'copycats' who imitate WM.

On the other hand, the Ch'amsillyŏn calls WMDs '*Yangbangsa*,' likewise removing 'medical doctor' title at the end, using the same strategy as that of the WMDs', or they call them '*Yangbangŭsa*', with emphasis on '*Yangbang*' which means 'western', in order to signify the western origin of the profession of WMD. Recently, Ch'amsillyŏn argued that

¹⁴⁹ The political fault line of the WM community seems to be determined largely by specialties. So having a solid 25,000 members among a total 100,000 KMA members is substantial. According to remarks by people who have access to both sites, it seems that Swimtŏ's solidarity is stronger than Docple.

¹⁵⁰ When a designation of '*bangsa* 方師' or '*gisa* 技師' is used in a person's title, it signifies the person to be a technician rather than a professional.

WMDs should be given the name ‘Japan-Oriented-Doctor (*Oebangsa*)’¹⁵¹ to highlight the Japanese, hence anti-nationalistic, influence on its profession (Sun Choi 2013). In criticisms targeting the KMA’s License Unitarization Special Committee which had been arguing for the scrapping of KMD license, the Ch’amsillyŏn even described WMDs as ‘Western doctors who are the dogs of the Japanese imperialists’(C. Hong 2013).¹⁵²

Finally, despite their strong professional interest-driven orientation, both groups were claiming to put a higher level of ethical control over the behavior of their community members. The Ch’amsillyŏn even tried to help some patients who were adversely affected by some KMDs’ malpractice, though their attempts, not surprisingly, invoked suspicion from the patients. The Chŏnŭch’ong also acknowledges issues such as drug rebate as problematic, and has pledged to eradicate unethical practices by imposing stricter control in the community.

All these resemblances notwithstanding, what distinguished the Ch’amsillyŏn from the Chŏnŭch’ong was the fact that while the Chŏnŭch’ong took over the KMA in 2012 by electing the head of their organization as the KMA president, the Ch’amsillyŏn still remained a marginal group in the KM community.

2.3 Summary

In this section, I dealt with the details of the KM community and of the botanical drug controversy. I outlined first the circumstances within which I came to expand the

¹⁵¹ ‘Oe 倭’ is a derogatory expression that have been historically used to designate the Japanese in the Korean peninsula.

¹⁵² This level of negative rhetoric is unimaginable in official statements issued by either KMA or AKOM.

purview of my fieldwork into the KM community. Then I highlighted real-life values of the online space in the world's most wired country, and I subsequently showed why and how KM online communities play a central role among members of the community. And I presented a situation where young doctors were raising concerns about botanical drugs policy on the ground that they were being unfairly discriminated against by the policy.

Then, I presented situations regarding the botanical drug controversy with emphasis on the internal and external factors contributing to its emergence. I showed, for example, how the state's promotion of those drugs is related to its attempt to stimulate the competitiveness of the domestic pharmaceutical companies.

Finally I focused on the young doctors' group which was criticizing AKOM for their inaction on this issue. However, we have seen that the AKOM's disinterest was obvious as it was working 'with' the state and not 'against' the state. Furthermore, I illustrated similarities between young doctors in the Western and Korean medical communities, despite their harsh rhetoric against each other's community.

3. A Rebellion in the Korean Medicine community

3.1 Introduction

Young doctors' resentment toward AKOM executives became progressively stronger. As the AKOM did not compromise, the growing resentment eventually translated into a whole-scale anti-establishment campaign aimed at overthrowing AKOM's bureaucratic structure. If we were to conceptualize the situation as part of the conflict cycle, the botanical drug controversy was now operating as the 'object basis for conflict' (Pharr 1984, 221).

The young doctors' campaign, however, was not easy because they soon faced the main obstacle along the way: the age-based rank ordering, one of the biggest norms that dominated the social consciousness of every contemporary Korean. The fact that they were 'young', meaning they were under 40 and 'inexperienced', was a big predicament in a society where Confucianism is still 'alive and well' (Robinson 1991, 209), and 'deference to elders' was 'ingrained' and 'firmly established' (Brandt 1971, 113,162).

Challenging age and seniority-based society rank orderings, the young doctors began to slowly transform themselves into 'revolutionaries'. They started to behave in a way that defied the rule of deference to one's elders, teachers and seniors, and on one occasion, went a step further by putting their seniors under entire physical and psychological submission in their bid to overthrow the 'fundamentally unjust' system. Interestingly enough, all these actions were done in the name of another Confucian value of 'meritocracy' that dictates that people with 'better education' should have a higher

status than those who have lower educational credentials (Brandt 1971, 27; Haboush 1991, 86; Robinson 1991, 205; Koo 2001, 131).

Their three-month long campaign eventually came to an end when they were successful in installing some administrative measures through which their influence could be sustained for the time being, although they could not bring in ‘revolutionary changes’ in the community.

I present an ethnographic account of the young doctors’ rebellion that occurred in the Korean Medicine community from September to December, 2012.

3.2 Ordinary Members’ meeting (1st September 2012)

Although members of Ch’amsillyŏn were increasingly frustrated at AKOM’s reaction, the chairman’s hunger strike brought a tangible outcome. A chance came for them to pursue the matter more formally in the AKOM councilors meeting, the AKOM’s highest governing body, which would be held two weeks later. Two motions were to be discussed: (i) botanical drugs; (ii) the demand for the current AKOM president to step down on grounds of incapability.

A notice was put up on Swimtŏ summoning ‘ordinary members’ (*p’yŏnghoewŏn*)’ to attend a preparatory get-together on the eve of the councilors’ meeting. Though I was busy with the policy work at Yangsan, utilizing my policy meeting schedules in Seoul, I decided to take part. Because I was no longer engaged in running my Hamsoa clinic¹⁵³

¹⁵³ The Hamsoa Korean Medicine Clinic is the nation’s biggest franchised KM clinic focusing on pediatric conditions. I was running its Kangdong branch for about a decade before I started my postgraduate studies

and I did not hold any official position at the AKOM, I considered myself fully qualified as an ‘ordinary member’ (see Picture III-7).

Picture III-6 Seoul Kangdong Branch of Hamsoa Korean Medicine Clinic I Used to Own



Note: a) The consulting room b) A TV morning news coverage of my consultation. Due to good PR strategies, major media frequently came to get information on various pediatric conditions. c) The wall of the clinic that shows the children friendly interior.

Source: Author

The ‘ordinary members’ meeting took place in a small conference room at Yongsan KTX station, Seoul on 1st September, 2012.¹⁵⁴ The room was soon occupied by about twenty people whose age ranged from late-20s to mid-30s. A thin spectacled man in his mid-30s nicknamed ‘Lion’ on Swimtō went up to the front, and began to speak in a low and soft tone. He was the Ch’amsillyōn chairman.

Somebody texted me yesterday telling me that the AKOM tries to finish the meeting quickly to pre-empt ordinary members’ action. If we slightly ‘overact’, it is said that they will define the situation as ‘violent’ and will resort to the police. Many Ch’ōnghan¹⁵⁵

in Oxford in 2009. At this time, Ch’amsillyōn were criticizing the founder of the Hamsoa clinic, Dr. Choi Hyukyong who also established Hamsoa Pharamceuticals, because they thought that Dr. Choi was using the KM community to pursue his industrial interests. See Picture V-4 for more information on Hamsoa.

¹⁵⁴ The KTX which stands for Korean Train Express is a bullet-train service. Many meetings take place at KTX conference rooms due to logistical convenience.

¹⁵⁵ The Ch’ōnghan is short for Chōngnyōnhanūsahoe, or Young KM doctor’s Association, and they are a group of KMDs who used to be student activists in the periods of the country’s democratic movements in the 1980s and 1990s. The Ch’amsillyōn assumed that the incumbent AKOM were taken over by this group. Prof. Lim and Dr. Ryu Jiseon at PNU KM policy unit are all Ch’ōnghan members.

people would then argue that the meeting does not carry any legitimacy.¹⁵⁶ I will say tomorrow, however, what I have always wanted to say.

I felt that this was not the meeting I had envisaged because I had expected the meeting to be a 'forum' in which people could discuss the issues freely. Particularly the way he referred to AKOM and Ch'onghan and the straightforwardness he showed right from the beginning of his speech made me feel like I was an uninvited outsider present in an insiders' meeting.

After a short pause, the Ch'amsillyŏn chairman continued in his slow but firm voice.

Up to now, I tried my best to act with manners and respect toward them [or AKOM executives] as they are seniors and elders but as I was just silently listening to what was being said to me [during my sit-in strike and afterwards], I could not bear it any longer (*Chŏngmal Yŏlbannŭng'ŏyeyo*), and I found myself exploding with anger.

He stopped for a moment at this point, as if he was being engulfed with emotions. Then he said.

And I found myself saying, 'those sons of bitches, I will bludgeon them to death (*Gaesaeggidŭl P'aejugilgŏya*).'

This is the moment that I felt I had to leave. I certainly belonged to the senior group, along with AKOM executives against whom 'Lion' just poured out violent expressions. I could not stay in a situation where a lot of hostility was expressed toward the colleagues I was collaborating with. While I was packing up my stuff and checking the opportunity to excuse myself, the Ch'amsillyon chairman continued,

¹⁵⁶ David Graeber highlights that it is common in situations of mass actions that both parties always assume that 'the other party is prepared to be more violent' and that 'they are the only one who restrain' (Graeber 2009, 429). His assertion seems to hold true here as I haven't seen any incidences in my interactions with AKOM executives with Ch'onghan background where they even think about bringing in the police in these matters.

We should be able to lead those who come tomorrow. We secured (*hwakbbo*) the 6th floor¹⁵⁷ but we couldn't do with 5th floor. Do we need to expose the assembly hall? Oh, [come to think of it], we can just go and tear off all the doors¹⁵⁸ (Italics and () added by author)

A female member in the back intervened, in a timid voice, "Oh, please don't tear off the doors." And the chairman replied, "Oh, don't worry. We will take them off and can compensate for the damages later."

Now, I could feel something close to what Nancy Abelman termed as 'bourgeois fear' (Abelman 1996, 72) coming up inside me. This term was used by student protesters to characterize Abelman's hesitancy and uneasiness in encountering an imminent violent action. She was with a group of Korean tenant farmers and student protesters inside the Samyangsa building in Seoul which the protesters had occupied in their struggle to acquire land rights. The only difference is that I was on the 'wrong side' with a 'wrong people'.

The execution of my 'exit' plan, however, was not smooth as I was signaled by two Ch'amsillyŏn members in the back to follow them out.¹⁵⁹ They had already performed a background check upon me. Suspecting that I was spying for Hamsoa and AKOM, they forced me to provide reasons for my attendance and active note-keeping. Fortunately, I was able to leave the place without my items being confiscated, probably aided by my Oxford name card I handed over to them in defense of my activities in the meeting.

¹⁵⁷ He started to use tactical military languages.

¹⁵⁸ They are all metal doors.

¹⁵⁹ I noticed Lion giving a slight hand gesture to doctors in the back.

3.2.1 *Young doctors' rude statements and their socio-linguistic implications*

The societal and moral connotations that the expression 'Sons of bitch and I will bludgeon to death (*Gaesaeggidŭl P'aejugilgöya*)' can never be overstated in Korean contexts where the appropriate terms of address in communication have been highly developed (M. Kim 2005). As similar expressions will continue to appear in this thesis, it is useful to understand the socio-linguistic implications of the words before we proceed. By uttering this sentence, the Ch'amsillyon chairman, one can conclude, expressed the most extreme degree of aggression toward AKOM executive directors as well as the seniors in the KM community in general.

For analysis, the statement can be divided in two parts. The first part is the word '*Gaesaeggi*' with plural suffix '*dŭl*' attached. '*Gae*' originally means 'dog' and when it is used in an abusive situation such as this or in '*gae gat'un nom*', meaning 'the bastard who acts like a dog', the use of the word convey the sense that 'the person who is being sworn at is mean-natured, or behaves despicably' (Gisang Shin 1992, 27). In the chairman's statement, however, the word '*gae*' was used with dual significations of meaning 'dog' and functioning as a prefix to amplify the speaker's sentiment of repulsion (Gisang Shin 1992, 28). In addition to that, the word is combined with another strongly abusive word '*saeggi*', meaning 'offspring', in order to magnify the speaker's sentiment.¹⁶⁰ Also the statement was uttered in the public space by a respectable doctor to target the seniors in his own community.

¹⁶⁰ In this use of '*Gae*', the pronunciation is generally lengthier as '*gae*' than when it is used to refer to dog. The Ch'amsillyon chairman also pronounced the word '*gae*' in a lengthier form.

The second part of the statement '*p'aejugilgöya*' literally means 'I will bludgeon to death', and it shows the maximum degree of anger he wanted to express. A similar linguistic device was also applied to this word as the prefix '*p'ae*' meaning 'to bludgeon',¹⁶¹ is attached to '*Juginda*' meaning 'to kill' which is another abusive word (Gisang Shin 1992, 22–24). What is more, the part was finalized with an ending '*göya*' that shows the speaker's strong intention of committing the deed indicated in the utterance, rather than '*sipda*' or '*sipö*' expressing somewhat softened intention.

The consideration of the social contexts within which the statement's socio-linguistic function lies will reveal how norm-defying the utterance was, which in turn can explain my emotional discomfort at hearing it.

The following two paragraphs are extracts from the article "“Polite word” comes only after “rude words” are delivered: Civility, Power and Strategies in Communication' written by a Korean communication scholar (Joonwoong Lee 2009). In this article, he analyses social situations in Korea where initial 'rude communication' among parties are transformed into polite ones. What is important for our discussion are the examples of everyday situations he cites to support his argument. He explains one situation where rude communication could be used as a power strategy in the context of *age-based rank* and other situations where the rude communication can be transformed into a polite one on the basis of *age-based rank ordering*.

...in a situation where power hierarchy within the organization is apparent, it is likely that the people with power would initiate a 'rude' communication (Kipnis, Schmidt, and Wilkinson 1980). For example, even if they meet for the first time, when they found out

¹⁶¹ Just like '*gae*' as a prefix, the word '*p'ae*', though it is a shortened form of verb '*p'aeda*', has a similar linguistic function of amplifying the speaker's intent.

that both are junior/senior relations from the same region or the same high school, and thus the social hierarchy is established, it is highly likely that seniors will start the strategy of using 'rude communication'. Particularly, in societies or communities where the prescriptive norms or the solidarity among the member is strong, 'rude communication' based upon the power-hierarchy can develop easily...

...On the other hand, communication initiated in a rude way can be suddenly transformed into a polite communication after the appropriate social cues such as their age and hometown were confirmed. As soon as the fact they belong to 'the same genealogy', or are from 'the same village' and someone is 'someone's brother' is confirmed, 'rude words' suddenly disappear and 'polite words' begin to appear (Joonwoong Lee 2009, 398–399)

The author of the article assumes clearly that the constant in this rule of linguistic exchange is *the 'normality' of the age and seniority hierarchy-based interaction*. A variety of linguistic tactics I utilized or observed during my fieldwork, some of which I highlighted in the beginning of this chapter, would operate on the basis of this socio-linguistic norm. In other words, the seniority-based linguistic interaction is almost like a 'premise' in Korean society upon the basis of which people use various communication strategies depending on the situations.

Now, the Ch'amsillyon chairman's 'rude statements' challenged this premise to a very high degree. It was certain that Ch'amsillyŏn were willfully going against the grain of the 'normal' social rule, and this meant that something was happening in the community.

3.2.2 'Ordinary member' and 'minjung'

Another fact made explicit to me during this meeting was that I was not an 'ordinary member'. After the meeting, I could not resist the temptation to link the word 'ordinary members' with the word *minjung*, or common people. Minjung is the term

referring to 'those who were oppressed, exploited, and marginalized in the contemporary system but were capable of rising up against it' (N. Lee 2007, 42) or to 'those who were politically oppressed, socially alienated, and economically excluded from the benefits of economic growth' (Koo 2001, 143), and the term was frequently used by Korean social and labor activists in the 1980s.

Although the contexts in which two words appeared were different, the significance of these two words looked very similar to me. 'Ordinary members' meant a group of unestablished young doctors, not the people like me who have had experienced some success in the business. The irony was that the Ch'amsilyon's target, namely former Ch'önghan members who had now become AKOM executive directors, were the social activists who used the *minjung* discourse in their activism.¹⁶²

3.2.3 Similarity between young doctors and the social activists in the 1980s

Indeed Ch'amsilyön's collective behavior in terms of their political discourse and protest tactics showed great similarity to the activists in the 1980s.

As the 'minjung' discourse was strategically deployed by social activist groups for mobilization (Abelmann 1996, 7,10; Koo 2001, 18,143; N. Lee 2007, 46), the Ch'amsilyon used 'ordinary member' discourse. In the 1980s, intense 'consciousness-raising' or 'small group' activities were undertaken by activists in an attempt to educate the uninitiated, and subsequently to expand their rally base (Abelmann 1996, 37; Koo 2001, 96,106; G.-W. Shin et al. 2011, 33). Likewise, the Ch'amsilyön was performing similar activities on

¹⁶² Many AKOM executives used to be deeply involved in 'minjung health movements (minjung üryo).'

Swimtǒ and other online communities through deliberations where leaders educate the uninitiated on various ideological and strategic aspects of their campaign.¹⁶³ Just as the cultural performance was also continuously practiced with a view to sustaining the protest participants' engagement with the cause in the street the protests of the 1980s (Koo 2001, 18.143–144), cultural practices were performed in the online space in the form of various rituals and games which effectively served the same roles.

As for the specifics of the protest, various tactics employed by pro-democracy activists were all used by young doctors. They include sit-ins (G.-W. Shin et al. 2011, 33), the occupation of buildings (C. S. Kim 1992, 185; Abelmann 1996, 69–74; Koo 2001, 90,111), the manipulation of electoral politics (Koo 2001, 108), the formation of special committees (Koo 2001, 110), street demonstrations (Abelmann 1996, 1,58; Koo 2001, 87; G.-W. Shin et al. 2011, 33), public declarations (G.-W. Shin et al. 2011, 33), the use of verbal and physical violence (C. S. Kim 1992, 186–187; Koo 2001, 72,108,112–113,115), and even the use of human excrement in protests (C. S. Kim 1992, 185; Abelmann 1996, 56; Koo 2001, 84).

Despite the changes in issues and causes, and most importantly, in the balance in political power over the decades, it seemed that protest tactics and strategies were still the same. The major difference that existed between these two movements seems to be the nature of 'the publics' (Graeber 2009, 432) the protest attempted to influence, namely *minjung* and *ordinary member* because it is clear that the image of 'ordinary member' is not fashioned upon that of the farming communities which inspired the

¹⁶³ Famous usernames on Swimtǒ such as BK, Parachute Military Physicians, and Handsome Kim are the leaders of this campaign, and various aspects of their activities will soon appear in later sections of this chapter.

creation of 'common people' (Abelmann 1996, 10). As we shall see, the image of 'ordinary member' is fashioned upon those who have enough online literacy or capacity to enjoy the culture of what can be called 'controlled anonymity' offered in Swimtö, or on any online-space where anonymity plays an important social role.

3.3 The 'Revolution'

The 'ordinary members' meeting marked the beginning of the young doctors' campaign of anger that lasted about three months. The momentum began to accelerate after the first councilors meeting, and reached the highest point when the young doctors staged a surprise occupation of the AKOM headquarter buildings on 28th Oct. 2012. After the occupation, the situation entered the stage of brief calm or 'convalescence' (Brinton 1965, 207; Davies 1997, 112) before the young doctors' collective anger towards the AKOM executives erupted again in a discussion meeting held on 4th Nov. 2012. The conflict slowly deescalated after this point and the young doctors started to show some signs of organizational weakness. However, their pressure continued until the second councilors' meeting on 11th Nov. 2012 during which they achieved some objectives of their campaign. The conflict almost terminated after this event so that in a month or so, the entire Korean Medicine community, both in online and offline, returned to normal (see Table III-6).

Table III-6 Timeline of the Rebellion

Event	Date	Organizer
Ordinary members' Meeting	1 st September, 2012	Ch'amsillyŏn
First Councilors' meeting	2 nd September, 2012	AKOM
National Assembly Hall Protest	24 th October, 2012	Special Committee on Botanical Drugs
Occupation of the AKOM Headquarters	28 th October, 2012	Ordinary Members' Association
Gathering at AKOM	1 st November, 2012	Ordinary Members' Association and Ch'amsillyŏn
Gyobo Discussion	4 th November, 2012	Ordinary Members' Association and AKOM
Second Councilors' meeting	11 th November, 2012	AKOM

It would be useful to distinguish the developments of the situation into two phases with the young doctors' occupation of the AKOM headquarters as the watershed. It is because power balance shifted in the direction of the young doctors after the occupation. This was also the point when the campaign took an 'offline turn', meaning their previous online maneuvers came now to be visibly translated into offline actions. Second phase is also characterized by counterattacks from the AKOM as the young doctors showed some signs of organizational fatigue.

3.3.1 Prior to the Occupation

In the councilors meeting on 2nd Sep. 2012, the councilors did not pass the motion of sacking the AKOM president Dr. Kim Jonggon, though they decided to install an independent special committee to investigate the botanical drug issues (see Picture III-8).

Picture III-7 The First AKOM Councilors Meeting

a)

b)

c)



Note: a) b) In the morning of the meeting, young doctors were picketing outside the AKOM headquarter asking for the resignation of the AKOM president. c) The meeting was televised to the audience. I stayed with a group of Ch’amsillyŏn supporters.

Source: Author

A. The Generational Divide

The generational divide was obvious. In the beginning, there were some debates among the councilors as to whether to give the Ch’amsillyŏn chairman a chance to speak. To me, it was a *fair* decision-making process as the meeting was following the procedures depicted in the AKOM constitution, and the president of the councilors did not look to be biased towards one side either. Eventually, it was decided that the Ch’amsillyŏn chairman should be given a chance to speak.

In the middle of the debate, I heard a female doctor,¹⁶⁴ a Ch’amsillyŏn member who had been walking around the seats to handle the crowd, make a comment to the audience, “Don’t listen to him with too much attention. It’s Ch’ŏnghan’s strategy to drain the strength off [of us]. It will be a long day so please save some energy.” Initially, I thought she was joking, which seemed to be verified, at least in my opinion, by a spate of

¹⁶⁴ She is the one who objected to Lion about tearing the doors off at the ordinary members’ meeting.

laughter in the audience. It was only during the break that the meaning of the young doctors' laughter was revealed to me when I overheard a conversation between two young male doctors in the restroom.

A: What do you think [of the meeting]?

B: They are talking rubbish things (*Isanghan yegimanhagoissö*)

A: Yea...I agree. They are.

After I returned to my seat, I came to experience a situation where I and the young doctors around me were looking at the same situations but interpreting them in opposite ways. What I thought was a *legitimate* process was booed and laughed at by all those around me, and what I thought was *trivial* got all the nods from them. I had been considering myself to be politically neutral in this debate, but as I experienced this situation, it seemed that I was on the conservative side.¹⁶⁵

B. The Young Doctors' Claims and Objectives

A perusal of the slogans written on the picket signs in the morning of the councilors meeting provides us with insights into the young doctors' claims and the objectives of their campaign. Their ultimate objective, which was to sack the AKOM president, seemed to have been formed around this time. Though signs of aggression had already appeared

¹⁶⁵ In class terms, I certainly belonged to the establishment side in the KM community. I might have been inclined to think that anything that breaks the 'social stability' is dangerous just as the discourse of prioritizing 'social stability' and 'harmony' was the tactics of the bourgeoisie-military-junta complex during the country's military dictatorship (Janelli 1993, 194) and that of the management during labor conflicts (Koo 2001, 177).

in online communities, it seemed that young doctors in general were not yet overly emotional as was evidenced in the use of respectable language in many statements.

Slogans ranged from policy oriented messages such as ‘The choice of council members changes the future of Korean Medicine communities (*Daeŭwönnimdŭrŭ sŏnt’aegi hanigyeŭ miraerŭl baggumnida*)’ which still used a respectable honorific suffix ‘*nim*’ to designate the councilors and a respectful ending like ‘*nida*’ to simple slogans such as ‘AKOM president Kim staying = KM communities recognizing the shared use [of the botanical drugs with the WMDs]’ which emphasized the importance of bringing down the AKOM President Kim.

Some indicated a generational divide with a hint of intimidation as was shown in ‘The names of today’s council member will be remembered by your juniors (*hubaedŭl*)’. Foreboding a more violent unfolding of the situation, some strong language started to be used, particularly in handwritten picket signs which included such messages as ‘Kim jonggon¹⁶⁶ should step down as he is responsible for the robbing of Korean Medicine (*Hanyak gangt’al ch’egimjigo kimjonggonun mulŏnara*)’, or in ‘*Kimjonggon out*’ which would soon become the major buzzword in later parts of their campaign. Another handwritten slogan resorted to nationalistic sentiment by stating ‘Dokdo Island¹⁶⁷ is Korean territory.’ *Hanyak* is KMD (*Hanisa*)’s territory’. Another one simply stated, ‘The staying of President Kim means the end of *hanyak*’, which signified growing desperation among the young doctors.

¹⁶⁶ It does not use his official title President (*Hyŏphwŏejang*) and honorific suffix.

¹⁶⁷ This is a small island in Eastern part of Korea which has been in a severe territorial dispute with Japan for long time.

C. The Defeat and the Young Doctors' Realignment

As the Ch'amsillyön president failed to impress a hundred and fifty councilors in the meeting, President Kim was not sacked in the meeting. Short and pointed speeches of AKOM executives with Ch'öngghan background revealed the staunch power of the AKOM establishment which led to the councilors' support for the existing AKOM in the vote.

The Ch'amsillyön supporters took it as a big defeat, and it fueled their resentment. They knew now that the incumbent AKOM president would not resign on his own accord, and realized that the Ch'öngghan group was politically savvier than expected.¹⁶⁸

In the meantime, AKOM executives indicated, in an attempt to play down the conflict situation, that the 'real force behind the scene' (*paehuseryökron*) were a group of former AKOM executives who wanted to regain the control of the association. They were masterminding the anti-AKOM campaign putting in young doctors as their figureheads, AKOM executives argued.¹⁶⁹ It was reasoned that the inexperienced group of 150 young doctors could not organize a campaign against the AKOM without being assisted by those who know how to play the game.¹⁷⁰

¹⁶⁸ One Ch'öngghan member revealed to me that the Chongghan had an estimate of the number of core Ch'amsillyön members. She thinks there are about 130 to 150 active members operating on Swimtö.

¹⁶⁹ During the labor conflicts in Korea, the companies used the similar discourse to delegitimize the workers' demands (Koo 2001, 117).

¹⁷⁰ This was the view taken by the AKOM executives, and Prof. Lim who had been branded by Ch'amsillyön as Ch'öngghan's brain.

Indeed, despite the Ch'amsillyŏn's continued denial, key members of the newly instituted Special Committee on the Botanical Drug¹⁷¹ contained former AKOM executives who were active during the 1990s Korean Medicine-pharmacy conflict¹⁷² and have been in a tense relationship with the current AKOM administration. In the Committee luncheon meeting that I attended after the National Assembly Hall protest in late October, I observed that the former AKOM president Dr. Hŏ Ch'anghoe, whom the current AKOM executives had been accusing to be the real mastermind, was indeed commanding great respect, to the point of loyalty, among the Special committee members.¹⁷³

What the AKOM was clearly misjudging, around the period of the first councilors' meeting, was the Ch'amsillyŏn's capacity to link up with the tightly knit, internet-savvy young generation of doctors. Taken simply, the number of newly qualified doctors from the nation's eleven Korean Medicine schools over the previous five years easily amounted to 3,500,¹⁷⁴ and they were the ones who could be easily mobilized by the Ch'amsillyŏn.

To expand their support base, the Ch'amsillyŏn members now started to assert themselves more fully on Swimtŏ, using expressions that went beyond the acceptable limit even by the Swimtŏ standard. They seemed to be determined this time to destroy their psychological constraints. The word such as '*(gae)saeggi*' began to appear more frequently than before in reference to those 'Enemies of Korean Medicine', a category

¹⁷¹ Its official name is Ch'ŏnyŏnmulshiyakbisangdaech'aekwiwŏnhoe (天然物新藥非常對策委員會).

¹⁷² See section 3.3, Chapter II.

¹⁷³ His group was collectively called 'Dr. Hŏ's Regiment (*Hŏsadan*)' because of Dr. Hŏ's charisma. Possibly from his authority and age, it looked as if he was almost treated like a patriarch by the Special Committee members.

¹⁷⁴ Yearly about 700 new KMD licenses are issued after the national examination.

they used in order to designate AKOM executives, Ch'ŏnghan members, Hamsoa and other 'collabos', or collaborators who worked with pharmaceutical companies in developments of botanical drugs.

Soon Swimtŏ became entirely one-sided as many young doctors showed support while they poured out their own long-held dissatisfaction about the community and profession. The negative sentiments spread like a bush fire to the extent that it would be very hard to express any opinions in favor of the AKOM without risking becoming the target for a barrage of abuse from angry Ch'amsillyon supporters.

The status-quo was destroyed at FB Hanusadang and many Ch'amsillyon members became more vocal there. Frequent clashes occurred between supporters of both camps which roughly corresponded to the generational groupings. The posts uploaded at FB Hanusadang were transferred to Swimtŏ with the original poster's name intact so that the writers of the post had to face a torrent of aggressive comments.¹⁷⁵

D. The Battlefronts

At least for young doctors, the campaign was a full-blown war, namely a war against the system in the Korean Medicine community. Military metaphors indeed started to be used among them. 'Backup' was frequently asked on Swimtŏ to support the Ch'amsillyon members in debates occurring in Hanusadang or AKOM homepage. 'Enemies' were real 'enemies' whose words were never trusted. And the war had to be 'won' by all means.

¹⁷⁵ A rule thus was created at FB Hanusadang that posts or replies could not be transferred without the poster's consent.

Three recognizable battle fronts were soon formed: the fronts of the policy, the ideology, and the social relation. The battles fought on these fronts also worked as spaces for the education of the masses with regards to the cause of their collective action. This situation was similar to the ‘small group activities’ undertaken by social activists in the 1980s and church leaders in the 1970s which eventually became ‘the seed of the increasing working class awareness’ (Koo 2001, 118). Just as the activists’ works, consisting of ‘studies, discussions and recreational activities’ (Koo 2001, 106), contributed to ‘developing a strong solidarity among the workers themselves and sharper awareness of the injustice in their workplace’ (Koo 2001, 96), these small but consistent battles engaged in three online communities contributed to the solidification of the young doctors while at the same time fortifying their sense of the ‘injustice’ in the operation of the AKOM. Without a doubt, these activities also helped ‘the leaders in mobilizing the people’ (G.-W. Shin et al. 2011, 33).

a. The Policy

On the policy front, the biggest source of contention was whether the AKOM and the Ch’ŏngha had indeed made a claim for ‘exclusive use’¹⁷⁶ of the botanical drugs, not claims for their ‘shared use’¹⁷⁷ with WMDs. The AKOM and Ch’ŏngha repeatedly stated that they argued for the ‘exclusive use’ from the beginning but each statement was investigated to its finest details, line by line, by the Ch’amsillon until they concluded that

¹⁷⁶ In Korean, the term ‘*dandoksayong*’ was used.

¹⁷⁷ The Korean term used for this is ‘*gongdongsayong*’.

AKOM executives were either lying or incompetent.¹⁷⁸ Whenever the AKOM presented evidence supporting its claim, the documents led to more suspicion as small details in the documents were magnified to further sully the AKOM's credibility. All policy-related communication from the AKOM was handled in this way by Ch'amsillyon supporters.

With regards to the management of AKOM, executive directors were accused of 'authoritarianism (*gwŏnwijuŭ*)', a 'lack of communication (*sot'ongbujae*)' and of being 'undemocratic (*biminjuŏk*)'. Emphasizing the fact that councilors were chosen rather ceremonially in local chapters and they are the only ones eligible to vote for the president in the community,¹⁷⁹ young doctors argued that the AKOM did not represent the interests of 'ordinary members'. They also argued that the AKOM executives' failure to visit Swimtŏ more often was the sign of their unwillingness to engage with 'ordinary members'.

b. The Ideology

On the 'ideology' front, the young doctors dichotomized the community into the pro-AKOM and the anti-AKOM on the basis of loyalty to 'true' and 'authentic' Korean Medicine.¹⁸⁰ Anyone expressing the slightest approval of the AKOM's official policy was immediately branded as 'anti-KM', and was considered either to be practicing non-authentic Korean Medicine among which franchised clinics would belong, or to be

¹⁷⁸ From my investigations, it is true that AKOM did not ask for 'exclusive use' in the beginning, but Ch'onghan did indeed ask for the exclusive use in a very early stage. I acquired a photographic evidence of their claim made in February, 2012.

¹⁷⁹ American Medical Association has a similar bureaucratic structure (Freidson 1988, 28).

¹⁸⁰ Chapter IV focuses on ideological debates within the community. See particularly section 2.1, Chapter IV for more information.

following non-licensed practitioner (*dolp'ari ch'ujongja*). They defined Ch'ŏngha as half-baked socialists who had little knowledge of the authentic Korean Medicine, and were trying to 'sell off' the community for the realization of their socialist ideals. They even posted on Swimtŏ a list of Ch'ŏngha members with their personal details and wrongdoings highlighted in color so that Swimtŏ users could one-sidedly deliver blame to them.¹⁸¹

c. *The Social Relation*

The most vicious attacks were, however, made on the 'social relations' front. As mentioned, the young doctors' biggest barrier in the campaign was to overcome the 'age-based social hierarchy'. Their predicament was this: if they blatantly ignored the social order, moral backlashes were obvious and would result in the loss of support; but if they respected the AKOM executives' seniority, there would be no way for them to pursue their objectives.

In this community of professionals, 'meritocracy' whereby people with capacity are eligible to lead was the only way out of this moral predicament. The young doctors started to argue that they were much more competent members of the community by highlighting their higher university entrance scores than their seniors. Education is one of the most important sources of social capital in the country (C. S. Kim 1992, 113)¹⁸² and is

¹⁸¹ The *sinsant'ŏlgi*, or 'identity exposure', is a well-established mode of online violence, or a measure of private justice, in Korean society. For example, the identities of a group of teenagers who raped a girl with a mental disability about ten years ago but escaped punishment on the basis of their minor status were exposed online after the event and are still regularly updated.

¹⁸² Choong Soon Kim (1992, 113) mentions specifically the SKY universities which meant Seoul National, Korea and Yonsei as the country's most prestigious universities. He reports that the graduates from these schools have higher prospects of promotion.

considered a key ‘criterion of human worth’ (Brandt 1971, 95). They also emphasized that they had opted to come to the KM schools, deserting top WM schools, in particular reference to those who entered KM schools in the late 1990s and early 2000s when it was much tougher to enter KM schools than WM schools. Hence, according to the logic of *meritocracy*, they were better suited to deal with WMDs, their less bright counterparts, than current AKOM executives who, they believed, failed to get into top WM schools and entered KM schools as alternatives.¹⁸³

University academics, or the young doctors’ teachers, were targeted first as they were responsible for the development of botanical drugs. The Ch’amsillyŏn accused them of having been incompetent, and thus of failing to establish the discipline decently enough to have capacity to defend itself from WMDs’ attacks. Writings blaming their incapacity were constantly posted on Swimtŏ, and negative sentiments intensified until they reached a point where in one post, university academics, or the teaching profession with the highest status commanding great public respect in Korea (C. S. Kim 1992, 26; Janelli 1993, 136,168), began to be called ‘son of a bitch (*gaeseggi*)’. With a wave of anger spreading like an epidemic, the AKOM president and executives, Ch’ŏnghan members, leaders of franchised clinics were all called ‘*gaesaggi*’ regardless of their seniority in age and school as if the word had become the buzz word symbolizing the young doctors’ campaign.

¹⁸³ I browsed past entrance scores in the 1970s and early 1980s, and it is true that Kyunghee and Wonkwang universities did not match up to nation’s top WM schools such as SNU, Yonsei and Korea in entrance difficulties. However, it is also true that the difficulty of entering these two KM schools was more or less similar to that of other WM schools. It is also useful to remember that in that period of an engineering-based industrial development in the country, medical majors were not top choices for the nation’s brightest students on the science track who generally preferred science or engineering.

Thus, young doctors turned the Confucianism-based age-rank ordering around by utilizing the Confucian-based social norm of meritocracy as a rationale in which educational credentials are considered an important criterion in determining hierarchies (Brandt 1971, 27; Robinson 1991, 205,223; Koo 2001, 131).

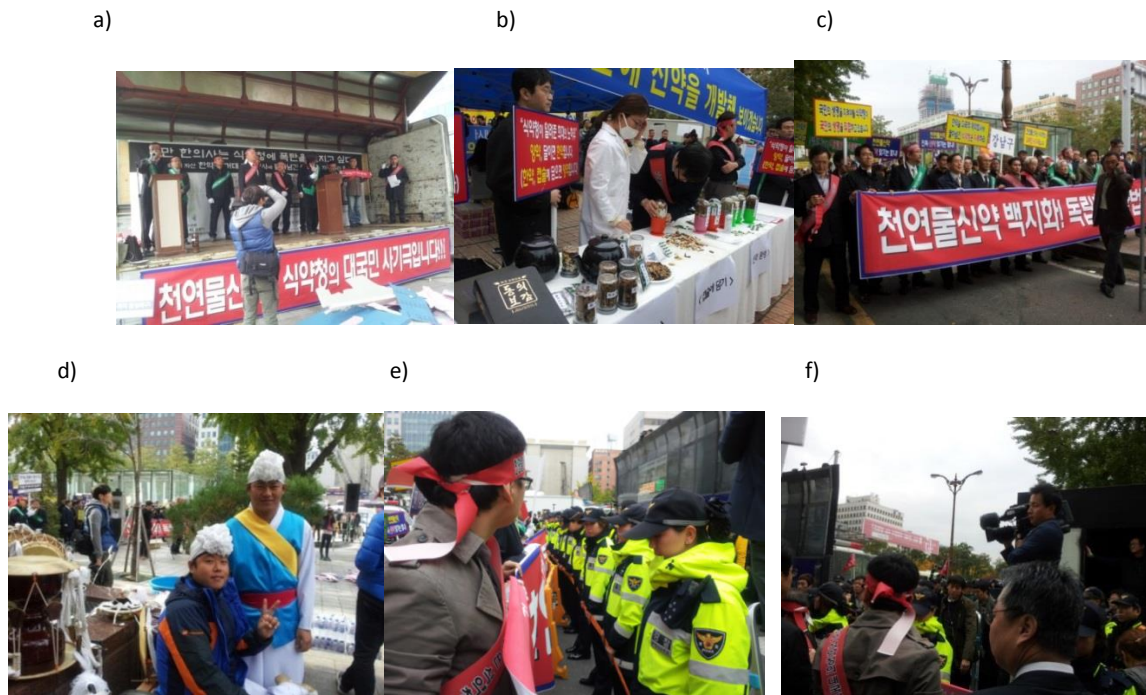
E. The Special Committee on Botanical Drugs and the National Health Insurance (NHI)

Ch'öbyak Coverage scheme

For the full two months after the first councilors meeting early September, the Ch'amsillyön's assaults against the incumbent AKOM administration continued. Primarily these took place within the online communities. Meanwhile, the Special Committee on Botanical Drugs¹⁸⁴ which was formed to tackle the botanical drug issue right after the first councilors' meeting had just successfully organized an 'anti-botanical drug policy' protest near the National Assembly Hall on 24th October (see Picture III-9).

¹⁸⁴ The AKOM executives called them 'the occupying force (*jömyungg'un*)'.

Picture III-8 The Protest Near the National Assembly Hall



Note: a) The Special Committee members are addressing the crowd in a makeshift stand established inside an open truck. The placard behind says, “20,000 KMDs want to throw a bomb at the KFDA.”

b) The head of the Ch’amsillyŏn is acting out making a new botanical drug by putting raw herbs into a plastic capsule where a Western Drug name is written. The big book on the left corner of the picture is Donggūbogam.

c) A group of former AKOM executives are marching with a banner that says ‘Nullify the Botanical Drug Policy and Enact the independent Korean Medicine Law’. The person in the middle with white hair wearing a red cloth across his shoulder is former AKOM president Dr. Hŏ Ch’anghoe. The person talking on the mobile phone in front of the placard is the head of the police.

d) Doctors from Southern Kyonggi region performed traditional Korean music at the scene.

e) The police erected a barricade to block the advancing protesters who were stimulated by Dr. Hŏ’s shout ‘Lets’ go all the way to the National Assembly!’ A line of female officers, or the ‘lipstick line’ (J. B. Kwon 2011, 63), was soon deployed.

f) The media including KBS, the country’s major news corporation, covered the protest

Source: Author

The protest received good media attention¹⁸⁵ boosting the morale of the Special Committee members who had been accused of performing tasks in outdated modes

¹⁸⁵ Publicizing their cause through street demonstrations has been one of the most common protest practices in Korea (Koo 2001, 87). According to statistics, it was utilized in one out of five protests (G.-W. Shin et al. 2011, 33).

characteristic of the 1990s. The Ch'amsillyŏn supporters staged an all-out defense for the committee by accusing whomever raised the issues of its integrity to be 'swaying' it for the incumbent AKOM president and the 'enemies of Korean Medicine'.¹⁸⁶ The Ch'amsillyŏn president, in the meantime, kept a very low-profile in order to foil the accusations against him that he was staging all these actions in order to fulfill his political ambition.¹⁸⁷ Many were actually saying openly on Swimtŏ that he would be a great next AKOM president, a remark on which nobody dared to express different opinions.

Even before the KM community had a chance to reflect upon the implications of the protest, a piece of news broke out in major daily newspapers two days later. It was about the government's decision to expand the national health insurance scheme to include the formerly uncovered *ch'ŏbyak*-based treatments for any conditions affecting the elderly aged over sixty-five twice a year. They also stated that the government already allocated 200 billion Korean won for the trial implementation of the policy and that the current AKOM president was welcoming the government's decision (B. Song 2012a).

Ch'ŏbyak is the most favored form of *hanyak* preferred both by patients and doctors because, unlike pre-manufactured powdered or extracts, in *ch'ŏbyak* forms, individually tailored prescriptions could be prepared (see Picture III-10). This *ch'ŏbyak*, however, had been excluded from NHI reimbursements, partly due to the financial burden in NHI, and partly due to the lack of scientific means to assess its efficacy (Hyo-je Cho

¹⁸⁶ They were compared to 'five enemies of Ŭlsa Treaty (*Ŭlsaojŏk* 乙巳五賊)' the Korean government officials who signed the Treaty of Protectorate with Japan in 1905. The treaty became the legal platform for the country's annexation by Japan in 1910.

¹⁸⁷ I saw him on various occasions but he avoided me, possibly due to the 'ordinary members meeting' incident.

1999, 186–188), though the WMDs’ opposition to its inclusion probably played a major role.

Picture III-9 Hanyak and Decocting Facilities the PNU Hospital of Korean Medicine



Note: a) The chobyak preparation room where ingredients of the prescriptions are mixed. b) Due to the hygienic reason, I could not enter the decoction chamber. c) *Ch'ŏbyak* packets from a KM clinic. As two packets are consumed daily, the patient gets about 20-30 packets for 10-15 days of consumption d) Granules and other *hanyak*-based products such as nose spray by Hamsa Pharmaceuticals

Source: Author

This ‘present’ which the state suddenly gave to the community, according to some rosy projections, might drive the KM clinic’s portion in annual NHI reimbursements up to 8% from current 4%. This almost equals local WMD clinic’s portion of the reimbursements¹⁸⁸ when the 50% patient co-payment and other additional economic advantages are taken into account (see Table II-5). Overall, it was considered to be very good news.

The AKOM was now able to argue that its strategy of *siding with* the state had finally worked as it leveraged WMDs’s absence in the NHI Policy Deliberation Committee. The busy moves of the AKOM insurance director, Dr. Kim Kyungho, which I observed while I visited the MOHW might have been to work out this scheme.

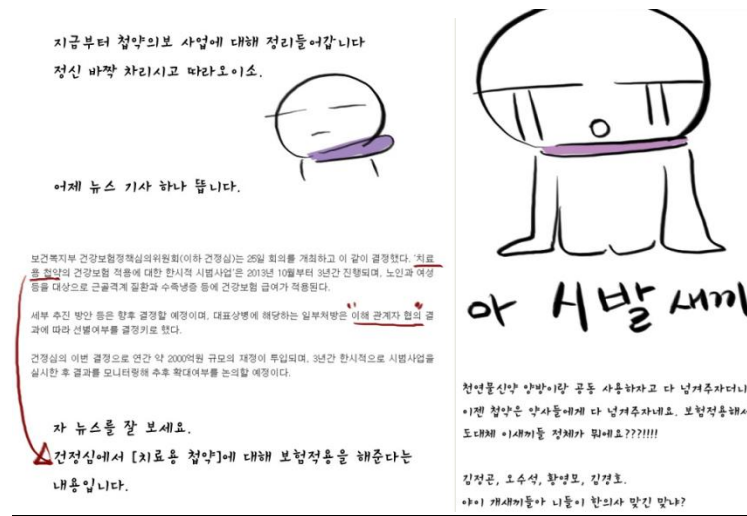
¹⁸⁸ Currently, WMD clinics take up 22 percent of the overall NHI annual reimbursements.

This, however, was a big blow to the Ch'amsillyŏn as simply the fact that incapable AKOM executives had acquired this outcome itself was sufficiently detrimental to their cause. Confused and shaken, some wrote posts asking how they should 'interpret' this situation.

F. The Emergence of a New Leader

As the young doctors' campaign encountered a 'crisis' in this unexpected turn of events, a new leader emerged. An amateur cartoonist and local clinic owner calling himself 'Dr. BK (*BK Paksa*)' on Swimtŏ came forward with drawings replete with tables, photos, and stories in order to provide 'explanations' which 'revealed' that the 22,000 pharmacists who had been entitled to dispense *hanyak* as a result of the 1990s KM-pharmacy conflict were also part of the scheme. He declared with confidence that the 200 billion Korean won originally considered to be streaming into the KM community with the policy would be ultimately spent on the pharmacists because the AKOM had no way whatsoever to exclude them from the scheme. Dr. BK lamented the current AKOM administration's incapacity, and concluded the post with the warning that if the AKOM did not change the terms of the scheme, he might even try to buy some rifles (see Picture III-11).

Picture III-10 BK's Drawings on the NHI Ch'ŏbyak Coverage Scheme



Note: Other than the '*ssibal saeggi*' which means 'fucking son of bitch', written in large-size font, this post contains numerous abusive words against the AKOM executive.

Source: Swimtō

Expressing a strong doubt upon the AKOM's counterargument that the right to accept or reject the scheme was entirely upon the KM community, Dr. BK threw an additional accusation that the AKOM president had accepted the offer willingly despite the knowledge of the pharmacists' involvement. Debates ensued again over the truth of the AKOM's claim across the three online communities. In this process, the Ch'amsillyŏn accused AKOM executives of document forgery when the AKOM produced a document to prove its case.¹⁸⁹

Now, thinking the tide is turned with this accession of a new leader, young doctors pushed the AKOM administration with the strongest force ever, asking it to produce a

¹⁸⁹ Roger Janelli mentions that in Korea, there has been a culture of distrust in official documents. He argues on the basis of his fieldwork experience in Taesong that there is a pervasive sentiment in Korea that official documents are 'human constructs', and thus that official documents don't enjoy the legitimacy as in the US (Janelli 1993, 127–128). The document provided by AKOM was later confirmed to be genuine.

clear roadmap by which to exclude the pharmacists, or otherwise, to entirely discard the scheme.

3.3.2 The Occupation of the AKOM headquarters (28th October 2012)¹⁹⁰¹⁹¹

In the heat of the discussions, a rumor broke out,¹⁹² in quite a timely fashion, that if the AKOM president Kim Junggon were to sign a document at the MOHW on the following Monday, the decision to implement the scheme would be irreversible. This put Swimtö on high alert. After some messages expressing his ultimate frustration with the AKOM administration, the cartoonist Dr. BK declared that night that ‘they’ would now drag the AKOM president down by force to prevent him from wreaking further havoc on the community. Revealing the presence of a secret organization called ‘SDB’ which he characterized as being much tougher than the Ch’amsillyön,¹⁹³ he stated that ‘his group’ would resort to ‘whatever’ means available to achieve the objective of nullifying the power of the AKOM administration (see Picture III-12).¹⁹⁴

¹⁹⁰ Most major daily newspapers gave major coverage to this incident. See Dongju Park (2012) and Dongwook Park (2012).

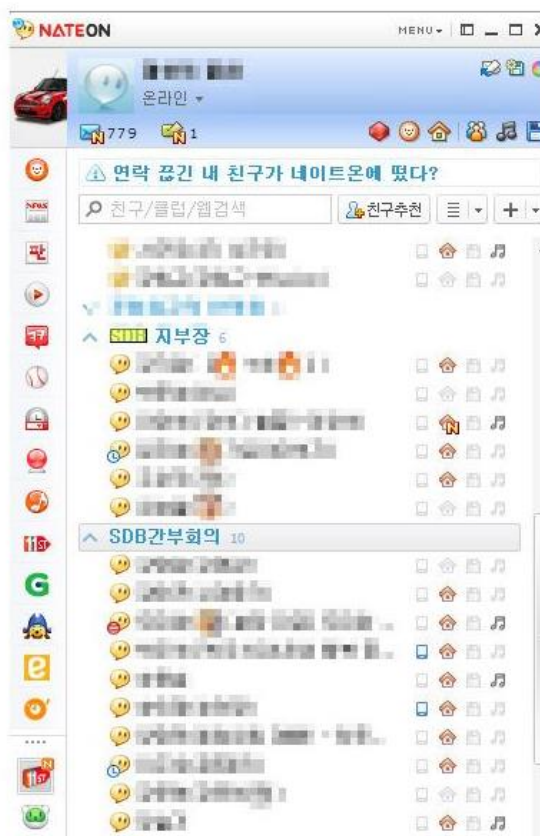
¹⁹¹ This ‘surprise raid’ was all narrated live on Swimtö with pictures and accounts constantly uploaded. The description of the event is based upon those accounts.

¹⁹² Rumors seem to be a quite common feature of the protest scene. Graeber (2009, 194) also reports the breakout of a rumor indicating that ‘the government was calling in the army’ in his descriptions of a protest against the Summits of the Americas held in Quebec city in 2000.

¹⁹³ According to Koo (2001, 121), a ‘secret committee’ also played an important role in Kuro Solidarity Labor Struggle in Seoul that occurred in 1985.

¹⁹⁴ The ‘SDB’ is short for ‘*ssakdivibulza*’ or ‘let’s turn the entire thing over’, and according to BK’s official explanation, it also has its student representative. It seems, however, that this group is a study group formed to study Donguibogam. There is a possibility that SDB might actually be acronyms for ‘Study DonguiBogam’ group. This group has an interesting parallel with a group of secret militant social activists appearing in David Graeber’s ethnography in the name of ‘Black Block kids’ who partook in Democratic National Convention Protest in 2000 in Los Angeles. They were considered to be so ‘violent’ that even among activists themselves, they were called ‘marines of our movements.’ However, David Graber (2009b,

Picture III-11 BK's SDB Network



Note: This is a screen capture of an instant messenger app called Nateon where contact details of the organization appear in blurred form.

Source: Swimtö

On the evening of 28th October, 2012, this ‘new’ group of young doctors gathered, carrying tools,¹⁹⁵ and broke open the main gate before they forced themselves into the AKOM headquarters in Gayangdong, Seoul.¹⁹⁶ They took out the belongings of the AKOM

263) reports that he was quite surprised to find out that they were ‘a bunch of shy, ectomorphic teenagers’ in his real-life encounters with them. Like ‘Black Block kids’, SDB members might be just a group of studious doctors.

¹⁹⁵ Whereas ‘wooden bars and iron pipes’ were carried in labor struggles (Koo 2001, 115), these doctors carried the tools to break open the gate. It is possible that when the Ch’amsillyon chairman mentioned the possibility of breaking open the door in the ordinary members meeting (See Section 3.2 of this chapter), he might have envisaged this action.

¹⁹⁶ The occupation of buildings is a common form of protest in Korea. Abelman records the tenant farmer’s occupation of Samyang building in Seoul (Abelman 1996, 63–73). Koo mentions the case of the Daewoo Automobile strike where workers occupied its technology development center (Koo 2001, 111). YH workers’ occupation of the National Democratic Party headquarter in August, 1979 had a symbolic

president and shipped them all to the president's clinic located in Gangnam, the most affluent area in Seoul. They sprayed walls of the presidential office with paint and threw eggs at traditional paintings and calligraphies hung there. Children's urine, which was said to have been handed over to them by women doctors, was poured all over the floor in an attempt to show their disdain toward the AKOM president.¹⁹⁷ With white masks on, the young doctors stood guard at the main gate to prevent anyone belonging to the AKOM from entering the building.¹⁹⁸

Soon, a large notice was put up on the front door under the name 'The KM Doctors' Congregation of Ordinary Members' which was formed after the occupation and it read,

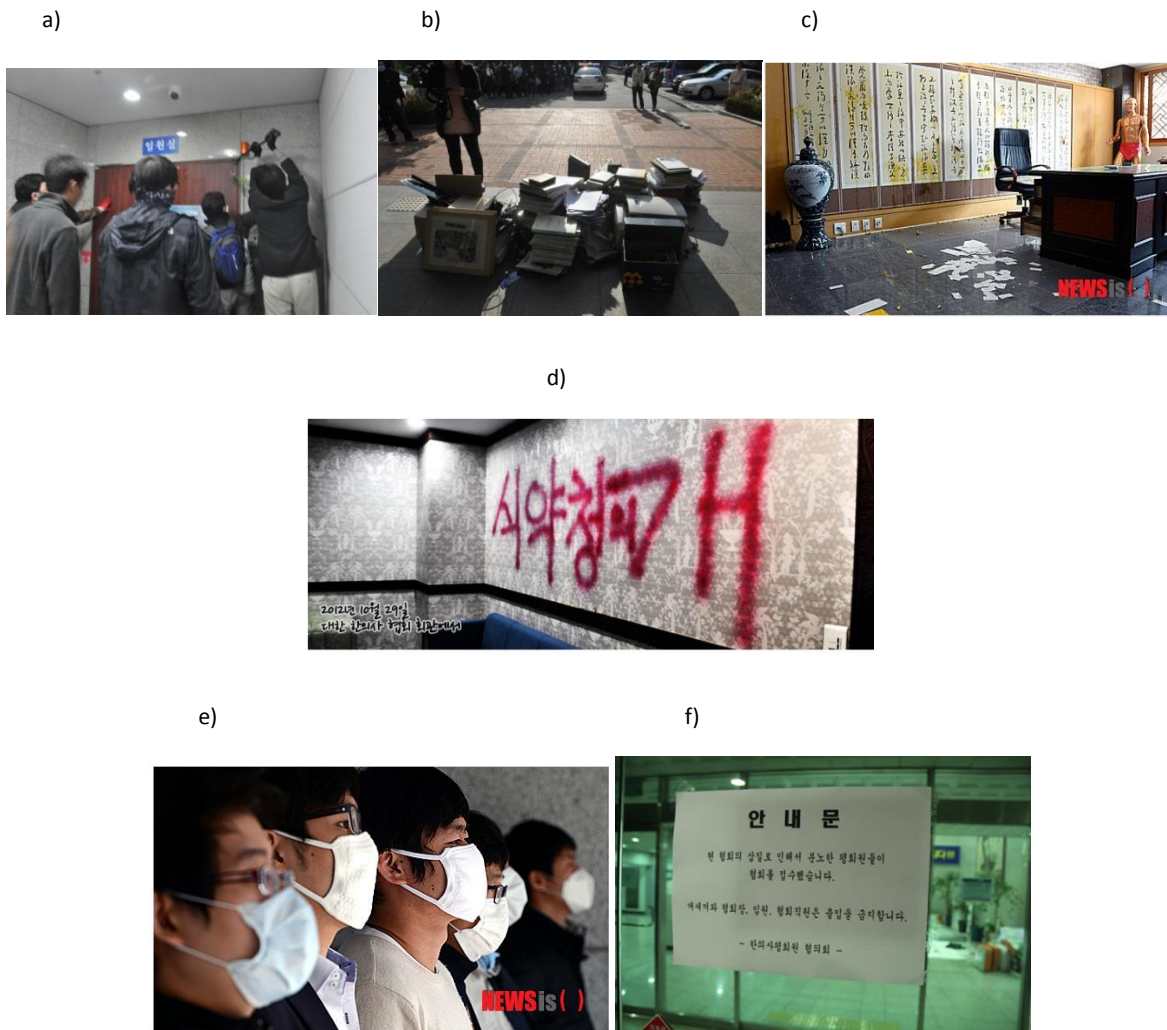
Due to the repeated incapacity of the AKOM, angry ordinary members decided to take over the AKOM. *Gaessagi*, AKOM president, executives, and the administrative staff cannot enter the building' (see Picture III-13).

significance in Korea's political history (Koo 2001, 90). Choong Soon Kim also described the occupation of the Pungsan Corporation headquarters by workers at the corporation's Angang and Bupyung plants (C. S. Kim 1992, 185).

¹⁹⁷ The use of human excrements in protest also has been recorded by several authors. Nancy Abelmann records the uses of feces and urines in the protest that had been carried out by women farmers (Abelmann 1996, 56). The use of the children's urine here, however, has different implications because children's urine has been used in East Asian medical formulas in the name of '*dongbyŏn* (童便)'. I doubt, however, that any of young doctors use children's urine in their practice. This also signifies that women doctors must also be under forty having toddlers or young children as kids. Koo also records the company management's use of human excrements against protesting workers at UIM and the Dongil company in 1978 (Koo 2001, 84). Choong Soon Kim also records the use of human feces during the protest by Angang workers who poured the paint and scattered human faeces throughout the plant (C. S. Kim 1992, 185). David Graeber also mentions the psychological fascination the US police have with regards to human excrement shown in the practice of 'refusing' detainee protesters 'to allow bathroom visits for twelve hours at a time on the police bus' and of using 'pressure-point techniques intentionally designed to cause victims to shit their pants' (Graeber 2009, 426).

¹⁹⁸ During Kuro Solidary Struggles and other major protests where the occupation of a building was involved, barricading the entrance was an essential tactic used by the protesters to prevent the possible intrusion of the 'company hired thugs' (Koo 2001, 112–113.115).

Picture III-12 Occupation of the AKOM Headquarters



Note: a) Angry doctors are forcing open an AKOM executive room. b) The belongings of the AKOM president were all taken out to be shipped to his clinic. Though you can see the police car in the background, the police did not intervene in the event. c) The AKOM president's room was vandalized. d) The statement '[the AKOM] is the dog of the KFDA' is spray-painted on the wall of the AKOM building. e) Young doctors' are guarding the gate. f) The notice put up by the Congregation of the Ordinary Members.

Source: AKOM homepage (a,b,e), Newsis (O. Chung 2012) (c,e), AKOM Daegu branch homepage (d)

That night, they called their action the 'KM community's Jasmine revolution' in reference to the Tunisian Revolution that occurred in early 2011, and in order to signify the active, violent show of their power against corruption, injustice, and the authoritarianism of the AKOM establishment. As if to show that balance of power was on

their side, the young doctors threatened to sack the AKOM administrative staff on charges of inefficiency.¹⁹⁹

The four days inside the AKOM building was, in a sense, a moment of ‘liminality’ characterized by ‘comradeship’ (Turner 1996, 96). Collectively, they relished their experience of spending nights on the cold floor of the building demonstrating their passion for authentic Korean Medicine. The speech by a doctor who is well-regarded among the young doctors for his passion for ‘true Korean Medicine’,²⁰⁰ was particularly well received. They also threw a young female doctor a birthday party by organizing a ‘puritanical’ (Brinton 1965, 180) celebration in a cold and drab office room. The scene was one in which the female doctor was surrounded by her peers who were standing firm in solidarity and comradeship around a brightly-lit birthday cake.²⁰¹

To stage an effective finale to their several days of ‘sacred’ occupation, the young doctors, now under the name the Ordinary KM Doctors’ Congregation, sent around a text to all AKOM members informing that they would stage a big protest at the headquarters on 1st November with an aim of ‘resetting the AKOM’.

3.3.3 The Gathering (1th November 2012)

On 1st November, 2012, the AKOM headquarters were draped with a large number of banners containing various statements protesting against governmental policies and

¹⁹⁹ When I met some AKOM staff while working on insurance policy a few weeks later, they all looked quite worried at the possibility.

²⁰⁰ I will call him Dr. P.

²⁰¹ The picture of this celebration was uploaded on Swimtö.

expressing the KMDs' determination to keep their licensure rights. Through active mobilization, about three thousand members, the majority of whom were young doctors, gathered. Participants were asked to cast a vote for the no-confidence motion on the AKOM president.²⁰² The front yard was full of picket signs and banners, reminding me of the anti-governmental street protests in which I occasionally participated during my college days in late 1980s and early 1990s. The cartoonist Dr. BK's banner containing the rabbit-like figure was flying high with other banners bearing the names of the Ch'amsillyŏn and the Ordinary Members' Congregation (see Picture III-14).²⁰³

Picture III-13 The Young Doctors' Gathering at AKOM on 1st November, 2012



Note: a) The large gathering at AKOM headquarters. b) The symbolic voting of no-confidence. c) The flag displaying Dr. BK's cartoon. d) A large placard at the façade of the AKOM building asking for the resignation of all the incumbent executives. e) The flag of the Ordinary Member's Association.

Source: Author

²⁰² However, as the AKOM is a legal entity (bŏbin), this voting did not carry any procedural legitimacy.

²⁰³ The Ch'amsillyŏn and the Ordinary Members' Congregation are effectively the same organizations.

The Ch'amsillyon PR executive director²⁰⁴ presided over the official, one hour-long ceremony. Near the end, a female doctor delivered a speech which was full of criticism against the AKOM president in which she concluded with an ear-splitting shout 'The son of a bitch to the doghouse and Kim jonggon to prison (*Gaesaggi nŭn gejbŭro and Kim jonggonŭn gambbangŭro*)!' (see Picture III-15).

Picture III-14 Picket Signs and Slogans and the Ch'amsillyon Chairman's Speech

a)

b)

c)



Note: a) The pamphlet says 'Kimjonggon Out Hyŏphoe (AKOM) Reset'. B) A picket sign stating 'The son of a bitch to the doghouse and Kim jonggon to prison'. C) The Ch'amsillyon president is showing a logbook for the expenses taken out from the safe at the AKOM which, he thinks, contains the evidence of President Kim's corruption. Afterwards, he was accused of violating the law by his adversaries for this action.

Source: Author

²⁰⁴ He is the one with whom I had a phone call before the ordinary members meeting. Many Ch'amsillyon members were aware of my presence at the scene.

Before the ‘official’ ceremony ended, however, Dr. Kim announced that he had been tipped off that the AKOM president was nearby. He raised his voice and asked the AKOM president to present himself before the audience as he would provide a safety guarantee in the form of two rows of female doctors so that he could travel through the long corridor that was created. It was the young doctors’ version of a ‘lipstick line’ in which a line of female police officers were deployed at the front to control the crowd in the protest (J. B. Kwon 2011, 63). However, the AKOM president did not respond to the young doctors’ call.²⁰⁵

Soon the gathering’s unofficial session started during which the young doctors’ connection with Swimtö was frequently highlighted. To the audience’s applause and laughter, usernames from the online community known for being extremely violent, argumentative, scholarly, erudite, ambiguous about their sexual orientation, or for delivering explicit contents, were all teasingly called out to speak for the occasion. However, no one came forward to speak in response to any of these calls using online usernames’.

The gathering, however, could not continue in the afternoon as the police did not grant the planned street demonstrations near the MOHW building.²⁰⁶

²⁰⁵ One of my informants, Dr. S, who had a close connection with Ch’amsillyon, told me later that she and her Ch’amsillyon friend directly went to ‘get’ him in a Chinese restaurant where he was supposed to be staying, but she said they narrowly ‘missed’ him. See Section 2.1.2, chapter IV for more on Dr. S.

²⁰⁶ On the day before, KMDs working in public health offices were notified by the MOHW not to leave the office on that day, possibly to prevent them from participating in the event.

3.3.4 The Great Battle at Gyobo (4th November 2012)

Now the onus was on the Ch'amsillyŏn as it had embarked on a 'real' action, and the conflict started to escalate. However, despite the physical show of their force, the Ch'amsillyŏn could not achieve their main objective, which was *to sack* the AKOM president. The AKOM simply issued a statement condemning the young doctors' action as 'an incidence destroying the principles of democracy'. As a conciliatory measure, however, the AKOM president suggested a KM-community-wide global vote on the NHI scheme which would occur after a round of information sessions across AKOM regional branches.

Though the reason behind their agreement was not entirely clear,²⁰⁷ it was announced, rather unexpectedly, that the young doctors and the AKOM would have an open joint-meeting to discuss the NHI issues. The format had been arranged in such a way that both parties could freely talk with the 'safety' guarantee provided to the AKOM executives.²⁰⁸ The meeting took place in a conference room at the Gyobo Securities building in Gangnam, Seoul, on Sunday, 4th November, 2012 (Picture III-16).

²⁰⁷ As Steinhoff (1984, 186) observed in her research on radical student activism in Japan in 1960s and 70s, the occupation might have given the young doctors some 'bargaining power'. It is possible that the 'bargaining' might have taken place over the AKOM executives' attitude towards impending police investigation regarding the occupation.

²⁰⁸ This was revealed by Dr. Guk Sungpyo, the head of the Ordinary Members Association during the discussions at Gyobo. The frequent appearance of 'safety guarantee' signifies that the power balance in the community had already shifted significantly in the direction of the young doctors.

Picture III-15 The Gyobo Meeting on 4th November, 2012

a)

b)



Note: a) A notice about the meeting at the entrance of the Gyobo Securities. b) The discussion meeting took place in the afternoon. The AKOM president Dr. Kim Jonggon and vice president Dr. Choi Munseok sat at the front left, while Dr. Guk Seungpyo, Dr. Choi Inho (nicknamed the “Parachute Military Physician” on Swimtö) and Dr. Park Sangjung from the Ordinary Members Association sat at the right. Many in the audience were young doctors.

Source: Author

Though it was supposed to be a ‘discussion’ meeting, considering what had happened, it was obvious from the outset that any meaningful discussion would be impossible. The AKOM president added fuel to the fire by denouncing the violent possession of the AKOM headquarters in his opening speech. I am not sure whether this action by the AKOM president was a well thought-out strategic plan resembling what Graeber (2009b, 428) described as a ‘Rules of Engagement Trap’ which is an activists’ device wherein they use ‘the other side’s rules of engagement against them’. This could take the form provoking the police intentionally so that the other side is made to look repressive and dictatorial. If that was the case, his strategy of using the young doctors’ ‘rules of engagement’ such as the use of verbal violence to his advantage was successful as Ch’amsillyŏn supporters immediately shouted harsh words not only at the AKOM president, but also at the moderator of the meeting from the AKOM Seoul branch who were trying to intervene.

The meeting that started at two in the afternoon continued well into the evening with an abundance of verbal abuse poured out at the AKOM executives and president by the young doctors in their attempt to get 'voluntary' resignations from them. The Gyobo building administrator had to intervene finally. On the pretext that the meeting passed beyond the agreed lease hours, he asked everybody to depart. Nobody in the audience, however, consented and the young doctors simply replied that they would pay whatever fees incurred. Sensing that the situation was not usual, the building administrator turned off the lights for a few seconds, presumably to disperse the crowd. However, this produced unexpected effects because the darkness made an already precarious situation more uncertain.²⁰⁹ Violent shouts could be heard and, momentarily, a certain degree of real danger seemed to be immanent for the AKOM executives.

Fortunately, the lights were turned on, albeit with a different atmosphere, as the head of the Ordinary Members Congregation, who had lost his power to control the situation, now also had to surrender his role as a leader. A young doctor nicknamed Handsome Kim on Swimtő darted up to the podium and snatched the microphone from the head of the Ordinary Member's Congregation, and immediately ordered the blockage of the front and back doors so that AKOM executives could not escape. The demarcation of boundaries seemed to have been made in the beginning in order to create a 'ritual field' (Turner 1969, 27–43).

Handsome Kim then staged a 'question' time, asking the 'ordinary members' to come forward to express their opinions of the AKOM executives. One doctor who was

²⁰⁹ According to some authors, darkness has some psychological effects on human motivation. Darkness increases the possibility of risky behavior as it provides 'illusory anonymity' (Zhong, Bohns, and Gino 2010). By disinhibiting 'constraints', however, it is also reported to improve creativity (Steidle and Werth 2013).

undergoing residency training at the Department of the Acupuncture²¹⁰ in the Kyung Hee University Hospital of Korean Medicine came forward, and after acknowledging the AKOM president's seniority in his school and clinical department, he strongly asked him to resign on the basis of his incapacity, confronting him directly. However, the AKOM president kept his silence and this attitude sparked the young doctor's anger, which ultimately led him to condemn him in a fit of anger by uttering the word '*(gae) saeggi*' toward him.²¹¹ A woman doctor who was carrying a baby on her back also calmly asked the president to resign immediately to no avail.

Then Handsome Kim called all the AKOM executives to come up to the podium and to express their opinions on two points, specifically, firstly, whether they themselves would resign and secondly, whether they had a trust in the integrity of president Kim. The instruction given by Handsome Kim was detailed: each AKOM executive should first say their name and title, and should remark on those two points only, not on others. The AKOM executives did so one by one, with their heads stooped low. Most of them pledged support for the president. A unfortunate executive who failed to say his name and title in the beginning had to receive a barrage of verbal assaults from the audience.

²¹⁰ Though the name seems to signify the department only deals with acupuncture, it actually is a clinical department dealing with all major internal medical conditions in addition to musculo-skeletal conditions in collaboration with Western Medicine hospitals.

²¹¹ Later he had to post a formal apology for his action on Swimtŏ by the order of his clinical department. Many members on Swimtŏ were concerned about the career of the doctor afterwards. All the university clinical professors who will potentially employ him will remember this event, possibly for his lifetime. Vincent Brandt mentions the incidence of a young person's abusive confrontation to elders in the following way, 'Such 'deviant' acts occur, of course, and indeed they do lead to conflict. But rewards for this kind of behavior are still low, since the individual's personal reputation and effective relations with kin and neighbors are bound to suffer' (Brandt 1971, 35). In the Korean Medicine community where all members are somehow connected, the effect of his conduct is bound to be far-reaching.

By this time, the AKOM president had already been sprayed with coffee by the vice-chairman of the Special Committee in the audience²¹² and was also given liquid taffy, disguised as water, by the young doctors as a practical joke performed to embarrass him.²¹³ One AKOM executive in his fifties had to listen to the shout, ‘you son of bitch, don’t scoff at us (*gaesaggiya jjogaejima*)’ from a much younger doctor in the audience who suspected the executive to be smiling in derision, though the smile rather seemed to express his embarrassment.

The police finally came to President Kim’s rescue near midnight, thanks to a secret call made by an AKOM executive while he was alone inside the toilet.²¹⁴ In response to the urgent calls for backup that had been posted on Swimt’ŏ with the news of impending police intervention,²¹⁵ Dr. BK and his group arrived past midnight, but an hour earlier, in the absence of the AKOM president who had already been escorted out of the room by the police,²¹⁶ the young doctors had to release the AKOM executives. They did so, however, while shouting verbally abusive words at them on their way out. That night, celebrating the successful show of their power and dominance in the meeting, the young doctors called the event ‘the Great Battle at Gyobo (*gyobodaech’ŏp* 交保大捷), an

²¹² The vice-chairman of the Committee later became the AKOM president.

²¹³ Eating taffy or ‘*Yŏnmŏkdda*’ means ‘fucked up’ in Korean. I could not observe this incident myself, but there were pictures and explanations on Swimt’ŏ regarding how this prank was carried out. This is the only tangible form of harassment, other than verbal abuse, directed at the AKOM president that I witnessed throughout the entire campaign.

²¹⁴ Though I had to leave the scene around 9pm, I monitored the situation closely. Some Ch’amsillyŏn supporters lamented that this was their biggest mistake saying that they should have followed them inside the toilet.

²¹⁵ All these actions were organized through smartphone-based communication. The young doctors were logged into Swimt’ŏ continuously.

²¹⁶ It was later revealed that the police was surprised to find out that Dr. Kim Jonggon was the head of the AKOM. Despite the repeated requests from the police about the harm he suffered, he was said to stay ‘in silence’.

analogy to the nation's hero General Yi Sunshin's (1545-1598)'s legendary battles against Japan in 1592.

3.3.5 The Fatigue and Betrayal

Despite their success in dominating over their seniors, young doctors could not manage to force resignations from the AKOM executives. It could even be said that their campaign had not achieved any tangible outcomes. Furthermore, the loss of control shown during the meeting revealed significant weakness in their organizational integrity.²¹⁷ The young doctors started to show some signs of fatigue, not surprisingly after two full months of intense emotional and physical exertion.²¹⁸ The pressure was greater now than before because they bore the burden of showing a level of responsibility and quality in the work they were performing which matched the strong accusations they made against the AKOM.

A. The Special Committee and the Omission of 'Apitoxin'

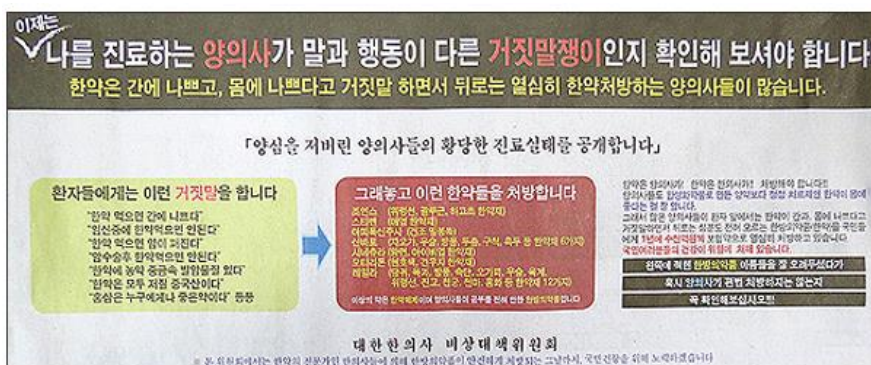
In the meantime, the Special Committee had been suffering from its own problems of 'capacity' and 'integrity'. In addition to their authoritarian attitude toward AKOM executives, the quality of their work was challenged by many. Their expensive newspaper

²¹⁷ After this event, 'Parachute Military Physician', a key Ch'amsillyŏn figure, expressed his intention to resign.

²¹⁸ Their psychological investments in this event were so serious that even the uploading the contents of entertaining nature, or 'fun stuff', was banned on Swimtŏ during these months.

III-17).²¹⁹

Picture III-16 The Special Committee's Newspaper Advert



Note: People said that the color layout as well as the statements themselves was crude and unsophisticated. The statement says that the WMDs who prescribe botanical drugs, or *hanyak*, are ‘liars’ as they are the ones who used to criticize Korean Medicine for being inefficacious. Many KMDs, particularly at FB Hanusadang, expressed their embarrassment at the message’s rawness, regardless of their generation.

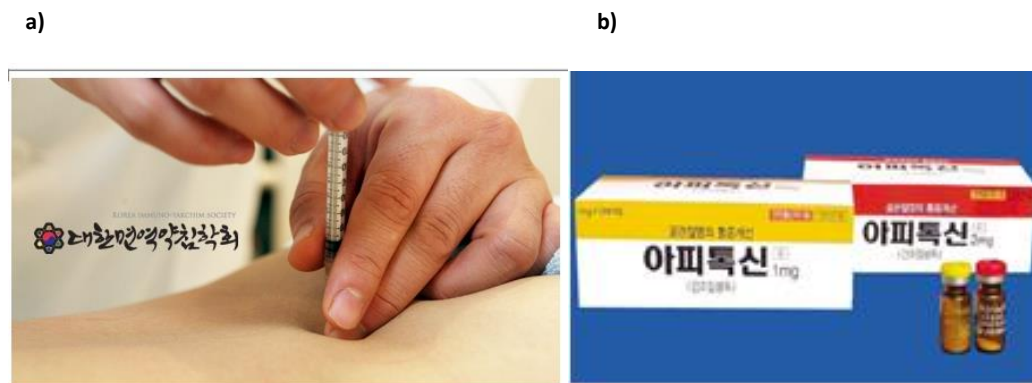
Source: Choongang Daily (13 December 2012)

A more serious accusation, however, was made with regard to the Committee's connection with pharmaco-acupuncture (*yakch'im* 藥針), an acupuncture technique of applying an intra-muscular injection of distilled herbal elements at various points of the body. Some suspected that the committee had a vested interest in *yakch'im*, and as evidence, pointed out that the number of botanical drugs which the committee had set to target for nullification, suddenly dropped to six from the original seven due to the exclusion of apitoxin, an injection-based botanical drug made from bee venom. As the yakchim method includes apitoxin as an important part of its therapeutic regimen and the yakch'im society had a monopoly in distributing apitoxin-based pharmaco-acupuncture

²¹⁹ It spent 700 million won for newspaper advertisements on the botanical drugs issue (Sujin Koh 2013). During the SPD conflict in 2000, newspapers also had a windfall as the KMA spent a huge amount of money on advertisements (Soonman Kwon 2003, 537).

formulas in the KM community, the charge did not look entirely unfounded. The committee countered the accusation by claiming the omission was a mistake, but considering the stakes that the yakchim society had in the potential industrialization of the pharmaceutical agent, it was relatively hard to take their justifications at face value (see Picture III-18).²²⁰

Picture III-17 CA Pharmaco-acupuncture and Apitoxin



Note: a) The picture of performing a CA (Controlled Apitoxin) pharmaco-acupuncture. b) The botanical drug Apitoxin developed by Gujoo Pharmaceuticals.

Source: Juhong Kim (2012)(a), Guju Pharmaceuticals (b)

To make the situation worse, in this critical phase where leaders of the young doctors urgently needed to solidify the group to create a final push during the second councilors' meeting on 11th Nov. 2012, another significant blow occurred. This blow came from an unexpected source, namely from the inside as an incident broke out concerning the head of Ch'amsillyŏn who had been keeping a low profile thus far. To the perplexity of many, the Ch'amsillyŏn chairman uploaded a long post on Swimtŏ, expressing his intention to resign from his chairman post. He blamed Dr. P, a figure renowned for his allegiance to 'true' and 'authentic' Korean Medicine and who delivered a speech during the Occupation, for his resignation for having tainted his reputation. He claimed that Dr. P

²²⁰ See also Picture II-14.

was contacting AKOM executives to accuse him of using Dr. P in order to fulfil his ambition to become the next AKOM president. As Dr. P was highly respected among the young doctors, this particular turn of event was damaging to their morale. It seemed that ‘the endless possibility of betrayal’ that had underpinned the ‘excitement’ (Graeber 2009, 262) of the young doctors’ campaign had become a reality.

Dr. P’s confession did not just lower the morale but affected the course of the events significantly. In the second councilors meeting that occurred on 11th November 2012²²¹ where the young doctors used quite a few manipulative measures²²² such as the blocking of the councilors’ exit²²³ and the continuous proposal of motions, they failed again, however, to sack the president with a margin of two votes. The outcome was resented because the young doctors thought that the result might have been in their favor, had it not been for Dr. P’s defection. They managed, however, to pass some motions that they had put forward, including the implementation of the system of a direct AKOM presidential election, the sacking of other AKOM executives, and the decision to put a temporary hold on the NHI chöbyak coverage scheme (see Picture III-19).²²⁴

²²¹ Due to my policy schedule at Yangsan, I could not partake in this meeting. Instead I monitored the narration delivered live on FB Hanūsadang. See Hyegyung Lee (2012) and H. Kwon (2012) for newspaper coverage of the event.

²²² Koo also mentions the YH workers’ tactics of using various measures to win the labor election by circumventing various existing rules (Koo 2001, 108).

²²³ This raised some complaints even from participating Ch’amsillyon supporters because they were also barred from exiting the venue.

²²⁴ This issue was re-kindled some months later when Prof. Lim at PNU and others continuously asked for its implementation, which led to the creation of the special task force team within the AKOM.

Picture III-18 The Second AKOM Councilors' Meeting



Source: H. Kwon (2012)

That night, though grudges still remained against Dr. P who they thought had betrayed them, the young doctors congratulated each other on what they had achieved thus far. 'Fun stuff' on Swimtö which had been banned for the past two months was now allowed to be uploaded. From this point, the conflict suddenly deescalated and came to a termination as I found that activities in all three on-line communities quickly normalized within a week or so.

3.4 Post Rebellion

In March, 2013, hardly any exchange of violent words took place in any of the three online communities as it had before. Five doctors who were responsible for the occupation were under police investigation. However, it seemed that they had a slim prospect of getting any substantial legal punishment as petitions from the AKOM president himself and from one thousand members streamed into the police.²²⁵ The

²²⁵ Unfortunately, this case had to be dealt with by the serious crime unit, to the embarrassment of the police and the AKOM, because the case was reported by the director of the AKOM administrative staff through the emergency police line 112. As the case was made 'official' through this route of reporting, the

Association's first direct election was held on 13th March, 2013 in a relatively well-managed and fair voting environment where six candidates ran for the office, debating the various issues that had rocked the Korean Medicine community for the past six months. The voters chose, with a very wide margin, the candidate Dr. Kim Pilgun, the vice chairman of the Special Committee on Botanical Drugs, who was heavily backed by the young doctors (M. Chung 2013).

No visible external changes were observed yet except for the changes in AKOM leadership, which produced for some in the community an uncomfortable generational rift, or the young doctors' dominance. Reflecting this tension, someone replied to the congratulatory remark on the election results that had been written by the head of the Ordinary Doctor's Congregation on the AKOM board, by saying that the results were a good thing for 'the young'. A comment was soon attached stating that the results were not only good for the young but for the whole community, to which nobody added a comment.

time necessary to strike a compromise between the concerned parties would be lengthier than the usual cases.

4. Conclusion

The event described thus far clearly indicates the generational shift in power occurring in the Korean Medicine community in particular, and in the country's medical communities in general. The young doctors opposed what they considered to be an 'ideology driven' AKOM, and wanted their representatives to focus exclusively on guarding professional interests. It should also be highlighted that for them, the internet operated as an efficient device of mobilization.

It seemed that the changed market environments in healthcare fields affected what occurred in the KM community. The decrease in *ch'öbyak* prescriptions and the fear of losing economic opportunities related to it drove the Ch'amsillyön into embarking on campaigns of opposition with regards to botanical drug policy and the public consumption of *hongsam* or red ginseng products. Also, the slightly decreased competitiveness of KM departments in the university league table in the past few years could have increased the sense of crisis among the younger doctors who had particularly high self-esteem.

Politically, the event shows that the state plays an important role in a healthcare-related conflict like this. In particular, the state's divide-and-rule style intervention²²⁶ seemed to have affected the course of the event. In the country's paradoxical structure of healthcare governance where the private practitioner-based provision of medical service is controlled through the national health insurance, the role of the state as the

²²⁶ The deputy health minister himself once said that he was using this strategy of 'causing a stir from within (jajungjiran)' to control the KMA and AKOM (Youngmi Lee 2012).

bureaucratic regulator is destined to be critical. The intensive political maneuvering shown in the event, and the frequent collective actions shown by the medical provider groups in the country, might reflect the way healthcare politics works on a higher level. The fact that the young members staged a 'rebellion' against their own representative group also signifies the fact that medical associations are the major policymaking body in the country.

What warrants further investigation with regard to the young doctors' rebellion, however, is the nature of the extremely high degree of anger shown by the young doctors in the course of the event. I already highlighted the degree of the young doctors' resentment and anger against the establishment as demonstrated in my analysis of their statements and actions. The fact, however, that young professionals with elitist backgrounds staged the highly aggressive assaults towards their seniors in public needs further explanation. Personally, I have never witnessed in my life someone or a group of people committing such a high degree of continuous verbal violence on someone else in a public space, except for some cases of random street brawls between drunken men. Even during the pro-democracy street protests in the 1980s, it was the case that verbal assaults from the students were more aimed at the 'system' than at individuals.

This aspect of 'unusualness' present in the event, however, seemed to have escaped the attention of the actors themselves. Somehow, both the protagonists of the conflict and its audience seemed to be oblivious of the emotional and psychological tension present in the event, though they were patently recognizable to an observer like me. Victor Turner's statement 'what is *visible* to a trained anthropological observer is

psychologically unconscious to individual member of the observed society' would find evidential support in this case (1969, 176).

My arguments in the subsequent chapters of the thesis will be centered on the question of 'why were the young doctors in the Korean Medicine community so angry?' I will be looking for *the structural conditions* that could have underpinned the young doctors' anger by contextualizing it within the various conditions defining their professional lives in contemporary Korean society.

My explorations will focus on two major conditions. In Chapter IV, I will firstly explore 'the professional conditions', a constellation of factors that affect the young doctors' lives as KMDs under the dual medical license system. I will attempt to find the source of the inter-generational schism within the KM community that was characterized by the *discursive divide* witnessed during the rebellion as well as the community's relationship with the WMDs in the wider context of the country's inter-professional healthcare politics. And in Chapter V, I will explore 'the political-economic conditions' affecting the young doctors. This will include an investigation of the business environments surrounding the KM clinics and of the political elements that affect the country's medical communities in general.

Chapter IV Korean Healthcare Politics under the Dual Medical License System

1. Introduction

This chapter explores ‘the professional conditions’ behind the breakout of the rebellion. More concretely, the objective of this chapter is to explore and identify the elements of the intra- and inter-professional politics under the country’s dual medical license system, as potential sources of the young doctors’ heightened anger demonstrated during the conflict.

In the previous chapter, I presented how the Ch’amsillyŏn effectively employed the discourse of ‘authentic Korean Medicine’ in order to criticize the AKOM executives. In a sense, they could be considered ‘the fundamentalists’ in the community because they argued for the need to be loyal to what they believed to be the fundamental basis of their profession. On the other hand, the AKOM executives who envisaged the community’s deeper involvement in the state’s healthcare system could be termed ‘the integrationists’ as they prioritized the community’s practical needs over its loyalty to fundamental principles. Most Ch’amsillyŏn supporters would belong to the group I refer to as the ‘fundamentalists’ while the senior groups such as AKOM executives, the Ch’ŏnghan members, the networked clinic owners and the university academics, who were collectively called as ‘the enemies of Korean Medicine’ by the young doctors, belonged to the ‘integrationists’.

This issue of internal politics, however, can best be understood in the context of the inter-professional healthcare politics whose background largely lies in the dual medical license system and which is also characterized by challenges from the Western Medicine community. The influence of these challenges on the young doctors was clearly manifested during the rebellion in the form of their extensive grievances towards WMDs.

In the following sections, I will explore the professional politics in and out of the KM community to investigate the ways in which they affected the breakout and progression of the young doctors' rebellion that was described in the previous chapter.

2. Intra-Professional Schism

In the rebellion, ‘authentic Korean Medicine’ and the community members’ loyalty to it was an important political discourse utilized by the rebellious doctors. Young doctors accused the AKOM executives of not ‘knowing authentic Korean Medicine’ and of selling it for the realization of their socialist objectives. I termed this as the division between the ‘fundamentalists’ and the ‘integrationists’. In economic terms, this internal division can also be seen to represent the difference in the business strategy favored by these different groups. The fundamentalist group ultimately aims to guard the *hanyak*-based economy and the integrationist group intends to broaden the territory of the profession.

In the context of professional culture, however, the schism represents a deep-seated tension existing in the community relating to professional identity, namely the tension between, in the language of the KM school curriculum, the ‘classics’ and ‘biomedical science’. In other words, the fundamentalists view classical text-based EAM ideas as the most important identity-bearing element while the integrationists view biomedical science as something the community has to be engaged with constantly to ensure their survival.

The Ch’ŏnghan’s work on social solidarity with other activist groups, for example, is essentially contingent upon various concerns of the nation’s healthcare from the users’ perspective, and they are mostly informed by bio-medical knowledge. The success of the networked clinics is also dependent on the degree to which appropriate biomedical equipment is utilized for the care of the patients. The majority of hospital-based KM

academics have also been working in the area of biomedicine-based clinical research for decades.

A parallel to this division in the KM community is found in the development of American healthcare. In American osteopathic medicine, for example, a similar schism existed on the basis of the members' loyalty to the techniques endorsed by the founder of the discipline. On one side, the lesionists emphasized the lesion-based manipulative techniques of their founder A.T. Still (1828–1917) as the central professional identity marker,²²⁷ while the broadists emphasized the broad application of osteopathy and even argued for the use of drugs, which was fervently rejected by the founder himself (Baer 1987, 187; Gevitz 2004, 69–84). A similar debate among American homeopaths in the 19th century also occurred between the 'purists', or the high homeopaths, and the 'mixers', or the low homeopaths. It is a division created on the basis of the practitioners' allegiance to Hahnemann's original treatment regimen by which it was argued that only the maximum thinning-down of a potent agent, or the maximum purification, can produce the most powerful therapeutic effect (Baer 2001, 12–13).

To summarize, two camps exist within the KM community regarding the members' perspectives on the identity of their profession. One camp argues that the ideas and practices described in the traditional East Asian classics, or 'authentic Korean Medicine', is the central element defining the identity of the profession. In contrast, the other group argues that the discipline's cooperation with 'biomedical science' is more important and practical in the modernized world, although they also acknowledge the importance of

²²⁷ A.T. Still believed that for any ailments, the doctor could find lesions that are mostly palpable along the spinal column by a skilled physician. He believed that correcting these lesions is the most efficient way of treating diseases (Gevitz 2004, 25,37).

classical ideas. As mentioned, this division is not surprising if KMDs' role in the country is defined as that of mainstream physicians with a strong scientific orientation while the rationale of their therapeutic practice is grounded on classical East Asian medical texts. I will delineate the characteristics of each camp in the following sections on the basis of the ethnographic data gathered during fieldwork.

2.1. The Fundamentalists and the 'Classics'

2.1.1. 'Classics' as the Hallmark of the Profession

There are many members in the KM community who regard 'medical classics' as the hallmark of the profession. In Kyung Hee university and most other schools that essentially follow the Kyung Hee university curriculum,²²⁸ a considerable amount of time is spent on the education of such medical classics as Sanghanlon (傷寒論), Donggubogam (東醫寶鑑) and Donggusebowon (東醫壽世保元). In this aspect, the PNU School of Korean Medicine where I conducted fieldwork is different from the rest as the teaching of classics has been reduced drastically in the curriculum. There were only two full-time professors teaching the combined course of classics, medical history and medical informatics while I was carrying out the fieldwork, in contrast to other schools where the

²²⁸ While emphasizing the importance of curriculum reform towards the outcome-based curriculum as installed at PNU, Prof. Shin Sangwoo at PNU who was responsible for the creation of the PNU curriculum told me that the Kyung Hee University's stance on this issue is really crucial as it is the role model for most other KM schools in the country (The interview taken on 8th Jan. 2013)

department of classics and medical history (*ŭsahakgyosil*) is generally one of the primary departments in the school.²²⁹

Prof. Baek who teaches medical classics at PNU complained to me about the lack of teaching on classics at one point and about what he perceived to be its consequence, namely the students' inability to read classical medical texts.

When the block curriculum²³⁰ was introduced at PNU, *the subject that was reduced the most in terms of teaching time was classics*. Students already had their second grade Classical Chinese Language Certificate, along with their MEET (Medical Education Eligibility Test)²³¹ score, when they were admitted to the school as it is an entry requirement but their competency to read classical Chinese texts falls far behind [than when I was studying]. The *problem* [with the reduced classics teaching] is that they do not have an opportunity to master philological competency [that might be necessary when they read classical texts by themselves]. Most of my classes which are fifteen hours in total finish in the first year so there is a case that second year students cannot even write in Chinese character Ojangyukbu (五臟六腑)²³² (Italics added by author)

Generations of KMDs have been acculturated into the world of Korean Medicine believing that 'authentic' Korean Medicine lies in the medical classics. A KMD's clinical competency, the reasoning goes, ultimately lies in the degree to which one masters the contents of the key medical classics. Precisely because of this sentiment, many clinical lectures advertised at Swimtŏ are being conducted on the basis of the key classical texts

²²⁹ In Kyunghee, for example, there are three full time faculties in the Department of Medical History alone. It has an additional three full time faculties in the Department of Medical Classics.

²³⁰ At PNU, subjects are categorized along several main themes that are taught across year groups.

²³¹ This is the test one must take to enter graduate-entry WM and KM schools.

²³² The interview took place on 21st March at Prof. Paik's office.

such as Dongubogam, Ŭhakimmun (醫學入門),²³³ Binhomaekhak(瀕湖脈學)²³⁴ and Sanghanlon.

A concept called *gwan* (觀), or ‘the Perspective’, which is familiar to many KMDs, encapsulates this sentiment regarding the centrality of the classics-based thinking in the identity of the profession. It is an idea that you can reach the plateau of spontaneous understanding of the world around you if your ‘*gwan*’ is securely established. Your personal, professional and social selves are fused in an integrated whole in that state of enlightenment, the reasoning goes. During my junior years in KM school, for example, the seniors and professors used to tell us to embark upon the journey to attain this *gwan* as quickly as possible. Some of us enrolled in various out-of-curriculum classes such as calligraphy, martial arts, meditation, and residential Confucian classics seminars while others with a Christian background resorted to the brute force of ‘faith’ to attain the understanding. The foremost reason behind our endeavor to acquire this concept of ‘*gwan*’ was to understand the principles of East Asian medicine, which were more or less quite alien to the ways that students who had been on the ‘science track (*iggwa*)’ in high school had been trained to reason.²³⁵

The rationale for this high degree of ideologization around this concept also seemed to lie in a need to enhance the students’ ability and patience in acquiring

²³³ This is a general medical encyclopedia that is similar to Dongŭbogam in nature. The book was written by Lee Chon (李梴) in 1575 during Ming Dynasty in China.

²³⁴ This is Ming Dynasty (1368–1644) scholar Janggyungak (張景岳)’s book on pulse diagnosis. Dr. P who was regarded by the young doctors as a spiritual leader in the beginning and a betrayer in the final phase of the rebellion is also a well-known ‘local’ teacher of pulse diagnostics. His lecture was also based upon the readings of *Binhomaekhak*.

²³⁵ Until recently, entrance to KM schools was strictly limited to the high school students on the science track. However, many KM schools now allocate a small portion of their entrants to humanities track (*mung’gwa*) students as well.

necessary philological skills to read classical texts written in the classical Chinese language (*hanja*).²³⁶ As anyone who has tried to read Chinese classical texts would agree, years of hard training are necessary to master these reading skills. Sometimes, it requires memorizing entire texts to understand the meaning of archaic sentences whose grammatical structure was completely out of its conventional form. For example, one of the graduation requirements of the part-time Chinese Classical Studies Diploma course I followed for three years outside the university was to memorize the entire four classics of Confucian philosophy.²³⁷ Our classical text teachers would tell us about the sudden realization of the meaning of the texts, just as our college seniors told us about the process of attaining *gwan*, which comes only after much painstaking effort. They said that it comes generally with a sound of '*ddak*' which indicates that your '*munli* (文理)', or textual understanding, has finally been achieved.

The classics-based thinking surely affected the young doctors as shown in their fundamentalist orientation wherein their loyalty to authentic Korean medicine was emphasized. To provide a snapshot of the ways in which classics-based thinking functioned in the collective mindset of the rebellious doctors, I will present below, in the form of a vignette, a detailed story of a young doctor who actively participated in the rebellion. The vignette will demonstrate, through the investigation of her rather 'impossible' research project, the ways in which this ideologized thinking had bearings on the young doctors' subjectivities to the extent that the concerns of their professional identity could have been a source of the young doctors' anger and frustration.

²³⁶ It was also a time when satisfactory Korean translations of these texts were not available.

²³⁷ They were the Analects, Book of the Mean, Great Learning, and Mengzi.

2.1.2. Classics-based Thinking: a Ch’amsillyŏn Supporter’s Research Project

My connection with a young doctor, whom I will refer to as Doctor S, developed due to a common interest in Sanghanlon.²³⁸ Doctor S was in a postgraduate program after a stint in a local KM clinic. We agreed to do some skill swaps in which I would learn Sanghanlon from her in exchange for helping her with English, which resulted in several lengthy meetings across the months of September and October when the young doctors’ rebellion took place. The vignette was constructed on the basis of several of these encounters.

A graduate of a KM school located in her provincial hometown, Dr. S. in her late 20s, is an ardent supporter of Ch’amsillyŏn. Her decision to apply to the local KM school in 2002 was motivated by many factors. Firstly, she had a very high mark on the SAT so although she was very interested in studying science subjects such as physics and engineering, she could not ‘waste’ her score by applying to departments such as Seoul National University Physics or Engineering²³⁹ whose expected entry cut was 40 points lower than KM schools that year.

As she had received a high enough score such that she could choose any school, except for the highly esteemed medical schools such as KM of Kyung Hee and WM of SNU

²³⁸ This is an initiative I have had since I started fieldwork. It is expressed in my written piece entitled ‘Scarlet Letter’ published in the PNU KM school student magazine (Na 2012b).

²³⁹ SNU is the country’s most prestigious university. Among the majority of high school graduates and their parents, admission to one of the country’s three most prestigious schools of SNU, Korea, and Yonsei, collectively called SKY, is considered to be the hardest goal to achieve in life.

or Yonsei where the prospect of getting accepted was unclear, she safely chose a provincial KM school rather than second-tier WM schools in Seoul. At that time she applied, entering a KM school was also considered ‘cooler’ than entering a WM school among her peers. Additionally, her parents persuaded her to become a KMD due to its good economic prospects.

Although she had some difficulties in acclimatizing herself to the discipline, she managed to fare well. Now, after a few years of staffing in a local clinic, she is doing a Master’s degree on a scholarship at a prestigious school in Seoul. When I met her in September 2012 she was entertaining the idea of going abroad or of enrolling at a graduate WM school to pursue her passion in the subject of pharmacology.

She looked to me as a suitable person to inform me of the various aspects of being a young KMD at this turbulent time for the KM community. Her academic orientation crisscrossing classics, medical humanities and pharmacology also stimulated me in getting in-depth information on her general outlook on topics such as the situation in the community, Korean Medicine and her views on the profession. Dr. S not only had a line of key contacts to the central administrative position at Ch’amsillyon, but she herself acted in a raid-style lookout to find the AKOM president during the time of the Young Doctors’ Gathering that occurred at the AKOM headquarters at the end of the occupation.²⁴⁰ Due to the generational nature of the young doctors’ campaign and the clandestineness obtaining in their operations, I was having a hard time accessing the key young doctors for information. Using this opportunity, I wanted to have access to the mental landscape of the young doctors who actively participated in the rebellion.

²⁴⁰ See Section 3.3.3, Chapter III for details.

Therefore, I instigated many discussions, whenever opportunities arose. Particularly, an ad-hoc interview conducted in an informal online chat with Dr. S revealed something about the subjectivity of the young doctors who were part of the action. While we were discussing her prospective graduate study in the field of pharmacological science, I thought that by putting a series of short and straightforward questions to which she could simply reply ‘yes’ or ‘no’, I could have a better idea about her perspective on the various aspects of Korean Medicine I wanted to learn about. I have to confess, however, that the initial purpose of the interview was to confirm my suspicion that her aspiration to pursue a new science subject overseas might have come from her dissatisfaction with her study of Korean Medicine (see Table IV-1).

Table IV-1 The Young Doctor S’s Answers to Questions on Professional Identity

	Questions	Answers	
		Yes	No
1	As a KMD, I know enough about Korean Medicine.	x	
2	After six years of education, I think I am reasonably competent in doing differential diagnosis (byŏnjŭng 辨證) and do not have many difficulties in choosing the right formulas for the patient	x	
3	Sometimes I am very unhappy with the fact that I am a KMD. I want to go into a graduate entry WM medical school (ŭjŏnwŏn) right away.	x	
4	I would have been going overseas even if I had a different occupation. My aspiration to study overseas and the fact that I am a KMD is an entirely different matter.	Conditional Yes and No	
5	If I had earned enough money in the practice, my career would have been different, and my idea of KM and KMD would have been very different from what it is at the moment.		x
6	I think KM is a discipline that will disappear eventually. If does not disappear, I think this is not a discipline that should have high status as in our country.		x
7	Doing clinical work was a joyful and rewarding experience.		x

I asked seven questions in total, and despite the straightforward nature of the questions, she responded quickly to each with a simple yes or no. Though some responses were expected, others defied my expectations. She said yes to 1, 2, 3, and no to 5, 6, 7, and a conditional yes and no to 4. For questions 1, 2 and 3, her answer was rather expected considering her former statement about her life at the school and her involvement in the campaign itself. However, her answer to questions to 4, 5, and 6 completely defied my expectations. For question 4 to which she replied in a conditional 'yes' and 'no', she said 'yes' because she would have liked to go overseas had she chosen another profession. But it was 'no' at the same time because her current decision to go overseas is related with her identity of being a KMD. Her answer to number 5 and 6 also showed her loyalty to the discipline. It was revealing that she wanted to go overseas or to enroll at a WM graduate school just because she liked Korean Medicine to its core not because she hates the discipline as I had, rather wrongly, surmised.

In subsequent follow-up interviews, she revealed that she really enjoyed studying medical classics, particularly Shanghanlon, and liked to go overseas to incorporate the cutting edge medical science into her practice to establish a proper system of medicine by which her conviction in the Shanghanlon-based theories of medicine could be legitimized and vindicated. Her entire intellectual endeavor seemed to have been based upon her conviction of the Shanghanlon-based system of medical practice. On being asked to elaborate on the specifics of her plan, she replied that she wanted to establish a new type of pharmaceutical therapeutics informed by Shanghanlun that would 'truly' advance Korean Medicine. She particularly professed a strong trust in the veracity of the claims of therapeutic efficacy described in the 18th century Japanese scholar Yoshimasu Dodo's

(吉益東洞) rendition of the original Shanghanon text where the author described clinical cases in empirical detail while systematically debunking the classical Five Phase-based understanding of pharmaceutical efficacy.²⁴¹

When it came to the details of how her grand scientific project to link classical ideas with cutting edge science, however, she did not seem to be prepared to provide well-constructed answers. I raised, for example, philological and ethno-botanical difficulties of bringing to life the clinical cases described in the 18th century book, no less its 2nd century C.E. original text, so that the manifestations and characteristics described in the book could be well mapped-out onto more readily available contemporary nosological entities. She was unfazed, and despite my concerns, she expressed her strong belief that this was the only way Korean Medicine would develop and otherwise that the discipline would be subjected to the criticisms from biomedical communities forever. She added that this is the science the KM communities should be involved with, not the ones which have no connections whatsoever with fundamental principles of Korean Medicine, such as the one being produced day in and day out in the name of ‘SCI’ papers in the KM schools.

The ‘fundamentalist’ orientation is obvious in her views on Korean Medicine. Strong belief in the ideas expressed in medical classics such as Sanghanlun and the determination to pursue and actualize those ideas were also observed, however hard and impossible it might be in reality. Dr. S’s strong denunciation of the research activities performed by academics in the KM school also shows the young doctors’ strong antipathy

²⁴¹ Yoshimasu Dodo was an 18th-century Japanese doctor who made advances in medicine through the detailed application of empirical observations.

towards the ‘scientific’ approach pursued by the community. Her strong will to vindicate the discipline from the charges of the WMDs also show the negative effect those challenges have had on young KMDs.

2.2. Integrationists and Biomedical Science

Unlike the fundamentalist thinking that prizes the medical classics as the strong identifier of the discipline, the integrationists in the community show more adaptive attitudes towards the discipline. They assume that the discipline should be more open to outside disciplines or sectors, whether they are policy, business practice, or academic research, on the basis of its proactive engagement with biomedical science.

2.2.1. Engagements with Biomedical Science as Necessity for Survival

Many Ch’ŏnghan members whom I had been working with during my policy activities were trained in public health. Prof. Lim, who was called as ‘brain of Ch’ŏnghan’ by the Ch’amsillyon, is one of the most trusted experts in the area of Korean Medicine policymaking due to his long-term engagement with the issues of public health and social justice. Many government officials wanted him as principal investigator of their projects simply because of his reputation despite their knowledge that Prof. Lim sometimes could not be fully involved in some. Dr. Ryu Jiseon, the researcher in the PNU KM Policy Unit who is also a Ch’ŏnghan member, has also finished her master’s degree in medical

statistics in a WM school before joining the unit. Dr. Lee Junhyok, another Ch'ŏnghan member, who was in charge of the KM policy unit at KIOM, was pursuing a health policy course at the Korean Advanced Institute of Science and Technology (KAIST), the prestigious science and engineering national university.

Their policy orientation and emphasis on social justice have put them in collaboration with like-minded professionals in healthcare communities such as the WMDs' group Doctors for Humanity and the Pharmacists for a Healthy Society as well as the Dentists for a Healthy Society. The deal that was concocted between the pharmacists and the KMDs during the 1994 conflict was also forged through the collaboration of these three social activist healthcare groups. The common interests of these groups are, as mentioned, matters of health policy aimed at providing equitable health services across the socio-economic classes in the population, and their shared academic basis is largely policy-relevant, biomedical knowledge.

Networked clinic owners like the Hamsoa also heavily relied on the use of biomedical equipment. The equipment used in these clinics depends upon the pathological conditions they specialize in. Hamsoa clinics which focus on pediatric conditions use auto-scopes and other diagnostic equipment to deal with diseases such as inner-ear infections and sinusitis, atopic dermatitis, and failure to thrive. KM clinics specializing in the care of ENT and dermatological conditions also use many relevant treatment machines. As KMDs are mainstream physicians, the use of this biomedical equipment does not generally construe any legal impingements, despite WMDs' sporadic challenges on the basis of the dual medical license system. These challenges, however, are generally invalidated at the initial phases of the legal investigation. They do not,

therefore, affect KMDs' medical practice, unless the biomedical equipment in question is patently violates the principles of the dual medical license system.²⁴²

In recent decades, academics in KM schools have also been engaged in scientific activities more pro-actively than before. This was due partly to the increased scientific funding from the state into the area of Korean Medicine, and partly due to the need to adapt to the changed governmental system of assessing the universities on the basis of the number of international peer-reviewed publications.

The integrationists view the KM community's engagement with the outside world on the basis of biomedical science as a necessity, and they intend to broaden the basis of the discipline in contrast to the classicists whose focus, they think, is rather inward-looking. Their activities produced outcomes in various forms over the years and one of the most important outcomes was to garner state funding for science-based research activities in the community. The increased scientific activities within the community then lent support to their integrative position.

2.2.2. The Growth of Scientific Activities in the KM Community

The most important background behind the growth of scientific activities in the community is the establishment of Korean Medicine and Pharmaceuticals Promotion Law in

²⁴² Even in this situation, the legal judgment is not always clear. There was a case where a KMD had installed CT machines within his obesity clinic. Local WMDs brought the case to the court but the lower court ruled in favor of the KMD. WMDs appealed and the higher court delivered the opposite verdict. The case eventually reached the Supreme Court where decisions of the lower court and higher court were all overturned to rule that the KMD's installation of the CT was illegal on the basis of the dual medical license system, but his action to fulfill his duty as a physician for the care of his patients was fully justified. See Chapter 4 of EJ Ma (2007) for details.

2000 which specified the duty of the national and state governments to promote Korean Medicine and Pharmaceuticals activities. The state's increased R&D spending across industrial sectors including healthcare also helped bumped up the funding into the community. The research funding started to stream in and this contributed substantially to the growth of scientific research on topics of Korean Medicine.

A. The Korean Medicine and Pharmaceuticals Promotion Law (*hanŭyakyuksŏngbŏp*)

The Korean Medicine and Pharmaceuticals Promotion Law that was implemented in 2003 formed the basis of the state's active investments in Korean Medicine. The law was considered by many in the community as a great achievement with which to develop the discipline further, while it was depicted by a senior MOHW official 'as a law instituted by the pressure of interest groups' (C. Moon 2008, 199).

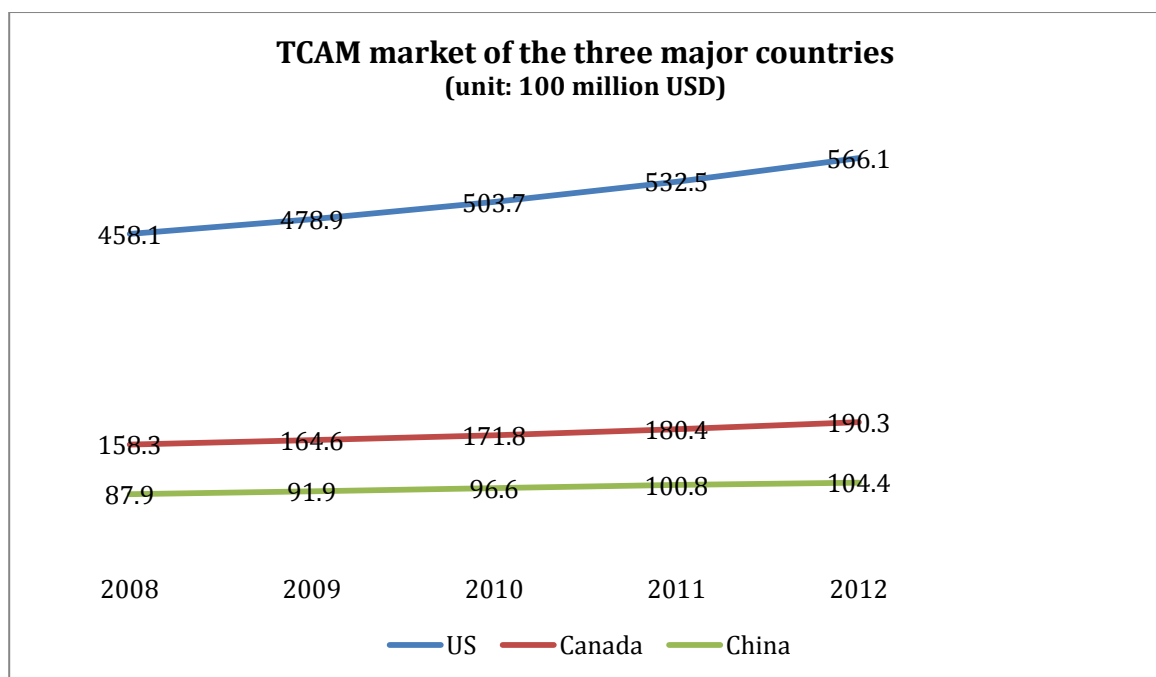
The reason behind the establishment of this law, however, at least from the perspective of the Korean state, was mainly industrial. The fact that the name of the law was not the Korean Medicine (*hanŭhak* 韓醫學) Promotion law but the Korean Medicine and Pharmaceuticals Law (*hanŭyak* 韓醫藥) also shows that the state was considerably invested in Korean Medicine's pharmaceutical potentials. One of the outcomes of this law is the development of the botanical drugs that sparked the conflict in the KM community.

Politicians' remarks I encountered at the National Korean Medicine Convention supported this hypothesis strongly. A lawmaker from the conservative Grand National Party, for example, addressed a meeting of KMDs as follows.

Korean Medicine that was developed based upon our ancestor's experiential clinical results is our precious asset. Already, developed countries are taking a keen eye to the exponential growth of the TCAM market in recent years which already surpassed 2000 trillion won which is already larger than the [market size of] the IT industry. The size of the market is expected to be 6000 trillion won in 2020. We will give bi-partisan support for it.

As he mentioned, the expansion of the global CAM market, particularly in the North American region, is indeed notable as is seen in the figure below (see Figure IV-1).

Figure IV-1 The Expansion of the Global CAM Market in the Late 2000s



Note: Though not appearing in the figure, the South Korean market is estimated to be 4.8 billion USD accounting for 2.3% of the global TCAM market.

Source: B. Lim, Ryu, and Na (2012, 8)

Another lawmaker from the main opposition Democratic Party also remarked:

In the 16th National Assembly, we instituted the Korean Medicine and Pharmaceuticals Promotion Law. Now we will put forward our best efforts to make it into a strategic industry. [I believe] we should put more [resources] in this sector.

And he made it clear that the state sees the field of Korean Medicine as an ‘industry’. The following remark from the newspaper interview with the former director of the Botanical Drug Development Institute at Seoul National University, suggests that the state has had long term industrial interests in the field:

Since 1992, our institute has been working as the principal research institute on ‘New Eastern Medical Pharmaceutical Project (*sindongŷyaksaoŷp*)’, one of the Global Seven (G7) projects.²⁴³ The reason why this project was chosen at the last minute [in the G7] was because of the insights gained by the Minister of Science Kim Jinhyun’s insights during his tour of Chinese cities. He had been on a mission to China for the facilitation of scientific collaboration between two countries. And he was impressed to find *the high level of state’s investments in TCM-based pharmaceuticals development*, and it made him think that the area of Eastern medicine should be developed at least to the Chinese level. As soon as he came back to Seoul, he ordered his team to include the ‘New Eastern Medical Pharmacy Project’ in the G7 project immediately’ (I. Chang 2011) (Italics added by author).

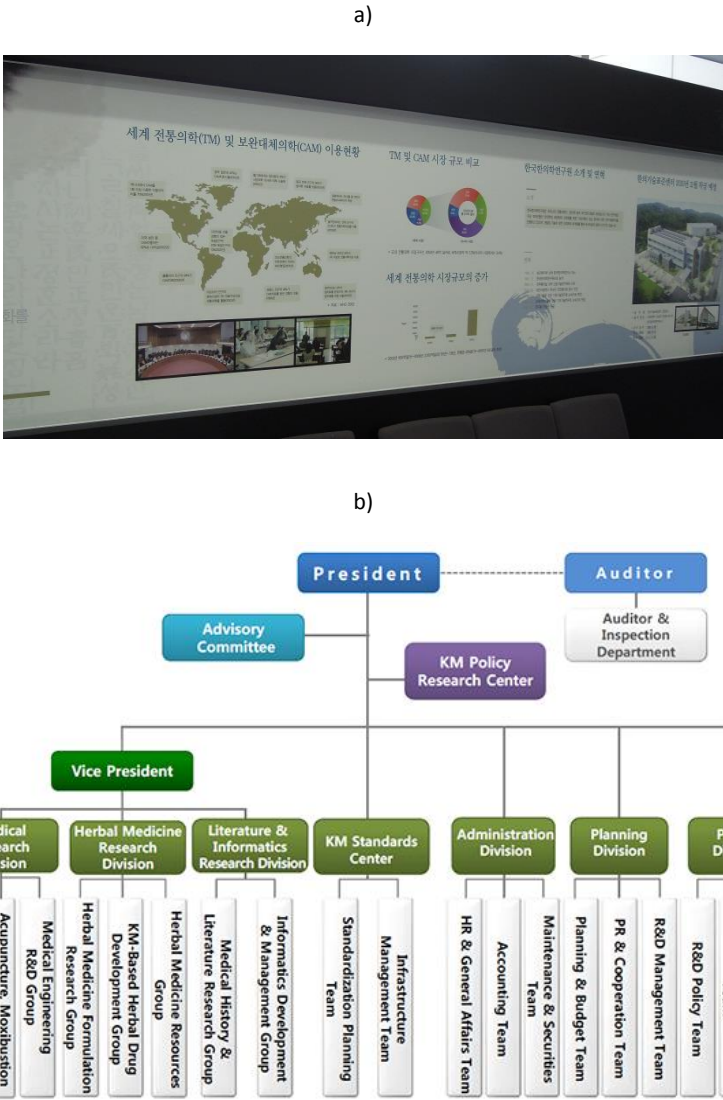
Not surprisingly, a great portion of research activities conducted at KIOM where the government’s major KM related R&D funding is concentrated,²⁴⁴ are targeting the development of pharmaceutical products aimed at the expanding global market for botanical drugs. The intention of the state’s investment is betrayed in the organizational structure of KIOM in which the Korean Medicine Pharmaceuticals Research Division is one of its three main research divisions. If research conducted in the Literature Research Division is included-as its main role is to conduct literature surveys to aggregate ethno-

²⁴³ G7 means that the state will choose seven strategic areas which will potentially grow to become a global player in those fields.

²⁴⁴ As of 2010, for example, out of 60.9 billion won spent in the KM field, the research funding that went to KIOM was 22.1 billion won accounting for 36% of the entire KM funding (Lim, Ryu, and Na 2012, 26–27).

botanical knowledge-the research on pharmaceuticals can be said to be the main research area of the entire institute (see Picture IV-1).²⁴⁵

Picture IV-1 A Map of the Global TCAM Market in a KIOM Building and KIOM's Organizational Chart



Source: Author (a), KIOM (b)

²⁴⁵ It seems like the KIOM is trying to reproduce the success of *artemisinin*, an antimalarial drug developed by the Chinese with information from a Chinese medical classic. The Qinghao (青蒿), *artemisia annua* was mentioned in 'The Handbook of Prescriptions for Emergencies (Zhouhou Beiji Fang 肘后备急方)' as a medicine that can be used for the treatment of fever. See Hsu (2006) for detailed descriptions of the process in the development of artemisinin from *Qinghao*. At the moment, the KIOM's research focus seems to be on developing 'anti-obesity' drugs (Choson Dotcom Danmee 2013).

B. Increasing National R & D Expenditure and Investments in Healthcare Technology

The state's investment in the field of Korean Medicine seemed to have been coupled with the trend of the state's increased R&D spending across the industrial sectors. Corporate South Korea indeed has spent much in this field in recent years. The country's overall per GDP R&D expenditure in percentage doubled since 1990 and the state's own R&D expenditure during the same period showed an eightfold increase (see Table IV-2). South Korea is now second only to the US, among OECD nations, in the percentage of the state R&D expenditure in GDP and takes up the second spot after Finland in the overall domestic R&D expenditure.²⁴⁶

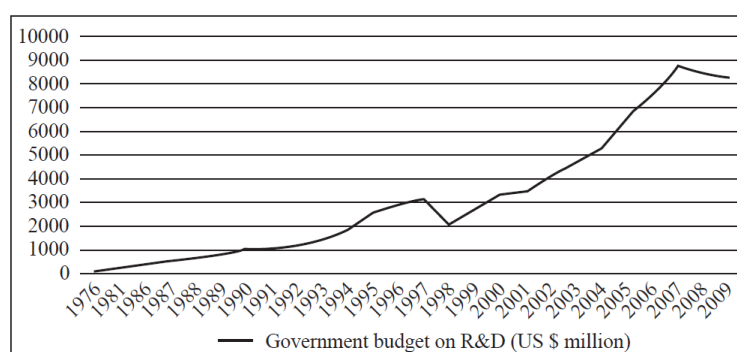
²⁴⁶ OECD 2013. "Gross Domestic Expenditure on R&D 2012." <http://www.oecd-ilibrary.org/content/table/rdxp-table-2012-1-en>.

Table IV-2 South Korea's R&D Expenditure

a)

Year	R&D expenditure (billion won)	Public sector R&D expenditure/GDP (%)	Private sector R&D expenditure/GDP (%)	R&D expenditure/ GDP (per cent)
1963	1.2	NA	NA	NA
1970	10.5	NA	NA	NA
1976	60.9	NA	NA	0.44
1980	211.7	0.30	0.28	0.58
1985	1,155.2	0.31	1.28	1.59
1990	3,349.9	0.36	1.51	1.87
1995	9,440.6	0.47	2.03	2.50
2000	13,848.5	0.66	1.73	2.39
2005	24,155.4	0.68	2.11	2.79
2010	43,854.9	0.94	2.80	3.74

b)

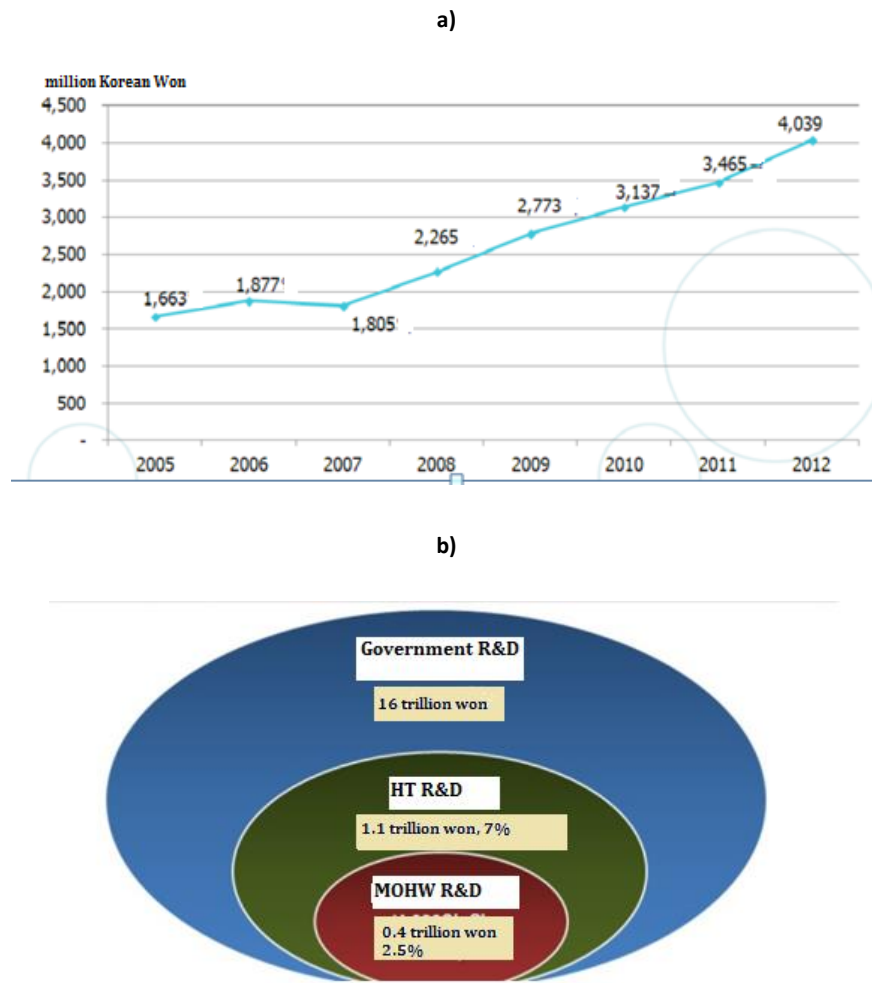


Note: a) Korea's R&D overall expenditure from 1963 to 2010. b) The increase in the Korean government's budget on R&D from 1976 to 2009. South Korea's per capita GDP (PPP) was measured in USD as 5,543 in 1980, 10,548 in 1990, 17,410 in 2000, and 33,189 in 2013.

Source: Jung and Mah (2013, 175) (a) Jung and Mah (2013, 178) (b)

With steep increases in R&D expenditure in general, the R&D expenditure in healthcare technology (HT) also increased, showing more than a two-fold increase since 2005. As of 2012, for example, the amount of HT R&D was 1.1 trillion won and it accounted for 7% of the entire annual governmental budget. Specifically, R&D by MOHW was 400 billion won, accounting for 2.5% of the national R&D budget, and this has shown an annual 16% increase in the past five years (see Figure IV-2).

Figure IV-2 The Increase in MOHW R&D Expenditure from 2005

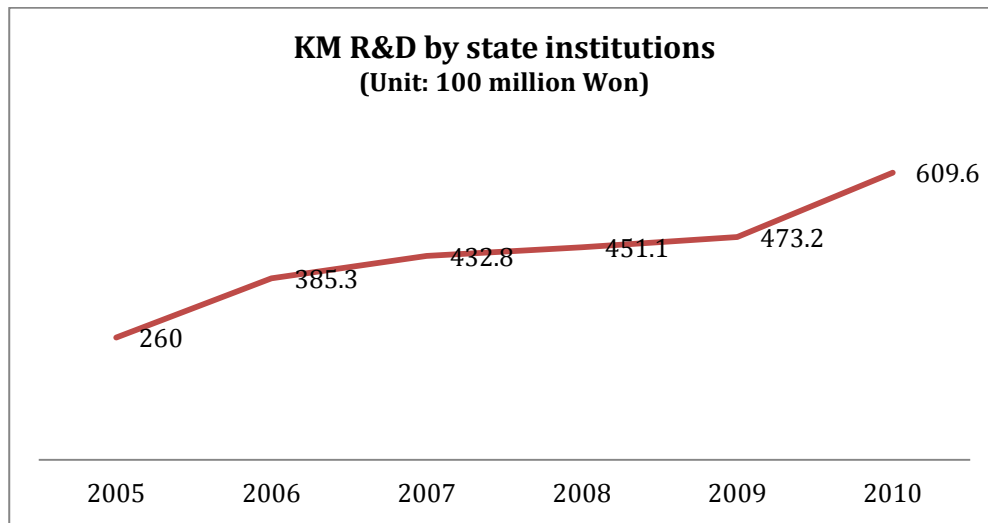


Note: The increase in MOHW's R&D budget in the past five years (a). The HT and MOHW R&D budget as a portion of total government R&D (b)

Source: MOHW

As mentioned, with the introduction of the Korean Medicine and Pharmaceuticals Promotion Law in 2003, the KM related R&Ds also showed substantial increases, more than a two-fold increase since 2005 (see Figure IV-3). Now the accumulated R&D expenditure in the KM field amounts to 329 billion won, a substantial increase from its pre-2005 figure of 93.8 billion won since its implementation around 1998 (B. Lim, Ryu, and Na 2012, 26–27).

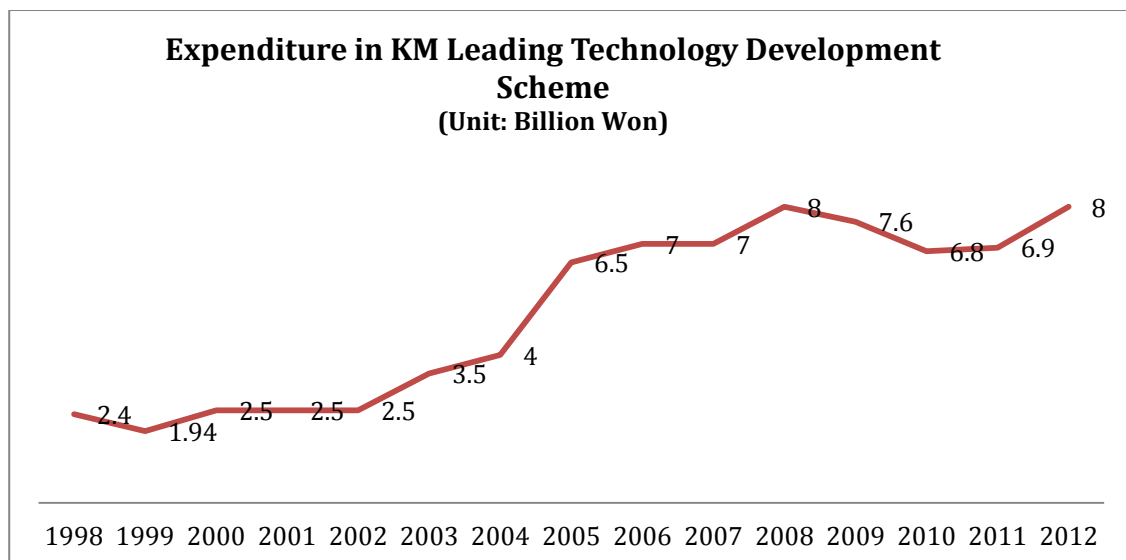
Figure IV-3 The State's R&D Investment in the KM Field since 2005



Source: B. Lim, Ryu, and Na (2012, 29)

Specifically, ‘the KM leading technology development project’, a R&D funding scheme designed just for the development of new health technology in the KM field, has been steadily increasing in the past decade, though the size of the budget was somewhat stagnating in recent years (see Figure IV-4).

Figure IV-4 Increase in the Expenditure for the KM Leading Technology Development Scheme

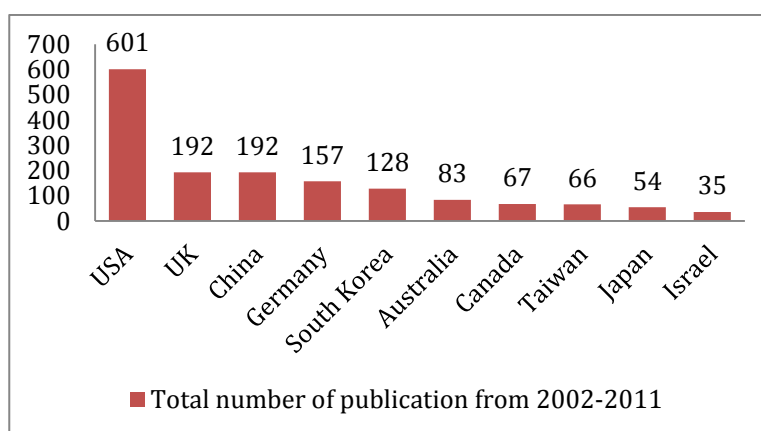


Source: Eom (2011, 179); B. Lim, Ryu, and Na (2012a, 29)

C. The State's Investments in Korean Medicine and the Growth of Scientific Activities

The influx of research funding into the community led to the growth of scientific activities within the community. The growth curve in the number of the peer-reviewed research publications produced in the community over the past ten years is quite steep. In acupuncture research, for example, South Korea comes fifth in the world in 2011 in total number of English-based peer-reviewed publications, showing almost a 20-fold increase since 2002. In an institutional-level breakdown, the Kyunghee University and KIOM takes third and fourth position after the University of Exeter²⁴⁷ and Harvard University in number of articles published (Korea Institute of Oriental Medicine 2011, 53) (see Figures IV-5,6).

Figure IV-5 A Total Number of International Publications in Acupuncture Research

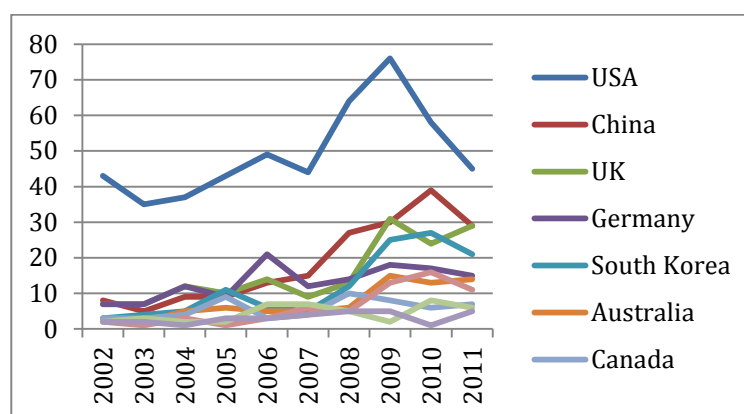


Note: Korea now is one of the top five countries producing research papers in this field

Source: Korea Institute of Oriental Medicine (2011, 52–53)

²⁴⁷ At Exeter University, the world's first academic Chair in Complementary Medicine was established in 2002. Edzard Ernst who came to the university in 1993 became the chair. See Rustin (2011) for his controversial 18 years of work until his retirement.

Figure IV-6 The Number of Peer-reviewed Publications in Acupuncture Research



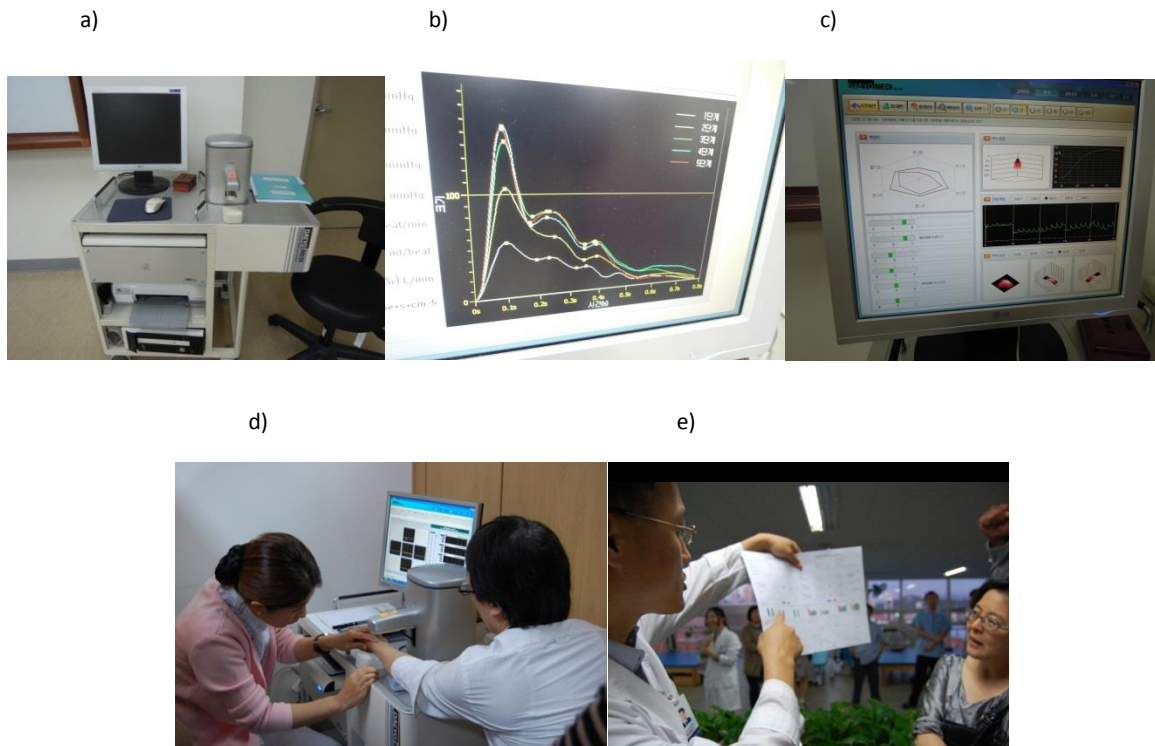
Note: Most of these publications have arisen out of the KM R&D projects. It has grown from 3 in 2002 to 21 in 2011, seeing a 7-fold increase.

Source: Korea Institute of Oriental Medicine (2011, 52–53)

In the technological area, there have been some developments that came out of the funding, though not many. Robot pulse diagnosis machine developed by KIOM in collaboration with a company called Daeyomedi is one example (see Picture IV-2)²⁴⁸.

²⁴⁸ The development of a diagnostic algorithm was undertaken by a team at KIOM headed by Dr. Kim Jongyeol, the then vice president of KIOM.

Picture IV-2 Robot Pulse Diagnosis Machine



Note: a) This machine produced by Daeyomedi is marketed as a 3-dimensional pulse wave analyzer. This is the one at PNU. b) The physical characteristics of the pulse taken are shown on the screen. The four lines represent the attributes measured at four different levels of pressure application on the radial artery at the wrist. c) The screen shows various features of your pulse in terms both of KM-based pattern diagnosis and of cardio-vascular conditions. d) The author is taking a pulse examination under Robot Pulse Diagnostics machine at Wonkwang University Chonju Hospital of Korean Medicine. e) A clinical staff at Wonkwang University is explaining the result of my pulse diagnostic before a group of UK delegates partaking in 'Experience Korea and Experience Korean Medicine' program organized by the Korean Tourism Agency in October, 2013.

Source: Author

The Korean state has put many resources into the KM field in the hope of maximizing its industrial potentials, and this contributed to the growth of scientific activities in the community. The Korean Medicine and Pharmaceuticals Promotion Law became the legal platform on the basis of which the state's support for KM could continue and this resulted in the academic outputs in the community reaching an internationally competitive level. Whatever the state's motive behind its support, the

visible effect on the KM community could have been a great source of empowerment for those in the community with the ‘integrationists’ orientation.

In Sections 2.1 and 2.2 of this chapter, I explored how ideas of professional identity have formed the two recognizable groupings in the KM community. A neat division that separates the entire community into two camps is impossible, and overlaps do exist as was observed in Dr. S’s vignette where the young KMD’s flair for science, in addition to her fundamentalist attitude to ‘authentic Korean medicine’, could also be observed. For an equally convincing reason, it is also hard to think that anyone from one camp argues that the profession should only stick to ‘classical ideas’ or that it should completely discard them in favor of ‘biomedical science’. With regards to the objective of defining the identity of the profession, however, it is also true that an *ideological schism* does exist, roughly according to the division between ‘the classics’ and ‘biomedical science’. My aim in this section has been to highlight the two poles around which these two groupings within the KM community coalesce.

In the following section, I will introduce another ethnographic vignette where the tension between these two camps is shown. It occurred in the unlikely venue of an academic meeting where KM school professors were debating on the translation of classical medical terms. The debate was between ‘classically minded’ or ‘fundamentalist’ KMD professor and the ‘biomedicine-minded’ or ‘integrationist’ KMD professors who convened to exchange ideas on the KM term standardization. The ways the debate progressed will show the concrete manner in which internal identity discourse played out along with the internal politics of the community.

2.3. The Clash Between Two Camps: Hyuknik vs Ch'uknik

The academic meeting was convened by Prof. Lee Choongyeol of Gachon University who is the president of the Korean Oriental Medical Society (KOMS), the academic leg of AKOM.²⁴⁹ The attendees were KM school professors who were conducting various KM standardization or classificatory initiatives both on a domestic and international scale. Some were involved in the World Health Organization's revision of International Classification of Disease (ICD)-10 which will include terms of traditional medicine.²⁵⁰ Others were involved in task force meetings at the International Standardization Organization (ISO) as official country representatives where contents of a new category, namely that of Traditional Chinese Medicine (TCM) which had been proposed by China, were being discussed in sporadic international meetings.

There were also those who were involved in updating the World Health Organization International Standard Terminologies on Traditional Medicine (WHO-IST), an initiative by the WHO Western Pacific branch wherein proper standardized English transcriptions of traditional medical terms were discussed among representatives from member countries. Some KM professors who had been involved in the update of the Korean Classification of Disease (KCD) in which Korean Medicine terms had been integrated in its sixth revision²⁵¹ also attended the meeting. The chair of the meeting,

²⁴⁹ This organizational structure of AKOM where there is a parallel academic society within the main administrative body of centralized professional organization is identical to that of KMA. It seems that Japan Medical Association has the same structure (Steslicke 1973, 57–58).

²⁵⁰ This initiative is collectively called as International Classification of Traditional Medicine (ICD-TM).

²⁵¹ This led to the creation of the country's single disease classification system that is now used by both WMDs and KMDs.

Prof. Lee Choongyeol, was revising the standardized Korean Medicine term manual which is regularly published by the Korean Oriental Medical Society. The objective of this two-day meeting was to discuss the current progress of various KM terminology standardization and classification initiatives so that each expert could have good bearings on the projects that were under way (see Picture IV-3).

Picture IV-3 The Committee for the Standardization of Korean Medicine Terms



Note: The person in the middle leaning against the wall is Prof. Lee Choongyeol. Dr. Yuna Han from KIOM is presenting her work on ICD-TM.

Source: Author

The debate occurred on the second day. Prof. Um Dongmyung who teaches medical classics at Wonkwang University was briefing the panel on his Korean interpretation of each of the classical KM terms which were to appear in the updated version of the KOMS standard term manual. From the beginning, opinions were divided between professors of classics and professors of clinical medicine. For example, over such terms as '*Taemaong* (大痲癰)' denoting conditions of leprosy, Prof. Um claimed that the term should be transcribed as '*moondungbyŏng*', a lay Korean term denoting leprosy, while clinical professors contended that the term should be transcribed as 'Hansen's Disease', as it was the standardized modern-day term for leprosy.

After several small disagreements over various terms, Prof. Um finally had a major clash with Prof. Han Changho from Dongguk University who teaches Internal Medicine, when the entry reached ‘搐搦’, a classical East Asian medical term that indicates a condition of involuntary muscular traction. Although the half an hour-long debate finished with a humorous intervention by Prof. Kim Yongseok who is a gynecology specialist at Kyung University, the debate was intense.

Prof. Lee: Should the official pronunciation of this term be Ch’uknik or Hyuknik?

Prof. Han: **In practice**, we call it *Ch’uknik*.

Prof. Lee: In the standard KM terminology book it used to be transcribed as *Ch’uknik* but later we changed it to *Hyuknik*. What should we now do?

Prof Han: If it is *hyuk*, most [local] KMDs won’t recognize the meaning of the term.

Prof Lee: Do clinicians pronounce the word as *ch’uk* more frequently?

Prof. Han: That is how we learned [to read the term in the university].

Prof. Um: If you are accustomed to it, *hyuk* is not bad.

Prof. Han: The problem is that when you use the Korean word-pressing computer software [called] *Hangul*, you should look for that word under the heading of *hyuk* [for its conversion into the correct Chinese character], and [as it does not contain the character under the Korean heading of *ch’uk*] that poses the problem [of using *hyuk* instead of *ch’uk*].

Prof. Um: Originally, *Hyuk* means ‘pull’ and *ch’uk* means the spasm. **In *Hyuknik*, the word actually means ‘pull’ so it should be *hyuk*.**

Prof. Han: If you see *Gyejongchuknik* (痙攣搐搦)²⁵² for example, the word [which is read *ch’uk*] means ‘spasm’ there [not pull].

²⁵² It means rhythmic and continuous spasms that occur on the part of the body.

Prof. Um: That is what I said. In that word [you mentioned], the term means ‘pull’ [and that’s why it should be read *hyuk*].

Prof. Han: The fundamental **clinical manifestation** [of the condition] is different from what you describe. The term should be able to **signify a drastic [uncontrollable] spasm**.

Therefore the transcription *ch’uk* conveys the [clinical] meaning more faithfully.

Prof. Kim: Let’s get rid of Chinese characters! (Emphasis added by author)

What occurred during the meeting, particularly the debate on *ch’uknik* and *hyuknik*, clearly exemplifies the presence of tension in the Korean Medicine community between those who put emphasis on the ‘proper’ or ‘authentic’ understanding of the classical concepts and those who try to integrate the ‘biomedicine’-based understanding into the discipline. Both the classicists’ stubborn loyalty to the concepts of EAM medical texts and the integrationists’ strong argument for the practical necessity of accommodating the biomedical science were clearly visible. Prof. Kim Yongseok’s final joke aptly sums up the kind of sentiment that the integrationists are feeling, rather negatively, towards the classicists’ discourse of authenticity. Both camp’s hard-pressed arguments also signify that the internal tension runs quite deep and uncompromisingly in the community.

2.4. Summary

In this section, I have explored intra-professional schisms existing within the Korean Medicine community. I argued that the inter-generational division shown during the rebellion between the young doctors and the senior members represents the discursive divide existing within the community.

At one end lies a camp who believes classical EAM ideas expressed in the texts are the central identity marker of the discipline. I introduced 'the gwan discourse' as an example that represents this style of thinking. In order to illustrate the young doctors' fundamentalism shown during the rebellion, I presented an ethnographic vignette of a young Ch'amsillyon supporter Dr. S in which the strong influence of the classics-based thinking, or fundamentalist ideas, on the young doctors' subjectivity could be observed.

Then, I explained the camp at the other end of the ideological divide in the community. They showed a tendency to emphasize the profession's practical need to incorporate the 'biomedical science' in order to broaden the basis of the discipline. To contextualize the growth of the integrationists within the community, I highlighted the growth of the scientific activities in the community in detail from such factors as the economic and political background of the state's financial support for KM and the national trend in investments in scientific activities, and to the increased funding into and the resulting expansion of scientific activities in the KM community.

Finally, I presented another ethnographic vignette where the clash of these two camps could be observed over the translation of classical medical terms. The vignette showed that a deep tension exists between these two factions over their perspectives on core identity of the profession.

3. Inter-Professional Politics: WMDs' Challenges on KMDs

As mentioned in the beginning, I will now focus on the elements of inter-professional politics that have contributed to the breakout of the rebellion. Inter-professional politics

are mainly underpinned by the WMDs' challenges to the KM community. Their negative effect on the young doctor's subjectivity had already been illustrated earlier in this chapter as seen in the vignette about a young doctor. In this section, I will explain the WMD's challenges in detail, which include a systematic action for license unitarization, the public anti-KM publicity, negative policy interventions, attempts to academically erase KMDs' medical identity, and initiatives aimed at legally monopolizing the term 'medical doctor'.

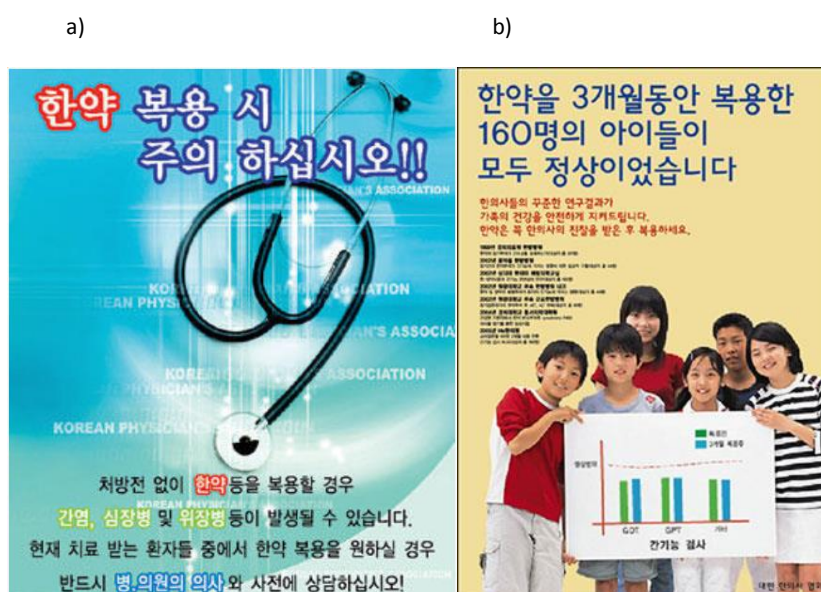
3.1. WMDs' Anti-Korean Medicine Campaign

3.1.1. Bids for License Unitarization

WMDs' anti-Korean Medicine campaign has been mainly led by KMA's Subcommittee on the Medical License Unitarization (Ŭryŏirwŏnhwawiwŏnhoe).²⁵³ Though their actions vary depending upon issues, their past activities included a campaign to avoid *hanyak* by highlighting liver toxicity that they claimed was caused by its consumption (see Picture IV-4).

²⁵³ The homepage can be found at <http://www.truemedicine.or.kr/tm/index.php>.

Picture IV-4 The 'Poster War' Between WMDs and KMDs



Source: a) The poster distributed to local WM clinics by the Association of the self-employed WM Internal Medicine Clinics regarding the liver toxicity of *hanyak*. Later, the anti-KM force in the WM community formally crystallized into the KMA's Subcommittee on the Medical License Unitarization Committee in 2006. The person who led this 'poster war' was Dr. Jang Dongik who later became the KMA president. (B) The poster was distributed by the AKOM to refute the WMDs' claim. It shows the result of a clinical study where 160 children showed no sign of liver toxicity after three months of *hanyak*-based treatments.

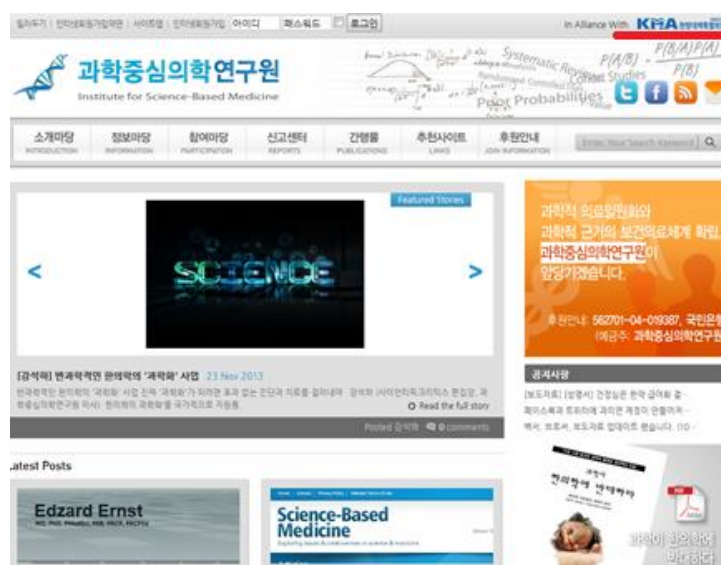
Source: Jaeun Kim (2005) (a). Joo (2005) and Jinwoo Park (2010) (b)

The Committee recently joined forces with an organization called the Science-based Medicine Institute (gwahakjungsimyöng'uwöñ) that professes to attack what they believe to be 'the unscientific' characteristics present in theories and practices of Korean Medicine, and the KMDs' blind loyalty to Dongübogam.²⁵⁴ Interestingly, in a newspaper interview regarding the establishment of the institute, the founder of the institute was already pledging that he would do his best to achieve 'medical license unitarization on the

²⁵⁴ The site (<http://www.i-sbm.org/>) seemed to have been inspired by the similar online site in the US called Quackwatch (<http://www.quackwatch.com/>) which has been consistently attacking various non-biomedical treatments used by Americans. In the UK, a renowned pharmacologist David Colquhoun manages a website called *DC's Improbable Science* (<http://www.dcsience.net/>) and it has similar orientation.

basis of science-based medicine’ (Sujin Koh 2012), acknowledging its connection to KMA’s License Unitarization Committee. One of the key members of the Institute Dr. Han Jongho is also the key member of the KMA Subcommittee on License Unitarization,²⁵⁵ and Dr. Han is a very well-known anti-KM figure in the country (see Picture IV-5).²⁵⁶

Picture IV-5 The Institute For Science-based medicine



Note: You can see in the upper right hand corner the link to the KMA Subcommittee for Medical Unitarization (underlined in red)

Source: The Institute For Science-based medicine

Though most WMDs acknowledge KMDs’ biomedical competency on a personal level as mentioned earlier,²⁵⁷ they do not acknowledge it on collective level and have attempted to restrict the practice of KMDs within the ‘epistemologically defined’ boundaries of ‘traditional medicine’ in order to secure their professional territory. The medical license unitarization has been the KMA’s agenda since the enactment of the

²⁵⁵ Dr. Han was recently sued by Dr. Choi Wonchol, a KMD formerly based at the Kyunghee University, for the charge of defamation due to his consistent negative campaign against Dr. Choi’s cancer therapies (Jingu Kim 2013; H. C. Park 2013).

²⁵⁶ They are collectively called as ‘Hang’ga in the KM community, meaning KM-bashing.

²⁵⁷ See Section 4.3.3, Chapter II.

nation's healthcare law in 1951 (N. Kim 2013). During the meeting for the enactment of the nation's first medical law at the National Assembly, for example, then WMD-turned Minister of Health is said to have raised his strong objection to the law by contesting that there was no country in the modern world that recognized two doctors, and that its enactment would mean that the country would be going backward in development (Hyunji Lee 2008, 117). The Korean Medicine community, however, has refused to accept the scheme ever since (see Picture IV-6).

Picture IV-6 The KMA President Kyung Manho is Staging a One-man Protest at the National Assembly



Note: Though in the picket, he mentions the cancellation of the Korean Medicine Promotion Law, the media concurred that the main message of his protest was to ask for the Medical License Unitarization. He is reported to have stated that KMA, AKOM, and the national Assembly healthcare future committee should discuss the medical licence unitarization urgently for the efficient use of the nation's healthcare resources rather than devising a law that will further solidify the dual medical license system.

Source: Y. Chang (2011a)

3.1.2. Negative Policy Intervention and Attempts to Erase KMDs' Medical Identity

WMDs have attempted to oppose almost all national-level KM policy objectives. There is a long line of legal proceedings from WMDs on such matters as KMDs' use of stethoscopes in the 1970s and the use of sonography and computed tomography in the

2000s (Ma 2007). It was the KMA again who opposed the enactment of Korean Medicine and Pharmaceuticals Promotional Law in 2008 (J. Sung 2011) and who attempted to thwart the integration of Korean Medicine terms into the Korea Classification of Disease in 2009 (KMA Medical License Unitarization Subcommittee 2009).²⁵⁸

Another case of WMDs' negative policy intervention occurred recently, and it was significant for the young doctors as it directly affected them. The policy interference was on an international scale this time. The KMA intervened directly to block a KMD who was attempting to get a US medical license by sitting at an examination for foreign medical school graduates (USMLE). The young doctor was originally eligible to sit on the exam according to the regulations set by USMLE, as all the KM schools were listed in their foreign medical school list called the International Medical Education Directory (IMED), a platform on the basis of which the eligibility of international applicants is decided. The KMA informed the American Medical Association and the related agencies that the graduates of the KM school were not fully playing the role of primary care physicians on the basis of the fact that their degree is a 'BA in Korean Medicine (*hanŭhaksa*)' not a 'BA in Medicine (*ŭhaksa*)' degree. It obviously did not mention the country's dual medical license system in its correspondence.

Despite the Korean government's strong protest that the KMDs be recognized in the country as fully functioning primary care physicians,²⁵⁹ and that they are medical

²⁵⁸ I also heard about this in a private conversation I had with a KM school professor who participated in the project. He even thought that the KMA's consistent refusal might have harmed the career of a government official who was in charge of the term integration scheme.

²⁵⁹ Actually, the government's approval of the school is the central criterion by which the medical schools outside the US are registered in the list. In FAIMER (Foundation for Advancement of International Medical Education and Research)'s website (<http://www.faimer.org/resources/imed.html>), for example, it is said 'A medical school is added to IMED after FAIMER receives confirmation from the Ministry of Health, Ministry

professionals educated at a higher level than the graduates of TCM in China who are currently eligible to take the USMLE,²⁶⁰ the Foundation for Advancement of International Medical Education and Research (FAIMER), an organization which is responsible for the exam, nonetheless ruled that KMDs are not eligible. Subsequently, the institution deleted all the names of the nation's KM schools in its foreign medical school directory, causing great frustration to many young KMDs.²⁶¹

The KMA's action was alleged to also provoke anger in a senior governmental official who regarded it as 'unethical' because it blocked global outlets for the country's highly qualified medical practitioners.²⁶²²⁶³ These incidences also exemplify why the AKOM executives assumed that the absence of KMA in the negotiation scene created a great window of opportunities, and why they decided to adopt a pro- negotiation stance with the government rather than an anti-governmental one.

In addition to these straightforward acts of deterrence, the WM community also had been subtly challenging the KM community in the area of academic communication. By avoiding the use of the words 'medical practitioners' or 'doctor' in direct reference to

of Education, or other appropriate agency that the Ministry or agency has recognized that school.' There might be a possibility that wordings in this regulation might have been slightly changed after this incident.

²⁶⁰ This information is based upon the MOHW's documents sent to FAIMER. The AKOM kindly allowed me to view these documents.

²⁶¹ All KM schools are, however, listed in the WHO medical school list. See <http://avicenna.ku.dk/database/medicine> for details.

²⁶² One KMD who has been at the center of this issue informed me about this. An article was also published with regards to this KMDs' attempt to sit at USMLE. See Hyunjoo Cho et al. (2008).

²⁶³ According to my informant, it seems also that there existed some collective apprehension in the WM community with regards to this incident. He once informed me that while he was visiting a USMLE preparation online community organized by Korea applicants, he could feel the apprehension shared by some WMDs when one of them commented, "If one of them (KMDs) passes, we are done with", while mentioning the prospect of KMDs passing the test.

KMDs in their English-language publications or by explicitly referring to them as ‘traditional or alternative medical practitioners’, they gave the impression that they were not properly educated medical professionals, and in doing so, they tried to obliterate, discreetly but thoroughly, the KMDs’ medical identity in research publications. My involvement in research projects at PNU, some of which were in collaboration with WMDs, also confirmed their tendency to persistently use ‘practitioners of traditional medicine’ or even ‘TCM (Traditional Chinese Medicine) practitioners’, and their consistent non-use of the term ‘medical doctor’ or ‘medical practitioners’ in reference to KMDs.

I later found out that the situation stemmed from the academic power differentials existing between KMDs and WMDs. It seemed that mainly due to the WMDs’ extensive international connection, WMDs tend to become, by the request of KMDs, the corresponding authors in many clinical research publications. In this practice of co-authoring, WMDs subtle ‘screening’ of words and concepts seems to occur with the excuse of making the articles ‘fit’ to the international norm by adopting ‘standard’ terminologies to the effect that Korean Medicine becomes a mode of ‘CAM’ and ‘traditional medicine’, and KMDs become ‘practitioners of traditional medicine’ in an over-simplification that leaves out domestic institutional subtleties. Then again, the corroborating KMDs are not in a position to argue against WMDs’ ‘recommendations’ of this kind because currently, there is no reference point outside the Korean healthcare system in other countries, and no research literature that has investigated KMDs’ professional identity convincingly from cross-cultural perspectives exists.²⁶⁴

²⁶⁴ As for the cross-country comparisons with regards to the country’s dual medical license system, the article I published ‘East Asian Medicine in South Korea’ in 2012 seems to be the first of its kind. And as for the comparative research on the professional identity of KMDs, this thesis is the first research that made an

In this process of ‘translation’ whereby Korean Medicine is depicted as CAM that is mostly performed on the patient’s self-help basis in the Western context, all the institutional features unique to the country’s dual medical license system come to be ‘lost’. These published articles then operate as the references to which WMDs could use in fortifying their argument that *WMDs are the only ‘medical doctors’ in the country*.

This claim regarding ‘medical doctors’ will lead us to the next section smoothly as it contains the central message which WMDs’ anti-KM campaign wishes to convey to the public.

3.1.3. *KMDs are not ‘Ŭsa’?*

The WMDs have continuously attempted to monopolize the term ‘medical doctor (Ŭsa)’. Whilst it is true that in the Korean legal context, ‘Ŭsa’ really designates WMDs, KMDs are designated as ‘*Hanŭsa*’, and dentists as ‘*Ch’ggwaŭsa*’, what WMDs have been trying to do is to legally own the everyday use of the word. I explained in Chapter II, however, that people frequently call WMDs as ‘Western doctors (*Yangŭsa* 洋醫師)’, KMDs as ‘Korean Medicine doctor (*Hanŭsa* 韓醫師)’ and use the term ‘Ŭsa’ (醫師) to designate both of them. So, it is almost impossible not to call KMDs as ‘Ŭsa’ in everyday communication.

Not surprisingly, WMDs themselves showed some contradictions in the use of the term. In the following statement that was issued by Chŏnŭch’ong right after the Korean

informed comparison with other medical practitioners, for example with American Doctors of Osteopathic medicine (DO) as illustrated in earlier part of this section, on the basis of the process of medical professionalization.

Medicine National Convention that occurred in 19th Feb. 2012 where KMDs rallied for the use of modern biomedical technology without restrictions, the inadvertent calling of KMDs as 'Ŭsa' can be observed. A short statement implying that they would sue any KMDs using the title of 'Usa'²⁶⁵ was released just after this one. So it is not hard to imagine that the wording of this statement was concocted very carefully. The following is the statement.

[Chŏnŭch'ong Statement]

KMDs should rescind their licenses and immediately shut down the nation's Korean
Medicine schools

The AKOM public announced that it would push forward its agenda of using modern diagnostic and treatment technology, a result of modern science, in the KM convention that took place on 19th Feb. 2012. It is shocking for the AKOM that are representing KMDs to say officially that it will carry out the illegal activity despite the fact that the current medical law stipulates that any activities out of their licensure rights are illegal...

Despite the fact that almost all of the countries in the world have a single medical doctor (*Ŭsa*) system, the fact only our country still has a system of KMD (*hanŭsa*) is not the proud history of conserving Korean Medicine as the government and KMDs are saying, but a result of humiliating Japanese colonial legacy. During the colonial regime, the Japanese who thought that Koreans should not receive the same level of high-quality Western medical treatments as the Japanese created the ambiguous title of '*ŭsaeng*', which is not doctor (*ŭsa*) or student (*haksang*), for the practitioners of traditional medicine, and left it as an [extension] of popular medicine (*minganch'iryo*). However, the KM law passed the National Assembly during the chaos of the Korean War and it created one singular country in the world where there exists the dualized-medical license (*ŭsa myŏnho*) system...

²⁶⁵ See Y. Yang (2013) for details.

Chŏonŭch'ong will react with the strongest methods that could be imagined by the government when KMDs continue to do illegal activities, if we judge that the reactions from the government and the KMA [to KMDs' activities] are not sufficient.

2012. 2. 20.

The President of Chŏonŭch'ong No HwanGyu²⁶⁶

Though the contents of the statement strongly condemns the KMDs' claims, it is obvious that the statement used the term 'ŭsa' to refer to KMDs, for example, when it mentioned KMDs' license as '*ŭsa myŏnhŏ*' in highlighting the country's dual medical license system which was acknowledged by the organization to be an internationally exceptional case. It also implied more than once that there are two *medical doctors* in the country.

Dr. Han Sangyul, another well-known anti-KM figure who has written many anti-KM posts on his homepage also once wrote the following, explicitly stating that KMDs are playing the role of mainstream medical practitioners.

In the 1960s there was only one KM school, but with the support of the government, the number of KM schools has grown to become eleven nationwide, and KMDs are practicing mainstream medical practice (*juryuŭhak*) with the same legal rights as [W]MDs (*ŭsa*).²⁶⁷

On a collective level, WMD's intention to disallow the '*ŭsa*' title for KMDs is indeed strong, and I experienced it personally several times during my fieldwork.

In the first case, it occurred when I made a short presentation before my longtime academic colleagues among whom many have medical backgrounds. Breaking the

²⁶⁶ He is the current head of KMA.

²⁶⁷ Hanbit Internal Medicine Clinic Homepage. 2005. <http://user.chollian.net/~handor>.

convention of circumventing the politics of the term,²⁶⁸ I argued that we should accept the fact that KMDs had been professionalized to play the role of ‘*ŭsa*’ in the country’s healthcare system, emphasizing the term ‘*ŭsa*’ unambiguously.

I noticed that a colleague with a dentist background Prof. J was immediately nodding in agreement, and I heard that he added in a low voice, “Of course, that is the case.” However, the colleague Prof. K who is a WMD did not show his immediate approval to my comment. Instead, he said later that ‘the *problem* of KMDs is that they are not doing proper [traditional] Korean Medicine but have been trying to copy Western medicine’. It was the same ‘copycat’ argument used by the WMDs to delegitimize KMDs’ biomedical knowledge by limiting their practice to the epistemic boundaries of traditional East Asian medicine. My colleague’s response typified the WM community’s collective perspective on the KMDs’ professional identity.

At PNU, I had another chance to confirm this sentiment while having a conversation with Professor Y who has both WMD and KMD licenses. Due to Professor Y’s social activism background and experiences across two professions,²⁶⁹ our conversation naturally led to issues of national healthcare. Also, because we were meeting for my farewell near the end of my fieldwork, I was able to throw in some straightforward

²⁶⁸ Due to this political implications of this word, the direct expression of the word, even among the close colleagues, is sometimes avoided, and the more neutral sounding term ‘*ŭryoin* (醫療人)’, meaning healthcare professionals, is instead used as a substitute expression for ‘*ŭsa*’, in reference to both KMDs and WMDs collectively. The term ‘*ŭryoin*’, however, originally designates not only doctors but also other healthcare professionals such as nurses, but when the word is used among KMDs and WMDs, the word strictly means only ‘doctors’.

²⁶⁹ She first attended SNU medical school before her study was suspended due to her extensive engagements in labor activism in early 1980s. She then enrolled herself in Dongui University KM Department and qualified to become a Doctor of Korean Medicine. With the country’s democratization in the late 1980s, she was given a chance to finish her suspended study at SNU, and by finishing the remainder of her undergraduate training at SNU, she also acquired a WMD license.

questions. I assumed that Professor Y was in the best position to answer these potentially ‘provocative’ questions without reserve, and to question my perspectives if they were ill-placed.

I asked her first by saying, “So do you agree that WMDs do not recognize KMDs as medical doctor (*Ŭsa*)?” She seemed to be surprised at the abruptness of my question, but she replied rather timidly but clearly, “Yes”. I continued, though with a soft tone, by saying “That’s the starting point of the conversation [between the two professions]”. This time her response was more emphatic as she replied, “Yup, I know. The problem is how we achieve that.” This is where we sensed the political connotations of our conversations. I decided to push the boundary a bit further and said, “The KMDs are already within the remit of Western biomedicine.” And she agreed immediately, “That’s what KMDs do not admit.”

This conversation that I had with Professor Y nicely summarizes various aspects of intra- and inter-professional politics which I have elucidated thus far in this chapter, from the existing schism with regards to professional identity within the KM community to the WMDs’ challenges, including their persistent refusal to allow KMDs the title of ‘medical doctor’. The fact that both parties, the KMDs and WMDs, do not acknowledge the ‘bio-medicalization’ of Korean Medicine is notable here. For WMDs, it is to delimit the KMDs’ professional territory while for KMDs it is to keep their competitive edge over WMDs in the country’s healthcare market under the dual medical license system.

Throughout this thesis, however, it has been highlighted that the bio-medicalization of Korean Medicine has occurred and all the stakeholders are implicitly acknowledging it. In that regard, it can be argued that the politics of healthcare in contemporary Korea are

truly complex as elements of healthcare politics crisscross with each other against a background of structural features that underpin healthcare provision in the country.

3.2. Dead-End Discourse (Makjangron)

Matters of inter-professional politics, namely the WMDs' consistent challenges on KMDs, did seem to have affected the young doctors' subjectivity. The *Makjangron*,²⁷⁰ or the Dead-End Discourse, which was once popular at Swimtŏ among young doctors exemplifies their negative impacts. *Makjangron*, a word consisting of '*Makjang*', meaning dead-end or mining pit, and '*Ron*', the discourse, refers to a constellation of posts that imply that the profession of KMD has now reached its dead-end. The sentiment typified by this discourse is well captured in the following statement.

When I chose KM schools, I thought I would be on a luxury cruise but now I realize, rather too late, that I am on a sinking ship.

Makjangron posts contain various complaints about the profession such as their low income compared to that of WMDs and dentists, bad education received at the KM school, and frustrations with WMDs' constant accusations. These complaints tend to be wrapped up with the fatalistic appraisal of the profession, recommending others to discard the profession as quickly as possible in favor of alternative careers such as WMDs, dentists or civil servants. It is clearly recognizable that these posts do not stop at venting their frustrations on economic concerns, or the perceived relative poverty they were

²⁷⁰ This word has an interesting phonetic similarity to a word *hyŏnjangron*, a discourse of labor praxis, which used to be one of the main discourses employed by labor activists in the 1980s in which active participation at *hyŏnjang*, or the field, was considered to have a paramount importance in raising the class conscious of the workers (Koo 2001, 104).

feeling, but also they clearly expressed frustrations arising from the WMDs' continuous accusations. I was curious about the reasons behind their extreme frustration, other than those coming from the economic factors, so one day I asked Dr. S who is a keen user of Swimtö²⁷¹ about the supporters of *Makjangron*. And she replied.

Some of them are really angry because of their passion for the discipline. If you see other fields such as mathematics, people could say about the [potentially grim] career prospect of being a mathematician or [academic] difficulties of solving specific mathematical problems, but nobody who doesn't know about mathematics would give a sweeping remark that mathematics is a trash. But think about Korean Medicine, it's a daily occurrence that Korean Medicine is being accused and blamed.....A few days ago, a guy at Swimtö, saying that he came to KM school in 1997 discarding the Korea University WM school, attempted to join our conversation, and everybody was just laughing at him, saying " 1997? Get lost [because most of us who came to KM school later scored much higher SAT scores than was necessary to enter Korea University WM School]!".²⁷² Those who come to a KM school had really high self-esteem, so they couldn't bear the constant accusations that face them.

This account reveals that some parts of young doctors' frustration expressed in the rebellion could have come from emotional injuries inflicted by WMDs. The antagonistic environment must have been something that the young doctors did not expect to encounter when they chose to become KMDs in the first place. In that sense, it would be possible to argue that the young doctors' discontent intensified when they thought the executives of the current AKOM admiration were not staging efficient fights against the WM community, their ultimate enemy, or against the entire system that produced this 'unfair' professional environment.

²⁷¹ She seemed to be also well-regarded among some Swimtö users.

²⁷² After 2000 every KM school was higher than med school in SAT entrance achievements. See also Table II-3.

4. Divergent Views among Young Doctors and the Chǒnŭch'ong's Endorsement of the Rebellion

According to what has been investigated, the elements of professional politics, whether they are internal or external, seemed to have played a significant role in the rebellion. It is true that the young doctors' fundamentalist orientation and the negative effect of the WMDs' challenge on young doctors' subjectivity were confirmed through ethnographic evidence. However, it is also true that there exist other incidents that conspire against our urge to define the rebellion as a matter of everyday inter-professional interest group politics.

Two sets of empirical data nudge us to look beyond the KMD-WMD relationship. Firstly, the fieldwork observation revealed that the fundamentalist orientation was not shared by many young doctors that supported the Ch'amsillyon's action. I met many young doctors in the field, for example, who did not harbor the fundamentalist orientation as did Dr. S. They seemed to consider being KMD as a 'job' not as something you live your life through. One of my former students who attended the gathering after the occupation of AKOM, for example, told me rather straightforwardly the following. Like Dr. S, she also entered the KM school in 2002 at the height of the KM schools' popularity.

I think their action is all about money and livelihood. [I think] They would be alright if they can earn decent enough amount of money.

Actually, except for Dr. S, there were few among the young doctors I met in the field who showed the similar level of commitment to the discipline as Dr. S. Even Dr. S was doubtful of the Ch'amsillyon's ideological stance on the discipline's identity and occasionally complained to me about the lack of the organization's integrity on that issue.

In addition, the *Makjangron* protagonists who were once popular at Swimtǒ became increasingly marginalized on the ground that they were depicting an unnecessarily bleak picture of the profession. And most importantly, by the time the young doctors' active campaign started, their voice had already been silenced within the community.

Secondly, the reaction of the WM community to the event was different from its normally sarcastic and accusatory tone. In contrast, the public statement they issued on the event was fully supportive of the young KMDs' action, sympathizing deeply with the young doctors. As mentioned, the WM community had a conflict with the government the previous year over the designated doctor system and again in 2012, it clashed with the MOHW severely again over the expansion of DRG system.²⁷³ So when the conflict occurred in the KM community, the WM community had been keeping a low profile strategically and stood on the sideline assessing the situation.

Then, the young doctors' occupation of the AKOM headquarters took place and the Chǒnũch'ong intervened by issuing a statement. Differently from the past statements they issued in numerous other occasions in which criticisms of the KM community took the center stage, the statement the Chǒnũch'ong issued this time endorsed the young KMDs' actions fully. Not just that, the statement even implied the possibility of creating a solidarity front against the tyrannical state which it perceived to be unfairly controlling the medical practitioners to the benefit of pharmacists.²⁷⁴ This is the statement issued several days after the young doctors' occupation of the AKOM headquarters.

²⁷³ See Pictures III-6 and IV-7 for details.

²⁷⁴ Pharmacists are frequently criminalized by the doctors to be colluding with the state. Ch'amsillyon also claimed the state's initiative of the expanded NHI would only benefit pharmacists.

Why do KMDs (*Hanŭsa*) willingly wear the yoke of hell?

In 2000, WMDs (*ŭsa*) staged passionate anti SPD (Separation of Prescription and Distribution of Drugs) actions against the government's decision to push through the policy by raising our collective voice in the agora replete with harsh rain and strong winds. We did it because we predicted, rather correctly, that the introduction of SPD would increase the user's inconvenience and devastate the NHI finance. The SPD went through, but like our expectations, the NHI finance almost went bankrupt to the extent that...the country's president who pushed through the policy had to deliver apologies four times over...

But the SPD continues. Those who most benefited from the policy are pharmacists who supported its implementation full-heartedly. The rate of NHI reimbursements to pharmacies increased to 26.2% in 2011 from 9.2% in 2000 whereas that of the WM clinic plummeted to 21.6% in 2011 from 35.5% in 2000. Because of that, the current closure rate of WM clinics is over 6% now, and many clinics are almost close to bankruptcy...

At the moment, the Korean Medicine community is undergoing severe internal conflicts due to the government's decision to include *ch'ŏbyak* in NHI in its attempt to expand NHI coverage. The Special Committee in the KM community asked for the immediate scrapping of the policy because the policy will ultimately approve the pharmacists' [illegal] rights of diagnosis...Now pharmacists and the pharmacists eligible to deal with EAM medicines are savoring the prospect of the implementation of the policy. Pharmacists think that the inclusion of *ch'ŏbyak* in NHI and their inclusion in the scheme will expand the herbal medicine market in local pharmacies. Indeed many of the conditions indicated by the government as target conditions eligible for the scheme can be covered by the 100 formulas the pharmacists are allowed to handle under the current law.

If the current pilot policy is implemented as the government announced, *hanyak* will be handed over to the pharmacists in its entirety. Also, though some might think that a stable income would be created through its inclusion in NHI, it is not very hard to predict, if we base our judgment on the prior process of deliberations on the reimbursements,

²⁷⁵ Chŏnŭch'ong (2012)

that the reimbursement rate will be set at a much lower price than the amount that was being levied under the current system where *ch'öbyak* is not covered by NHI. The inclusion of the *ch'öbyak* in NHI also means the start of the myriad interferences in the doctor's clinical practice by NHIC and HIRA. Numerous legal notices will be issued [by MOHW] and you will lose everything to other interest groups in the end.

It is not too late. The Korean Medicine community should immediately object to the inclusion of *ch'öbyak* in NHI in order to guard its own economic interests and to protect the occupational territory from the pharmacists. You should learn from what WMDs have gone through in the past. Once the inclusion of *ch'öbyak* takes place, the downfall of the Korean Medicine community would occur in no time. We are simply feeling great sympathy at the moment.

1st November, 2012

The National Doctor's Association

The contents of the statement strongly indicate that both medical professions are essentially in the same boat bracing themselves against the “tyrannical” tide of governmental interference. Additionally, a similarity in patterns of collective behavior in both of these medical communities existed. It was the fact that the big altercations in both of these communities that ultimately led to a change of leadership were all sparked by the young doctors' resistance to government.

In order to give additional insight into the ways in which the WM community perceived the situation, I will briefly mention the WM doctor's protest that occurred a year later after I left the field. Though it occurred a year later, the way the WM community views the situation is essentially the same, and the event throws an illuminating light behind their motive of issuing a sympathetic statement toward the KM community back in 2012. The governmental initiatives that the WM community was strongly against in December, 2013 was the introduction of telemedicine and the

establishment of for-profit hospitals (Seoul News 1 2013). The KMA criticized the governmental interference in the protest by performing a mock funeral where a coffin draped with the words ‘government-controlled medical care’ was symbolically buried. To show their defiance, the KMA president Dr. Noh Hwangyu, the former Chŏnŭch’ong leader, even attempted to slit his throat while other KMA executives shaved their heads in protest (IV-7).²⁷⁶ This incident shows the kind of sentiment that underpinned the WM community’s endorsement of the young doctors’ rebellion in the KM community in 2012.

Picture IV-7 WMDs’ Protests Against Telemedicine and For-profit Hospitals in 2013



Note: (a) Dr. Noh Hwangyu put the bandage over the wound he created in the neck after he tried to cut his throat during the speech. (b) The KMA executives are shaving their heads. On the large black tablet behind them is written the slogan ‘government controlled medical care’. (c) Participants are performing a mock funeral.

Source: Seoul News 1 (2013)

²⁷⁶ Shaving one’s head in public in Korea is considered to be an activity that conveys the seriousness of their commitment or defiance. Traditionally, Koreans did not cut hair, and simply formed a bun on the top of the head. Therefore, when the Japanese-backed reformers attempted to change the practice by banning long hair in 1895, huge public protests occurred across the nation which ultimately expanded into anti-Japanese military campaigns (The Korean Society for Modern History 2007, 207).

5. Conclusion

In this chapter I explored the ‘professional conditions’ that could have contributed to the breakout of inter-generational conflict in the Korean Medicine community. I started off by elaborating on the ‘inner politics’ of identity. The schism of professional identity was summarized as a division between ‘classics’ and ‘biomedical science’ each of which is conceived by the supporters of each camp to be key elements in the formation of their professional identity.

For a ‘classics-based view’, the *gwan* discourse was introduced to show the extent to which it operates as a background behind the fundamentalist orientation in the community. A vignette of a young doctor who participated in the rebellion was presented to illustrate the ways in which the campaign was affected by the classics-based, fundamentalist orientation present in the community on matters of professional identity.

In the next section, I presented the integrationist camp. This group opted for the necessity of the profession’s proactive engagement with ‘biomedical sciences’ for the aim of broadening the basis of the discipline to various sectors such as public health policy, business practice and academic research. The activities of this camp were then contextualized within the general growth of scientific activities in the community which further empowered the integrationist position in the community. This growth was then explained by the state’s active investment in Korean Medicine for industrial benefits, and by the general increase in the state’s funding on R&D across the board.

Then I introduced a case in the next section where the clash of two discourses could be observed in an academic debate to show that the tension between the two camps is running deep.

In the following section of this chapter, I explored the elements of inter-professional politics under the country's dual medical license system. The WM community's challenges to the KM community were then explored in detail through the investigation of the WMDs' anti-KM campaign that was mainly aimed at limiting the territory of the KMDs' practice to make it as narrow as possible. In fact, recent incidents of their negative intervention were seen to directly affect the young KMDs. By introducing some ethnographic cases, I then illustrated the extent to which the WMDs are trying to monopolize the term 'medical doctor' in their attempt to delimit the boundary of KMDs' professional practice in public space as much as possible. In the next section, I highlighted the negative impact of these challenges on young doctors' subjectivity

In the final section of this chapter, I argued, however, that despite the obvious negative influences of these 'professional conditions' on the young doctors, there were still many aspects of the event that defied its understanding simply through the lens of professional politics. That included the diversity of opinion existing among the young doctors who did not fully embrace fundamentalism, and the WM community's full endorsement of the young doctors' action in which an indication of forming solidarity against the interventionist state could be observed. This leads us to expand the remit of the explanatory framework for the young doctors' rebellion beyond the antagonistic KM-WM relationship to include a comprehensive look at the relationship forged between the country's medical communities and the state.

I will call these 'political-economic conditions' and I will explore them in the next chapter.

Chapter V The Political Economy of Healthcare Provision in Contemporary South Korea

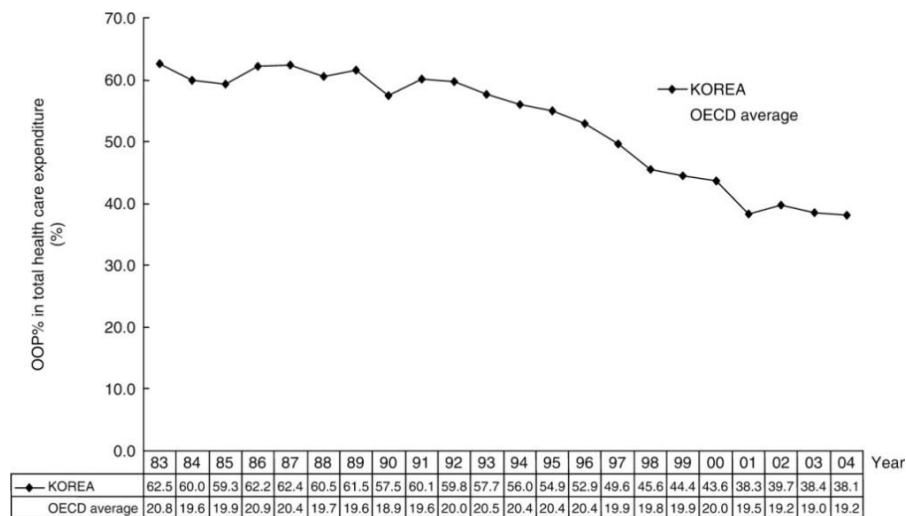
This chapter focuses on the political economy of the country's healthcare provision that might have contributed to the breakout of the rebellion. Primary attention will be given to the exploration of *the 'strained' relationship* between the state and the doctors. The factors that have contributed to the emergence of this relationship will be discussed and the ways in which the state has intervened in the business of doctors' clinical practice will be explored.

Thirty years since the country's NHI was formed, and twenty years after universal coverage was implemented,²⁷⁷ the state-doctor relationship has been completely reversed. As you can see in Figure V-1 below, the percentage of the out-of-pocket payments, which are the payments over which the doctors have full control, was 62% in 1983. However, in 2004, it was reduced to 38%, meaning that now 62% of their clinical practice is under the control of the state. This figure remains the same because as of 2013, the NHI accounts for 62% of the nation's total healthcare expenditure (Juyeoun Lee 2014). This is a complete reversal of the state's role in healthcare provision as it is now controlling, at least financially, the majority of healthcare service provided to the public.²⁷⁸

²⁷⁷ KM treatments were included in NHI at this point.

²⁷⁸ The NHI coverage rate for KM clinics shows similar rates. See Table V-3 for more information.

Figure V-1 The Share of Out-of-pocket Payments in Total Health Expenditure in South Korea



Source: Soonman Kwon (2009)

If the expansion of national health insurance, or the ‘nationalization’ of healthcare services, is the source of this growing antagonistic relationship between doctor and state, factors such as demographic change, democratization and the expansion of the state-level welfare measures are contingent factors that reinforced the relationship. As a result of these various factors, I assume that the relationship between the state and doctor has become that of pressure and resistance. In other words, the state does its best using all the means to control the doctors’ behavior in an attempt to sustain the national health insurance, and the doctors are very unhappy about the state’s interference and react by attempting to resist its interference as much as possible.

Korean Medicine is a part of mainstream healthcare, and this pressure and resistance relationship is reflected in its relationship with the state. The aim of this chapter is to elucidate the details of the relationship as clearly as possible, and to present an argument that this strained relationship between the state and the doctors is partly responsible for the breakout of the young doctors’ rebellion.

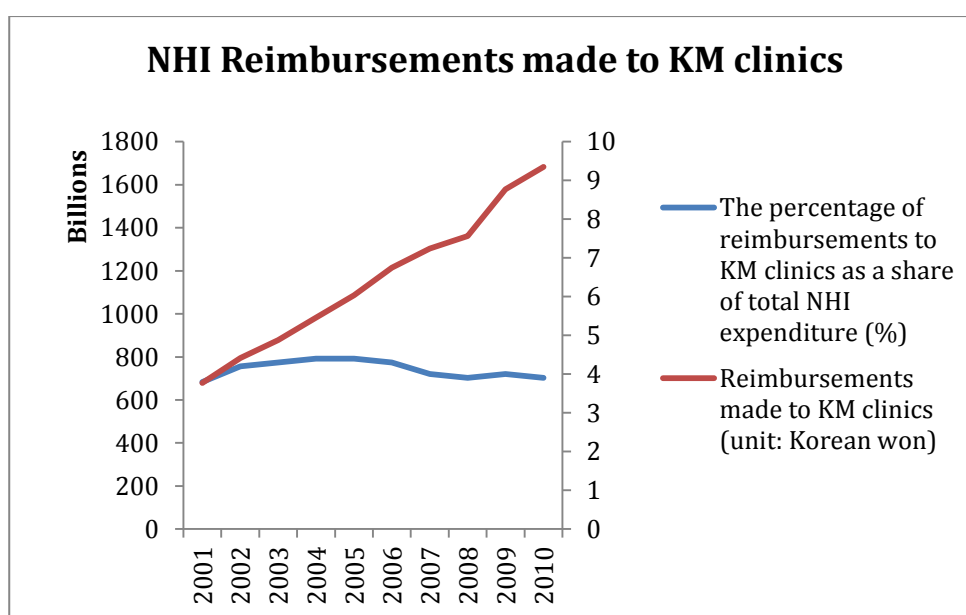
In the first section of the chapter, I will clarify the current economic conditions of the KM community, with a particular emphasis on that of the young doctors and on the *ch'ōbyak*'s importance in the business model of KM clinics. Then in the second part, I will explore the various 'political conditions' that could have affected their economic reality. I will present in detail various political factors that could have informed the state's perspective on the country's healthcare provision. Near the end of this chapter, I will introduce an ethnographic case of policymaking where both the state's perspective on healthcare and the doctors' attitudes toward the interfering state can be observed. This case study will provide ethnographic evidence to buttress my arguments.

1. The Business Environment Surrounding the KM community

1.1. An Overview

Let us first see how KM clinics fare business-wise. Generally speaking, statistical indicators point towards the fact that KM clinics' performance is robust. The amount of government insurance reimbursements to KM clinics is shown to be steadily increasing (see Figure V-2).

Figure V-2 The Amount of NHI Reimbursements for KM Clinics in the 2000s

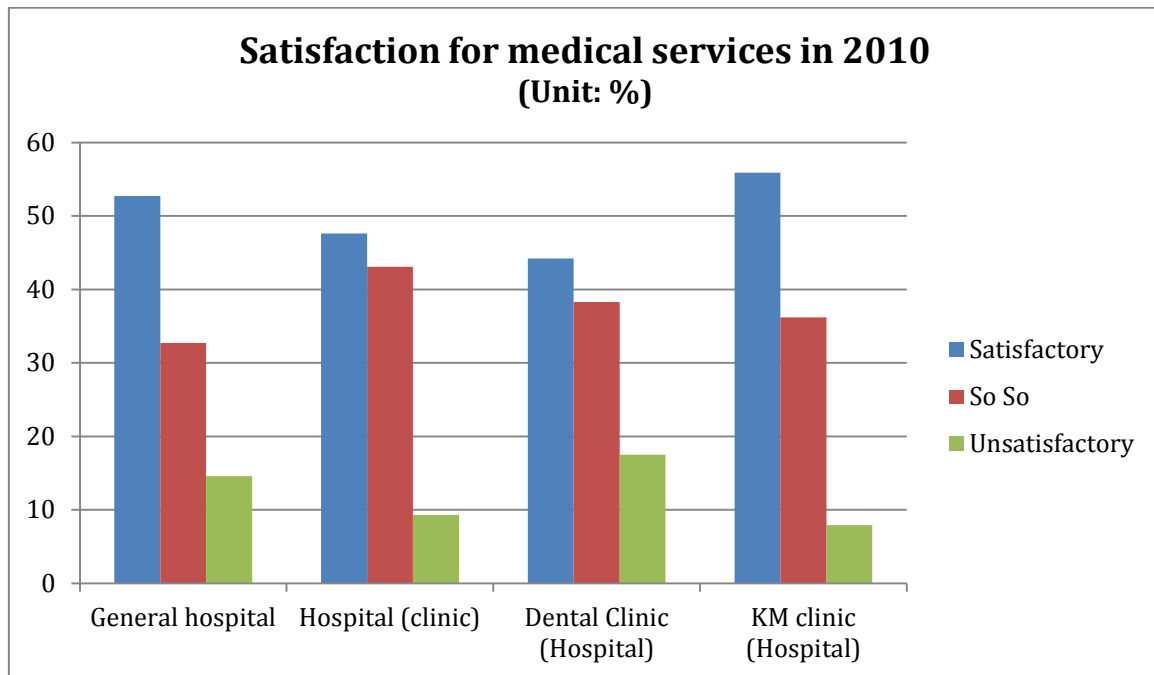


Note: The amount of reimbursements made to KM clinics significantly increased in the last decade, though its share of total NHI expenditure remained constant. The total reimbursements include the reimbursements made to pharmacies.

The data is from HIRA (<http://stat.kosis.kr/nsieu/index.jsp?hOrg=354>)

KM clinics have consistently scored the highest points in patient satisfaction among clinics and hospitals. In 2010, for example, KM clinics showed higher satisfaction rates than general hospitals (see Figure V-3).

Figure V-3 A Comparison of Patient Satisfaction in Clinics



Source: The Korean Department of Statistics (Hyegyung Lee 2010)

In comparison of three-year business survival-rate in Korea, carried out by the Korea Development Institute (KDI), KM clinics are ranked fourth, one spot above WMD clinics, in terms of both three-year survival rate and the average survival period (see Table V-1).

Table V-1 Three-year Business Survival Rates in Korea in 2012

Rank	Business with higher survival rate			Business with a lower survival		
	Businesses	Average survival period	Three year survival rate	Businesses	Average survival period	Three year survival rate
1	Lodging	5.2	74.3	Sports education facilities	2.0	24.8
2	Dental clinic	4.9	71.3	Shirts and other clothing retailers	2.1	24.1
3	Other tourism hotels	4.5	66.9	Shirts and clothing wholesalers	2.1	24.2
4	KM clinic	4.5	64.3	Business suit (male and Female) retailers	2.2	25.8
5	General clinic (WM)	4.5	63.1	Communication device retailers	2.3	28.2
6	Laundromat	4.5	62.5	Interior and decorative carpentry	2.3	28.4
7	Singing room	4.4	62.1	Shoe retailers	2.3	27.9
8	Rice cake manufacturers	4.4	61.3	Clothing, accessory retailers	2.5	30.0

Source: KDI Market Analysis (Joo 2012)

Opening and closure rates indicate the sustainability of business performance, thus it is important to illustrate that the closure rate of KM clinics, though it has been increasing over the years, is still registered at a point lower than that of WM clinics (see Table V-2).

Table V-2 Yearly Clinic Open and Closure Rates in Korea

Year	KM hospital		KM clinic			WM Clinic		
	Open	Close	Open (A)	Close (B)	% (B/A)	Open (A)	Close (B)	% (B/A)
2009	34	22	1175	727	61.9	1986	1487	74.8
2010	40	30	1121	842	75.1	2001	1559	77.9
2011	43	27	1203	863	71.7	2030	1662	81.8

Note: Increasing closure rates were observed both in KM and WM clinics, particularly starkly among WM clinics. It represents overall business difficulties faced by primary care level clinics due to the shift of the patient population to secondary and tertiary care sectors in 2000s.

Source: HIRA (Ha 2013)

The KMDs' annual income collated by the Korea Institute of Employment Service (KIES) in 2013 also shows that a KMD's annual average income of 67.9 million,²⁷⁹ which is slightly lower than that of pediatricians who earn 68.8 million won, but higher than that of radiologists who earn 65.8 million won per year, is competitive among other doctors.²⁸⁰ For comparison, an average worker's income in Korea in 2010 was about 24 million won,²⁸¹ and the starting salary for the college graduates in medium and large size companies were 33.5 million won in 2013 (G. Yu 2013).²⁸²

²⁷⁹ According to the exchange rate (1GBP=1.746 won) on 5th August, 2014, it amounts to 39,000 GBP. The income statistics for doctors here collated are from all the doctors who are employed, whether they work as trainee doctors, military doctors, public health office doctors or they are self-employed. The incomes of the first three jobs, for example, are very low and there is a big hike as soon as they get a proper job after their three years of mandatory service (military doctors and public health office) and clinical training.

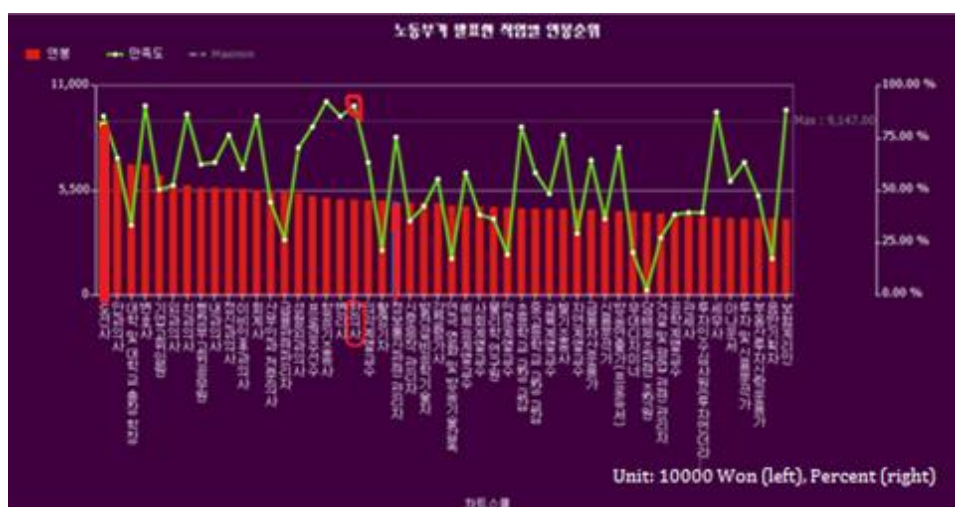
²⁸⁰ This information was retrieved from "2013 *Jiköpyöl Yönbong Sunwi* (Yearly Income Ranking)' in Daum Blog *Saengjongwa Insaeng* (<http://blog.daum.net/kipfaf12720/165>.)

²⁸¹ See Table II-4 for more information.

²⁸² As will be clearer over the course of arguments in the chapter, the starting salary of the doctors is much higher than the average college graduates employed in medium to large size companies. Generally speaking, as for the doctors' income, the statistics needs to be looked at with caution, although it is true that official statistics roughly reflect the economic situations of the medical communities. It is partly because medical associations do not want to be explicit about the doctors' income, being wary of tax implications. And that is one reason why the income statistics for doctors fluctuate severely every year. So the best way is to dive deeply into the life of the doctors' community and try to get a sense of their economic conditions on the ground.

As was shown in Picture V-1, despite the fact that KMDs are not the most highly paid job, it comes at the top in terms of job satisfaction, presumably due to its longevity and to its lower incidence of treatment-related legal disputes in comparison with other medical professions.

Picture V-1 The Income and Job Satisfaction Ranking in 2011 by the Korean Ministry of Labor



Note: The position of KMD is circled in red. It shows job satisfaction rate among KMDs is the highest among all the occupations surveyed. The operator of the blog site *Jing'yŏgŭgraph* created this graph on the basis of information from the Ministry of Labor (<http://ranky.tistory.com/12?viewbar>).

Reflecting upon the competitiveness of the profession, even at Swimtŏ where the Dead-end Discourse (*makjangron*) or the fatalistic discourse of the profession,²⁸³ used to hold sway, there is a consensus among members that being a KMD provides them financial security which cannot be provided by other careers. In a country where '100 million won annual income (*ŏkdae yŏnbong*)' is a dream for most people,²⁸⁴ being a KMD still offers you an easy and sustained way to pass beyond the threshold with an added

²⁸³ See Section 3.2, Chapter IV for more information.

²⁸⁴ Most CEO of national science institutes get an annual salary of 100-150 million Korean won (Jungi Lee 2013). One of the country's most famous classical conductor Mr. Gum Nansae's annual salary is around 200 million won per year.

benefit of a later retirement age than most other occupations.²⁸⁵ This realistic self-assessment on the financial stability given by the profession is also well manifested in classifications made at Swimtŏ with regards to the levels of affluence among KMDs. According to an agreed standard in the community, one is a 'poor doctor (*binŭ*)' if your monthly net income comes in around 10-15 million won, which already passes the '100 million won' mark in yearly income. To qualify as a 'reasonable-level doctor (*jungŭ*)' one should consistently earn around 20 million won²⁸⁶ a month while one earning more than 20 million would qualify as a 'rich doctor (*buŭ*)'.

Despite complaints about the economic downturn in the Korean Medicine community (E. Park 2013), it can be observed that the statistical data testify to the fact that the livelihood of the KMDs is still well-maintained at the higher end of the country's income spectrum. Considering that sixty to seventy percentage of the doctors' income comes from the NHI and that governmental reimbursement to KMD clinics has shown a steep increase in recent decades, it seems very unlikely that the economy of the KM clinics would suddenly go downhill in the near future.

1.2. The Commercial Significance of *ch'ŏbyak* in Korean Medicine clinics

Among young doctors, however, the perception of their 'poverty' in comparison with dentists, some specialist WMDs and most importantly, with the older generations of

²⁸⁵ Many KMDs are active in their practice into their late 70s and even in their 80s.

²⁸⁶ This is an income level that you can achieve on the basis that you have a clinic of your own. The amount comes close to what is considered a 'six figure' income in the UK. It is equivalent to 130,000 to 140,000 GBP.

KMDs, does exist. And the key element to consider here is *ch'öbyak*,²⁸⁷ a decocted form of East Asian medicine that is dispensed in Korean Medicine clinics. Until quite recently, *ch'öbyak* used to be synonymous, at least on symbolic level, with the profession of the KMD as it functioned as the major revenue-creator in KM clinics. Even in the current business environment where NHI reimbursements account for the major portion of the local doctors' income, *ch'öbyak* still accounts for a substantial part of their earnings. Though the figure fluctuates considerably in yearly statistics, *ch'öbyak*-based payments are believed to account for 20 to 25% of the total healthcare expenditure in KM clinics (see Table V-3).

Table V-3 The Yearly NHI Coverage Rate for the Treatments in KM Clinics and Hospitals During 2007-2010

Institution Type	2007			2008			2009			2010		
	NHI	Co-pay	OOP	NHI	Co-pay	OOP	NHI	Co-pay	OOP	NHI	Co-pay	OOP
Overall (%)	64.6	21.9	13.7	62.2	22.5	15.5	64.0	22.7	13.3	62.7	21.3	16.0
KM Hospitals	43.8	17.6	38.6	41.5	19.4	39.1	38.2	17.9	43.9	37.5	16.0	46.5
KM Clinics	63.9	23.2	12.9	67.7	24.0	8.3	62.6	20.4	17.0	54.2	17.2	28.6

NHI: NHI coverage rate, Co-pay: enrollee legal co-payment, OOP: out-of-pocket payment

Note: The majority of Out-of-Pocket treatments in KM clinics are accounted for by *ch'öbyak* prescriptions.

Source: NHIC

As we shall see, Ch'amsillyon's negative campaigns against the consumption of red-ginseng (*hongsam*)-based products and its ferocious criticism of the *ch'öbyak* NHI coverage could then be seen as an attempt to secure this *ch'öbyak*-based economy. It is

²⁸⁷ The word *ch'öbyak* is used interchangeably with *hanyak* by the public because *ch'öbyak* is considered to be major form of *hanyak*. However, *hanyak* is a generic term including other forms of medicines such as pills and powdered extracts which are NHI reimbursable. But to avoid confusion, I will stick to *ch'öbyak* to refer to the decocted form of *hanyak* which is important in discussions here.

because *ch'öbyak* prescriptions still come with a considerable margin in contrast to other labor intensive treatments such as acupuncture and *ch'una* therapies.²⁸⁸ The overall yearly financial volume of *ch'öbyak* prescriptions is estimated to be around one trillion won or slightly smaller(Jiyeon Lee 2010).²⁸⁹

Local doctors attach great economic significance to *ch'öbyak*, in fact Swimtö members gauge the degree of their clinic's performance by the number of *ch'öbyak* decoctions dispensed that day such as 15:2, meaning there were 15 acupuncture or 'NHI patients'²⁹⁰ and 2 patients who had *ch'öbyak* prescriptions. When Swimtö members post that they had patients requiring forms of *ch'öbyak* that fetch a higher margin, such as *Gongjindan* (控眞團)²⁹¹ whose contains dried and processed deer-horn slices (*nogyong*) and can cost well over 200-300 pounds for 15 days of consumption,²⁹² I observed that a 'cuing ritual (*julsögi*)' occurred in which a series of replies were posted to the original post, expressing the hope that the same fortune would fall those who replied.

²⁸⁸ Chuna is a registered KM clinical practice though it is not eligible for NHI reimbursements. Though the charge for the treatment varies according to the clinics, the OOP charge for a session lasting about 15 minutes, costs about 10-15 pounds. For acupuncture treatment which is NHI-reimbursable, the co-payment charge for patients is about 2-3 pounds for the first visit, making it around 6 pounds in total when reimbursements is included, and for subsequent visits the patient pays only one pound, which makes the total payment for treatments at 3 pounds when reimbursements is included.

²⁸⁹ It is a number estimated from the amount of annual expenditure on NHI reimbursable granule-based *hanyak* prescriptions which is considered to be one trillion and 200 billion a year as data is available from NHI. It is estimated that the volume of *ch'öbyak* prescription is considered to be slightly smaller than volume of granule-based prescriptions dispensed in clinics.

²⁹⁰ As the majority of NHI revenues are created through acupuncture treatments, they call NHI patients 'acupuncture patients' (ch'imhwanja).

²⁹¹ It is a pill made from extracts of the formula that consists of deer horn (鹿茸), Angelica gigas Nakai (當歸), Cornus officinalis Siebold (山茱萸), and Moschus berezovskii Flerov (麝香). According to Dongübogam, it helps replenishing the primordial energy of the person (Seungyup Yang 2012).

²⁹² On average, 10-15 days of *ch'öbyak* consumption costs about 100-150 pounds.

The commercial aspect of *ch'ŏbyak* is also reflected in the expressions used in relation to its prescription and consumption. For example, in doctor's instructions to the patient, consuming *ch'ŏbyak* is expressed as '*hanyak dŭshinda*', '*dŭshinda*' being a respectful form of '*mŏkdda* (eating)'. The use of '*dŭshinda*' here is an unusual usage of the word as *ch'ŏbyak* is in liquid form, and an expression like '*drinking (mashinda)*' might be more relevant. However, due to the significance attached to *ch'ŏbyak*, doctors still prefer to use the respectful form of the word because they consider it a precious, solid and edible object. In contrast, when they instruct patients on the consumption of the NHI-covered granule-based *hanyak*, they use a more professionalized term '*bogyonghanda*' which connotes the therapeutic nature of drugs prescribed, a general term used to designate the consumption of medicines regardless of their WM or KM origin. In more explicit cases, doctors simply talk about '*selling ch'ŏbyak (yak p'anda)*' or '*done some ch'ŏbyak (yak haedda)*' to reveal the commoditized aspect inherent in its consumption.

It is true that the older generation in the community was able to garner economic success on the basis of *ch'ŏbyak*, and that the young ones were particularly attracted to the career of KMDs, among other medical professions, due to such economic success. Indeed, the public's preference for *ch'ŏbyak* has been very high. In the 1970s, people visited KM clinics more often than WM clinics. And according to Cho (1999, 187), the public is said to have spent twice as much money on KM treatments than on WM treatments in the 1990s. These visits were then translated into the success of KM clinics, and at the heart of this success lay in the role played by *ch'ŏbyak*.

It is fair to say that despite the decreasing portion it occupies in the overall economy of KM clinics, *ch'ŏbyak* still plays a non-trivial role in KM businesses to the extent that it is still considered a precious 'commodity' to doctors. However, it is believed that the amount of *ch'ŏbyak* prescriptions has been decreasing. In the next section, I will now investigate the negative effects of the public's increasing consumption of red-ginseng extracts, or *hongsam*, on the KM clinics' *ch'ŏbyak*-related economy.

1.3. The Impact of Increased Hongsam Consumptions on *Ch'ŏbyak* Prescriptions

Many in the Korean Medicine community consider that *ch'ŏbyak* prescriptions were negatively affected by the public's increased consumption of red-ginseng in the 2000s. Though there is no exact figure specifying the shrinkage in *hanyak* prescriptions, local clinicians said that they have been 'sensing the difference' (*ch'airŭlnŭggyŏyo*). And my recent conversation with a journalist who once interviewed an executive from Chŏngg'wanjang,²⁹³ which now has a 70% share in the domestic *hongsam*-based products market, also confirmed this view held in the KM community. The executive is supposed to have told the journalist that the Chŏngg'wanjang was 'killing off' KM clinics.²⁹⁴ Indeed, as you can see in Figure V-4, the increase in *hongsam* consumption is substantial as it showed increase in sales by 250% since 2006.

²⁹³ The official name of this company is Korea Ginseng Corporation (KGC). The company used to be owned by the state and monopolized the cultivation and distribution of *panax ginseng* in the country. The company is now privatized.

²⁹⁴ I conducted this conversation with a journalist who visited Oxford in 2013.

Figure V-4 Expansion of the Domestic *Hongsam* Market in the 2000s



Source: Choongang Dail (J. Choi 2013)

Two background factors need to be explained to understand the inverse relations that seem to exist between the increase in *hongsam* consumption and the fall in *ch'öbyak* prescriptions at KM clinics.

1.3.1. The Tonifying Effect

First, the root of the relationship can be sought in the way the public conceptualizes *ch'öbyak* decoctions.²⁹⁵ While doctors regard *ch'öbyak* formulas as the end-products of the physicians' judgement on the patient's condition, the public have always conceived of them 'tonic (*pyak*)' regardless of the roles these prescriptions may play in their body. This perspective on *ch'öbyak* could have resulted from the diagnostic label 'deficiency (*hö*)' that commonly accompanies the prescriptions. It is a term that is

²⁹⁵ I will continue to use the term *ch'öbyak* for consistency, although the term *hanyak* might portray the public's attitude towards *ch'öbyak* more faithfully as they almost always equate *hanyak* with *ch'öbyak* and uses the term *hanyak* to refer to *ch'öbyak*.

used to imply the fact that a specific element in the patient's system such as Eum, Yang, Qi, or Blood is depleted, warranting some supplementation or reductions of other elements that might have caused the depletion. So miscommunication is likely to occur in some situations where despite the doctors' prescription of *ch'öbyak* aimed at cooling-off the patient's body, not at tonifying it, patients still think of it as a 'tonics'.

The general opinion, namely the idea that the main function of *any ch'öbyak* formula is to treat 'deficiency' or to 'tonify', seems to have been formed at some point. Particularly as the public's trust in such substances as ginseng and deer horn is high due to their perceived potency, a situation that frequently takes place in KM clinics is a tug-of-war between doctors and patients over the contents of prescriptions. Patients insist on having either one or both of them in the formula despite the doctor's contrary opinions.

Chöngg'wanjang's marketing targeted this preference for 'tonics' among the public, particularly that of ginseng, despite the fact that beneficial effects of red or steamed ginseng are rarely described in such traditional medical classics as Donggŭbogam (see Table V-4).

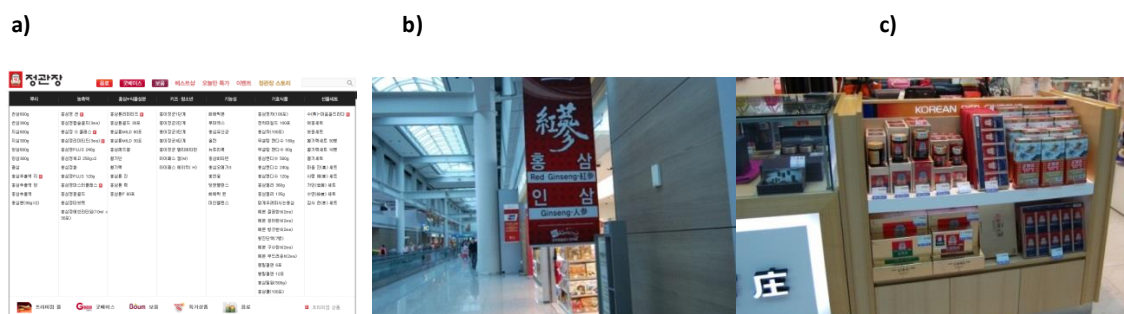
Table V-4 Pictures of Hongsam Products and Hanyak Decoctions

	<i>hongsam</i>	<i>hanyak</i>
Extracts decocted		
Packs		

Note: In terms of their outer appearances, one cannot observe difference between *hongsam* and *hanyak*. The pictures are from the official blog of Korea Ginseng Corporation (<http://www.kgcshop.or.kr/front/index.dx>) and Piburo KM clinic homepage (<http://www.pibro.co.kr/>)

The marketing, however, has worked very well and now the company is selling their products globally (see Picture V-2).

Picture V-2 Hongsam-based Products by Chöngg'wanjang



Note: a) The screenshot of the Chöngg'wanjang's homepage showing more than eighty *hongsam*-based products. b) c) Chöngg'wanjang's range of *hongsam* products range are on sale at a duty free shop at Incheon international airport.

Source: The Korean Ginseng Corporation (a), author (b,c)

1.3.2. Obstruction of Client Flow

The public's conception of *ch'ŏbyak* as a tonifying agent is related to the second factor that links the increased *hongsam* sales to the shrinkage in *ch'ŏbyak* prescriptions. The increased *hongsam* consumption could have negatively affected the behavioral patterns of clients visiting KM clinics in a culture where people utilize Korean Medicine, in addition to treatments, for reasons of disease prevention. During the spring and autumn, or the time of seasonal transitions,²⁹⁶ people visit KM clinics to attend to their bodies that have difficulties adjusting to sudden changes in climate. In many cases, the entire family visit the doctor for advice and *ch'ŏbyak* prescriptions, when necessary. Often they have known the doctor for years or even for generations. These visits then lead to the expansion of the clinic's patient base as these patients resort to the doctor for various other health issues. Increased *hongsam* consumption could have negatively affected the economy of KM clinics by preventing the inflow of new patients by cutting off this seasonal cycle of the clients' visit.

For example, if you look at the variations of yearly collective turnouts of a well-known KM clinic network in Picture V-4, the seasonal pattern of patients' visit is obvious. It peaks in the spring and autumn while it hits low during the summer. In addition, in year-on year-comparison, an exponential increase in the overall turnouts during the period of 2003 and 2005 is observed while its substantial decrease in the later half is also clear. Although with this graph alone, we cannot determine whether the decrease is

²⁹⁶ The seasonal variation in temperature is quite extreme in Korea. The country's highest summer temperature in 2013, for example, was 35 degrees Celsius and the lowest in the year was -15 degrees Celsius.

directly caused by the increase in *hongsam* consumption, it gives some indication as to the relationship.

Picture V-3 Patients' Seasonal Visit Patterns in KM Clinics



Note: The X axis is the month of the year and the Y axis is the turnout. The unit is in million Korean won.

Source: Author

So it is probable that *hongsam* consumption not only affected the revenues created in KM clinics directly, but also had an indirect negative effect on them by affecting the client flow. It seems that these *hongsam*-related changes in the KM community had a knock-on effect on the young doctors. I will explore these in the next section.

1.4. Doctors of the late 1990s and early 2000s (Kumalyŏngch'o)

The 'young doctors' whose economic conditions will be explored in this section are mainly those who went to the KM school in the late 1990s and early 2000s, or those collectively called the 'late 90s and early 2000s school years (*Kumalŏngch'ongch'o hakbbŏn*)'. As was frequently mentioned in previous chapters, they are the ones who

took center stage in the rebellion. I will explore their economic conditions and the two themes that typify this generation of doctors. The first is the very high expectation they have towards the profession, and the second, which is related with the first, is the disappointing job market waiting for them on their graduation that do not meet their heightened expectations.

1.4.1. Heightened Expectations

Among other things, it is important to note that the Kumalŏngch'o doctors have the highest expectation for the profession in the community. It is because they entered KM schools at the height of the schools' popularity when most KM schools required higher academic performance from applicants than WM schools. This was the time Kyunghee University KM department threatened the position of the SNU WM department, an all-time number one, as the department having the highest entrance difficulty in the country. And this trend of KM schools' dominance in the country's university subject league table, though less intense, continued through to the late 2000s (see Table II-3).

Reasons existed behind this popularity of KM schools during this period. Firstly, job security was the most important concern in late 1990s and early 2000s, the period characterized by nationwide restructuring and soaring unemployment in the aftermath of the Asian Economic Crisis that left the country in financial default in 1997 (Haggard and Mo 2000, 198).²⁹⁷ In 1998 alone, for example, out of the workforce of 10 million, 1.5

²⁹⁷ The unemployment rate increased from 2.5% to 8.7% in 1999 (D.-M. Shin 2000, 91).

million lost jobs due to the restructuring that took place in conglomerates, banking, and government sectors (Jesook Song 2009, 5–6). At this time, being an engineer or company employee could no longer guarantee job security, and top high school graduates and graduates from prestigious universities with engineering and science majors, flocked to medical schools, causing concerns among industry leaders on the brain-drain.²⁹⁸

Particularly, KM schools were an attractive choice for many, as six years of education and the successful passing of the license examination allowed them to practice medicine, firstly with considerable longevity and secondly with less risk of being implicated in malpractice-related legal matters than other medical professions. Also for the college graduates who aimed to enroll in med schools, being old was not a handicap, but even an advantage as the patients tend to prefer older doctors in KM clinics. The fact that the strict hierarchical or militaristic inter-year relationship²⁹⁹ was less intense in KM schools than in WM schools also boosted the popularity of KM schools. For fresh high school graduates, as we have seen in Dr. S's vignette in the previous chapter, they chose KM schools, partly because it was hip to become a KMD, and partly because their parents saw the financial viability of being a KMD with the increasing success of KM clinics observed around them.³⁰⁰

²⁹⁸ See J. Koh (2010) for example, in which the CEO of the Semiconductor company laments the brain drain by saying 'Geniuses in China make rockets while geniuses in Korea take pulses in KM clinics'.

²⁹⁹ While I was doing the fieldwork in the PNU medical school complex, WMD students still bowed frequently to me from a distance, despite my not being their teacher, to reduce the risk of being seen as 'disrespectful' to their seniors. This practice died out long ago in KM and dental schools.

³⁰⁰ Near the end of my fieldwork I was invited to a meeting of a group of young doctors who were active at FB Hanŭsadang. Many of them present in the meeting had a prior science bachelor's or master's degree from prestigious universities (SNU, KAIST and Postech) before entering KM schools. In the meeting, everybody took turns to talk about the reasons behind their choice of the career of KMD, and their motives did not go beyond these factors mentioned.

The success of many franchised or networked KM clinics during this period also drove the image of KMDs to a great extent. These clinics introduced the idea of ‘innovation’ in clinic management. They improved the overall *ch’öbyak* delivery pathway from its sourcing and the maintenance of the integrity of raw medicinal materials, to its decoction and home delivery, and in the process, cleared away many sources of concern on the part of the patients. Some of them introduced the ideas of ‘marketing’ and started to target specialized conditions with the active utilization of modern biomedical techniques. They also invested heavily in upgrading the clinic interior and catered to the needs of the patients or ‘the clients’ with improved skills of customer relationship management.

Among them, the success of the Hamsoa clinics of which I was part, was notable. The clinic with specialization in pediatric conditions was so popular among mothers in the Gangnam area, the three doctors who started the clinic in 2000 had to sign their autographs on the street, matching their popularity with those of TV celebrities. For Gangnam mothers, it was said, carrying a Hamsoa *hanyak* package had almost a similar level of prestige to carrying a Gucci bag at that time (see Picture V-4).³⁰¹

³⁰¹ While I worked there as staff physician in 2002, I myself could not even freely go around the area as I was also frequently recognized by mothers.

Picture V-4 The Factory Opening Ceremony at the HAMSOA Pharmaceutical Corporation



Note: As Hamsoa KM clinics were so successful, they eventually opened the KGMP-standard factory in 2007 to sustain their nationwide operations. The clinics combined yearly annual turnout generally reached 50 billion won (28 million GBP). I am sitting on the far right as the representative of the local Hamsoa clinic owners. It is also notable that there are no women in this picture, which indicates heavy male domination in Korean society as was pointed out by many scholars (Janelli and Yim 2002, 117–118,121–122; Seungsook Moon 2005, 84–85).

Source: Author

1.4.2. 'Disappointing' Job Market

The business environment meeting this batch of young doctors, however, did not meet their heightened expectations when they graduated in the late 2000s. From their perspective, the jobs were few, and the pay was much less than that of WMDs, though the comparison seemed at times to be inappropriate.³⁰² Although it was true that the *hongsam*-related changes in the business environment indeed led to drops in employment opportunities in franchised sectors in the latter half of the 2000s, I observed that the job market seemed to have been compensated by the increased opportunities at

³⁰² Many young doctors, for example, complained that they were paid much less in long-term care hospitals than WMD internal specialists. However, considering the four to five years more postgraduate clinical training that they undergo, it is inappropriate to directly compare a WMD specialist's salary with that of a fresh KM school graduate with six years of tertiary education.

long-term care hospitals which were providing the new graduates with handsome salaries in less demanding work environments. In addition, the career options for KMDs widened considerably in the late 2000s. Now many graduates could pursue careers in civil service, become researchers in national institutes, and work as physicians in public health offices or in long-term care clinics.

However, young KMDs did not view this job situation as satisfactory as it did not match their high expectations. At Swimtö, for example, I observed many posts where the young doctors were complaining of the lack of jobs in long-term care hospitals. I thought initially that the idea of 'job security' seemed to be on young doctors' agenda, a notion which I had never known during my entire professional career. However, it did not take long for me to realize that the young doctors were complaining not about the lack of jobs but about the lack of a 'good' job. For example, a stream of jobs were constantly advertised at other KMD sites such as AKOM, though most of these jobs were getting some kind of disapproval by job seekers on the basis of their low wage and the lack of good working conditions. In addition, I found out later that the reason for the tough competition for long-term care hospital jobs at Swimtö arose because Swimtö had allowed the advertisement of the jobs that were paying more than 5.5 to 6 million won per month, which amounted to 8 million won before tax and not those which paid less.

My observation was also confirmed when my co-worker at the PNU KM Policy research unit Dr. Ryu was able to get a job at a long-term care hospital after searching for only a few weeks. Her job was not able to be advertised at Swimtö because it did not meet the pre-defined lower limit at Swimtö. Under average working conditions, inexperienced KM school graduates at long-term care hospitals seemed to be paid from 5

million to 6 million won after tax depending upon circumstances. My recent observations at Swimtŏ also corroborated this estimate.³⁰³ So it can be safely assumed that their employment conditions are not bad and that what made their condition look dismal is their high expectations of the profession.

However, for specialist KMDs, currently, there seems to be a real stagnation or even deterioration in working conditions in comparison with the past. In 1995 when I graduated, for example, small- and medium-sized KM hospitals which had many stroke patients were very keen to recruit specialist license holders. Their pay was very competitive at the minimum net income of 7-8 million won per month.³⁰⁴ I do not imagine, however, that the freshly minted specialists get a monthly wage of higher than net 7 million won in KM hospitals nowadays because the demand for specialist doctors in KM hospitals has been drastically reduced as the number of stroke patients admitted to KM hospitals has sharply dropped recently.³⁰⁵ Patients now prefer such mammoth WM hospitals as Asan General Hospital run by Hyundai and Samsung General Hospital run by Samsung³⁰⁶ whose service and facilities have been significantly upgraded since the mid-2000s.

³⁰³ Recent monitoring of the Swimtŏ site, which included my observation of an ad-hoc survey conducted by a community member on working conditions in long-term care hospitals, revealed that the average monthly salary (after tax) continued to be in the 6-7 million won range. This is almost double what non-medical graduates would expect to receive in their mid-career stages.

³⁰⁴ This amounts to 10 million won per month before tax. The Korea tax rate is quite similar to the UK system in terms of the location of critical bands beyond which the tax rate hikes up to 40%.

³⁰⁵ Only the academically best, however, could still qualify to become a specialist in KM hospitals. At PNU, for example, I saw that many first-or second-year students already gave up the prospect of applying for postgraduate specialist training at the school hospital as they know that with their academic marks, they have no way to catch up with the leading group in the class.

³⁰⁶ The Asan General Hospital in Songpa-gu, Seoul is the biggest hospital in the country with 2680 inpatients beds. The second biggest one is Yonsei University Hospital with 2,500 beds. The Samsung General

1.5. Summary

In this section, I explored the business environments surrounding the Korean Medicine community as well as specially the economic conditions affecting the young doctors in the community.

Firstly, I illustrated the robustness of the overall economy of KM clinics through various indicators of business performances, and emphasized that the economy of KM clinics were not in a desperate condition by any measure. Then, I explored the *ch'ŏbyak*'s commoditized aspects and subsequent economic role in the business of KM clinics as well as the ways it contributed to the affluence of previous generation of doctors. The effect of the increased *hongsam* consumption by way of its negative influence on *ch'ŏbyak* prescription were then explored. I highlighted that *hongsam* consumption might have affected the business of local clinics both by affecting the number of *ch'ŏbyak* prescriptions dispensed in KM clinics as well as the cycle of the client inflow into the clinics.

Then, I focused specifically on the young doctors and provided a detailed look at the economic conditions affecting them. The economic conditions of those who entered KM schools in the late 1990s and early 2000s and those who graduated in the late 2000s were specifically explored. The investigation revealed that despite the fact that this group of doctors were the ones who were affected by the *hongsam*-related changes in business environments, their employment conditions were still sound. What made them draw a

Hospital in Gangnam-Gu established by Samsung is the third largest one with 1966 beds. The Asan and Samsung Hospital expanded their facilities aggressively since 2005 (Kitae Kim 2012)

bleak picture of their economic condition turned out to be their heightened expectations of the profession, particularly in comparison with specialist WMDs and the previous generation of KMDs which are the points of reference for the young doctors. It is noted, however, that the job conditions for specialist KMDs was stagnating, partly because of the reduced demand for them in KM hospitals.

Explorations of the economic conditions affecting young doctors allow one to conclude that the young doctors' frustration could have arisen from the gap existing between 'their sense of entitlement' and 'the unsatisfactory economic reality' they faced. The investigation showed quite convincingly that their livelihood was not in serious danger, and the economy of KM clinics is still robust across the board.

These findings suggest that the argument that the young doctors rose up 'out of economic desperation' cannot be empirically supported, and that for a comprehensive understanding of the young doctors' rebellion, additional sets of conditions must be explored. They are the political conditions affecting the economy of the country's medical communities in general. I made this point clear at the end of the previous chapter as I highlighted that there existed parallel, collective anti-state actions in the medical communities. The exploration of these 'political conditions' is the subject of the next section.

2. The Political Economy of Healthcare Provision: The Pressurizing State and the Resisting Doctors

I already highlighted the significance of the young doctors' militant stance against the state and their own professional organizations observed both in KM and WM communities. In this chapter I will explore how state-level healthcare politics can help us to understand the doctors' rebellion.

In a situation where at least sixty to seventy percent of most local clinics' income is accounted for by reimbursements from the National Health Insurance, it is certain that the state is already exerting a high degree of control over the country's private medical practitioners. As mentioned in the beginning of this chapter, this is the complete reversal in power relationship over the control of the doctors' practice from the early years of NHI when the doctors had control over the majority of their clinical practice.

In this section, I will first describe the basic structure of the country's NHI-based healthcare provision system as a background, presenting its various bureaucratic and operational details. Then I will present various political factors that made the relationship between the state and the doctors *a strained one* that is characterized by that of *pressure* and *resistance*. The factors to be explored are population ageing, the changed state-civil society relationship and the expansion of welfare measures. These are the measures that made the state's pressurization of the doctors a legitimate concern.

I will then briefly explicate how the state controls the doctors in a changed political landscape after the country's re-democratization in late 1980s. In order to illustrate concretely the conflict existing between the state and the doctors, I will present an

ethnographic case of health policymaking at the end of the chapter. There, the state's firm intention to control NHI finances and the doctors' resistance to the state's interference will be observed.

Considering these political economic factors, I argue that the young doctors' rebellion in the KM community can also be interpreted as the medical communities' collective resistance to the controlling state. In other words, it is also fair to say that the young doctors' collective actions were in part a reaction to their strained relationship with the state.

2.1. Background: National Health Insurance

The majority of healthcare provision in Korea is delivered by private practitioners with only ten percent being accounted for by the state, and it has limited the state's role to that of the regulator for a long time (Soonman Kwon 2009, 66–67). Even for crucial public health measures such as the control of roundworm infections that were affecting the population widely in the 1980s,³⁰⁷ a period when the country's economic ascendancy was visible, the state did not spend much (In-sok Yeo 2008, 82).

The state's non-interventionist stance, however, changed substantially when the state had to spend heavily in 2000 in integrating the country's fractionalized health insurance societies with a view to addressing the inequity in healthcare financing that existed between different income and occupational groups (Soonman Kwon 2003, 76). The single payer and single payment system in National Health Insurance was thus

³⁰⁷ This condition affected about 41% of the entire population in 1976 (In-sok Yeo 2008, 82) .

created. Two quasi-public organizations that were responsible for the integrated national health insurance were established; they were National Health Insurance Corporation (NHIC) and Health Insurance Review and Assessment Service (HIRA). The NHIC is responsible for the 'administrative and financial' aspect of the NHI while HIRA is responsible for the 'clinical' side by undertaking the role of assessing the providers' reimbursement claims.

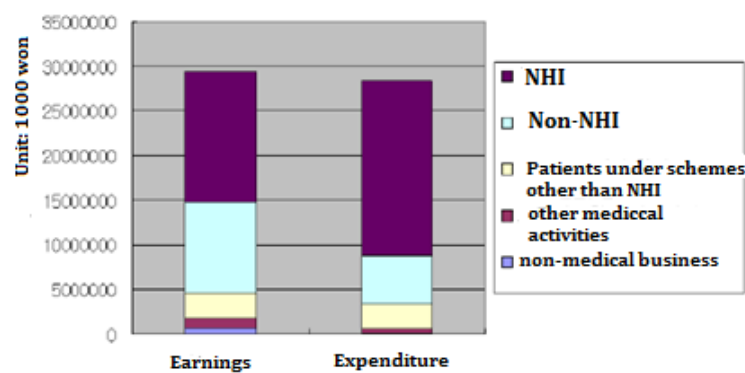
In the history of the country's national health insurance since its legalization in 1963 and the implementation of universal coverage in 1987, the completion of this single payer and single payment system was another major milestone. Considering that the state spent heavily in the form of subsidies to address the inequity among different insurance societies (Soonman Kwon 2009, 68), it was a significant event in the history of the country's healthcare policies as it was the first time that the state undertook major spending in healthcare. As of 2012, the NHI is now responsible for 62.5% of the country's entire annual healthcare expenditure (Yangjung Kim 2014).

2.1.1. Medical Fee Reimbursements Method

The current NHI payment system operates mainly on a *fee-for-service* basis except for a limited range of DRG (Diagnosis Related Group)-based payment system for such conditions as adenoidectomy and cataract surgery, and for the per-day payment system for the elderly patients in long-term care facilities (B. Lim et al. 2012, 9). When the fee schedule was introduced in 1977, the base reimbursement rates were set below the

market medical fees.³⁰⁸ As the original fee schedule is still being used, As the original fee schedule is still being used in the current NHI, many consider the baseline fees to be still quite low, despite their subsequent readjustments (Jeongho Park 2008, 116). Some even say that the baseline fees are actually smaller than what is being invested to produce the services, and that this discrepancy between investments and return leads to a situation where doctors try to compensate the financial loss incurred in performing NHI-related services through the provisioning of non-NHI services (G. Kang 2010, 23) (see Picture V-5). Also, there has always been a concern about the inequity between different clinical departments in the actual amount of reimbursements. It is because rules for deciding on the value of medical activities, technically called ‘relative value’ (*sangdaegachi*), had not been determined satisfactorily at the beginning.³⁰⁹

Picture V-5 The Proportion of NHI and non-NHI Treatments in the Earnings and Expenditures in WM Clinics



Source: G. Kang (2010, 23)

³⁰⁸ The original fee schedule was set at 55% of the market fees.

³⁰⁹ To rectify this problem, the government introduced Resource Based Relative Value Scale (RBRVS) in 2001 in which the relative values of medical activities could be decided according to the amount of doctor’s labor, expenses, and risk involved in performing the task (G. Kang 2010, 52) but this system has not been fully settled yet.

The process of the determining the actual amount of reimbursements is the following: Firstly, one has to consult the pre-fixed relative value of a specific medical activity performed on the patients. This value is then multiplied by a ‘conversion factor’ (*Hwansanjisu*), a unit of money, to produce the actual amount paid as the reimbursements.³¹⁰ Annually, these conversion factors are decided through negotiations among stakeholders in the session of The National Health Insurance Policy Deliberation Committee.

2.1.2. Inclusion of New Therapies

The process for the inclusion of a new treatment modality in the NHI begins at the National Evidence-based Healthcare Collaborating Agency (NECA) which assesses the technology in terms of its clinical relevance and economic viability. If the new therapy or technique passes the assessment,³¹¹ the Ministry of Health Welfare (MOHW) intervenes, in collaboration with the HIRA and the NHIC, to decide on the details of the reimbursements for the technique on the basis of existing medical and others laws and various other government regulations. For botanical drugs, it was at this stage that they were classified as Western drugs so that the reimbursements were made exclusively to WMDs.

³¹⁰ Expressed as an equation: ‘Reimbursement amount=Relative Value (RV) x Conversion Factor (CF) (B. Lim et al. 2012, 18).

³¹¹ It is officially called Healthcare Technology Assessment (HTA).

2.1.3. National Health Insurance Policy Deliberation Committee

Important matters on NHI are decided in the National Health Insurance Policy Deliberation Committee which is composed of various stakeholders. The inclusion of *ch'öbyak*-based treatments that featured centrally in the young doctors' rebellion was also decided in one of the committee sessions. A decision to include the provision of artificial teeth for the elderly was also made in the same session. The Committee convenes irregularly, and it has convened 15 to 25 times a year since its establishment in 2002 (Yongha Kim 2006).

Annual negotiations regarding the 'conversion factor' are considered to be one of the most important tasks undertaken by this committee. During the negotiation period, provider groups who are normally antagonistic sometimes coalesce with each other in order to get the maximum increase possible for their own organizations. In the session that took place in October 2012, while the KM community was in bitter conflict, for example, the Committee decided to give a 2.7% increase in conversion factor for KM clinics, 2.5% increase for dental clinics and 2.9% increase for pharmacists in following year's reimbursements, except for WM clinics and hospitals which opted out of the negotiations when their request for 3% increase was not accepted (Shinjeong Koh 2012).³¹²

³¹² This was the time when the KMA was under the leadership of Dr. Noh Hwangyu, former head of Ch'önüch'ong.

2.1.4. Measures to Control Reimbursement Claims

In order to ameliorate the existing and potential financial pressure on NHI, the state implements many measures. They could be largely divided into the measures targeting the healthcare service ‘demand side’ and those targeting the healthcare service ‘supplying side’, namely the doctors.

As for the demand-side control, the MOHW’s decision to introduce a chronic disease management system first in WM clinics in 2011 and in KM clinics in 2012 is a good example. The governmental plan to change the roles of the public health offices from their current function as easy-access centers for limited primary care services, into ones aimed at health promotion and disease prevention is another initiative aimed at reducing the disease burden through early intervention. The state’s decision to subsidize *ch’öbyak* prescriptions as well as artificial teeth for the elderly in the NHI can also be seen as measures to strengthen preventive care for the growing elderly population who heavily use NHI services (see Table V-5).

Table V-5 The MOHW's Top 10 Policy Objectives for Year 2011

1	Developments of the differential functions of each type of clinics
2	Facilitating the networking between the clinics
3	Establishment of care for chronic conditions and the elderly
4	Specialization and characterization of the hospitals
5	High-tech development of tertiary hospitals
6	Rectification of patient over-loading in large hospitals
7	Improvement in education of the medical personnel
8	Establishment of a system of efficient management of the healthcare resources
9	Development of emergency care capacity to the level of developed countries
10	Improve the infrastructure for the improvement of clinical services

Source: MOHW

The measures aimed at controlling the supply-side, which is considered to be a crucial element in sustaining the finances of the NHI (Soonman Kwon 2009, 63), include the following measures. They focus on improving the bureaucratic efficiency and financial control over the reimbursement claims from the service providers. Firstly, the HIRA introduced in 2011 a measure called Index Synchronizing Management System (ISMS, *jip'yoyödongg'wanlije*) whereby the HIRA notifies doctors whose claims go over the pre-defined limit in one of the five categories. These notifications, or warnings to be exact, could lead to on-site reviews for these clinics if the practice does not change (see Table V-6 and 7).

Table V-6 Criteria for Selection in the Index Synchronizing Management System (ISMS)

Management elements	Criteria for selection
number of visits	Index for visit days (VI) 1.1 over & Costliness Index (CI) 1.0 over & top 15% among the clinics
antibiotics prescriptions rate for acute upper respiratory infections	Antibiotics prescription rate 80% over
prescription rate for Injections	Inject prescription rate 60% over
number of drugs prescribed	Number of drugs in the formula exceeding six constitutes more than 40%
outpatient drug expenses	Outpatient prescriptions costliness index (OPCI) 1.3 over

Source: S. Cho (2012)

Table V-7 The Number of Clinics Notified under ISMS in the First Quarter of 2012

	Total	Visit days	Antibiotics prescription rate	Injection prescription rate	Number of drugs prescribed	Outpatient drug expenses
Clinic	7805	2925	1198	1308	831	3382
Hospital	121	85	11	14	18	0
Long-term care hospital	117	98	0	8	16	0
Dental hospital	9	9	0	0	0	0
Dental clinic	2106	2106	0	0	0	0
KM hospital	10	10	0	0	0	0
KM clinic	117	980	0	8	16	0
	12025	7090	1209	1330	865	3382

Source: MOHW (Jiwhan Kim 2012)

There is another measure called the Voluntary Correction Notification System (VCNS, *jayulsijöngt'ongboje*), which the MOHW introduced in 2011. It is a system wherein the MOHW supplies the basic index of the median amount of reimbursements given to the doctors so that the doctors know the extent to which their claims are situated in the spectrum and should be able to *voluntarily* correct their practice of filing reimbursement claims.

The introduction of various 'lump-sum' payment methods such as the Diagnosis-Related-Group (DRG)³¹³ and the Global Budget System (*ch'ongaekyesanje*)³¹⁴ are other initiatives the government uses to control the financial pressure on the providers' side. The DRG is already in place and the expansion of the system had already encountered substantial resistance from the WM community in 2012 (Digital News Team 2012).³¹⁵ As for the Global Budget System whose implementation has been on the government's agenda for a long time, however, the state has yet to negotiate with provider groups.

Bureaucratic control over medical providers seems to have been intensified after the completion of the single payer system in 2000. It is plausible to think that in addition to the expansion of the NHI that led to the increasing power of the state over the doctors, the establishment of centralized organizations within NHI may have drastically improved the scale and efficiency of control on them. The government's determination to push for the separation of prescription and distribution of drugs (SPD) in the WM community in

³¹³ Under this system, payments are made on a pre-set amount for a list of standardized conditions.

³¹⁴ In this system, the state allocates a lump sum to provider associations on a yearly basis so that the provider organization distributes the money among them rather than the state allocating it on an individual basis.

³¹⁵ See Picture V-9 for more information.

2000, despite its strong resistance,³¹⁶ might have been partly aided by this organizational power newly established in the country's healthcare.

In the next section, I will elucidate in more concrete terms the state's pressure on doctors, and contextualize these actions within the country's political and economic situation in recent decades.

2.2. Doctors under the State's Pressure

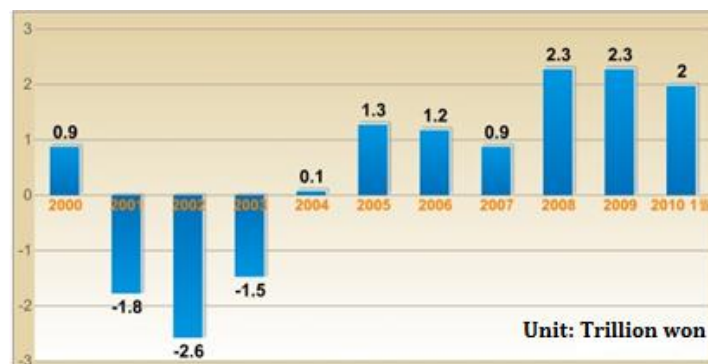
The doctors are certainly under the pressure of the state which is constantly striving to control the increasing costs of NHI. In this section, I will firstly elaborate on the various factors contributing to the state's increasing pressure before I explore the political contexts in which the state came to have more control over the doctors after the country's democratization in 1980s. Then, I will present an ethnographic case of health policy research where the nature of the relationship the contemporary Korean state had with the country's private medical practitioners can be observed. This case will illustrate many elements thus far discussed in this chapter, such as the state's dependence on private medical providers, the state's concerns about increasing expenditure in NHI, the doctors' resistance to the state's control, and the state's firm intention to strengthen its bureaucratic control over the doctors' practice.

³¹⁶ See Picture V-6 for more information.

2.2.1. Concerns for Cost Containment and Changing Demography

For the state's point of view there are four main reasons to wish to keep a tight rein on NHI-based healthcare costs. Firstly, there is the matter of tight NHI finance. As seen in Figure V-5 below, despite its recent surplus, NHI finances have been quite tight over the years (J.-C. Lee 2003, 48; K.-H. Cho et al. 2004, 1200; Soonman Kwon 2009, 67; Kunwoo Lee 2010), and its aggregate deficit could deepen easily if not properly controlled (see Figures V-5, 6).

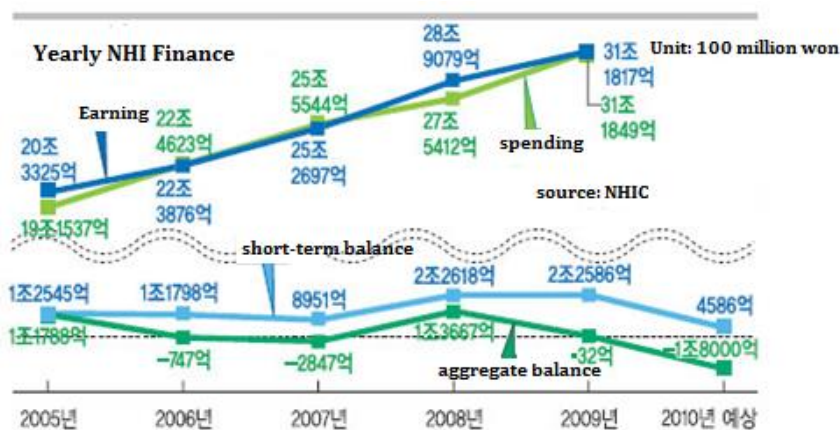
Figure V-5 The Balance of NHI Finance in the 2000s



Note: There was a deficit for a few years after the single payer system was introduced in 2000; and finances began to break even near 2004 and there has been a marginal surplus thereafter.

Source: Kunwoo Lee (2010) (NHIC and Institute of Taxation)

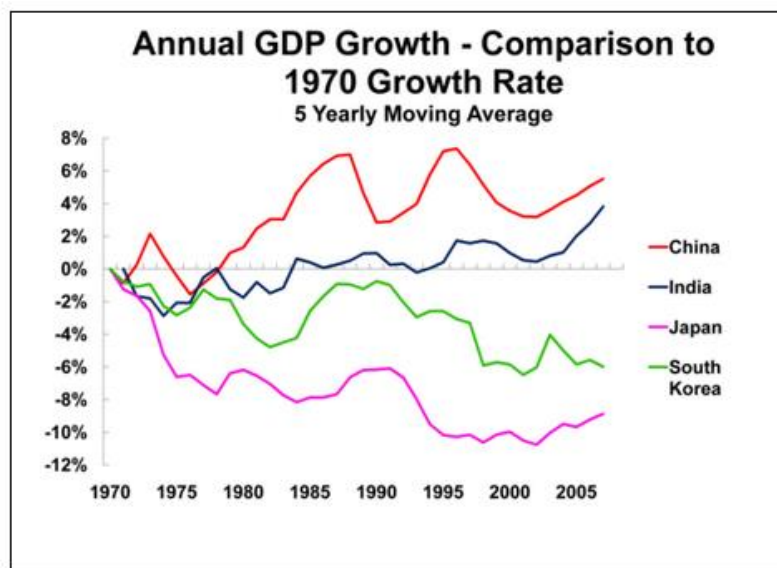
Figure V-6 The Aggregate NHI Financial Balance in the 2000s



Source: Soojung Moon (2013)

Secondly, the country's economy is not growing as fast as before and it is still in the shadow of the Asian economic crisis. The rate of the country's economic growth falls far short when compared with its performance in the past. The rate of economic growth in 2013 was 2.8% (YTN News 2013), significantly lower than 10% as recently as 1991, not to mention the 1980s when double digit growth was the norm (see Figure V-7).

Figure V-7 Korea, Japan, India and China's Annual GDP Growth Rates in Comparison to the Rates in 1970



Note: This chart is from "India and China's Challenge in the Current Economic Crisis." (uploaded in November 2008) in John Ross's blogsite *Key Trends in Globalisation* (<http://ablog.typepad.com/keytrendsinglobalisation/2008/11/the-economic-challenge-facing-india-and-china-in-the-current-financial-crisis.html>).

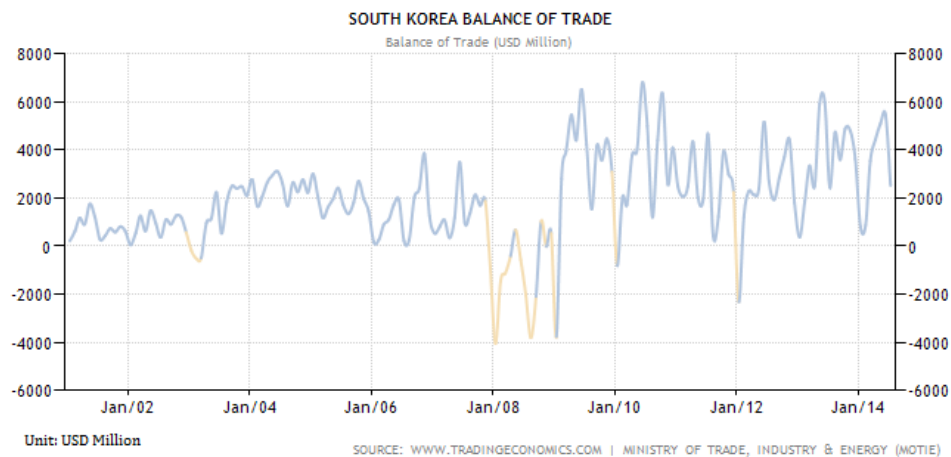
Furthermore, the country's external debt is continuously expanding while the trade balance, although it has surplus on average, fluctuates precariously every year (see Figures V-8, 9). As a country that had suffered a financial default in 1997, this is a worrying signal. It is fair to believe that the Korean state has no reason to slacken its grip on the country's finance, particularly in the context of the increased welfare expenditure since the financial crisis (D.-M. Shin 2000).

Figure V-8 The Increase in South Korea's External Debt



Source: The Bank of Korea, Trading Economics (<http://www.tradingeconomics.com/>)

Figure V-9 South Korean Balance of Trade



Source: The Korean Ministry of Trade, Trading Economics

Thirdly, the changing demography gives the state an additional burden. The population is aging at a fast speed with a dismal growth prospect characterized by the total fertility rate of 1.2 in 2010 (see Figure V-10). This demographic change is expected to become a societal wide burden not just because of the high number of elderly healthcare users which would account for a major share of the limited resources due to their lengthier disease course and higher treatment costs (Huh 1983; S.-J. Choi 1996, 11; Atkins and Chopra 2009, 72; Kemble 2010, 294), but also because of the shrinking

working age population that could sustain the country's economy (Goodman and Harper 2008, 2–5) (see Figure V-11, 12).³¹⁷

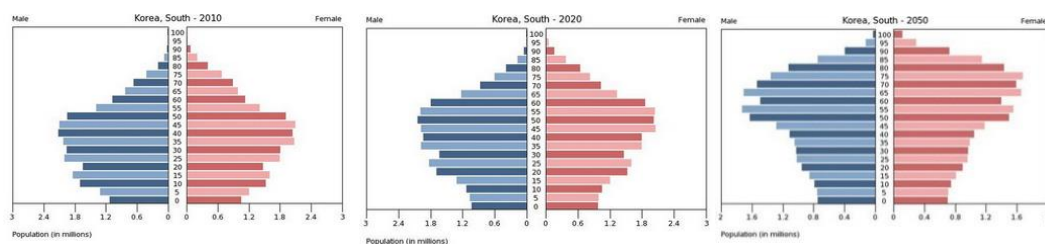
Figure V-10 Projections by the Korea National Statistical Office for Korean Population Characteristics Until 2050

	Population (in millions)	Growth rate (%) ^a	Fertility rate ^b	Life expectancy (in years)	Median age (in years)	Proportion of elderly population (%) ^c
1960	25.0	2.3	6.0	55.3	19.9	2.9
1970	31.5	1.8	4.5	63.2	19.0	3.1
1980	37.4	1.5	2.7	65.8	22.2	3.8
1990	43.4	0.6	1.6	71.3	27.0	5.1
2000	46.1	0.6	1.5	75.9	31.8	7.3
2010	49.2	0.1	1.2	79.1	37.9	10.9
2020	50.0	-0.1	1.2	81.0	43.7	15.7
2030	49.3	-0.5	1.3	81.9	49.0	24.1
2040	46.7	-1.0	1.3	82.6	53.1	32.0
2050	42.3	—	1.3	83.3	56.2	37.3

Note: As is seen in numbers highlighted in yellow, Korea is expected to be an aged society with 37% of the population aged over 65 in 2050. The total fertility rate in 2010 is 1.2, meaning the average woman gives birth to just one child during her lifetime.

Source: Yoon (2013)

Figure V-11 Population Pyramids Showing South Korea's Aging Population



Note: These age picture diagrams are from the US Census Bureau (<http://www.census.gov/population/international/data/idb/informationGateway.php>.)

³¹⁷ Some authors have even argued that the Korean healthcare system is 'in a state of disorder' as it failed to predict population needs before they arose, particularly in relation to the lack of long-term care facilities for the elderly. As a consequence these facilities were only taking up 0.39% of the elderly population in 2004 (K.-H. Cho et al. 2004).

Figure V-12 Increase in the Expenditure for Elderly Patients in Total NHI Expenditures



Note: The portion of the NHI expenditure spent on persons over the age of 65 is increasing over the years as is shown in the increasingly larger green bars.

Source: NHIC requited from J. Kang (2013)

The state's concern about the potentially deleterious effects of changing demography on healthcare finance has also been voiced by a senior government official who was in charge of funding for the development of healthcare technology. In one of the expert meetings in which I took part, Dr. Kim, bureau director of the Korea Health Industry Development Institute (KHIDI) which implements MOHW-funded R&D projects, expressed his view on the current situation of the country's healthcare:

Our Ministry's Korean Medicine R&D is not about KM in the space age or in a globalized world, but how to tackle the very urgent healthcare issues such as chronic conditions derived from demographic change, and attend to the needs arising from changing in healthcare values etc...Can you guess the annual turnout of the Yonsei University Hospital? It's 1 trillion and 600 billion won a year. Can you imagine? It's a [financial] black hole. The whole point of the Ministry's R&D is to develop a new technology that will reduce this disease burden and **thus ameliorate this financial pressure** [on the part of the government]. (Emphasis added by author).

The state's concern for cost containment was also stimulated by the unexpected increase in NHI expenditure since the implementation of the separation of prescription and distribution of drugs (SPD) policy in 2000. The scheme was originally conceived of as

a ‘social justice’ initiative by which it was hoped that practices of ‘commissioning’ or ‘bribery’ which were prevalent among doctors would be dispelled. Those practices whereby doctors were given monetary or other forms of compensations by pharmaceutical companies in return for the use of their pharmaceutical products were considered by civil organizations to be the culprit behind the increasing healthcare fees (J. Chung 2011) . Despite strong resistance from the WM community, therefore, the government pushed forward the implementation of policy in 2000 in the hope that separating drugs from doctors would not only dispel ‘unethical practices’, thus reducing the number of unnecessary prescriptions of antibiotics, but would also stabilize the country’s healthcare finance (see Picture V-6).

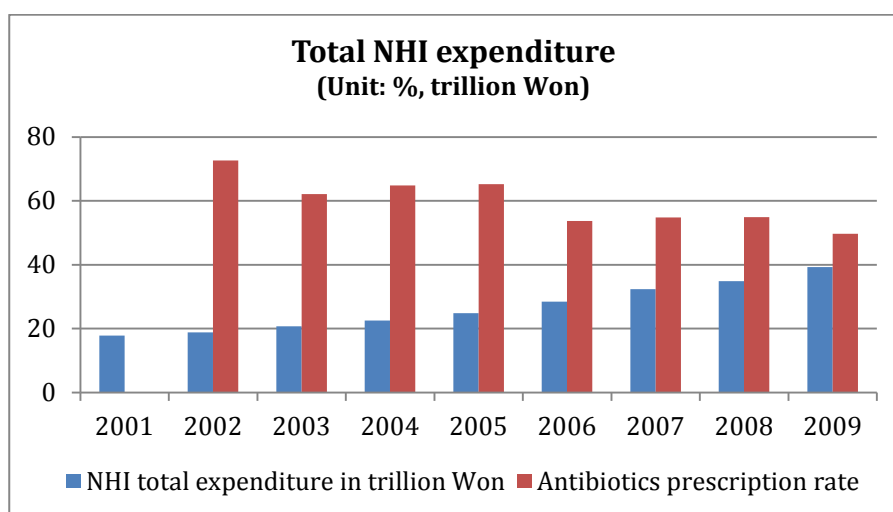
Picture V-6 WMDs’ Protest against SPD in Yeoudo, Seoul in 2000



Source: Sangheun Lee (2009)

The SPD, however, turned out to be a very expensive policy as NHI expenditure increased more than two-fold since its implementation, although the rate of prescriptions of antibiotics was indeed lowered (see Figure V-13).

Figure V-13 The Increase in NHI Expenditure after the SPD



Note: We can see the increase in expenditure more than doubled over a decade, though antibiotics prescriptions declined over the years.

Source: HIRA and NHIC (S. Shin 2010)

The source of expenditure increase could be explained as a result of the creation of *prescription fees* for WMDs and *dispensing fees* for pharmacists and partly as a result of the rise in the cost of drugs dispensed after the scheme was introduced. After the scheme, it turned out that local doctors, who no longer had to worry about the price of drugs, now began to prescribe original drugs in cases where before they might have opted for generic ones. With this increase in spending in NHI, the insurance premiums of healthcare users roughly tripled over the period 2000 to 2009 (see Table V-8).

Table V-8 The Increase in Per-capita NHI Premium Payment From 2000 to 2009

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
The Employed	7688	9542	12220	15727	17752	18999	70713	23449	26304	27049
The Self-employed	10965	12982	14650	16807	18256	19237	21050	24065	27736	28652

Unit: Korean Won

Note: The number of the employed is based upon the amount of premium paid by the users themselves and does not include the amount paid by the employer.

Source: NHIC

The four main factors behind the state's concern - tight NHI financial balance, the country's sluggish economic growth, the aging population and the unexpected increase in NHI expenditure after the SPD-policy have now been described. I will now explain in the next section the political contexts in which the state has pressurized the doctors as a way to combat these concerns. The most important factor is power dynamics within the NHI committee, the central decision-making body of the country's NHI-based healthcare. I will explain how changes in the political landscape affected the state-civil society relationship and led to the 'marginalization of medical providers' in the NHI committee, at least from the doctors' point of view.

2.2.2. Pressurized Doctors: The Changed State-Civil Society Relationship and the 'Marginalization of the Doctors' in the NHI committee

The National Health Insurance Policy Deliberation Committee is the seat of political negotiation where all the important decisions on NHI are made, but it is also the venue

where the state's pressurization on doctors is manifested. So it is important to understand the nature of its operation.

A. The National Health Insurance Policy Deliberation Committee

The National Health Insurance Policy Deliberation Committee

(göngangbohömjöngch'aeksimüwiwönhoe), or 'gönjöngsim' in short, was created in 2002 after the single payer system in NHI was completed two years earlier (Yongha Kim 2006). The structure of the Committee was modeled on the Economic and Social Development Labor-Employer-Government Committee, or the labor-employer-government tripartite committee (nosajöngwiwönhoe), which is considered to have functioned successfully on a democratic basis after being established in the wake of Asian Economic Crisis.³¹⁸

The National Health Insurance Policy Deliberation Committee shares, therefore, similar organizational features with the Labor Tripartite Committee. Just as in the tripartite committee, the NHI committee is also composed of all healthcare stakeholders that include the insured, the providers, the insurer, the government, and academic experts representing the public good. Members of the committee serve a three year-term.³¹⁹ To expedite its executive functions, the NHI committee reports directly to the Minister of Health in the same way that the tripartite Committee reports directly to the

³¹⁸ In fact, the Labor-Employer-Government Tripartite Committee itself had played an important role in the creation of the single payer system in NHI by discussing the issue as its central agenda in its inaugural committee meeting (Seungil Yang 2013). The Tripartite committee which was comprised of the representatives from labor, employers, government and the public, was the outcome of the Korean state's response to the Asian economic crisis while it attempted to reduce the shock of the large-scale restructuring and to facilitate the fast economic recovery of the nation (Koo 2001, 202–203). And since its inception in 1998, the committee is still working as the country's supreme decision-making body in all matters of labor relations. Its homepage can be found at http://www.esdc.go.kr/eng/en_index.asp.

³¹⁹ The members of the Tripartite Committee serve for two year term.

country's president. The committee convenes on an irregular basis. As mentioned, the NHI committee has convened about 15 to 25 times a year on average.

With regards to the membership of the committee, on the side of the insured, there are various organizations that represent the users, and they include employee and employer representatives. Ordinary service users are represented by civic groups. An association representing small business owners also sits in the committee and the farming and fishery organizations represent the interests of small-scale farmers and fishermen.

On the provider side, there are medical provider groups such as the KMA, the AKOM, the Korean Hospital Association, the Korean Dental Association, and nursing associations. The Korean Pharmacist Association and the Korean Pharmaceutical Industry also take part in the committee as pharmaceuticals providers. While representatives from NHIC and the HIRA sit on the committee as the insurers, officials from the ministries of MOHW and the Ministry of Strategy and Finance also participate to represent the voice of the government. Finally, academic experts also participate to represent the public good (see Table V-9).

Table V-9 A List of NHI Committee Members Elected for the 2013-2016 Term

Sector	Organization	Title	Name
Employed	Korea Labor Association	Vice chairman	Lee byunggyun
	Korean Association for Democratic Labor	Vice chairman	Kim kyungja
Employers	Korean General Associations for Employers	Director for social policy	Ryu kijong
	The Association for Small and Medium sized businesses	Board Director	Paik yanghyun
Civil	Citizen's committee for right society	Board member	Kim yongha

organization			
Consumer organization	The Korean Association for consumer organization	Director of Implementation	Hwang Seonok
Agriculture and Fisheries	The Korean Farmers' association	Vice President	Song Inbom
Self-employed	The Central Association for Food and catering businesses	Chief Vice president	Chang Hungsik
Medical Providers	Korean Medical Association	Vice President	Yun Changgyum
		Director of Insurance	Lee Sangju
	Korean Hospital Association	Chairman of Insurance committee	Na Chungyun
	Korean Dental Association	Vice president for Health Insurance	Ma Gyunghwa
	Korean Association for Korean Medicine	Vice chairman	Oh Susok
	Korean Nursing Association	Chairman	Song Myungsook
Pharmaceutical Industry	Korean Pharmacy Association	Vice Chairman	Park Inchun
	Korean Pharmaceutical Association	Executive Director	Gal Wonil
Government Ministries	Ministry of Health and Welfare	Head of the NHI Bureau	Chang Jaehyuk
	Ministry of Planning and Finance	Director for Policy Management	Hong Namki
National Health Insurance Corporation and HIRA	National Health Insurance Corporation	Executive Director for Reimbursement	Han Mundok
	Health Insurance Review and Assessment Agency	Executive Director for Development	Song Eunbok
Experts	Hanyang University School of Management	Principal	Sa Gongjin
	Seoul National University School of Public Health	Head	Kwon Soonman
	Korea University Department of Preventive Medicine	Professor	Yun Seokjun
	Korea Institute for Health and Social Affairs (KIHASA)	Director of Research	Lee Sangyoung

Source: Sungwoo Lee (2013)

At first glance, the NHI committee seems to have a fair distribution of stakeholders with equal representation of various stakeholders. However, a second look at the list will reveal that there is a possibility to interpret the membership construction to be skewed in the direction of users. What potentially disrupts the balance, in comparison, for example, with the Tripartite Committee, is the presence of the two government ministries and the four figures representing the public interest. The government ministries, unlike their role as intermediaries between the employer and the employees in the tripartite committee, do not play a neutral role in the NHI committee but should be rather considered as actors supporting the insurer party along with NHIC and HIRA because the two organizations are under MOHW's absolute control. The four public interest experts in the committee are also generally those figures who have track records of supporting the user groups and of working extensively with the state since the country's democratization. It is therefore not surprising that many members of the doctors' community argue that the provider groups are 'marginalized' in the committee (H. Shin 2012; Chun 2012; J. Pae 2012).

At least from the membership distribution, it is clear that medical provider groups are not in a favorable position. They are effectively surrounded by user groups who share the same cost-containment concern with the state. It is partly because the country's recent political history has allowed the state and user groups, or civil society, to become increasingly cooperative that the doctor groups' negotiating power in the committee has become weaker.

B. Changed State-Civil society relationship

Civil society in Korea, however, has not always been supportive of the state. Rather, in the latter half of the 20th century, civil society was a force of resistance against the fundamentally 'authoritarian and developmental state' (White 1988) which spent little on social welfare for fear of creating 'welfare dependency' (D.-M. Shin 2000, 85–86). It was only after the 1987 civil uprising during which 'the streets of Seoul and other major cities looked like battlefields' (C. S. Kim 1992, 185) that the country was back on the road of re-democratization after three decades of military junta rule.

In the aftermath of 1987, the relationship between civil society and the state began to change. As former dissidents and student activists started to enter mainstream politics (Sookyung Kim and Chang 2011), an atmosphere of a growing social acceptance of human rights was also created (G.-W. Shin et al. 2011, 39) which again empowered civil rights movements afterwards. The CCEJ's mediation in the KM-Pharmacy conflicts in 1993, for example, symbolized the burgeoning power that civil society had in the changed political context after the country's democratization (see Picture V-7).

Picture V-7 The Mediation by the Citizen's Coalition for Economic Justice in the KM-Pharmacist Conflict



Source: The head of AKOM Dr. Heo Changoe (left) and the head of KPA shake (right) shake hands. The chairman of CCEJ Reverend Suh Kyungsok stands in the middle. The agreement, however, was nullified later that year.

Source: CCEJ homepage (<http://old.ccej.or.kr/INTRO/history.html?HYear=1993>)

A budding relationship of cooperation was sustained between the state and civil society following democratization due to improvements in workers' economic and living conditions and increases in wages following labor protests at this time. According to Choong Soon Kim, who conducted fieldwork in Poongsan Corporation during this period, wages increased by 190% between 1987 and 1990 (C. S. Kim 1992, 99–100). It was also during this time that the population was feeling 'genuine excitement' over the diversified and expanded domestic market for consumer goods (Nelson 2000, 23,87). With higher spending power due to rising wages, improved living conditions (Koo 2001, 5,210–214), and newly gained political freedom, the labor and employer relationship also began to change from that of 'confrontation' to that of 'cooperation' (C. S. Kim 1992, 172).

The cooperative ties between civil society and the state were fortified about a decade later when they worked together to overcome the shock of the economic crisis that befell the nation. The Korean government had to declare financial default on

November 21st, 1997 when it could not pay creditors who wished to withdraw their money from the country. The event was triggered by financial turbulence referred to as the 'Asian Financial Crisis' that affected mainly Thailand, Hong Kong and South Korea (Haggard and Mo 2000, 198). The country's economy which had been growing 10% on average for three decades (Nelson 2000, 14) now registered negative growth. To make matters worse, in the wake of soaring unemployment and company layoffs that followed the major restructuring of businesses,³²⁰ the country had no social safety net at all. At the end of 1997, for example, only 0.8% of the population was on benefits and a meager 2.3% of industrial workers were eligible for 'livelihood protection' (D.-M. Shin 2000, 89). The economic crisis that was producing 1.8 million jobless people turned into a major 'social crisis' (D.-M. Shin 2000, 90–91).

The newly elected leftist government decided to expand measures of social security. The action included such measures as strengthening the existing social insurance system, improving the social assistance system, and expanding the unemployment entitlement scheme. In order to take care of daily workers who were not eligible for unemployment schemes, the government also introduced the scheme of 'public works' in which a low wage was given to participants in return for simple public tasks. For the fortification of social security, the government integrated the national health insurance, and undertook the reform of the existing national pension system. The state also revised the standard labor law so that workers in small workplaces could be protected from illegal employment practices (D.-M. Shin 2000, 93–98). Therefore, by 2000 the Korean state was able to establish the nation's first comprehensive social safety net, or *the*

³²⁰ This was performed on the basis of recommendations from the IMF who provided emergency rescue loans.

welfare state, in the form of four major social insurance schemes for the public, and of the National Basic Living Standards (NBLS) Law for the poor (see Picture V-8).

Picture V-8 Four Major Social Insurance Schemes



Note: National Pension Scheme, National Health Insurance, the Workplace Accident Insurance and Employment Insurance (Clockwise)

Source: NPS, NHI, Employment Insurance, and Work Insurance

What was important in the process of establishing the European-style comprehensive welfare state is the fact that the state actively and fully cooperated with civil society. This active cooperation accelerated the co-optation of the civil society into the state's political governance afterwards (Jesook Song 2009, 2–3). An increasing number of past labor and social activists entered into the ranks of mainstream politics, generally in high-capacity roles (P. Y. Chang and Shin 2011, 4). For example, former militant labor activist Hong Yongpyo who led the Daewoo Auto Strike in 1985 (Koo 2001, 111) served as the Director of FTA Policy team at the Ministry of Finance in 2007 while many prominent labor figures such as Kim Moonsoo, Lee Taebok, and Lee Jaeoh all became either provincial governors or government ministers throughout the 2000s. The 'institutionalization' of social movements, as observed in the establishment of such

institutions as the Korea Democracy Foundation and the National Human Rights Commission, also occurred In this process (P. Y. Chang and Shin 2011, 7–9).

C. Doctors under attack from the State-Civil society complex

This turn from ‘confrontation’ to ‘cooperation’ in the state-civil society relationship weakened the negotiating power of the provider groups in the NHI committee. The moral high ground the state assumes, after its full cooptation of civil society, was precisely behind the state’s harsh stance towards the protesting WMDs’ in 2000 in the wake of the implementation of SPD (Daeyoung Kim 1999; Ahn 1999; W. Lee 2001). Unlike in the KM-Pharmacy conflict in the 1990s where the state’s authority was almost untrusted by the public, the state pursued a hardline policy against WMDs in 2000. With the full backing from media and civil organizations who accused the doctors of egotism and moral degradation, the state strongly condemned the protesters and threatened to ‘treat them according to the law on any illegal practices that took the public’s health hostage’ while taking a firm stance on negotiations (S. Yu 2000).

The alignment between the state and civil society was still functioning well in the 2010s. When the KMA opted out of the committee in 2011 in protest against the expansion of the DRG scheme, the media again vilified the doctors for their extreme egotism. The KMA president was even sued by the NHIC (Picture V-9) while a group of civil organizations reported KMA to the Korea Fair Trade Commission on charges of unethical collective behavior (SBS News 2012) .

Picture V-9 Members of the NHIC Labor Union are Showing a Letter of Complaint against the KMA



Note: NHIC officials show the document detailing the legal charges against KMA over its members' collective threat against NHIC employees during arguments over the expansion of DRG

Source: Eum (2012)

A view expressed by my acquaintance with a background in activism, who was working as an executive researcher at a governmental labor institute, exemplified the kind of negative sentiment civil society had toward the doctors. At this time during my fieldwork, WMDs were claiming that they would close off their clinics in protest against the expansion of DRG. Although the WMDs' threat was extreme, the way my acquaintance phrased the doctors' communities in his post to a social network site conveyed his impressions of medical professionals.

If we see what the KMA does these days, it seems that doctors are brazenly utilizing the tools of the socially marginalized to improve their [already high] socio-economic conditions. That's why *the gang-like collective behavior* of those in power should be subjected to social criticism and surveillance... (Translation and italics by author).

It is clearly visible that this former activist researcher sympathizes with the state when he conceptualizes the doctors' collective behavior as 'gang-like', a problem to be dealt with rather than a stakeholder to be negotiated with. The civil society, at least in the area of healthcare, seems to be strongly behind the state. The empowered state has

now only to do its best to control medical practitioners. In this perspective, it is no wonder why a senior state official stated that he was quite happy that medical communities were being broken up through conflicts among themselves. In fact, the deputy health minister, in referring to the inter-generational conflicts that occurred both in WM and KM communities, recommended that officials at MOHW use the tactic of causing 'fights among themselves (*jajungjiran*)' to deal with the doctors' associations while emphasizing he himself was using these tactics to control the KMA and the AKOM (Youngmi Lee 2012).

Thus far, I described how the doctors are pressurized by the state in the changed context of the state-civil society relationship and how as a result, they felt they were being 'marginalized' in the stakeholder dynamics in healthcare. In the previous section, I explored the politico-economic backgrounds behind the state's pressures on doctors.

In the next section, I will introduce a health policy project I was part of during fieldwork to illustrate concretely this strained state-doctor relationship that is characterized by the state's pressure and the doctors' resistance. The snapshot of this relationship will be observed in the project where many elements contributing to its formation will be manifested, including the state's dependence upon doctors in service provision and policymaking, its intention to minutely intervene in the doctors' practice due to the cost-containment concern, and the doctors' resistance to the intervention.

2.2.3. A Case of 'The Korean Medicine Outpatient Classification' Project

From June, 2012 to January 2013, I participated in a policy project of updating a manual used by HIRA officials in assessing the reimbursement claims for outpatients coming from KM clinics and hospitals. The official name of the manual was the Korean Outpatient Group-Oriental Medicine (KOPG-OM). It is a system of patient classification in which the patients are grouped according to similarities both in pathological manifestations and in the level of resource utilization in treatments. The HIRA believed that it needed to update the KOPG-OM manual so that it could faithfully reflect the integrated KCD (Korea Classification of Disease) disease classification system that was made possible by the full integration of Korean Medicine terms into its 6th revision in 2010. As this manual is the basis for everything that is related with NHI reimbursements such as what are included and excluded in reimbursements and which claim is legal or illegal in individual clinical practices, the progression of this project was constantly monitored by HIRA and AKOM.

A. The Basic Structure of KOPG and KOPG-OM

The classificatory structure of KOPG-OM followed that of KOPG in that it classifies the outpatients into groups where members of a certain group share both clinical manifestations and the financial level of resource utilization. What distinguishes the patient classification from the disease classification is the fact that in patient classifications, the characteristics of interventions used in treating the patient's pathological conditions are considered more important than the detailed characteristics of the disease itself. To be specific, for example, the classification of a cancer would be

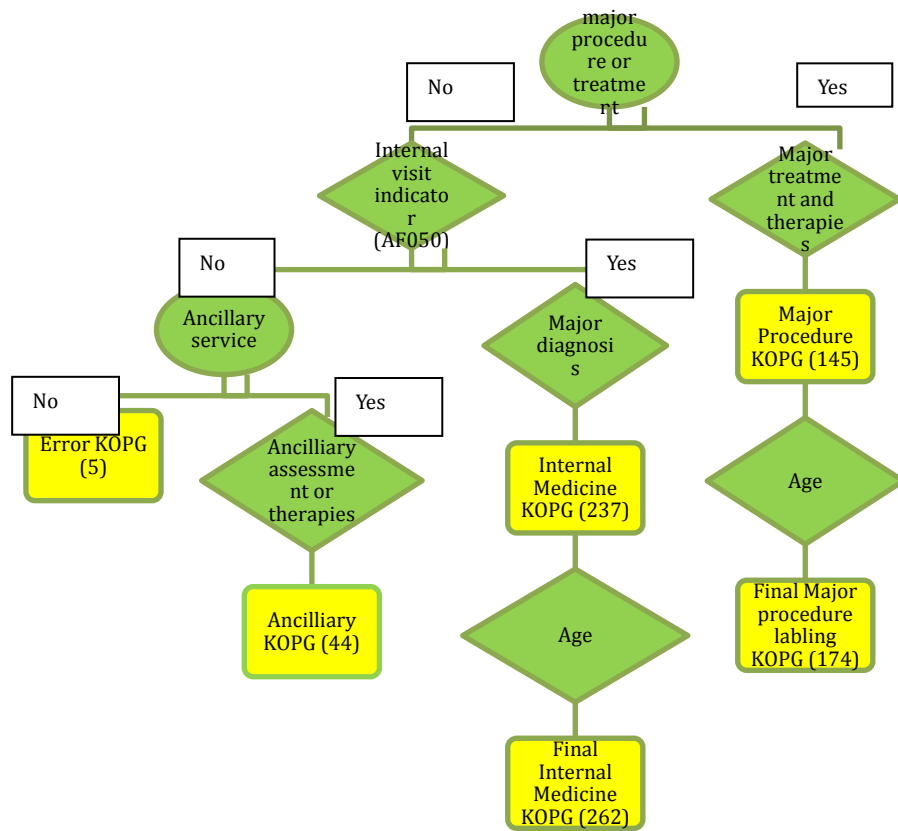
determined by its pathological features as they formed the basis of subtyping various cancers, whereas the classification of cancer patients would be based mainly on their treatments, or their needs for surgery, which belongs to a major ‘resource-intensive’ procedure, or for another type of treatment.

The KOPG follows this logic, and as you can see in the diagram below (Figure V-14), it divides the patients firstly according to whether they need Significant Operations or Procedures (SOP), before they are further classified according to age, another significant variable that determines the amount of resources used in treatments. In cases where there is no significant procedure involved, patients are grouped as ‘visits for medical conditions’ which are then classified according to KCD-6 classifications.³²¹

³²¹ The DRG is an advanced form of this kind of classification applicable to the inpatients, and its Korean Diagnosis Related Group (KDRG) has 467 groups at the moment.

Figure V-14 The Classificatory Logic of the Korean Outpatient Patient Groups

The Korean Outpatient Group (KOPG)



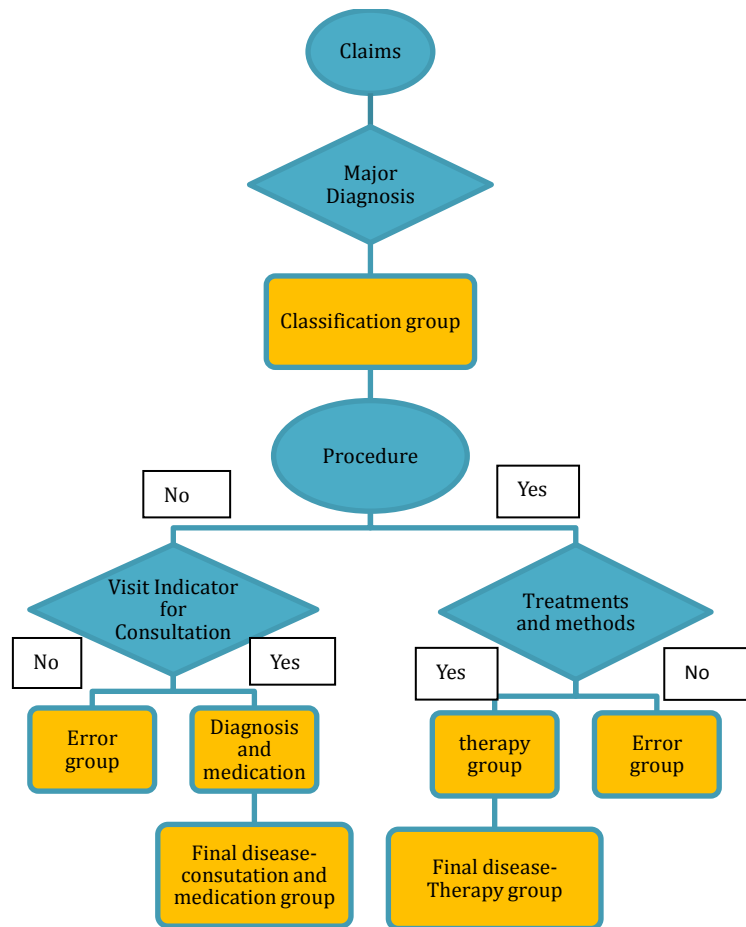
Source: HIRA

What the HIRA officials wanted us to do was to update the existing KOPG-OM book into one that integrates both the newly revised KCD-6 and the results of the analysis of prior reimbursement data after the implementation of the integrated KCD system 2011. The HIRA staff thought that by applying a new disease classification system in consultation with NHI claims data, they could create a patient classification system that would have higher statistical power and have more robustness in groupings than the previous versions.

As we conducted an initial inspection on the KOPG-OM, we found out that it essentially had the same structure as the KOPG. The only major difference was the fact that in KOPG-OM, ‘the significant’ or ‘resource intensive procedure’, the criteria that critically divided the groupings of the patient in the beginning, did not play the major role in the system. It seemed that it was because, unlike the surgery in the KOPG, there was no high cost procedure involved in current NHI-covered KM treatments. Hence, patient classification was more simplified than in KOPG, and the difference in groupings between the ‘procedure’ group and the ‘internal visit group’, namely the ‘medication group’, was not as significant in terms of the financial amount of resources utilized as in the case of KOPG. This lack of difference between the ‘procedure’ group and ‘medication group’ meant essentially that these groupings might not be meaningful in the first place which is need to create as a proper patient classification system. The HIRA officials recognized this problem so they asked us to rectify the issue by attempting to calibrate the subtle difference between these two groupings on the basis of the existing reimbursement data (see Figure V-15).

Figure V-15 The Classificatory Logic of the Korean Outpatients Group-Oriental Medicine

The Korean Outpatients Group-Oriental Medicine (KOPG-OM)



Note: The diagram has been redrawn and translated into English by author. Unlike KOPG, it will be seen that there is no major division in the beginning according to the presence of major procedure or treatments, and the claims are classified by 'major diagnosis' group from the start.

Source: HIRA

B. The Initial Stage: Encouragements to Reflect 'the Real-World' Conditions

Even from the initial project report meeting (*ch'aksubogohoe*) that occurred at the HIRA headquarters in Seoul on 20th July 2012, there were unanimous voices among HIRA officials wishing for the streamlining of the KOPG-OM in line with KOPG by, for example, integrating the 'U' code, a group of 'unclassifiable' code names that had been specifically

created for the terms of Korean Medicine whose WM equivalent could not be found, into the new classificatory system.³²² They also made it clear that they wished all the aspects of WM and KM to be integrated into one system so that managerial efficiency could be improved. Many HIRA officials also indicated that the redrafting of the KOPG-OM would benefit the doctors as with the updated manual, the overall reimbursement scheme could be restructured to reflect the reality of local clinical practice, or the 'real-world' conditions.

Indeed, a lot of grey areas did exist in the current reimbursement system wherein some claims could be judged to be illegal despite their appropriateness in clinical terms, in which case doctors had to pay heavy fines, or be subjected to more serious legal punishments. To avoid this potentially devastating situation, many doctors are believed to conduct what was commonly called 'set claims' whereby they set a threshold for the reimbursement claims, regardless of the details of the treatments they performed on the patients, so that the final amount would not go over that threshold. According to a survey conducted by B. Lim et al. (2012, 65–66), for example, about 44% of KMDs that participated in the survey replied that they carried out 'set claims'.

Another issue is that of charging co-payments from the elderly patients who are one of the main clients of KM clinics. Though the amount is very small, amounting to around one pound in a visit, local clinic owners were having a hard time charging their elderly patients this co-payment, particularly from their second visit onwards.³²³ As the

³²² Many Sasang Medicine concepts and KM-dermatology words belonged to this category.

³²³ According to Yoon (2013, 363), it is estimated that 38.5% of the elderly persons were in absolute poverty, with an income which is below the minimum cost of living. And elderly patients, in many KM clinics, take up a major portion of total patients.

failure to charge co-payments is regarded as a serious breach of the Medical Law, doctors sometimes had to provide them with non-reimbursable additional treatments to reduce their complaints.³²⁴

The HIRA officials said that they knew about this situation, and throughout initial month meetings conducted at alternating venues of PNU and HIRA, they emphasized continuously that the new manual should make both the government and the doctors happy. They even hinted that HIRA would consider the inclusion of treatment modalities outside the NHI if including them was necessary, and said that the KOPG-OM manual should be as ideal as possible. In one meeting, the Associate Director of the DRG Department at HIRA³²⁵ Ms. Kang, for example, said the following to encourage us.

Korean Medicine is something that we should be really proud of. To my knowledge, there is no other country that has a system like us. It will be really great if we can grow this. Please give your best effort to this effect.

The message was ubiquitous from the most senior executives at the organization to director-level officials at HIRA so we decided to embark on making a manual which would best reflect the ‘real-world’ practice.

C. Emergence of Cost-Containment Concerns

As mentioned, the existing KOPG-OM lacked a clear classificatory logic. As we explored, it seemed to have simply matched the disease entities with a range of NHI-

³²⁴ About 37% of the KMDs surveyed said that they are not charging 100% co-payment for the patients for the treatments they provide, and the 29% of them cited the patients’ complaints as the main reason (B. Lim et al. 2012, 65)

³²⁵ All the HIRA officials are from DRG department.

reimbursable treatment modalities such as acupuncture, moxibustion, cupping, and extract granules in a rather mechanical fashion, although some degrees of difference did seem to exist in levels of resource utilization in these four treatment categories.

To make the existing classification more robust, the policy research team had first to browse how the practice was being done. In other words, we needed to know the ‘real-world’ conditions to draft a manual based upon them. So, we revised our original plan and rather than constructing the clinical expert panel with only specialists based in university hospitals, we decided to include local KMDs on the panel and were ready to send invitations to the clinicians. However, as we prepared what would be discussed in the expert meeting, it seemed that the issue of whether we would include non-NHI covered treatments in the manual became increasingly salient.

Prof. Lim, the PI of the project, had to raise the issue. In one of the meetings, Prof. Lim cautiously enquired by asking, “Do we include in the classification scheme non-NHI modalities in the project, which might cause some financial burden to the NHI?” And that was the first time when HIRA officials started to express their concern with regards to the project, namely the significance of the project with regards to HIRA’s cost-containment agenda.

Ms. Kang, vice director of the DRG department, who had been emphasizing the creation of the ‘ideal’ manual thus far, hesitated to answer the question. And Dr. Kim, the reimbursement assessment executive with a KMD background, came to the rescue. He looked at Ms. Kang and said,

Why do you beat around the bush? One of the main objectives [of this project] is to exert the cost control.

In the clinical expert meeting that occurred a few weeks later, Dr. Kim confirmed again that the HIRA would not consider non-NHI modalities in this project. This time, the HIRA's message was very clear: It wanted the researchers to consider only the therapies that were currently reimbursed by the NHI scheme (see Picture V-10).

Picture V-10 The Clinical Expert Panel Meeting for the KOPG-OM Project at Taejon Convention Centre



Source: Author

This confirmation came while clinical experts expressed concerns over the appropriateness of the current reimbursement system under which, they believed, the actual practice was being distorted and doctors were not able to provide the best treatments for the patients. The resentment among the clinicians toward the HIRA was much deeper than I had expected.

One professor of KM paediatrics, for example, complained about the inadequacy of the current classification system by saying,

In fact, in each and every twenty odd disease categories we are dealing with, we can perform all treatments listed in the classification manual. We do not do it simply because the reimbursement would not go through. The non-NHI portion [in real-world practice] is very big, so I doubt if there is any [practical] benefit in making a new one based only on NHI-based treatments.

After hearing the HIRA's intention not to include the non-NHI modalities, another professor aired a strong feeling of annoyance and almost protested when he said.

We could only think of this project as a measure to get confirmation from experts in the Korean Medicine community to legitimize what the HIRA has been doing so far. I think the HIRA should reimburse non-NHI treatments as well if those therapies are being used quite widely

With a slight hint of an embarrassment, Dr. Kim of HIRA had to reply like the following as if he indicated that the administrative expediency was the main reason behind the HIRA's decision.

This manual is for use at HIRA so the staff at HIRA should be able to use it. To use this manual, we should exclude the non-NHI treatment modalities. We should be able to use it on the reimbursement claim sheets...

For the project team, however, the clarification on the issue in the expert meeting made the work more straightforward because the objective of updating the classification manual was clear now. It seemed that the HIRA fundamentally wanted the status quo in terms of the basic structure of NHI but it wanted a better system with which it could monitor the claims more efficiently. Afterwards the discussions only focused on technical details. Whenever concepts related with the cost-containment or claims surveillance were discussed during the meeting, it was done so with great caution and reluctance on the part of the HIRA officials. For the project team at the PNU KM policy unit, however, 'a carrot' was dangled as they mentioned a possibility of continuing to trust the policy team for subsequent, potentially bigger, projects.

Near the end of the project, Ms. Kang mentioned in a personal remark that 75 additional staff including a fulltime KMD will be employed to her current DRG team which

was a substantial human resources investment in one division.³²⁶ She also mentioned the HIRA's intention to commission an inpatient classification in Korean Medicine the following year, the KM version of DRG. The state's directive to improve the operational efficiency of NHI finances through the introduction of the package-based payment system such as DRG seemed to be strong and determined.

D. Summary

In the course of the project, the tension between the state and the doctors was obvious. There was an understandable tension because the state has to contain rising healthcare costs to maintain the financial viability of the NHI, but the doctors were quite unhappy about the ways the state attempted to control their practice without paying it due respect. In the attitude shown by the HIRA officials towards the policy team, the state's reliance on private medical providers not only in service provision, but also in health policymaking, was clearly visible. As most healthcare service is being provided by the private medical practitioners, the state had to persuade and sometimes cajole the medical communities. However, in addressing the taxpayers' interest in controlling the costs of healthcare, the state had to be strict and bureaucratic, and its intention in that direction was manifested in its bid to introduce the package-based reimbursement systems across the WM and KM communities. In the meantime, the doctors were very unhappy because they thought that they were unfairly treated by the state despite their services.

³²⁶ As of 2012, the HIRA has 23 divisional offices, and the number of staff is 1720. Its headquarter office is in Seoul and has 7 branches across the country. See <http://www.hira.or.kr/dummy.do?pgmid=HIRAA040011000000> for details.

3. Conclusion

This chapter explored the political economy of healthcare provision that formed the context in which the outbreak of rebellion in the KM community occurred.

In the first part of the chapter, I outlined the status of business in the KM community as well as the economic conditions affecting the young doctors. The conclusion of this section was that despite the robust economic conditions of the KM community in general and the young doctors' favorable employment conditions, the young doctors are still unhappy because the reality does not match their heightened expectations of the profession. As the young doctors still maintained a high economic status relative to their career stages, I also demonstrated that the argument that the doctors rose out of economic desperation does not hold water in the face of the empirical data.

In the second part of the chapter, I considered the political factors that might have impinged on their economic conditions. I explored the factors in detail with a particular focus on the state-doctor relationship which I defined to be that of pressure and resistance. It was one of pressure because the state applies control to the doctors in order to maintain the country's healthcare service. It was also resistance because the doctors were thinking that their fundamentally private practices were unfairly controlled and interfered with by the state.

As background, I presented the country's national health insurance system, including its administrative structure and its methods of managing reimbursement claims. I then broke down the elements feeding the state's increasing concerns for cost control,

such as the tight NHI finances and the ageing population. The pressure was 'on' the doctors in the context of the National Health Insurance Committee, particularly due to the cooperative relationship forged between the state and civil society since democratization. I highlighted this alliance through the description of cases that show that the user groups share a similar outlook to the state on medical providers.

To illustrate the relationship between the state and doctor concretely, I then introduced a policymaking ethnographic case in the final part of the chapter. This case showed, through a detailed description of the ways in which the patient classification system was commissioned and conducted, how the strained state-doctor relationship is manifested on the ground in the process of health policymaking.

Chapter VI Conclusion: Conflict and Rebellion as Ritual

In this thesis, I explored the country's healthcare politics in relation to Korean Medicine. For analytical purposes, I introduced a series of events in which junior members of the Korean Medicine community 'rebelled' against their senior members, contesting the seniors' pro-governmental attitudes. I elaborated on various elements of healthcare politics while exploring inter-professional relationships and the political economic factors underpinning health service provision. By extensively engaging with the events in the Korean Medicine community and investigating the various structural conditions behind them, I explored deeply the country's healthcare politics in the context of the dual medical license system, a unique Korean institution of medical licensing. The investigation revealed that the seemingly local inter-generational conflict among doctors was affected not only by economic and inter-professional concerns, but also by changes in stakeholder relationships brought about in Korean society post-democratization and post-welfare state.

This chapter is comprised of three sections. Firstly, I will summarize the central arguments presented in each chapter briefly. I will then offer, as a conclusion, some anthropologically-informed reflections on the young doctors' rebellion. I will argue mainly that the conflict was a classic case of 'rituals of rebellion', drawing on a theory introduced by Max Gluckman who proposed that rebellions operate to fortify existing social orders rather than to destroy them. Finally, I will discuss the contributions of this research.

1. Summary of the Chapters

In Chapter II 'The Korean Medicine: an Overview', I presented a broad overview of Korean Medicine. I illustrated the mainstream status of Korean Medicine under the country's unique dual medical license system. To show the ways in which it is fully integrated into the country's systems of healthcare provision and governance, I emphasized the 'bio-medicalized' aspects of Korean Medicine. I also highlighted the importance of the Japanese colonial period on the development of Korean Medicine and explored how the understanding of the social, economic and political contexts shaping the country's health system affected its development. Thus, I provided a 'structuralist' model to explicate the professionalization of Korean Medicine, rather than an 'epistemological' one, the dominant research approach wherein the epistemological difference between Western and Korean Medicine is given analytical primacy.

Building on what had been discussed in Chapter II, particularly Korean Medicine's mainstream status in the country's healthcare, Chapter III 'A Rebellion in the Korean Medicine Community' dealt with situations of conflict in the Korean Medicine community. Despite the manifestation of inter-generational divides within the community, the way the conflict progressed revealed that all the major stakeholders of healthcare were involved in the conflict in some way. The young doctors were angry as their livelihood was affected by the government's interventions either indirectly through the state's promotion of domestic pharmaceutical industries, or directly through the policies of expanding coverage in national health insurance. The state and the users were also hard pressed to keep an equitable and sustainable healthcare system in the wake of the country's increasingly aging and shrinking population. The senior members of the Korean

Medicine community, at the same time, wanted to stay closer to the state, or to accelerate its integration into the remit of the mainstream healthcare system, in order to secure the profession's interests despite the young doctors' grievances.

The rebellion also showed the characteristics of a social movement, albeit on a small scale. Many protest practices that had been utilized by the senior members of the community, the young doctors' enemies, when they participated in pro-democracy movements in the 1980s, were repeated in a different cause. The protesters' full utilization of the country's hyper-connectivity also made possible the seamless transposition of an 'online' reality into the 'offline' reality, facilitating the efficient progression of the campaign. During the course of its progression, the campaign had, not surprisingly, ups-and-downs. A very high degree of anger registered among the young doctors in the process, however, was rather unexpected, partly because they were part of the country's elite class and had a high socio-economic status. And this necessitated explorations into the structural conditions that might have underpinned the young doctors' rebellion.

In Chapter IV 'The Healthcare Politics under the Dual Medical License System', I explored those structural conditions. I explored the *professional conditions*, or the internal and external conditions in the community affecting the young doctors' professional lives under the dual medical license system. Explorations of the intra-professional conditions revealed that the inter-generational division shown during the rebellion partly reflected a long-standing inner division over the profession's identity, one party being the 'fundamentalists' and the other being the 'integrationists'. The fundamentalists argued that the core identity lay in the ideas expressed in medical

classics of East Asian medicine. The integrationists emphasized that the community needed to engage with outside disciplines on the platform of 'biomedical science', rather than looking inward by focusing only on 'classics' and EAM heritage. This division surely reflects the KMDs' dual role in the country's healthcare, both as bio-medically competent mainstream physicians and as practitioners of a medicine that is legally different from Western Medicine. However, the analysis revealed that the internal divide also reflects differing perceptions of the economic significance of *chŏbyak*, which are decocted *hanyak* formulas that are prepared on the basis of classical EAM principles.

The external conditions of the profession were largely characterized by WMDs' challenges to the KM community. As manifested in the young doctors' grievances towards WMDs during the rebellion, the WM community has been persistently interfering in KM issues to delimit KMDs' professional territory as extensively as possible. Their challenges were subtle but thorough to the extent that it appears that some attempts had been made to delegitimize KMDs' medical identities in the public sphere. A recent case in which some young doctors' aspirations for an international medical career were thwarted by a negative intervention carried out by the WM community was cited as one example.

By now one is tempted to define the rebellion as matters of intra or inter-professional politics, or WM-KM antagonism. However, I argued that evidence such as the WMDs' rather unusual endorsement of the rebellion and their willingness to create solidarity against the state indicates that the situation is more complex. This leads us to consider the political conditions that affect the economy of the medical communities in general for a balanced understanding of the conflict. In other words, it prompts the need to investigate the relationship between the Korean state and the country's medical

communities in general, one of the most important elements of the political economy of the country's healthcare provision.

In Chapter V 'The Political Economy of Healthcare Provision in Contemporary South Korea', I explored this state-doctor relationship, or the political conditions underpinning the rebellion. I argued that the relationship could be conceptualized, in a nutshell, as that of 'strain' created by the state's increasing control over the doctors' practice, following the substantial expansion of the country's national health insurance over the past several decades. Political and economic changes that occurred during the period also accelerated the friction between the state and the doctors. It is because, among other things, the doctors believed that the strong ties forged between the state and civil society after the country's re-democratization in late 1980s contributed to their marginalization in negotiations on healthcare matters. I explored the contexts of these political conditions in this chapter as well as the economic conditions of KMDs.

Firstly, the investigation revealed that the KM economy was robust, despite the young doctors' complaints regarding their economic hardship. The business environment underwent some changes, however, as the public's increasing consumption of red-ginseng products led to the reduction in the number of *ch'öbyak* prescriptions dispensed in KM clinics. The employment conditions for fresh KM school graduates were not as dismal as the young doctors claimed them to be as they were still receiving much higher incomes than graduates from prestigious colleges in Seoul.

Then what was behind the young doctors' large-scale expression of anger? The analysis revealed that their grievance is partly a result of the fact that they had higher expectations for the profession than the senior members of the community. In other

words, they were feeling 'poor' in relation to the seniors and other medical professions because they felt that due to the changed business environment, they could no longer achieve the economic affluence the previous generation was able to achieve. This sense of 'relative poverty', however, was not able to fully explain the urgency and desperation shown by the young doctors who acted as if their livelihood hung in balance. This leads one to ask, what additional factors made them so desperate and angry when they were still enjoying the upper-middle class life styles and the benefits of a highly regarded career?

Part of the answer was sought in the relationship the doctors have with the state as the state tries to put an increasing portion of the doctor's practice under its control. In the challenging contexts of the country's aging and shrinking population, it cooperates with the public in order to maintain equitable and sustainable healthcare. In doing so, the state has been reining in private practitioners through control measures built into the national health insurance system. The doctors, in the meantime, are resisting this accelerated institutional pressure on their practice with increasing vigilance and animosity. I highlighted this strained relationship through an ethnographic illustration of a health policy project where the state's subtle but persistent pressure on the medical communities as well as the doctors' corresponding resentment toward the state's interference could be observed.

In the context of the state's increasing interference in their private practice, it can be assumed that a sense of economic insecurity and desperation could have been felt more urgently by the young doctors whose livelihoods have yet to be secured. These sentiments expressed during the rebellion might be a manifestation of this insecurity felt

by the country's medical communities in general under the post-welfare regime South Korean state that increasingly takes an interventionist stance in matters of healthcare.

2. The Conflict, Rituals of Rebellion and the Formation of Collective Identity

The young doctors' rebellion was a series of conflicts. In terms of the actors involved, it was an inter-generational conflict while in the sense that those who revolted were the economically and socially weaker, it was also a status-based one. Elements of professional conflict were also present, namely between KMDs and WMDs. It is also a conflict between the state and doctors because the rebellion is partly an outcome of the strained state-doctor relationship.

As for the way the rebellion progressed, it has characteristics of a political upheaval as one group of people systematically attempted to challenge the political authority of their establishment, albeit on a small scale within a confined social space. As was seen, the young doctors themselves termed their action as a 'revolution'. However, despite declaration and call for radical changes in the bureaucratic structure of the community, no substantial changes occurred in that direction, making it hard to conceptualize the conflict as 'revolution' *per se*.

One way to look at the conflict is to view the event as 'rituals of rebellion'. Max Gluckman proposed this theory in early 1950s in which he argued that rebellions operate as ways to solve innate conflicts in a community through cathartic effects, and thus to fortify its existing social structure, rather than to destroy it.³²⁷ The characteristics present in the progression of this ritualistic rebellion would then be best analyzed by the theories of Victor Turner, an anthropologist who followed Gluckman's footsteps in studies of

³²⁷ He proposed this theory first in his Frazer Lecture 'Rituals of rebellion in South-east Africa' in 1952 and developed further in his book *Custom and Conflict in Africa* published in 1955.

conflict (Schroter 2003, 45) and employed the concepts of 'liminality' and 'communitas' to explain the other-worldly and utopian aspects pertaining to ritual processes.³²⁸

These concepts are relevant for the analysis of the young doctors' rebellion whose characteristics defy simple categorization in social scientific terms. As mentioned, the rebellion does have some characteristics of a social movement as it showed 'the presence of collective identity' and was 'engaged in political and cultural conflict with other actors over a range of issues', following Della Porta and Diani's (1999, 16) definition of social movements. However, characterizing the rebellion as a social movement is not satisfactory as the rebellion was not the kind of social movement that anthropologists have studied in recent decades such as those described in Nash (2005) or Graeber (2009).³²⁹ Although the young doctors' rebellion showed clear signs of being a social movement, such as class-consciousness, mobilization and collective action, their position stood in contrast to the norm as they were socio-economically advantaged.

Moreover, the young doctors' cause did not have wide social and political appeal when compared with such themes as women's activism, rights for indigenous people, and fair-trade movements which are dealt with in Nash (2005). Rather, the young doctors are more like junior bankers fighting for bigger salaries, or junior lawyers fighting for better career prospects. The anthropological literature on social movements, therefore, does not

³²⁸ These concepts were formally presented in his book *The Ritual Process: Structure and Anti-structure in Ritual* published in 1969.

³²⁹ It seems that serious anthropological attention to social movements has not really paid until quite recently. In 'Uniting theory and practice in the ethnography of social movements: Notes toward a hopeful realism', for example, Burdick (1995) argued forcefully for the necessity for the ethnography-based study of social movements. Six years later, however, Gibb (2001, 8) still states in 'Toward an Anthropology of Social Movements' that 'anthropological study of mass politics, and particularly its institutional aspects, is still at an embryonic stage'.

seem to provide us with as useful conceptual resources for the analysis of the rebellion as do Gluckman and Turner's theories. Furthermore, since the event is a social phenomenon of protest with focalized aims and limited discourse of a political nature, it would be analytically distracting to use the terms and concepts of Foucauldian micro-politics in order to anthropologically reflect on it.³³⁰ What is certain about the rebellion, however, is that it was a campaign of 'protest' based upon a strong collective discontent, and that it was termed a 'revolution' by the protesters themselves, and that it showed distinctive stages in its progression. It is precisely these attributes of the event that make the works by Gluckman and Turner very relevant.

Another related way of looking at the event is to view the conflict as a ritual-based exercise of collective identity-making. Harvey Whitehouse (2004; Atkinson and Whitehouse 2011; 2012; Whitehouse and Lanman 2014)'s theory of '*ritual as social glue*' provides insights as to how this intense 'dysphoric' event increased social bonds among the members of the community, solidifying their in-group solidarity while increasing out-group hostility. In a situation where the KM community is significantly outnumbered by the WM community, or where the country's medical communities are out-powered by other healthcare stakeholders of the country, it is possible to conjecture that regular rituals of this 'imagistic kind', those with low-frequency and highly dysphoric elements, would operate for the group members' benefit by increasing the member's social bonds through shared experiences of emotional intensity, therefore strengthening their collective identity.

³³⁰ In highlighting Foucault's influence on anthropology since 1980s, for example, Curtis and Spencer (2012, 170–174) argue that his influence practically killed off political anthropology as an anthropological sub-discipline by making 'everything potentially political' and the issue of politics 'ubiquitous and inescapable'.

And one of the central elements linking the rituals performed and the creation of solidarity among the participants, according to Whitehouse and his colleagues, is a process called identity fusion. It is the psychological process wherein group members come to fuse their personal identity with social identity to the effect that their ties to the group could be maximized. I highlighted in Chapter IV that the presence of this kind of identity fusion was witnessed in the case of young Dr. S who participated in the rebellion. In the detailed ethnographic vignette, for example, I illustrated how almost complete fusion of her personal and collective goal occurred in the young doctor's intellectual project.

For these reasons, the anthropological conceptualization of the young doctors' rebellion as a ritual of collective identity-making becomes another compelling anthropological perspective with which to interpret the young doctors' rebellion.

In the sections that follow, I will expand this analysis a bit further on the basis of what occurred during the rebellion.

2.1. The Conflict

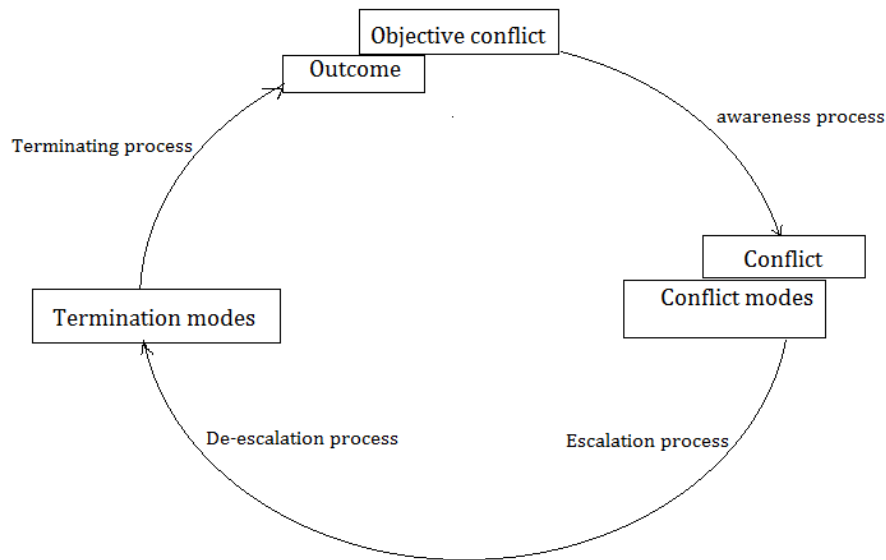
2.1.1. *Inter-generational and status-based conflict*

The young doctors' rebellion was, first and foremost, a conflict between junior and senior members of the KM community. On the surface, it was a revolt of the young doctors against 'gerontocracy', a system where the 'rule over the group is in the hands of the elders' (Weber 1978, 231).³³¹ If looked at closely, however, the conflict was more about 'status' than about 'age' as in the event, those who were disadvantaged in the age-prescribed social system, or with lower social status, essentially rebelled against those situated higher in the social hierarchy. So defining the rebellion as a status-based conflict would be a fair conceptualization.

Susan Pharr (1984, 219) has some insights to offer in this respect. On the basis of Kriesberg (1973, 19)'s five conflict stages model (see Figure VI-1), she argued that status-based conflicts tend to have the 'awareness process' as an integral part and have a lengthy 'termination stage'.

³³¹ There is a considerable anthropological literature on age grades and age-sets; see, for example, Eisele (1979).

Figure VI-1 Five Stages of Conflict



Source: Kriesberg (1973, 19)

Let us first try to categorize the young doctors' rebellion according to this conflict stage model. The first stage in which 'an objective condition for conflict' is supposed to present would correspond to the period when the controversy over botanical drugs began in the community. It would be about a month before the ordinary members' meeting. The second, or the conflict manifestation, stage would then be around the ordinary members' meeting as that was the period when clear signs of conflict between Ch'amsillyŏn and AKOM executives were discerned. The third or 'conflict behavior initiation' stage then follow when the young doctors started to mount, mainly through online means, multiple attacks on the establishment. This was also the time when the young doctors decided on the modes of relation, among persuasion, coercion or reward, that they planned to forge with the senior members of the community. As expressed, the young doctors decided to adopt the mode of *coercion* at this stage. With the occupation of the AKOM headquarters and the Gyobo Discussion meeting, the conflict entered the stage of conflict escalation with the presence of violent encounters, and subsequently of de-escalation after some

defections occurred in the young doctors' camp. The conflict finally reached its fifth stage of termination after the second councilors' meeting (see Table VI-1).

Table VI-1 Five Stages of Conflict and the Young Doctors' Rebellion

	Characteristics	Rebellion
Stage 1	Existence of an conflict situation	Controversy over botanical drugs
Stage 2	Conflict become manifest	Ordinary members' meeting and first councilors' meeting
Stage 3	Parties initiate conflict behavior	Campaign of online accusations
Stage 4	Escalation and De-escalation	AKOM occupation and Gyobo meeting, and signs of organizational fatigue
Stage 5	Termination of conflict	Second Councilors' meeting

The ethnographic data partially support Pharr's thesis in that the awareness stage was integral in the rebellion. I showed in Chapter III, for example, how the young doctors were intensely involved in 'consciousness raising activities' to mobilize. In viciously attacking the age-based hierarchy, the young doctors were obviously attempting to empower the participants of the campaign so that they could overcome their 'status concern'. However, in that the termination stage was not lengthy in the rebellion, Pharr's thesis is not supported by the ethnographic data. Although the feeling of inter-generational schism lingered on in the community, as far as I could observe it in the field, the termination of the campaign was abrupt and sudden.

2.1.2. The Conflict between Western Medicine and East Asian Medicine

As KMDs have a heritage of East Asian medicine, the conflict can also be conceptualized as a conflict between Western medicine and Eastern Asian medicine. It seems now, however, that the WM and EAM conflict has become a thing of the past. Except for the cases of Korean Medicine whose conflict with WM was well illustrated in Chapter II, the most recent collective movements for EAM against WM seems to be in China in 1929 when a national demonstration occurred under the Nationalist government³³² when it officially announced its plan to adopt WM as the country's official medicine (Taylor 2005, 7). Thirty years earlier in the 1890s, a similar collective action took place in Japan when the Meiji government chose WM as the state medicine, stimulating the establishment of a Kampo practitioners' organization called Onchisha (溫知社) which attempted to reinstate the medical license for Kampo practitioners through various collective actions (K. Yun and Kim 2013, 78). The lack of noticeable conflicts between WM and EAM since then, apart from these cases in Korea, seems to indicate big political power differences existing between practitioners of these medicines, particularly in Japan and Taiwan. Or, it might reflect the cooperative relationship that developed between these two practitioners under the state's guidance as in the case of China (K. Yun and Kim 2013, 51–53) where institutional environments within which healthcare provision is situated are more or less socialistic.

³³² The demonstration was later called 'the national medicine (國醫)' movement.

2.1.3. The Strained State-Doctor Relationship

The young doctors' rebellion is also a conflict between the state and doctors. It occurred as the state attempted to rein in on the doctors, and the doctors had grudges about the state's interference. Who generally wins when both parties' interests clash then? According to sociological research, it seems that regardless of the types of political structures within which the relationship is situated, the doctors seem to be in an advantaged position. After exploring the state-doctor relationships in US, UK and Soviet, eminent medical sociologist Eliot Friedson (1988, 46) concluded that doctors in all three of these countries had an 'upper hand' over matters of healthcare, essentially because their 'conceded expertise in diagnosis and treatment' worked effectively for the profession. This means that the doctor groups have the power which even the strongest state cannot fully control. In that regards, it is not surprising, as observed in this ethnography, why the Korean state, while it relies on the doctors for provision of health services and for implementation of health policies, at the same time worked so hard to control them.

As Japan's healthcare is similar to Korea in that it is based upon the structure of the private practitioner-led provision controlled through a system of national health insurance,³³³ it would be useful to compare the rebellion and other Korean doctors' protests with a similar protest that occurred in Japan in the early 1960s. This protest refers to the anti-state collective action that the Japanese Medical Associations (JMA) was

³³³ See Figure III-1 for example for the OECD statistics on the proportion of private sector in health service provision.

engaged in for over a year regarding the implementation of SPD and subsequent settlements in NHI.³³⁴

Although the young doctors' rebellion, in fact, shows more similarity to the Japanese students' radical movements, in terms of protest tactics employed and violence involved, and of its ideological orientation,³³⁵ the rebellion also shares with the JMA's protest some similarities as a state-doctor conflict. First of all, I could mention that both conflicts were sparked by SPD and the issues of NHI. In 2000, the WM community in Korea strongly resisted the introduction of SPD, and the young doctors' objection to the inclusion of *ch'ōbyak* in NHI and their rebellion can also be understood as an objection to the introduction of SPD in the KM community. As mentioned, the implementation of SPD across all medical communities was the basis of the resolution of a KM-pharmacy conflict in 1996.³³⁶ Now that the government implemented the policy in the WM community, it is a matter of time for the state to push the agenda in the KM community, and the young doctors might have surmised that the NHI inclusion of *ch'ōbayk* is the harbinger of a whole-scale SPD in the KM community.

Secondly, in both conflicts, an extreme aversion towards the state's interference into, or perceived unjust dealings with, their clinical practice was present. In the rebellion, the young doctors strongly objected to the expansion of NHI, and WMDs alerted to them its potential negative economic consequences for the medical communities. In the JMA

³³⁴ William Steslicke explored the protest in detail in *Doctors in Politics: the Political Life of the Japan Medical Association* (1973).

³³⁵ Steinhoff (1984), for example, provides a good overview of radical student movements in post-war Japan.

³³⁶ See section 3.3, Chapter II for details.

protest, the doctors' aversion towards the state's interference was also present. Among the four demands the JMA made with the threat of clinic closure (Steslicke 1973, 69,174),³³⁷ the number one demand was exclusively about keeping the autonomy of their clinical practice (see Table VI-2).

Table VI-2 Japanese Doctors' Four Demands During the Protest in 1960

JMA's Demands	
1	Elimination of certain restrictions on health insurance medical treatment.
2	Thirty percent increase in health insurance medical fees.
3	The integration of the two separate health insurance medical fee schedules then in use and an end to all regional differences in medical fees.
4	Simplification of the complicated and time-consuming health insurance paperwork.

Thirdly, just as the Korean medical communities perceived that they were fighting against the state-civil society complex, it seems that the JMA and JDA alliance also thought that they were pitting against all other stakeholders as the government cooperated with pharmacists, insurance societies and labor-employer organizations (Steslicke 1973, 49). It is also interesting to note that in both protests, the doctors saw a common enemy in pharmacists, signifying the fact that at least at primary care level, pharmacists are the doctors' contenders in the privatized healthcare market even in developed economies like Japan and Korea.³³⁸ The collusion of labor and employer

³³⁷ They called it 'medical holidays'.

³³⁸ In developing or under-developed economies, it is common that pharmacies dominate primary care provision due to their accessibility (van der Geest 1982; Logan 1983; Hardon 1987; Ferguson 1988). In a recent study, Trankell and Oveson (2007, 41–44) also depict how pharmacists, on the basis of the economic power of pharmaceutical companies, dominate primary care in Cambodia.

organizations is also notable in both conflicts. William Steslicke (1973, 244) who explored the protest even stated that 'perhaps this is the only policy area in which the two associations have not been engaged in bitter, continuous conflict'. Although the employer-labor relationship has been contingent upon the contexts of political and economic developments in Korea, I also highlighted that those elements of collusion were present in stakeholder dynamics in the NHI committee.

2.2. Rituals of Rebellion and Rebellions as Ritual

In addition to the 'conflict' nature of the event, the event can best be conceptualized as 'the rebellion' as I have called it thus far, despite the fact that the young doctors themselves termed it a 'revolution'. This *rebellion/revolution* distinction is the first and foremost element that makes Max Gluckman's theory of 'rebellion as ritual' most relevant in the analysis of the event. As mentioned, one of the puzzling experiences that I had in the field was that the actors behaved as if they were following some rules of which I was ignorant.

The source of this puzzlement is to be found in multiple sources. Firstly, it could be the case that my lack of knowledge in utilizing online-based communication, exacerbated by my absence from the country for a few years, could have made me slow to adapt to the fast-changing digital culture into which the young doctors fully immersed themselves. Or it could have arisen because I was the only one in the community who attempted to make sense of the event by following the actions of all the parties concerned as closely as possible. It could also have been partially due to my lack of knowledge on how

bureaucratic organizations such as AKOM operate as I did not have first-hand experience of working in those organizations.

Whatever the reasons behind the puzzlement might be, it was certain that there were many aspects that defied my expectations in the way the actors behaved at key junctures of the event. It seemed that the actors interacted with each other in a way that contradicted my reading of the situations. Practically, all the parties involved in the rebellion at times showed 'ritual-like' patterns in their interactions with others.

Firstly, the AKOM directors' continued weak reactions to the acts of humiliation at the Gyobo Discussion were hard for me to understand. It seemed that the AKOM directors were collectively resigned not to react. The young doctors' action also defied my expectations as in the Gyobo battle where they showed extremely confrontational attitudes toward the directors, at the same time, they engaged quite contentedly in mundane everyday activities there such as greeting each other and exchanging jokes, etc.

The protesters participating in the KM community-wide National Assembly Hall gathering as well as the police also displayed some patterns of interactions that I found surprising. As the leaders of the protest tried to cross the police line, defying the repeated request from the police for them not to do so, the police had fortified their anti-riot arrangements. The confrontation was intense. The police threatened the protesters with the possibility of incarceration and the potential deployment of the special anti-riot unit while the protesters showed utmost determination to advance beyond the police line. For fear of violence, some protesters in the front line started to opt out. At this juncture, the president of the Special Committee on Botanical Drugs staged some 'emergency' intervention and persuaded the protesters to dissolve by expressing his strong will to

continue the collective actions in the future. Indeed, the protest ended this way. As I followed the Committee leaders to their lunch meetings for interviews, I then saw a group of senior policemen who had been in charge of the anti-protest operation coming into the same restaurant. When I asked the protest leader, he replied that he had invited them for lunch in order to show his appreciation for their services. Then what about the intense confrontation that occurred just before?

As for the rebellion itself, I could not make sense of the abrupt discontinuation of the young doctors' campaign in the field. Initially, as mentioned in Chapter I, I had been quite skeptical of the young doctors' campaign due to my background. However, as it progressed, I began to empathize with the young doctors in their aspirations to change the fundamental structure of the community, or 'reset the AKOM (*hyŏphwŏe reset*)' in their words. I was even secretly hoping for the real 'revolution' to occur as I shared their wishes for radical reform. So when the entire campaign ended completely just after the second councilors' meeting in which nothing of merit befitting their fundamental objective was achieved, I was not only disappointed but also puzzled.

It is true that tactically, the young doctors gained a lot through their campaign. For example, they were managing the Special Committee for the issue of botanical drugs. And in the second councilors' meeting, they not only passed the motion for the direct presidential election, but also managed to sack most AKOM executives and put a temporary hold on the NHI *ch'ŏbyak* issue. So it is understandable that the young doctors congratulated themselves on their achievements after the councilors' meeting.

However, on close inspection, it becomes clear that the only significant measure achieved, with regards to the young doctors' overall aim of bringing in radical changes in

the community, was the direct presidential election mandate. Other measures were either *tangential* or meaningful only as 'political gestures'. As for the botanical drug issues, firstly, many members of the KM community had been already positive about the need to address the issues to the extent that many including myself donated money to fund the Special Committee, assuming that it would be a long community-wide struggle.³³⁹ The decision to put a temporary hold on the NHI scheme would look significant, but this scheme had been neither agreed to be implemented nor to be properly discussed in the first place.³⁴⁰ Therefore, putting a temporarily hold on the scheme did not carry any meaning in realistic terms, other than as an act of political gesture. Furthermore, with regards to establishing the right structure in the community for the support of 'authentic Korean Medicine', the ideological backbone of their campaign, nothing at all has been achieved.

Then what about sacking many AKOM executives in the second councilors' meeting? In order to understand the implications of the action, it is important to understand the transformed nature of the young doctors' campaign. It is certainly true that the campaign started with the young doctors' dissatisfaction with policies. However, as it progressed with a 'revolutionary' atmosphere, its focus completely changed into something that aimed for the overhaul of the social and bureaucratic structure of the community, or 'resetting the AKOM'. This is where the young doctors' ideological attack on the establishment for having no loyalty to 'authentic Korean Medicine' carried significance in the campaign. To emphasize this orientation for radical changes, the young doctors

³³⁹ Even the AKOM directors quickly changed its position in the early stages. In the National Assembly Hall protest, most KM members participated.

³⁴⁰ The Gyobo Discussion took place just for this, although no 'discussions' were staged.

frequently employed the phrase '*storing the new wine in the new bag (saesulŭn saebudaeae)*' to define their actions.

And that was another reason why they kept trying to force the 'voluntary' resignation from the AKOM president in public spaces, despite the fact that the terms of president and directors were about to end anyway. Without bringing down the AKOM president who symbolized everything the establishment stood for, the reasoning went, the 'revolutionary' changes in the community would be impossible. In the second councilors' meeting, the young doctors pressurized the establishment again to bring the AKOM president down. However, they failed. What was significant about the meeting was not that they sacked many AKOM executives whose terms had already been limited, but that they failed to sack the president, for fifth time in a row.³⁴¹

If radical changes in the social and bureaucratic structure of the community³⁴² were not present by the end of the second councilor's meeting, what about signs of them? In their words, was the AKOM ready to be 'reset' with imminent changes? This was also unlikely as the conservative structure of the community remained unchanged and it did not show signs of immediate transformation. The only change, namely the installation of direct presidential election, was definitely not of the 'revolutionary' kind the young doctors had been rooting for so adamantly during the campaign. The rebellion did not achieve complete educational reform, set the foundation for the renewal of the

³⁴¹ The first was at the time of first councilors' meeting, and the second was at the AKOM headquarter occupation. The third attempt was made at the young doctors' gathering when they ended their occupation. The fourth was at the Gyobo meeting so the second councilors' meeting was their fifth official challenge to end his leadership openly.

³⁴² For example, they continued to discuss the possibility of establishing an alternative KM association during the campaign.

community's relationship with the state, nor 'reset' the social and bureaucratic structure of the community.

Due to all these reasons, I was puzzled when the young doctors suddenly finished their campaign, satisfied with small, 'corrective' changes in the system whose implications were unfitting to their professed objectives of the campaign for the past three months. I was more puzzled, however, by the reactions from the KM community as it returned to normality so quickly, without showing any significant trace of internal conflicts on either side of the generational divide.

2.1.1. The Ritualistic Character of the Rebellion

Gilbert Lewis (1988, 21,26) stated that one of the central features of ritual is its formality and the participants' clear knowledge of what to do, or the presence of a relative consensus. With regard to the doctors' rebellion, it would be hard to argue convincingly that all the actors knew their scripts in advance. However, on the basis of the incidents just discussed, I think it would be possible to argue that some consensus existed among the actors, although its detail might have been different according to the contexts in which the interaction took place. If we take the situations of conflict in the Gyobo Discussion and the National Assembly Hall protest, for example, the consensus reached might be the following: one would be pushing the boundaries of their pre-agreed and rule-binding actions only up to a point so that their actions could have some 'effects' on their adversaries. In other words, the actors seemed to have a consensus that they would permit the actions of the other parties up to a point where the actions have some

‘alerting qualities’, another key attribute of a ritual (Lewis 1988, 25). In the Gyobo Discussion, the young doctors collectively chanted ‘no violence, no violence (p’okryōnandōe)’ whenever they thought the situation might spiral out of their control. Following this logic, this chanting can then be interpreted as the young doctors’ attempt to confine the potentially volatile situation within the pre-agreed-upon boundaries of their consensus, or a ‘ritual field’ (Turner 1969, 27–43).

2.1.2. Max Gluckman’s Theory of Rituals of Rebellion

Max Gluckman proposed the theory of ‘Rebellions as Ritual’ in 1951 in his Frazer lecture *Rituals of Rebellion in South-East Africa*, and presented a more detailed version of the theory in *Custom and Conflict in Africa* published in 1956. This theoretical framework proves to be a useful analytical tool for the young doctors’ rebellion where, as explored, many attributes of ritual were present. What Gluckman argues, through this theory on rebellion and conflict, is that: rebellions actually ‘fortify the established social orders’, rather than destroy them, through the effect of ‘catharsis’ by which innate psychological and social tensions of a community are resolved openly through events of conflict (Gluckman 1954, 20; Gluckman 1955, 3, 28–29).

Gluckman uses two ethnographic examples found in the South African region to support his thesis. The first is a group of rituals conducted among Zulu and other tribes that are aimed at propitiating *Nomkubluwana*, or the Princess of Heaven, who is in charge of agricultural productivity. And the second is the ritual of *Incwala* among the Swazi, the

first-fruit ritual that is conducted for about three weeks before the winter solstice.³⁴³ In elaborating the nature of these agricultural rituals, Gluckman points out that in both of these, the social tensions inherent in the communities are exaggerated, and then ultimately resolved openly in simulated acts of rebellion.³⁴⁴

In *Nomkubluwana* rituals, for example, the Zulu girls rebel against the existing patriarchal social systems by wearing men's clothes, going naked, singing lewd songs and attacking men (Gluckman 1954, 4,5). This ritual of status reversal is acknowledged by the community to give blessings to the community. And in *Incwala*,³⁴⁵ songs called *simemo* that express hatred and rejection of the king are sung while the king is being pitied by and is segregated from the people after being subjected to humbling situations. The objective of this *Incwala* ceremony where status reversal is also observed, Gluckman (1954, 19) argues, is not just a 'simple mass assertion of unity' as participants believe it to be but a 'stressing of conflict, a statement of rebellion and rivalry against the king'. He argues that through these rituals of rebellion, the participants were actually 'acting out the conflict' in order to emphasize 'the social cohesion' within which the conflicts exist, and that through the mechanism of 'purging of emotion thorough pity, fear and inspiration', the community is able to achieve social cohesion (Gluckman 1954, 20–21). Therefore, Gluckman (1955, 28–29) concludes that these are the cases of 'rebellions', not those of 'revolution', because while 'a revolution aims to alter the nature of political offices and of

³⁴³ The exact timing is between the last full moon of the year and the day of winter solstice.

³⁴⁴ It seems Gluckman's interpretation of the *Incwala* ceremony seemed to have inspired later anthropological work such as that of Marc Abeles (Abeles 1988) to explore the nature of political rituals in the context of modern societies such as the inauguration of President Mitterrand in France.

³⁴⁵ Gluckman bases his argument on the description of the ritual by Hilda Kuper who conducted fieldwork among the Swazi in the 1930s. Her account of the Swazi life was published as *An African aristocracy: rank among the Swazi* in 1961 and the book contains a lengthy description of *Incwala* in pages 197–225.

the social structure in which they function', rebellions do not aim to destroy the established social order, but actually operate so that 'they even support this order'.³⁴⁶

Although his theory was judged to be 'borne out by evidence from other parts of the world' and 'his conflict theory is now well absorbed' (Worsley 1961, 34,36), however, Gluckman's rebellion theory also has received some criticisms. T.O. Beidelman (1966, 401), for example, criticized Gluckman for not giving enough attention to the overall nature of the *Incwala* ceremony which, he believes, focuses more on maintaining the supernatural power of the king rather than on highlighting internal tensions. Decades later, Bruce Lincoln (1987, 149–150) also criticized Gluckman for not taking proper account of the historical context of British colonialism when he argued that *Incwala* rituals should be understood rather as rituals of resistance against British domination rather than as rebellion against internal authorities.³⁴⁷

Furthermore, Schroter (2003, 45,47) pointed out that Gluckman's idea of societies was 'quite static' and 'functionalistic' and other strong critics of functionalism such as Penner (1971) and Banaji (1970) also attacked the functionalist approach, an intellectual stream to which Gluckman's theory essentially belongs, as a non-method lacking theoretical sophistication.³⁴⁸ Nevertheless, I argue that Gluckman's work is vital as it brings out a very important aspect relating to their social conflicts in terms of their *ritualized and socially conservative attributes*. It is no wonder why some scholars such as

³⁴⁶ Evens and Handelman (2006, 4) also credit Max Gluckman with the anthropological distinction between rebellion and revolution. Gluckman's (1954, 21) statement that in African political life, 'men are rebels not revolutionaries', sums up his argument on rebellion well.

³⁴⁷ However, Lincoln (1987, 150) also credits Gluckman with elucidating 'how conflict at one level of social organization could foster cohesion and stability at a higher level'.

³⁴⁸ He defined functionalism in the context of religious studies as 'a theory which explain religion in terms of what it does' (Penner 1971, 93).

Davis (1959, 767–768) believe that those in functionalist traditions produced good works on social change, contradicting the criticisms directed against them. I think they were well-positioned to do so as they were attempting to make sense of, on the basis of the detailed ethnographic data, the ways in which actors behave and the wider network of social relations in which those actions occur.

Some of the puzzles I elucidated earlier can also be addressed well by Gluckman's approaches to conflicts. It is clear first of all that the young doctors' action does not qualify as a revolution as they did not attempt to nullify the AKOM leadership itself, but attempted to fortify it by revealing its weakness part of which was its incapacity to accommodate the junior members' needs. It is similar to the ways in which the kingship is not challenged in African rebellions as the kingship is divine although the king himself can be hated and rejected (Gluckman 1954, 22). Meek reactions from AKOM directors in the face of the young doctors' abuse could then be the outcome of a consensus reached among the parties that they all want 'strong AKOM leadership'. Although the young doctors criticized the AKOM president, the fact the young doctors did not put any 'young' candidates up for the election, despite their grievances about the undemocratic nature of the gerontocratic political norm, can be partly explained by this consensus. The young doctors might have conjectured that a young president would threaten the authority of the AKOM leadership.

The ritualistic interaction between the protesters and the police might also have been predicated upon their consensus to guard *the authority of police and freedom of expression in a democratized state*, or the existing order in their society. Although on the surface they acted as if they were defying those norms, some reflections on the ritualistic

nature of the actions reveal that they were actually working to fortify those social orders. By the same token, the chanting of 'no violence' among the young doctors can also be interpreted as their attempt to remind them that they are involved in *acts of 'rebellion' and not those of 'revolution'*.

2.1.3. *Liminality and Communitas*

When acts of 'rebellion' are defined as rituals that have definitive starting- and end-points and as a series of events that have an effect on the whole community in which they occur, the three-month long period of the rebellion could also be defined as the period of *liminality*, the period of threshold or in-betweenness. This is a concept that Arnold Van Gennep (1960) first proposed and Victor Turner (1969) expanded on. In *The Rites of Passage* Van Gennep defined life-stage transition rites such as birth, puberty, marriage and death as the *liminal* rites or the rites performed at the threshold. Calling these 'the rites of passage', he specified that the progression of these rites are marked by distinctive stages which are divided into a stage of 'separation' where the participants are separated from their previous social world, or the *pre-liminal* world, and the stage of 'liminality', or the neutral and threshold stage situated neutrally between the two social worlds, and finally the stage of 'reintegration' where participants are reintegrated into the new social world, or the *post-liminal* world (Gennep 1960, 19–21).

Victor Turner expanded this notion of 'liminality' by elaborating on the attributes found in these rites of passage such as 'lowliness and sacredness, homogeneity and comradeship' and on the characteristic changes in social relations taking place during the period where 'one often finds a simplification, even elimination of social structure' so that

'the underling comes uppermost and the supreme political authority is portrayed as a slave' (Turner 1969, 96,102,167). On the basis of the presence of this utopian sociality experienced communally by the ritual participants, he then proposed a concept of '*communitas*', arguing that these rituals are generally aimed at creating this *communitas*, an 'anti-structure' that is created in the '*moment in and out of time and in and out of secular social structures*' (Turner 1969, 96).

Elements corresponding to Turner's theory of *liminality* and *communitas* abound in the young doctors' rebellion. The existing social structures, namely the age-based social hierarchy, for example, was demolished in this liminal phase, and various rituals of reversals in which the 'underlings', namely the young doctors, overpowered the 'supreme political authority' also occurred quite frequently during the event. The social structure was also simplified on the basis of age, and of loyalty to authentic Korean Medicine. Liminal attributes such as 'sexlessness', 'anonymity', and 'being without his place' (Turner 1969, 103) also appeared on many occasion, no less when female doctors poured abuses on the elders at the Gyobo Battle, a significant deviation from their normative gender roles in the 'heavily male-oriented' Korean society (Janelli and Yim 2002, 117–118,121–122; Seungsook Moon 2005, 84–85). Also illustrated in this ethnography is the degree of anonymity that most young doctors upheld throughout the event.

There were also moments when the sense of '*communitas*' was pervasive among the participants of the event. The atmosphere at Swimtö for the intense latter half of the campaign was definitely that of *communitas* as the members were not even allowed to upload any contents of an entertaining nature, and any remarks tarnishing the 'purity' of the young doctors' action were regarded almost 'sacrilegious'. In the offline world, the

period of the AKOM headquarter occupation presented one of those moments. In staging overnight sit-ins on the cold concrete floor of the building, they gave support to each other in the face of their communal sufferings, united in the hopes of preserving the authentic Korean Medicine and of fighting against the incumbent AKOM leaders' authoritarianism. When they celebrated a female member's birthday with a simple birthday cake lit with makeshift candles, the communal sense of selfless devotion and purity seemed to have reached its zenith. These feelings of togetherness were being created outside of their everyday social structure in which they are staff doctors on payroll or local clinical owners.

On the basis of pilgrimage studies, Eade and Sallnow (1991, 5,24) argued that Turner's theories of liminality and *communitas* are not supported by empirical evidence and that pilgrimages, and by implication other rituals as well, should not be studied as 'merely a field of social relations' but be studied as 'a realm of competing discourses'. They further argue that pilgrimages are more about 'suffering bodies' and 'symbolic exchanges' wherein 'physical sufferings and penance are exchanged for material and spiritual favors', rather than about the search for '*communitas*' as proposed by Turner. Similar criticisms can be directed against the interpretations of the rebellion I provided because competing discourses did exist in the course of the conflict. The young doctors, for example, claimed that they rose out of their aspirations for justice and for true Korean Medicine while the AKOM directors saw the rebellion as an incidence of community-based internal power struggles. In chapters IV and V, I also offered up yet other competing discourses undercutting the rebellion on the basis of inter-professional relations and of the political economy of healthcare provision.

In that sense, it is partly true that the young doctors' action cannot be simply reduced to liminal-stage rituals aimed at achieving *communitas*. However, it cannot be denied either that Turner's theories provide invaluable conceptual tools with which to analyze the *processual* aspects of the young doctors' campaign in which a complex set of social relations influenced the progression of the conflict. The understanding of the event should be multi-layered, meaning that interpretations of one aspect of the event do not necessarily have to negate other analytical frameworks that have been offered to explain other aspects of the event, if interpretations are well-grounded in ethnographic data. In that regard, I think Turner provides us with valuable conceptual resources to explore the processual elements embedded in the doctors' rebellion.

2.1.4. Democracy, Nationalism and Collectivism

The conceptualization of rebellion as ritual and reflections on its liminality also allows us to look at the hidden social structure that emerges in times of conflict. Again, it is the legacy left by Max Gluckman who liked to see conflict 'as counter-intuitive optic through which to discern essential character of any social order' (Evens and Handelman 2006a, 3). Victor Turner continued his legacy and argued that in situations of conflict, 'latent conflicts of interest become manifest, and kinship ties, whose significance is not obvious in genealogies, emerge into key importance'. In emphasizing the role of conflict as a window to the social reality, he further asserts that 'the social drama is a limited area of transparency on the otherwise opaque surface of regular, uneventful social life' (Turner 1996, 93).

In the doctors' rebellion, as argued above, the actors were behaving within pre-set moral and social boundaries. A question can be raised as to what were the rules and norms that served as the basis of which actors set their boundaries. Put differently, the questions is: what was the 'the essential character of the social order' that had been commonly agreed upon by the actors and that came to emerge in times of conflict?; and what were 'the latent conflicts of interest' that came to emerge?

Like kinship ties that emerged as an important factor in conflicts, the norm that had been hidden in the background but came to emerge centrally during the rebellion was the 'principles of democracy'. American philosopher Richard Dworkin (Dworkin 2006, 127–159) offers a useful view on 'democracy' that is relevant to our analysis. He divides the conceptions of 'democracy' into two different views. The first is what he calls the 'majoritarian view' in which the essential test of the principle of democracy is whether it allows the opinion of the majority to rule in favor of others while the other view, or the 'partnership view', emphasizes that the essential value of democracy is whether it makes the partnership between those involved possible on the basis of mutual respect and attention.

When the young doctors mobilized against the authoritarianism of the AKOM leadership, they clearly indicated that they were dissatisfied with the one-sided management of their community. In that sense, they may have felt that the principles of democracy were being violated in both senses of the norm as highlighted by Dworkin. On the other hand, the successful deployment of a line of female police officers in protest control testifies to the fact that Korean social actors are prizing the 'partnership view of democracy' as it could be assumed that their idea of democracy involves showing respect

to others, not just the rule of the majority. This ‘partnership view’ can also be said to undercut the young doctors’ strong disdain for the age-based hierarchy. The young doctors effectively put the following rhetorical question before the community: *what is the value of the gerontocratic norm when it does not respect our opinion and the idea of mutual assent?*

The values of nationalism and collectivism also emerged visibly during the rebellion. It was clear from the way the young doctors mobilized ‘the ordinary members’ whose identity was similar to *minjung*, or the populace, that they were invoking the sense of political triumphalism associated with the country’s political achievements in the 1980s and 1990s. The very phrasing of their campaign as a ‘revolution’ also betrays a strong nationalist sentiment.

Particularly, anti-Japanese nationalism featured prominently as it appeared in protest slogans, campaign discourse, and public statements. The young doctors claimed ownership of botanical drugs with reference to Korea’s territorial claim over Dokdo Island, an island whose ownership is in dispute with Japan. And in public statements, they accused WMDs of having become the dogs of Japanese imperialists. When they referred to the senior members of the KM community as ‘five enemies of Korean Medicine’, they were comparing them to the five Korean leaders who signed the document endorsing the country’s annexation with Japan in 1905. The terming of their abusive action at the Gyobo

discussion as ‘the Gyobo Battle’ also invoked images of General Yi Sunshin’s historical victories against Japanese invaders in 1592.³⁴⁹

It is true that nationalism, due to its ‘profound emotional legitimacy’ (Anderson 2006, 4), appeals to the general public. And it is also true that ‘ethnic nationalism’, where the ‘Korean bloodline’ is crucial in determining national identity, is a tried and tested tool for mobilization. It ‘has served the Koreans in a variety of ways from being an ideology of anti-colonialism to that of national unification’ (G.-W. Shin 2006, 1–2,3). However, the persistent and continuous use of the nationalistic appeal made by the young doctors during the campaign needs to be contextualized more locally.

Among other things, as the name ‘Korean Medicine’ signifies, the profession itself could not escape from its connection with the ‘Korean nation’. For that reason, the KM community has been emphasizing their professional identity in the name of ‘*minjokŭhak*’,³⁵⁰ or Korean people’s medicine, for long. I noted, however, that the young doctors disapproved of this conceptualization of their discipline which they thought harbored socialist orientation. But the ethnography reveals that the young doctors continued to frame their actions in nationalist terms. It testifies to the fact that the young doctors, even when they were constructing their ‘imagined community’ (Anderson 2006) of their own accord, still could not escape the structural conditions surrounding them. They failed, for example, to adopt some modern ideals fitting to their biomedical orientation and high career aspiration such as ‘scientific profession’ or ‘globalized

³⁴⁹ Nationalistic sentiment also appeared on the WMDs’ side when the Chŏnŭch’ong described the development of the country’s modern healthcare in anti-Japanese terms. Please see Section 4, Chapter IV for details.

³⁵⁰ According to Shin, *minjok* is the most widely used term for ‘nation’ in Korea, and it is the notion in which concepts such as ‘race, ethnicity, and nation were conflated’ (G.-W. Shin 2006, 4).

medicine', and instead adopted the age-old nationalist image, despite their strong aversion to what the Ch'ŏnghan group has been standing for. And this behavioral tendency again confirms the relevance of the 'rebellion as ritual' theory as its presence also signifies the fact that the young doctors' campaign, despite its strong rhetoric of change, has indeed ended up reaffirming the existing social structure.

A positive assessment of 'collectivism', or a psycho-social trait in which one's strong feeling of involvement in others' lives, or 'a sense of oneness with other people' is a central feature (Hui and Triandis 1986, 231), was also evident in the events described. The sudden dissipation of the young doctors' enthusiasm near the end can be interpreted as an outcome of the quick loss in appeals for collectivism. Indeed, by the time the campaign reached the point of the second councilors' meeting, the young doctors had started to show signs of mental and physical exhaustion, and of the related organizational disarray. This was manifested in the form of a series of internal resignations, and occasional expressions of dissension on Swimtŏ with regards both to the ideological integrity of the campaign, particularly in the wake of Dr. P's defection, and to the ways in which the campaign was being operated. During the second councilors' meeting, for example, a doctor from a provincial region who had come to Seoul early in the morning to support the young doctors' campaign uploaded a post criticizing a rather draconian treatment he received from the key Ch'amsillyŏn members. He complained that despite his whole-day commitment, he was barred from leaving the place and as a consequence, had to miss his train back home.³⁵¹ This was also the time when Swimtŏ members, who used to enjoy

³⁵¹ The young doctors were blocking the front door of the room during the second councilors' meeting in order to sustain the legally-effective number of councilors.

the constant uploading of entertaining contents, began to express their dissatisfaction with the absence of 'fun'. In other words, around the time of the second councilors' meeting an implicit consensus began to be formed among the young doctors that *they would not be able to continue the campaign with a strong sense of oneness as before*.

The MOHW's decision to endorse the constitutional revision in AKOM can also be seen as another case in which the value of 'collectivism' was positively valued. The change seen in MOHW's stance on the outcome of the second councilors' meeting (from its initial reluctance on the ground of potentially illegal characteristics present in the process of decision-making to its eventual decision to endorse it a few months later) could be interpreted as a sign that the government ministry valued the 'collective' nature of the decision made in the KM community more than its concern for procedural justice.

Sources that have contributed to the construction of this collectivist ideology could be found in various social spheres of Korean life. If you focus on contemporary Korean history, elements such as the military culture that dominated the society for decades, the patriarchal leadership style of *chaebol* companies (Y.-H. Cho and Yoon 2001, 71–78), the successful collective experiences of bringing in political liberalization in late 1980s and of achieving success in World Cup Finals in 2002 would be some exemplary sources that could have affected the formation and fortification of the ideology. The analogy with corporate culture here would be particularly relevant because just like researchers who worked on collectivism in Korean companies (Y.-H. Cho and Yoon 2001, 78), I also observed 'optimistic progressivism' among the participants of the rebellion. When the young doctors defined their campaign as a 'success' just on the basis of the passing of the motion for the direct AKOM presidential election, for example, it was obvious that the

young doctors were ‘sharing’ an ‘expectation of progress’ (Y.-H. Cho and Yoon 2001, 78) although nobody among them was entirely sure of the benefit of the election method in advancing the community’s interests.

2.2. Ritual as Social Glue, Identity Fusion and Psychological Kinship

Thus far I highlighted how the rebellion could be interpreted, utilizing theories of Max Gluckman and Victor Turner, as a case of ‘rituals of rebellion’ and I expressed how the three-month period of the conflict can be considered as ‘the liminal period’. As mentioned at the beginning of this section, however, there is another way of looking at the event. It is based upon the ‘ritualistic’ character of the event upon which the anthropological theories utilized for analysis so far are predicated. It is the possibility to view this ritual of conflict as a *collective identity-building practice* for the members of the KM community in which events with strong emotional experiences such as this are actually helping to create a strong social bond among the members so that the group could out-compete its rivals. This explanation is plausible, considering the fact that the identity discourse plays a significant role in KMDs’ communal life and that the community struggles endlessly against competing professional groups such as WMDs and pharmacists.

This ‘Ritual as Social Glue’ theory was proposed by Harvey Whitehouse (2004; 2012). And it begins with the idea that in religious rituals there are two central modes of participant engagement. One is the ‘imagistic mode’ in which strong ‘dysphoric’, or stressful, experiences are shared by ritual participants (Whitehouse 2012, 270–273) . They occur rarely, but those experiences with high emotional arousal are so strong that they remain as ‘episodic memories’ within the participants which would eventually take

up substantial part of one's auto-biographical self (Whitehouse and Lanman 2014, 677).

One example would be initiation rites, or rites of terror, that are performed among many African tribes, although similar rituals are also found in the formation of military cells, terrorist organizations and rebel groups where high-risk activities are expected to be performed (Whitehouse 2012, 271,273).

The other kind is the 'doctrinal mode'. It is a repetitive, high-frequency low-arousal communal practice that helps shape the identity of the participants by making them exposed 'weakly and thinly' to the tenets and ideology of the group through routinized actions (Whitehouse 2012, 274–277,279). While the imagistic mode affects the participants strongly by way of giving the participants the perception of having a 'shared mental content' with other group members, the doctrinal mode prepares the participants to accept the ideology without reflection by giving them 'procedural fluency' through routinization (Whitehouse 2012, 274,279). He argues that this doctrinal mode is a necessary condition for the emergence of 'imagined community' in which members do not need to know all members of a group but can still form a coalition with them (Whitehouse 2012, 274).

What then are the social psychological mechanisms that link these modes of ritual practice with the formation of the group identity? Whitehouse and his colleagues (Whitehouse 2012, 272; Whitehouse and Lanman 2014, 675) argue that the key lies in two main factors, namely the ritual's *teleological opacity* and the mechanism of *identity fusion*. Teleological opacity, or causal opacity, is a characteristic of rituals that there is no definitive causal structure linking the elements of the rituals with their end-goals. At the beginning stage of Swazi *incwala* rituals, for example, the envoy called *Bemanti* went out

to get some water from the river in a sacred vessel in order to give vitality to the king (Kuper 1961, 197–202). But the process is so complicated and invested with multiple significations that it would be hard to imagine that the participants are able to grasp the causal structure pertaining to their actions. Whitehouse (2012, 272) argues that the teleological opacity of this kind is precisely the element that allows the participants to have ‘interpretive creativity’ when they try to understand the ritual. And this individualized grasp of the ritual action then leads to the ritual’s impact on their personal selves.

On the level of individual psychology, the formation of group identity is mediated through a process called *identity fusion*, or the fusion of personal and the social identities. It occurs when ‘the self-other boundaries...[are] blurred and the group comes to be regarded as functionally equivalent with the personal self’ (Swann et al. 2009, 995). Along with other psychological mechanisms, they further argue, these fused identities help facilitate the formation of what is called ‘psychological kinship’ among the group members. It is the sense of kin-like, or even stronger, ties with other members of the group (Whitehouse et al. 2014; Whitehouse and Lanman 2014, 677–678).

This theory can be cogently applied to an analysis of the doctors’ rebellion. The fusion of identities was evidenced individually through the case of Dr. S, participant in the rebellion, and collectively, through the presence of the ‘*gwan*’ discourse in the community. And a strong sense of psychological kinship was found to be present among the young doctors under the umbrella term of ‘*Kumalyŏnch’o*’ while a similar sense was pervasive among the general members of the community under the rubric of ‘Korean Medicine’. This social bond seemed to have been particularly fortified by the exclusive membership

of their community which is guarded under the institution of medical licensure. On the community level, it is also clear that they need to cultivate their collective identity in the face of constant challenges from WMDs and pharmacists. The collective power of the KM community had been regarded as stronger, despite its small size, than other groups in Korean healthcare politics. This situation then could be accounted for by their continued collective identity-building practices that have been staged since the community started to confront their adversaries of various kinds after the implementation of medical law in 1951.

The rationale behind the application of the 'Ritual as Social Glue' theory to the events of the KM community can also be found in similarities existing between the community and the religious communities upon which Whitehouse's theories initially have built. The 'ideological disputes' between the 'fundamentalists' and 'integrationists' which featured centrally in the rebellion, for example, strike a very similar tone with the 'sectarian schisms' frequently found in religious communities. It should also be noted that the medical profession is also similar to religious communities in that through their professionalization, the members are continuously exposed to the rituals of 'doctrinal mode'. Simon Sinclair, for example, describes in his book *Making Doctors* (1997) various rituals medical students undergo during their training. One of them is the rite called 'Bed Race', a team-race occurring during the 'Rag week' in which the students move around the streets of London carrying hospital beds and asking for charitable donations from people on the street. Through this ritual, students are believed to inculcate into their

psychology the idea of professional responsibility, although in a upturned and ironic way (Sinclair 1997, 118–226).³⁵²

The members of the Korean medical communities including the KM community have gone through similar routinized actions throughout their professionalization process. Although it is possible that the ‘ideological’ aspect of KM could have made the collective identity-building more intense than in other disciplines, the attribute of being a medical profession seems to have made the practice of collective identity-building significant for the survival of communities as it is among religious practitioners, although their schisms and practices are less visible to lay outsiders.

³⁵² Another relevant example would be that of the ‘Dissecting Room’ in which the students’ professional disposition as ‘future doctors’ are learned directly and tacitly through various elements such as the white coat worn by the students, the subtle expressions used by medical qualified instructors and the analogies used by doctors to the students’ own bodies (Sinclair 1997, 170–177).

3. Anthropological Contributions of the Research

The main anthropological contributions of this research lie at the intersections of Korean and medical anthropology as this research explored contemporary Korea healthcare politics through a conflict that occurred among doctors of Korean Medicine. The three major contributions of this thesis will be presented below.

Firstly, this research contributes to the anthropological understanding of Korean Medicine as it provides a rich account of the ways in which it is situated within the Korean society. Unlike previous published research which fundamentally viewed Korean Medicine as an extension of East Asian medicine (Son 1999; Hyo-je Cho 2000; Baker 2003; C.-Y. Kim and Lim 2004; B.-H. Cho 2009; Jongyoung Kim 2009), this research focused on Korean Medicine's bio-medicalization as its central identity-marker. And in doing so, this research tackled one of the 'wicked problems'³⁵³ in research on Korean Medicine, namely the 'problem' of explicating its uniquely high socio-economic, educational and institutional status.

Many experts followed the conventional rule of categorizing it as 'traditional medicine'. However, as mentioned in Chapter II, their efforts have not proved to be satisfactory. And it seems that many scholars in the field of health policy seemed to have avoided dealing with Korean Medicine, possibly due to its category-straddling status. And

³⁵³ Rittel and Webber (1973, 160–167) originally introduced the concept of 'wicked problems' to explain the complexity involved in dealing with 'societal problems' in urban planning, in contrast to 'problems of science and engineering'. According to the authors, societal problems are difficult to tackle because there exist no 'definitive formulations' of the problems themselves, hence their characterization as 'wicked', whereas problems of engineering are easier to deal with in the sense that the problems in that area can at least be clearly formulated, hence they deserve to be called 'tame', although the solutions might be as difficult. This concept fits well with the issues related to Korean Medicine because the complex mix of professional, political and commercial interests has prevented any clear formulation of the problems themselves.

it is indeed rare to find extended descriptions on Korean Medicine in articles published in that field. K.-H. Cho et al. (2004), for example, do not mention at all the presence of KM in the country's healthcare when they give an overview of long-term care in Korea despite the fact that the elderly are the one of the major client groups in KM clinics. In a recently published article on the Korean Healthcare system, Song (2009) also mentions KMDs very briefly in passing. The country's leading health policy expert Soonman Kwon (2003; 2008; 2009) also mentions Korean Medicine very sparsely in many articles he has published on the Korean healthcare system. Jongchan Lee (2003, 48) explicitly refers to WMDs as 'Westernized medical practitioners' in his article 'Health Care Reform in South Korea: Success or Failure?',³⁵⁴ thus acknowledging the presence of dual medical license system. Lee's work seems to be one of the few articles written by Korean health policy experts that explicitly allude to the country's unique bipartite system.

It was not just experts who had trouble accommodating Korean Medicine due to the lack of operational conceptual frameworks. The governmental bureaus also had trouble, for example, in producing national statistics on the country's physician numbers. They did not know in the past, for example, where to put KMDs in the categories given by international organizations where no corresponding categories exists for KMDs,³⁵⁵ although it seems to be now a common practice that the statistics include KMDs as 'physicians' along with WMDs with an asterisk to indicate the fact.³⁵⁶

³⁵⁴ This article is about the Korean experience of implementing SPD policy.

³⁵⁵ I used to collaborate with government officials in a WHO project on traditional medicine which was published into a book by Bodeker (2005).

³⁵⁶ See 'KOSIS 100 Indicator' at Korean Statistical Information Service (<http://kosis.kr>) and E. Hong (2012) for details.

In addition to this unique institutional structure, the country's healthcare politics have complicated people's understanding on KMDs' professional identity as explored in Chapter IV. The central argument I put forward with regards to KMDs' identity is that the bio-medicalization of Korean Medicine lies at the heart of the issue. I argued, mainly in Chapter II and in other parts of the thesis, that KM's bio-medicalization has become so obvious that it is almost impossible for any stakeholders of healthcare not to recognize it, although they are reluctant to do so due to reasons of professional politics. The situation has become complicated as the public, just like social scientists, governmental officials, and health-policy experts, did not have adequate conceptual resources with which to articulate their understanding of the KMDs' identity.

Therefore, I assume that the bio-medicalization of Korean Medicine has almost become '*an elephant in the room*', an object whose presence everyone is aware of but nobody wants to explicitly acknowledge. One of the key contributions of this thesis is that I have addressed this 'elephant', utilizing the ethnographic data gathered from my interactions with the professional communities and in national-level health policymaking contexts, the fields that are not frequently investigated by anthropologists due to issues of accessibility.³⁵⁷ In the policymaking case study I presented in Chapter V where I depicted the interaction between government officials and KMDs, for example, it was obvious that the 'elephant' was loitering around in the background, although nobody present explicitly alluded to its presence.

³⁵⁷ Laura Nader (1972) espoused benefits of 'studying up'. She argued that it could complement the dominant anthropological approach of 'studying down' by providing anthropologists chances to explore various social issues more holistically, particularly in the study of modernized societies whose inter-connections across substrata are getting increasingly complex. In the field of Korean anthropology, Jesook Song (2009) also based her research on her experience of policymaking at Seoul City Government, although hers was not based on national-level projects.

Secondly, this research contributes to the study of contemporary Korean society by providing ethnographic details into the ways in which actors living in a hyper-connected society interact with each other. In addition to laying bare latent societal norms that emerge in times of conflict this research makes additional contributions to the field by shedding some light on the dynamics of protest in the digital age. The research on protests mediated through online communities, however, is nothing new. Much research, for example, has been conducted on the political role of the online-based communication in the wake of the Arab Spring, a host of democratic movements that occurred in the Middle East and North Africa (Eltantawy and Wiest 2011; Khondker 2011; Howard et al. 2011; Castells 2012; Howard 2013). In the context of Korean society, research has been conducted on the Candlelight Protest (*ch'otbulsiwi*), the nationwide protest that occurred in 2008 against the import of American beef in which the teenagers' involvement and their extensive use of digital media were major elements of the event (Han 2009; Y. C. Kim 2009; S.-O. Lee, Kim, and Wainwright 2010; Seongyi Yun and Chang 2011a; Seongyi Yun and Chang 2011b).

As for the behavioral patterns shown in the young doctors' rebellion in comparison with those in the Candlelight Protest, it would be safe to say that both protests showed more or less similar patterns. Just as many teenage activists created Daum cafés and managed them with high degrees of self-governance, Daum café *Swimtõ* operated on a similar administrative basis. The online-based practices such as exchanging jokes and entertaining materials that helped to mobilize in the Candlelight Protest (Seongyi Yun and Chang 2011a, 145–146) were also manifest in the young doctors' rebellion. Cueing and number games at *Swimtõ*, for example, attracted many community members to the

online communities and helped the young doctors expand their support base. The ‘digital demonstrators’, or those who protest in cyber-space, that were believed to have been produced in the Candlelight Protest (Seongyi Yun and Chang 2011a, 145) also appeared in the rebellion as many young doctors moved around three online KM communities to engage in extensive ‘cyber wars’ with the pro-AKOM members. Active or even aggressive participation of the female members was also witnessed in the doctors’ rebellion as was reported in the Candlelight Protest (Y. C. Kim 2009; Seongyi Yun and Chang 2011b, 5–6), although more analysis would be needed to pinpoint the exact ways in which gender played a role in both events.

Despite these similarities, what distinguished the young doctors’ rebellion from the teenagers’ action in the Candlelight Protest the most is that the young doctors clearly resorted to ‘class consciousness’ for mobilization whereas the teenagers flocked to the street inspired by ‘bio-nationalism’, presumably to defend the country from outside biological menace, namely mad-cow disease (Gottweis and Kim 2009, 226–227). The young doctors even created their ‘public’, an entity to which their collective protest action was directed (Graeber 2009, 432), in the name of ‘ordinary members’ who harbored class-consciousness. And that is why I mentioned earlier in Chapter III that the young doctors’ public resembled the *minjung*, the class-conscious public created by Korean social movement activists in the 1980s.

Although the tech-savvy, highly educated and conservative ‘ordinary members’ could be placed almost in direct counterpoint to illegal, anti-elitist and educationally and socio-economically deprived *minjung* (Wells 1995, 40–41; Abelman 1996, 24; Koo 2001, 143; N. Lee 2011, 53), in terms of the ideology these distinct group wanted to convey,

there were commonalities. Firstly, just as *minjung* represented the ‘masses of farmers and factory workers’ that had been discriminated against in the distribution of wealth at the time of the country’s economy growth (Janelli 1993, 80), the ‘ordinary members’ also harbored grudges against the distribution of wealth in the community in the wake of the reduced *ch’ŏbyak* prescriptions, or ‘lost economic opportunities’. And as *minjung* ‘fashioned an utopian vision of social arrangement’ under the period of military dictatorship (Abelmann 1996, 23–24), the ‘ordinary members’ fashioned an utopian vision of their professional community with inspirations from ‘authentic Korean Medicine’ at the time of the state’s ruthless interference into their clinical practice. Finally, *minjung* resented the country’s politics as they felt that the state failed to represent its voice and thus they aimed to challenge the order through ‘broader class alliance’ (Koo 2001, 14,18). Similarly, the ‘ordinary members’ attempted to challenge the undemocratic practice of gerontocratic management of their community not only through the alliance of members of their generation within their own community but also, possibly, across the KM and WM divide.³⁵⁸

The similarity in class dimension present in both publics helps to explain why the young doctors’ rebellion progressed like one of the country’s *minjung*-inspired social movements. It is an irony that the young doctors, for the purpose of defeating their enemies, the Chonghan group members, had to create an imaginary class-conscious group whose identity is very similar to the one the Chonghan members used to embrace in the 1980s through the practice of ‘*minjungŭryo*’, or the minjung health movement.

³⁵⁸ Actually, it remains to be seen how Ch’amsillyŏn and Chŏnŭch’ong will behave later, particularly on the issue of license unitarization. I could feel a strange sense of solidarity between these two organizations in the field, although on the surface, they act like they are arch-enemies.

Another prominent online-related feature in the rebellion was the fluidity with which online and offline worlds intersected. The moment when Handsome Kim dashed to the front and performed a mock ideological trial during the Gyobo discussion was one of those moments in which the fluid intersection of both worlds was manifested. Handsome Kim have been known to be the ‘tough guy’ at Swimtõ for some time, and in that moment of confrontation, he suddenly sprung into the offline world, assuming his online-identity not his offline one whose personal attributes might be far from being violent.

Following Gee (2003, 51–72), this might be the moment when the young male doctor’s *projective identity*, or the virtual identity evolved within the constraints of virtual worlds, namely the identity of Handsome Kim, has found its way as his *real-world identity*, overwriting his offline world identity. This overlapping of identities might have been possible as the young male doctor was confident of performing his identity before the audience (Goffman 1959; Merchant 2006; Pearson 2009) which could have been regarded essentially the same, whether in online or offline settings, in the wake of successful campaigns in both worlds.

By exploring various social and political roles of digital media in contemporary Korea, this ethnography contributes not only to the study of the hyper-connected Korean society, but also to a growing scholarship on self-representation and identity performance among Korean internet users.³⁵⁹

³⁵⁹ For the issue of identity and organizational citizenship, see H. K. Shin and Kim (2009). H.-W. Kim, Zheng, and Gupta (2011) explore the knowledge exchange in blogging communities through the lens of identity communication. H.-W. Kim, Chan, and Kankanhalli (2012) also explore the idea of self-presentation in the transaction of digital items in virtual communities.

Finally, this research contributes to the anthropological research on East Asian medicine. It does so particularly by providing a case with which to critically reflect upon the dominant research trend in the field, namely the analytical trend that focuses mainly *on the epistemological factors* rather than on *the social, institutional and political structures* that underpin the practice of East Asian medicine. In Chapter IV, for example, I have described with convincing evidence how the epistemology-based distinctions on medical systems could be intentionally politicized for professional benefits both in the WM and KM communities. Also, throughout the thesis, I emphasized that the rebellion, due to its politico-economic complexities, could not be understood simply as an epistemological clash between two different traditions of Western Medicine and East Asian Medicine. The Korean case surely provides anthropologists with critical materials with which to reassess the dominant paradigm of the field.

Much well-known ethnographic research has purely focused on epistemological aspects of East Asian medicine, ignoring the deeply politicized aspects pertaining to its practice. Volker Scheid's acclaimed ethnography *Chinese Medicine in Contemporary China: Plurality and Synthesis* (2002), for example, made almost no mention of the ways in which modern practitioners of TCM in mainland China perceived their own practice in relation to WMDs or other healthcare stakeholders including the Chinese state, one of the most important stakeholders of all. His other book *Currents of Tradition in Chinese Medicine 1626-2006* (2007) also exclusively focuses on the development of the EAM theory-informed practices of Chinese Medicine. Most of Hsu's works on Chinese Medicine, such as *The Transmission of Chinese Medicine* (1999), *Innovations in Chinese Medicine* (2001), *Pulse Diagnosis in Early Chinese Medicine: the Telling Touch* (2010), also illustrate the

tendency of approaching EAM on the basis of the assumption that the fundamental attribute defining contemporary Chinese medical practice is seemingly-ahistorical EAM theories rather than the social, political and economic conditions surrounding TCM practice in contemporary China. Judith Farquahr's book *Knowing Practice: the Clinical Encounter of Chinese Medicine* (1996) also strongly exemplifies this epistemological tendency. Even Vincanne Adams (2002) who confronted the aspects of politics in the practice of non-biomedical systems and who famously argued that the 'biomedical model' unfairly dominates research on alternative medicine, assumes as a given that what ultimately distinguishes the practice of Tibetan medicine from biomedicine is its classical theory.

I am not arguing here that epistemology should not be given any attention, but I argue that anthropologists should give more attention to what doctors actually do in practice and in other social and political settings, in addition to researching the principles of EAM or other epistemological knowledge of non-biomedical systems. I am emphasizing this particularly because the field of medical practice, as it is intimately linked with state power through the institution of licensure, is no longer an individual enterprise but a part of a system that many actors have stakes in.

That is the reason why, I assume, Charles Leslie (1976; 1992) tried to explicate modern developments of Ayurvedic medicine on the basis of the social and political atmosphere of India in the 1960s, not purely on the basis of the medicine's epistemological characteristics, or its strength and weakness in comparison to Western medicine. Ayurveda failed to obtain a parallel status with Western Medicine, according to him, because it did not appeal to India's burgeoning middle-class nor to state bureaucrats

with modernizing aspirations. If Ayurvedic medicine had been successful in achieving the same status as Western medicine, however, I conjecture that it might have followed a similar path of professionalization as that trodden by Korean Medicine or American Osteopathic medicine. A similar degree of institutionalization and bio-medicalization would have occurred along the way.

Many institutional overlaps between Korean Medicine and Western Medicine exist. This thesis has highlighted those 'overlaps' and has argued that these overlaps are sometimes more, important than epistemological factors when exploring the presence and characteristics of a medical system and determining the identity of the profession practicing it.

Appendix

Aeyöp 애엽 艾葉	Buŭ 부의 富醫	Ch'imgu 침구 鍼灸
Aju T'ukbyölhan Keissüsijanayo 아주 특별한 케이스 시잖아요	Buyangböb 부양법 扶陽法	Ch'imgubosa 침구보사 針灸補瀉
Anjönsöngyuhyosöngg'öms a 안전성 유효성 검사 安全性有效性檢査	Ch'airülnüggyöyo 차이를 느껴요	Ch'imgyöng 침경 鍼經
Anmyömisochi'm 안면미소침 顔面微笑針	Ch'aksubogohoe 착수보고회 着手報告會	Ch'öbyak 첩약 貼藥
Apt'ong 압통 壓痛	Ch'amüryosilch'önyönhaph oe 참의료실천연합회	Ch'oi Hangi 최한기 崔漢綺
Ashihyölböp 아시혈법 阿是穴法	Ch'amsillyön 참실련	Chöng 정 精
Baesinja 배신자	Ch'angssigaemyöng 창씨개명 創氏改名	Chöngg'i 정기 正氣
Bangsa 방사 方師	Ch'ech'im 체침 體針	Chöngyagyong 정약용 丁若鏞
Banhansasimt'ang 반하사심탕半夏瀉心湯	Chejungwön 제중원 濟衆院	Ch'ongaekyesanje
Banryong 반룡 盤龍	Chi'ggaüsa 치과의사 齒科醫師	총액예산제 總額豫算制
Binü 빈의 貧醫	Ch'imhwanja 침환자 鍼患者	Chöngmal
Böbin 법인 法人	Chiin 지인 知人	Yölbannüng'öyeyo 정말 열받는 거예요
Bogyonghanda 복용한다 服用한다	Chijjüng 지증 知證	Chöngnyönhanüساهoe 청년한의사회 靑年韓醫師會
Bong'gwa 본과 本科	Ch'im 침 針	Chöng'uküsach'ongyönhap 전국의사총연합
Bot'ongsaram 보통사람	Ch'imdoyoböp 침도요법 針刀療法	Ch'önjiungi 천지운기 天地運氣
Buja 부자 附子		Chönüch'ong 전의총

Ch'önyönmulshinyak
천연물신약 天然物新藥

Ch'önyönmulshiyakbisangd
aech'aekwiwönhoe
천연물신약
비상대책위원회
天然物新藥非常對策委員會

Ch'önyönmulshinakyönguga
ealch'okjin'pöb
천연물신약연구개발촉진
법
天然物新藥研究開發促進
法

Chosön 조선 朝鮮

Chosönnch'ongdokbu
조선총독부 朝鮮總督府

Chosönüryöryöng
조선의료령 朝鮮醫療令

Ch'otbulsiwi 촛불시위

Ch'unayoböp 추나요법
推拿療法

Chungwan 중완 中腕

Daeggül 댕글

Daehanbokchi'ühakhoe
대한복치학회
大韓腹治醫學會

Daejjüngt'uje 대증투제
對症投劑

Daesobang 대소방
大小方

Daeüwön 대의원 代議員
Daeüwönnimdürü Sönt'aegi
Hanigyeü Miraerül
Baggumnida'
대의원님들의 선택이
한의계의 미래를
바꿉니다

Dandoksayong 단독사용
單獨使用

Daum 다음

Ddökpab 떡밥

Deqi 得氣 (Chinese)

Docple 닥플

Dolboyak 돌보약 돌補藥

Dolp'ari ch'ujongja 돌팔이
추종자

Dongbyön 동변 童便

Dongübogam 동의보감
東醫寶鑑

Düggi 득기 得氣

Dūmun 드문

Dūshinda 드신다

Eum 음 陰

Eumhö 음허 陰虛

Eumsil 음실 陰實

Eumyangohaeng 음양오행
陰陽五行

Gabülgwang'e 갑을관계
甲乙關係

Gaegat'ünnom 개갈은 놈

Gaehang 개항 開港

Gaesaggidül P'aejugilgöya
개새끼들 패죽일 거야

Gaesaggi nūn gejibūro and
Kim jonggon ün

gambbangūro 개새끼는

개집으로 김정곤은
감방으로

Gaesaggiya jjogaejima
개새끼야 쪼개지마

Ggondae 곤대

Gi 기 氣

Gisa 기사 技師

Gögwöl 거궐 巨闕

Gongdongsayong 공동사용
共同使用

Göngangbohömjöngch'aeks
imūwiwönhoe

건강보험정책심의위원회
健康保險政策審議委員會

Gongjindan 공진단
控眞團

Gongū 공의 公醫

Gosiwönsaeng 고시원생
 Gu 구 톳
 Gu-am Huhjoon 구암 허준
 Gubonsinch'am 구본신참
 舊本新參
 Gumi 구미 鳩尾
 Gürönnomi dainnya?
 Hyöngege Soljjiki Yaegi
 Hajiant'ani 그런 놈이
 다있냐? 형님에게
 솔직히 얘기하지 않다니!
 Gwahakjungsimyönguwo
 과학중심연구원
 科學中心醫學研究院
 Gwakhayngjöngg'isan
 곽향정기산 藿香正氣散
 Gwallugün 괭루근 栝樓根
 Gwiryongt'ang 귀룡탕
 歸茸湯
 Gwönwijuü 권위주의
 權威主義
 Gyobodaechöp 교보대첩
 交保大捷
 Gyöngrak 경락 經絡
 Gyöngrakiron 경락이론
 經絡理論
 Gyosu 교수 教授

Gyot'ongjönggrir ül
 Haeyahgödünyo 교통
 정리를 해야 거든요
 Hagoch'o 하고초 夏枯草
 Hakbbön 학번
 Han 漢 (Chinese)
 Hanbangböngrihak
 한방병리학 韓方病理學
 Hanbangsa 한방사
 韓方士
 Hang'ül 한글
 Hanja 한자 漢字
 Hanügye Gongdongsayong
 Injöng 한의계 공동사용
 인정
 Hanühaksa 한의학사
 韓醫學士
 Hanüsa 한의사 漢醫師
 Hanüsa 한의사 韓醫師
 Hanüsadang 한의사당
 Hanüyaksöndogisulgaebals
 aöp 한의약 선도기술
 개발사업
 Hanükyuksöngbö
 한의약육성법
 韓醫藥育盛法
 Hanyak 한약 韓藥

Hanyak Gangt'al
 Ch'egimjigo Kimjonggonün
 Mullönara 한약 강탈
 책임지고 김정곤은
 물러나라
 Hö Jun 허준 許浚
 Hongsam 홍삼 紅蔘
 Hösadan 허사단 許師團
 Hubaedül 후배들
 Hwakbbo 확보
 Hwangdineijing 黃帝內經
 (Chinese)
 Hwanjagusöng 환자구성
 患者構成
 Hwansanjisu 한산지수
 換算指數
 Hyangyak 향약 鄉藥
 Hyangyakgobang
 향약고방 鄉藥古方
 Hyangyakhyeminbang
 향약혜민경험방
 鄉藥惠民經驗方
 Hyangyakgugübbang
 향약구급방 鄉藥救急方
 Hyangyakjipsöngbang
 향약집성방 鄉藥集成方
 Hyökmyöng 혁명 革命
 Hyöl 혈 血

Hyöng 형	Jahyeüwön 자혜의원 慈惠醫院	Jöngsöng pyöngg'a 정성 평가 定性平價
Hyöngnim 형님		
Hyöngsangŭhak 형상의학 形象醫學	Jajungjiran 자중지란 自中之亂	Julsögi 줄서기
Hyöphwöereset 협회리셋	Jaoyujuch'imböp 자오유주침법 子午流注 鍼法	Jungŭ 중의 中醫
Hyöphwöejang 협회장	Jangbuhyöngsang 장부형상 臟腑形象	Kampo 漢方 (Japanese)
Hyöpjjin 협진 協診		Kangg'u 강구 薑灸
Hyöpjinböp 협진법 協診法	Jaryöjech'ulŭyakp'um 자료 제출의약품 資料提出醫藥品	Kimiron 기미론 氣味論
Igijökigo ggangp'aegat'ün 이기적이고 강패 같은	jayulsijöngt'ongboje 자율시정통보제 自律是正通報制	Kimjonggon Hyophoejang Yuim 김정곤 회장 유임
Ikge 익게	Jeryöng 제령 制令	Kobangp'a 고방파 古方派
Ikmyönggesip'an 익명게시판	Jesambyöngwön 제 3 병원	Koguryö 고구려 高句麗
Ilchim Hakhoe 일침학회 一針學會	Jip'yoyöndonggwanije 지표연동관리제 指標聯動管理制	Kohoha 古方派 (Japanese)
Ilch'imyoböp 일침요법 一針療法	Jinryoso 진료소 診療所	Koryö 고려 高麗
Imgyosujöngch'aekgwaje haebwanna? 임교수 정책과제 해봤나?	Ji Sögyöng 지식영 池錫永	Kumalöngch'o 9 말 0 초 9 末 0 初
Inhwa 인화 人和	Jölmün hanŭsa 젊은 한의사	Kungminŭryopöb 국민의료법 國民醫療法
Isa 이사 理事	Jölmün saram 젊은 사람	Kungnipŭryowön 국립의료원 國立醫療院
Isanghan Yegimanhagoisso 이상한 이야기만 하고 있어	jömyöngg'un 점령군	Künhyöngnim 큰형님
Ishimpo 醫心方 (Japanese)	Jöngryang pyöngg'a 정량 평가 定量平價	Kyöggü 격구 隔灸
		Kyöngsilryön 경실련
		Lingshu 靈樞 (Chinese)

Maekhujinch'al 맥후진찰 脈侯診察	Naeogyöng 내외경 內外景	P'alche'jilch'im 팔체질침 八體質針
Maesönyoböp 매선요법 埋線療法	Naesönilch'e 내선일체 內鮮一體	P'algangjindan 팔강진단 八綱診斷
Maijing 脈經 (Chinese)	Naggomsu 나꼼수	Palhae 발해 渤海
Makjangron 막장론 幕場論	Naver 네이버	Pech'ip'yo 배치표 排置標
Mansöngjirwang'wallije 만성질환관리제 慢性疾患管理制	Nebubyöngwön 내부병원 內部病院	Pidaewi 비대위 非對委
Mashinda 마신다	Nog'yong 녹용 鹿茸	P'ilbal jjüng 필발증 必發症
Meiji 明治 (Japanese)	Nop'ünbun 높은 분	P'okryöndandöe 폭력안대
Ming 明 (Chinese)	Nosajöngwiwönhoe 노사정위원회 勞社政委員會	Poyak 보약 補藥
Minjjung gganda 민증간다	Oebangsa 왜방사 倭方師	Puyangböb 부양법 扶陽法
Minjokühak 민족의학 民族醫學	Ojanyukbu 오장육부 五臟六腑	P'yojjüng 표증 表證
Minjung 민중 民衆	Onbyönggak 온병학 溫病學	P'yönghoewön 평회원 平會員
Minjung üryo 민중 의료 民衆 醫療	Önni 언니	Pyöngwisan 평위산 平胃散
Mökdda 먹다	Iggwa 이과 理科	Qing 淸 (Chinese)
Mudang 무당 巫堂	Paehuseryökron 배후세력론 背後勢力論	Qinghao 靑蒿 (Chinese)
Mujaböp 무자법 繆刺法	Paekgak ch'imböp 백각침법 百刻鍼法	Qianjinfang 千金方 (Chinese)
Mundungbyöng 문등병	Paekje 백제 百濟	Saam Ch'imböp 사암침법 舍岩針法
Mung'gwa 문과 文科	Paksa 박사 博士	Saesulün saebudaeae 새 술은 새 부대에
Naejiböpyöngjangjuü 내지법연장주의 內地法延張主義		Sagi 사기 邪氣

Samhwajahanyakbbang
삼화자향약방
三和子鄉藥方

Sangdaegach'i 상대가치
相對價値

Sangwan 상완 上腕

Sasangŭhak 사상의학
四象醫學

Sebaqwi 세바퀴

Sejong 세종 世宗

Shanghanlun 傷寒論
(Chinese)

Shilla 신라 新羅

Shin 신 神

Shinyak 신약 新藥

Shirak 실학 實學

Sibal ssageggi 시발새끼

Sikch'e 식체 食滯

Simgyenaeggwa 심계내과
心系內科

Simin 시민 市民

Simhabi 심하비 心下痞

Sindongŭyaksaöp 신동의약
사업 新東醫藥事業

Sing'yenaeggwa 신계내과
腎系內科

Sipda 싶다

Sip'ö 싶어

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素問學會

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선택의원제 選擇醫院制

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Sunhwangujoron 순환구조
론 循環構造論

Sŭppuhang 습부항
濕附缸

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Swimtö bomyön
sesangdoraganŭngö da
alssu issöyo' 습터 보면
세상돌아가는거 다 알
수 있어요

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Taidoruijupo 大同類聚方
(Japanese)

T'aiyang 태양 太陽

Tang 唐 (Chinese)

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