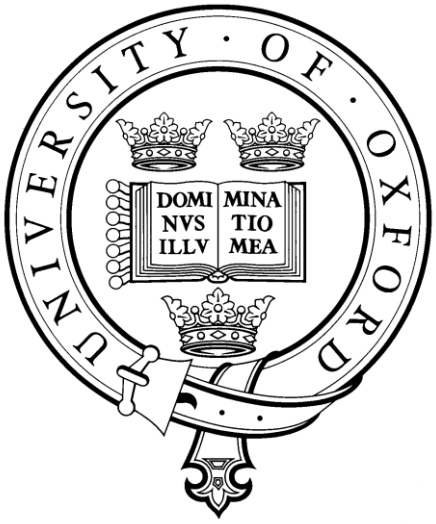
A Medicine of Constitutions:
Sasang Medicine in Contemporary South Korea



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Abstract

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This thesis investigates the process of standardisation, scientisation, and diversification of Sasang medicine in contemporary South Korea, through the lens of its central concept *ch'ejil* (constitution 體質). Sasang medicine (*sasang ŭihak* 四象醫學) is a current of medical tradition which emerged from the scholarly physician Yi Chema (李濟馬) in late 19th century Chosŏn. Sasang medicine is known as *ch'ejil ŭihak* (constitutional medicine 體質醫學) because it assumes that human beings have different constitutions with different physiologies and pathologies as well as different psychological traits. Sasang medicine is a unique example in [traditional] Korean medicine because it has constantly been practiced for over a century and is ingrained into health practices of modern Koreans as well as the contemporary health care system in South Korea.

Based on multi-sited ethnographic fieldwork in a school of Korean medicine and its teaching hospital, in a national research institute, and in private clinics, this thesis meticulously explores how an established form of Sasang medicine has been situated in the institutionalised system of Korean medicine. Ethnographies from different field sites provide microscopic details which are interspersed with various issues of collaboration, confrontation, and negotiation of different values and epistemologies. Furthermore, this thesis scrutinizes 'how practitioners of Sasang medicine know what they know' in such different social settings. These attempts are fulfilled by exploring how the central concept of Sasang medicine, *ch'ejil,* is understood in each field site. In so doing, this thesis aims to elucidate to what extent the practice of Sasang medicine in historical and social formation diversifies concepts of *ch'ejil*, which have played a role as a fluid medium to raise legitimacy or "efficacy" of Sasang medicine.

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Chapter 1. Introduction

1.1. East Asian Medicines as Assemblage

When walking along commercial zones in urban areas of South Korea, it is not difficult to encounter private clinics of Korean medicine (hereafter KM) located in commercial buildings, alongside private biomedical clinics with specialities such as internal medicine, ophthalmology, orthopaedics, dermatology, paediatrics, gynaecology, and dental medicine. Those KM clinics are run by doctors of Korean medicine (*hanŭisa* 韓醫師 한의사), whose license is acquired from the Ministry of Health of the Korean government just the same as those of biomedical doctors and dentists. As of 2018, the number of KM doctors was 20,759, and the numbers of biomedical doctors and dentists were 102,471 and 25,792, respectively (KOSIS, 2018). The significant amount of KM doctors is working in private clinics – e.g. 65.6% in the year of 2016 – compared to those working in hospitals (14.4%) [1][2] (Hanŭiyakyŏn'gam, 2018:228). Furthermore, the majority of KM doctors is *ilbanŭi* (一般醫 일반의; equivalent to the general practitioners in the UK) who has no official speciality. As of 2016, for example, the proportion of the KM specialists amounted only 11.7% (*ibid*:229). This phenomenon is a contrast to the

[1] The rest groups are public health doctors (0.33%) for their military duty, and KM doctors working in public health centres (0.2%) (Han'guk'anŭiyakyŏn'gam palganwiwŏnhoe, 2018).

[2] 'Hospitals' include both of public and private hospitals as well as university-affiliated hospitals. This thesis distinguishes private clinics (outpatient-based, primary institutions) and hospitals (inpatient-based, secondary and tertiary institutions).

case of biomedical doctors, whose considerable portion has specialities, that is, 80.1% in 2016 (KOSIS, 2020).

Visiting a KM private clinic, patients can usually see, on the wall of a clinic, a list of KM subjects which a specific KM doctor claims to treat (*chillyo gwamok* 診療科目 진료과목). These subjects generally follow the KM specialist system which legalises eight KM specialities. These are Internal Medicine of Korean Medicine (*hanbang naegwa* 韓方內科), Obstetrics and Gynaecology of Korean Medicine (*hanbang buin'gwa* 韓方婦人科), Paediatrics of Korean Medicine (*hanbang soagwa* 韓方小兒科), Neuropsychiatry of Korean Medicine (*hanbang shin'gyŏngjŏngshin'gwa* 韓方神經精神科), Ophthalmology, Otorhinolaryngology & Dermatology of Korean Medicine (*hanbang anibiinhup'ibugwa* 韓方眼耳鼻咽喉皮膚科), Rehabilitation Medicine of Korean Medicine (*hanbang jaehwarŭihakkwa* 韓方再活醫學科), Acupuncture & Moxibustion Medicine (*ch'imgu ŭihakkwa* 鍼灸醫學科), and Sasang Constitutional Medicine (*sasang ch'ejil ŭihak-kwa* 四象體質醫學科).[3] The enforcement regulation for the KM specialists was instigated in 1999, and

[3] The Korean characters for those eight specialities are as follows: Internal Medicine of Korean Medicine (한방내과), Obstetrics and Gynaecology of Korean Medicine (한방부인과), Paediatrics of Korean Medicine (한방소아과), Neuropsychiatry of Korean Medicine (한방신경정신과), Ophthalmology, Otorhinolaryngology & Dermatology of Korean Medicine (한방안이비인후피부과), Rehabilitation Medicine of Korean Medicine (한

246 KM practitioners acquired speciality certificates for the first time in 2002. Nevertheless, KM doctors with no official specialities can still claim competency in some or even all of the eight particular subjects.[4] Patients can often see that the given practitioner in a private clinic claims to be practising Sasang medicine (*sasang ŭihak* 四象醫學 사상의학) or Sasang Constitutional Medicine (*sasang ch'ejil ŭihak* 四象體質醫學 사상체질의학).[5] This generally means that the physician in question can provide so-called constitution diagnosis, constitution treatments, and rules of diet according to a given constitution. Hence, we can see that certain forms of Sasang medicine are being routinely practiced in private KM clinics, which take up the majority of clinical practice in the KM world.

Initiating the fieldwork in educational, research, and clinical settings to explore the contemporary practice of Sasang medicine, I realised 'Sasang medicine' is an assemblage of different sets of knowledge and practice in each site. Furthermore, it was z Korean society as well as the history of KM. This thesis hence aims to refute the idea of identifying Sasang medicine as a single unity. Such a view is generally observed in the following three ways.

방재활의학과), Acupuncture & Moxibustion Medicine (침구의학과), Sasang Constitutional Medicine (사상체질의학과).

[4] In this case, those subjects are not their *chŏnmun gwamok* 전문과목 (specialised subjects 專門科目) which are claimed by specialists in the given area.

[5] Although the terms Sasang medicine and Sasang Constitutional Medicine are often used interchangeably, but they are used in different contexts. "Sasang Constitutional Medicine" is more official in terms of indicating the specialty subject, whereas 'Sasang medicine' is more frequently used in ordinary conversations. The difference and origins of these terms will be discussed in detail in Chapter 2.

First, some people think that Sasang medicine is an everlasting tradition or cultural heritage. However, this thesis considers away such a belief of authentic Sasang medicine based on previous research on Asian medicine. For instance, Langford (2002) points out a paradox on Ayurveda in India, describing "the more that professional Ayurveda resembles biomedicine in its particular rationalities, the less prepared it is to satisfy desires, which are focused on 'tradition' or the promise of cure or – better yet – on a 'tradition' that is in itself a promise of cure" (190). Alter (2005) undermines a belief of authenticity with the frame of transnational nationalism, providing an example of the debate of the origin and authenticity of Ayurvedic acupuncture against the Chinese one (26-28). Similarly, Scheid (2007:169-70) demonstrates a process that a specific physician's clinical style of practice forms a collective one with authenticity. By doing so, he manifests that 'Chinese medicine' can be an umbrella term which embraces diverse styles of practice that form currents of tradition.[6] Zhan (2009) shows authentic traditional Chinese medicine can be seen differently according to different positionalities. She juxtaposes two different views on authentic traditional Chinese medicine: one as being from China, even if it is integrated with the bio-sciences or biomedicine; the other in the US based on the conservation of the theoretical purity against other societal and epistemological influences (190). In line with these analyses, this thesis aims explicitly to show the making of "Sasang medicine" in institutionalised settings such as KM schools and hospitals. Besides, the process of negotiations with other disciplines like biomedicine or statistics was also required to be situated in those institutionalised settings. This thesis particularly focuses on the coexistence of these processual practices related to Sasang medicine in those settings.

[6] This is also proposed by Hsu (1999:6-9), by indicating Chinese medical practice is intertwined with shamanic, temple-based, divinatory, fortune-telling, home-based herbal drug, and other practices.

Second, it is often believed as if Sasang medicine is limited in the realm of traditional thinking and practice as it has diverged from currents of medical tradition in Korea such as study associations reading *Donguibogam*, the most famous classic in Korean medicine. However, this thesis provides ethnographic evidence which is contrary to it by providing an example of the scientific research on Sasang medicine in a government-funded research institute. Translation of knowledge is not just epistemological but also ontological. That is, the translation process is related to the reformation or reassembly of the social. For example, during my fieldwork, I found that in the research institute KM doctors mingled with researchers from other scientific disciplines and led them to make their research projects look more scientific to the funders. Furthermore, as a creative integration between theories in the East and the West, I also observed that in private clinics some KM practitioners tried to integrate the theory of Sasang medicine with C. G. Jung's typology of four cognitive functions. From this, we can see that traditional knowledge does not just stay untouched under traditionalism, but crossbreeds with diverse types of knowledge from heterogenous epistemological origins.

Third, people tend to think that Sasang medicine is a static and unchangeable historical entity. However, this thesis instead sees Sasang medicine, in Zhan's words (2009:12), as "a set of contingent products of particular kinds of socialites". To demonstrate this, this thesis examines diverse styles of clinical practice of Sasang medicine in private settings. By doing so, this thesis intends to show vibrant dynamics - negotiations, dislocations, and conflicts – between the different practices and instances of innovation.

1.2. Contextualizing Korean Medicine and Sasang Medicine

Explanations of the Key Terms in the Thesis

Before exploring Sasang medicine in contemporary South Korea, it would be necessary to clarify what the term 'Korean medicine' means and its boundary in a social scientific sense. In the pre-modern era, all medical interventions and healing were terminologically called *ŭi* 醫 (*yi* in Chinese pronunciation) in East Asian countries, including China and Japan (Porkert, 1976). *Ui* denoted healers as a noun, or to heal (someone or something) as a transitive verb in Korean (c.f. see Andrews 2014:9 for the expalnation of *yi* in China). This designation acquired modifiers following the changing national consciousness of Korean people in history. One of the representative examples is 'Eastern medicine' (*tongŭi* 東醫 동의) of *Donguibogam* (*Treasured Mirror of Eastern Medicine* 東醫寶鑑 동의보감) published in the 17th century. The bearing of 'East' was determined by the location of the Korean peninsula to the East of the centre of China. Furthermore, 'Eastern medicine' reflected the Korean confidence that medicine in the Korean peninsula was distinct from Chinese medicine (Suh 2013:138). Meanwhile, as Andrews (2014:10) points out, by the time of the twentieth-century encounter with the West, the word *ŭi* had lost its association with Neo-Confucian piety. Instead, it became abstract, requiring modifiers such as *hanŭi* (oriental medicine 漢醫 한의) or *hanŭi* (Korean medicine 韓醫 한의). The designation of 'oriental medicine' came from Japan during the Japanese colonial period (1910-1945) and was officially used until 1986, the moment when the designation of 'Korean medicine' replaced it (Shin, 2005:121). Accordingly, this thesis

considers that it would be most appropriate to use the term 'Korean medicine' (or KM) to indicate the current praxis of traditional medicine in Korea.

On the other hand, in addition to this historical and continuous formations of *ŭi*, it should be noted that there are also discontinuities of tradition in Korean medicine. As Na (2012; 2015) illuminates, the so-called 'dual medical system' (explained below, in section 1.2.4) caused Korean medicine to exist in the legitimate health care system with the equivalent legal status with biomedicine. This means Korean medicine as a conventional medicine has had to compete with Western medicine in the same legal category, by expanding its field of expertise to incorporating 'non-traditional' or biomedical therapeutics. Even in this case, this thesis claims that the use of the term 'Korean medicine' could embody fluid or heterogenous attributes presented in the socio-political domain of medicine in Korea.

The Modern Institutionalisation of Korean Medicine: Three Crucial Moments since the 20th Century

This part deals with the institutionalisation of Korean medicine from a historical perspective. Here, institutionalisation includes processes of standardisation, professionalisation, and modernisation. It needs to be noted that there had been 'institutions' of Korean medicine before the modern efforts.[7] For example, there were also medical institutions in the Chosŏn dynasty (1392-1897) which were in charge of education and practice of medicine. However, those

[7] Such being the case, Hsu (1999:128) prefers to use the term 'standardisation' over 'professionalisation' or 'institutionalisation', in order to emphasise the continuity of the ongoing social efforts with those in the past. However, in this part, I prefer 'institutionalisation' to emphasise the establishment of social institutions which influence the transformation of the modes of existence of knowledge and practice in Korean medicine.

institutional efforts are not covered in this thesis because this work pays attention to how Sasang medicine, which emerged in the late 19th century, has been integrated to the contemporary health care system. For this reason, this part mainly focuses on the institutionalisation process of Korean medicine since the 20th century because it has decisively affected the formation of the current system of Korean medicine.

In Korea, the formation of a health care system in the modern sense can be firstly seen in the proclamation of the Decree of the Medical Doctor (*ŭisa gyuch'ik* 醫士規則) in 1900, declared by Emperor Kojong of the Chosŏn dynasty and the Ministry of Home Affairs. The decree was intended to replace the old national licensing system of [traditional] medical practitioners within an overall framework of public recruitment of Confucian literati administrators (Cho, 1999:139). The definition of the medical doctor (*ŭisa* 醫士 의사) in the decree was "those who … are well versed in the circulatory phases and seasonal influences of heaven and earth (*ch'ŏnji un'gi* 天地運氣), pulse taking, internal and external symptoms, therapeutics and herbology, acupuncture and moxibustion …"[8] (Kim, 2016:34). This meant that the definition of the modern medical doctor included the knowledge and practice of traditional Korean medicine, not those of Western medicine. Another decree identified the personnel who could work in the imperial [national] hospital, and it included KM practitioners as well as practitioners of Western medicine (Shin, 1999). This was because KM practitioners outnumbered biomedical doctors in that period (Cho, 1999:153) and the government aimed to

[8] The original sentence from the official gazette (*Kwanbo* 官報) on the 17th Jan, 1900 is as follows: "醫士는 醫學을 慣熟하여 天地運氣와 脈候診察과 內外景과 大小方과 藥品溫凉과 針灸補瀉를 通達하여 對證投劑하는 者를 云함".

use those health workforces for the modern state-building.

However, the country's efforts to establish Korea as a modern state died on the vine within a few years due to Japan's annexation of Korea in 1910. In 1913, the Japanese Governor-General in Korea promulgated the Regulations for Medical Doctors (*ŭisa gyuch'ik* 醫師規則), the Regulations for Dentists (*ch'igwa ŭisa gyuch'ik* 齒科醫師規則) and the Regulations for Students of Medicine (*ŭisaeng gyuch'ik* 醫生規則). In comparison with the decree of 1900, the regulation of 1913 differentiated practitioners of Western medicine from those of Korean medicine (Suh 2006:106).[9] The practitioners of Korean medicine were now called 'students of medicine (*ŭisaeng* 醫生 의생)' as a downgraded designation, and the range of their authority was also reduced. Although practitioners of Korean medicine could still survive in the legal health care system, they were in an inferior position compared to that of biomedicine practitioners.

Following independence from Japan in 1945, the confrontation between the two cold war superpowers of the USA and the Soviet Union made the Korean peninsula be divided into two zones of control, that is, the communist North and the capitalist South. In 1951, as a result of a series of intense debates, the country's first law related to health care, the National Medical Act was passed (Na, 2012:48). It was significant for KM practitioners in that the Act designated

[9] Comparing to the decree of the doctor in 1900, there was no legal or operational definition on 'medicine', 'Korean medicine' or those practitioners in the regulation of 1913. It just mentioned about the qualifications for the license exams such as graduates of medical colleges or a certain period of clinical experience. For details, see the official gazette (*Kwanbo* 官報), 15th November, 1913.

them as medical doctors (*ŭisa* 醫師 의사) alongside [Western-style] medical doctors and dentists, calling them as *hanŭisa* (漢醫師, later revised as 韓醫師 in 1986; 한의사). More importantly, the Act in 1951 laid the foundation stone of the 'dual medical system' in South Korea which gave independent status to doctors of Korean medicine (Lee *et al.* 2005; Jung *et al.* 2010; Jung and Lee, 2012).

Since 1951, Korean medicine has made impressive advances, in terms of institutionalisation. First, a division exclusively for Korean medicine in the Ministry of Health was established in 1975. Nowadays it consists of two departments: The Department of KM policy and the Department of KM industry. Second, the National Health Insurance (NHI) on Korean medicine was implemented nationwide in 1987.[10] Furthermore, a government-funded research institution, whose motto is standardisation, scientisation, and globalisation of Korean medicine, was established in 1994. In 2019, based on the newly revised Korean medicine promotion law, another national research institution devoted to the development of Korean medicinal herb manufacturing and processing and the promotion of the KM industry was established after a merger between pre-existing public institutions. In terms of the education of Korean medicine, 11 private and one national KM schools have been established so far and are offering not only 6-year bachelor course of Korean medicine to be KM doctors, but also postgraduate courses for master's and doctoral degrees in Korean medicine. All those schools now have teaching hospitals which oversee the clinical training of students and training doctors.

[10] It was a certain time after the initiation of the NHI. The inclusion of KM in the NHI was possible due to several reasons, including strong KM community's demand and public support. For the detailed historical process of the inclusion of KM in the NHI, see Cho (1999).

In 2002, the Ministry of Health initiated the KM specialist system which encompasses eight KM specialities. As described earlier, 'Sasang Constitutional Medicine' became one of the eight KM specialities (Im, Lee and Song, 2014).

To sum up, since the 20th-century Korean medicine has achieved its institutionalisation at an extraordinary level. It could be compared with the case of China, which belonged to East Asia and has also achieved the rapid and massive transformation of institutionalisation. Korea's case could be distinctive in terms of its existence in the country's health care: the exclusionary dual medical system (Shim, 2018:404).[11] Although there is an estimation that Korean government approaches to KM were characterised by indifference and inconsistency in early days as no concrete commitment was made towards KM in policy terms (Cho, 1999:23), the status of Korean medicine has improved based on the KM community's political power of negotiation and public support (*ibid*). In the aspect of discourse, the KM community could have secured its position in the discourses of nationalism and need of own weapon in the global market of complementary and alternative medicine (CAM) or traditional medicine, relating to the economic value which could bring economic interests to the nation-state.[12] Contemporary Korean medicine is situated in such vibrant and complex social ecologies.

A Biography of Biomedicine and Modern Healthcare in Korea

[11] Shim (2018) analyses that South Korean healthcare is based on "exclusionary pluralism" compared to "interpenetrative pluralism" in China and "subjugatory pluralism" in Japan. South Korea's unique healthcare system is discussed further in Section 1.2.4.

[12] This view is in line with Hsu (2008)'s analysis on the promotion of traditional Chinese medicine and "Chinese medicine and pharmacotherapy" based on nationalistic and economic motives.

Although this thesis mainly focuses on the sides of KM and will describe mostly on it in later chapters, knowing a history of Western medicine (or biomedicine) in Korea would be necessary not only to understand biomedicine in Korea but also to understand Korean medicine from a coevolutionary perspective. Lei (2014:9) argues that the coevolutionary perspective between traditional medicine, Western medicine and the state is essential to go beyond the dual history of the "survival of traditional medicine" or the "development of modern medicine". In this regard, this part briefly describes the history of Western medicine in Korea to understand the origins of mutual influences and dynamics between Western medicine and Korean medicine.

Yeo (2008:74) explains that Western medicine was introduced to Korea in two stages. The first stage covers the period from the seventeenth to the early nineteenth century when translations of Western medical texts were imported from China. In this period, Korean scholars such as Yi Ik (李瀷, 1681-1763) and Yi Kyu-kyung (李圭景, 1788-?) reproduced in their writings what they had learned from Western medical texts. However, interestingly, the knowledge that they acquired at that time was not that of contemporary Western medicine, in other words, the anatomy of Vesalius or physiology of Harvey, but the medieval version of Galenic medicine. Another attempt was made by Choi Han-ki (崔漢綺, 1803-1877) who wrote a medical work entitled *Shin'gich'ŏnhŏm* (*The Experiential Practice of the Body Organism* 身機踐驗) in 1866. This book was based on the five medical books of Benjamin Hobson (1816-1873), who was a British medical missionary in China.[13]

[13] For details of Benjamin Hobson's life, medical work, and its influence in China and Japan, see Bosmia *et*

The second stage of the introduction of Western medicine in Korea can be said the period from the late nineteenth century when Western medical practices and treatment were introduced by Japanese missionaries and medical missionaries from the West (Hwang, 1998:279; Yeo 2008:74). After the Japan-Korea Treaty of 1876, the Japanese navy installed a hospital in 1877 in Busan as the number of Japanese immigrants to Korea increased. The primary purpose of the hospital was to treat Japanese residents in Korea but it also covered the treatment of some local Koreans (Hwang, 1998:279). On the other hand, Horace N. Allen, the first American Protestant missionary in Korea, with the support of the Korean government, opened the first Western medicine hospital *Chejungwŏn* (House of Saving the People 濟衆院) in Seoul in 1885, and a medical school in the following year (Yeo 2008:75). The former is regarded as the first Western medicine hospital in Korean history, and the latter is known as the beginning of the first government-related Western medicine hospital in Korea. Thereafter, from the Korean empire (1897-1910) to the Japanese colonial period (1910-1945), the Christian medical missions and the national/colonial medical authorities sometimes cooperated, or they maintained a limited or asymmetrical rivalry (Cho, 2009:123), while formulating not only biomedical discourses but also bureaucratic power structures as seen in other non-Western countries under colonialism (Anderson, 1998; quoted in Furth, 2006:270).

In terms of the introduction and initial development of biomedicine, it would be worth comparing with the situations in other East Asian countries. For example, Japan had earlier banned Christian missionary works and adapted Western medicine with abolishing traditional medicine during the Meiji Restoration. In the same period, the Chinese government did not

al.(2014).

control its medical sector due to the interferences of the Western powers and was under the influence of missionary medicine (Yeo, 2007:124). Taiwan was occupied by Japan and absorbed its military medicine before the inflow of missionary medicine (Heo and Cho, 2015:622).

Korea was liberated from Japan in 1945. Soon after, the Korean peninsula was divided into two, and South Korea was managed by the USAMGIK (U.S. Military Government in Korea) from 1945 to 1948. The military government was reluctant to make long-term policy for public health because their primary concern was protecting American forces in South Korea stationed against the Soviet forces in North Korea. The military government promoted the expansion of the private sector, and this policy determined the basic characteristics of the health-care system of today (Yeo, 2008:81).

Lee *et al.* (2017) explain that two significant institutional changes took place in the Korean healthcare system since then. One was the introduction of compulsory health insurance in 1977, and the other was its transition to universal National Health Insurance (NHI) in 2000 (*ibid*:248). In the early 1970s, an authoritarian military government led by Park Chung-hee (presidency: 1963-1979) seized power in South Korea. The working class and other social forces were not well organized at that time. The authoritarian state overpowered all social forces, including capitalists, labourers, farmers, and medical doctors. In 1977, in order to gain political legitimacy and to promote the development of the heavy chemical industry, the Park regime implemented a corporatist Social Health Insurance system for companies with more than 500 employees. However, it covered only 8.6% of the population as the Park regime had no intention of using public financing to expand public health care facilities at the expense of investment in economic growth. As a result, health care facilities relied heavily on private

provision (*ibid*:250-51). In 1980, the Chun Doo-hwan government (presidency: 1981-88) pursued different economic development strategies, promoting an open economy and economic liberalization. Industrialization had been increasing the size of the working class since the 1960s, which increased the labour movement. Also, civic groups, including intellectuals, students, and democratic leaders mobilized their power resources and led public calls for a constitutional amendment allowing for direct presidential elections. Roh Tae-woo (presidency: 1988-1993), Chun's hand-picked successor to lead the ruling party, capitulated to several of the opposition's demand in June 1987. Roh decided to expand the number of health insurers to include self-employed workers in rural and urban areas. In 1989, the Roh government provided universal health insurance coverage to all Korean citizens. The main reason for this was that it formed part of Roh's political strategy for winning two elections. It was also possible because of the strengthened social forces in the civil society (*ibid*:251). In 1997, the effects of globalization struck the Korean economy during the currency crisis. At that time, the transition to National Health Insurance (NHI) was a significant item on the social reform movement's agenda (*ibid*:252). In 2000, a fully integrated NHI was established in South Korea. The predominantly private health care provision system made it impossible to transform the Korean health care system into a National Health Service type (*ibid*:252). It has been complemented by some public health facilities which provided medically necessary services at the central, regional, and municipal levels (WHO, 2015:13).

Despite the increasing public character of the Korean healthcare, the OECD (2020:47) estimates that there is not a well-established primary care system in South Korea. Patients have access to any speciality clinics in the community and general hospital, and they can receive the first consultation without a referral letter. This free access results in a high frequency of medical

consultation: the rate of medical consultation in Korea was 16.6 times a year compared to the OECD average of 6.8 in 2017 and the number of consultations in Korea had increased from 10.6 in 2000. Although the government guides the elderly and people from low-income groups to use public health centre, patients' excessive dependence on hospital care rather than primary care has always been pointed out as one of the main concerns in the country's healthcare system.

In summary, as Lei (2014:10) points out, it is important to understand the history of Korean medicine in the context of the general history of modern medicine in Korea because there have always been reciprocal relationships and coevolutionary processes among the histories of Korean medicine, Western medicine and the state. The institutionalisation of Korean medicine has been always interacted with the other two. It often emulated the institutionalization of Western medicine in Korea as seen in the KM speciality system in KM hospitals or the inclusion to the National Health Insurance. However, it should be noted that the direction of the institutionalization of Korean medicine also headed toward complementing the 'blind spots' of the Western medicine-centred healthcare, with the more concentration of KM practice in the primary care sector rather than the secondary or tertiary hospital sectors.

The Dual Medical System in South Korea

To understand Korean medicine or Sasang medicine in the contemporary health care system in South Korea, it is necessary to understand the 'dual medical system' (*ŭiryo iwŏnhwa ch'egye* 醫療二元化體系) in the country first. It is because it defines the range of practices of Korean medicine and thereby decides the level of the inclusion of Korean medical practice in the institutionalised and professionalised medical system. It can be interpreted that in the dual

medical system Korean medicine has the same legal, institutional, economic, and social recognition as Western biomedicine, creating a unique situation where two types of a legitimate medical doctor called 'MD' for biomedical doctors and 'KMD' / 'MD (DKM)' for doctors of Korean medicine (Na 2012:49). South Korea has various social institutions for its traditional medicine which includes the government departments for Korean medicine, universities, hospitals, research institutes, national advisory/expert committees, Good Manufacturing Practice (GMP) facilities on herbal medicines, national health insurance agencies, etc (WHO, 2012:47). One might think that the organizational structure of Korean medicine would be similar to those of Chinese medicine or traditional Japanese medicine, which have similar East Asian medical traditions. However, according to Shim (2018:401), compared to China or Japan, the contemporary South Korean health care system persists in the exclusionary pluralism,[14] which is defined as a plural system where the crisscrossing between Traditional East Asian medicine (TEAM) and biomedicine in professional practices is prohibited. In contrast, he argues that China and Japan have the interpenetrative pluralism and the subjugatory pluralism[15], respectively (*ibid*). This view of medical pluralism alludes that, as Nichter and Lock (2002:15) points out, there are not only the stablity of an enormous range of medical practices, but also the dynamics between indigenous medical systems and the forces of modernity. Shim and Lee (2017:2) explain that in Korea, the professional practice of KM is comprehensively and exclusively performed by KM doctors and is separate from the professional practice of

[14] Except for respecting Shim's (2018) usage of 'pluralism' in this paragraph, this thesis prefers to rely on the concepts of medical "diversity" (Krause, Parkin and Alex 2014) or "medico-scapes" (Hörbst and Wolf, 2014), to examine diverse practices of Sasang medicine in different spaces.

[15] Shin (2018:402) explains that the interpenetrative pluralism is a plural medical system in which TEAM and biomedicine incorporate each other bilaterally at multiple locations of professional practice, while the subjugatory pluralism is a plural system where TEAM is not recognized as an equivalent counterpart of biomedicine and subordinated to the practice of biomedicine.

biomedicine performed by biomedical doctors. In this system, there are unique systems of education and licensure for KM doctors who are legally permitted to practice the whole range of modalities of KM, independent from biomedical doctors.

This kind of healthcare system even affects patterns of the practice of traditional medicine. For instance, Shim and Kim (2018) point out that professionals, who are entitled to practice the whole system of KM modalities are not allowed to practice biomedicine, are more likely to practice traditional medicine holistically. This is contrasted to practitioners who are entitled to practice biomedicine as well as traditional medicine. For instance, Traditional Chinese medicine (TCM)[16] practitioners in China can select specific traditional modalities and biomedical treatments and mix them as necessary (*ibid*:538; also see Scheid, 2001:386-399). In such an institutional environment, the use of traditional medicine could be more selective and less holistic.[17] Regarding these aspects, it is necessary to know when and how the Korean way of the dual medical system has been historically situated.

In sum, the dual medical system of Korea means the coexistence of two epistemologically different medical systems—Korean medicine and biomedicine—in one national health care system. Compared to dual systems in other East Asian countries such as China and Japan, the dual system in South Korea is unique in that the practice of each medicine is exclusively allowed for only one profession, although the borderline between them has been

[16] Hsu (1999:6-7) defines 'Traditional Chinese medicine' as the traditional medicine that is promoted on a nationwide scale in colleges, hospitals, and clinics, which legitimation in the PRC took place only from the late 1950s and early 1960s onwards within the overall Maoist policy of *zhongxiyi jiehe* (Integration of Chinese and Western Medicine).

[17] This is at least partly because the aspects of being 'modernised', 'scientific', 'systematic', and 'standardised' in the institutionalised process (cf. see (Hsu, 1999:7)).

continuously disputed.[18] This systematic environment also affects ways of traditional medical practice and begets South Korea's unique practice styles. This will be examined throughout this thesis.

The Perception of Sasang Medicine in Different Social Groups

When I embarked on fieldwork in South Korea, I became keen of hearing commentaries on Sasang medicine not only from the inside of institutional settings but also from the hight street such as TV shows, newspapers, or conversations of ordinary people's everyday life. Although all of them were not well-researched in my fieldwork, it was the good starting point of my research because this experience made me realise that Sasang medicine does not only pertain to the health care 'system' of South Korea but is also ingrained in the society as cultural knowledge. In this sense, this part introduces different viewpoints from various social groups on how they perceive Sasang medicine in contemporary South Korea. The social groups are identified into five categories: 1) the general public, 2) intellectuals, 3) other medical professions, 4) KM doctors, and 5) SCM specialists.

First, the South Korean general public are aware of the term *sasang ŭihak* (Sasang medicine), although many of them do not know its theory in detail. They are generally interested in knowing their *sasang ch'ejil* (Sasang constitution) and what to do and what to eat for their healthy life. The idea in Sasang medicine that a person is born with certain physical and temperamental characteristics also corresponds with Ohnuki-Tiery's (1984) example of

[18] For example, see Ma and Lynch (2014) for the dispute on the right to use computed tomography (CT) as a diagnostic technology between biomedical doctors and doctors of Korean medicine.

taishitsu (inborn constitution) in Japan. Explaining the concept of *jibyo* (my illness), which means an illness that a person carries throughout life and suffers at sometimes more acutely than at others (*ibid*:53), she explains there is some interchangeability between *jibyo* and *taishitsu*. For example, she explains that the same symptom such as high blood pressure may refer to as *jibyo* or as *taishitsu* depending on its degree. She provides various examples of *taishitsu* as *jobu* (healthy), *futsu* (ordinary), *kyojaku* (weak and nonenergetic), *senbyoshitsu* (weak and constitutionally susceptible to TB), *horyushitsu* (weak), and *shinkeishitsu* (extra-sensitive), *hiesho* (chilling disposition), *hirosho* (tendency to get tired easily), *arerugisho* (allergic constitution), *asekakisho* (tendency toward excessive perspiration), and *nobosesho* (proneness to feeling hot in the head and feet and cold in the face) (*ibid*:54-55). She points out that the most important thing relating to these diverse designations is that the Japanese are required to understand their *taishitsu* because health is a somewhat ephemeral condition that represents a delicate balance between the *taishitsu* and external stimuli; the weaknesses of the *taishitsu* must be offset with appropriate food and bodily routines (*ibid*:56).

The attitude of people in South Korea is similar to this. For example, to indicate susceptible dispositions to certain body states or disorders, the word *ch'ejil* is used as various compounds combined with many words, such as *hŏyak ch'ejil* (constitutionally weak and nonenergetic 虛弱體質), *at'op'i ch'ejil* (constitutionally susceptible to atopic disorders; atopy-體質) or *allerŭgi ch'ejil* (constitutionally susceptible to allergic disorders; allergy-體質). Besides, the word of *ch'ejil gaesŏn* (constitution reform 체질개선) is not only used in the therapeutic process for health but also appropriated metaphorically. In this case, the word is used in from daily conversations to even official remarks such as presidential speeches to

represent ‘radical reform’ or ‘revamp’. For instance, the word of *kyŏngje ch'ejil* (economic constitution 경제체질) was used in a presidential speech to express a certain tendency of the national economic system (Timode Kim, 2017). In contrast, in ordinary conversations, terms such as *kongbu ch'ejil* (prone to study 공부체질) or *yŏnae ch'ejil* (prone to be good at dating 연애체질) are often used in daily conversations. In this way, the general public in Korea is likely to use terms of *ch'ejil* which are culturally bound and often combined with other words to make neologisms.

Second, some Korean intellectuals or humanities scholars have been interested in Sasang medicine. Some of them were interested in its Neo-Confucian philosophical roots, which were regarded distinctive from other branches of Korean philosophy (Hong and Eul-ho, 1995[1973]; Heo, 2008; Choi, 2009). Some others used the constitution classification system of Sasang medicine to apply their fields of study, such as politics, psychology, or even media studies (Hwang, 2002). For example, a political theorist was interested in four different psychological traits so that he tried to explain different styles of politicians, and to relate them to different types of leadership in general. Furthermore, a media scholar used the Sasang classification system to research on the communication behaviour and patterns of media use (Choi, 2016). By doing so, they sought for building their own inventive methodological approaches in Korea which could be distinguished from adventive (mainly Western) ones. In this way, beyond the field of Korean medicine, Sasang medicine has inspired Korean scholars who were thirsty for ‘Korea’s own methods against the West’.

Third, other medical professionals such as biomedical doctors nowadays are generally sceptical about Sasang medicine and problematize its weak scientific base. Specifically,

biomedical doctors who were offensive to Korean medicine formed a sub-organisation in the Korean Medical Association, which is the official association for biomedical doctors in Korea, in order to tackle controversial issues against KM.[19] On the other hand, although not many, there have been a few biomedical doctors interested in KM. For instance, a professor of anatomy at South Korea's renowned biomedical school became a passionate supporter of constitutional medicine after being treated for his chronic stomach problem. After being an apprentice of a KM doctor who treated him, he studied it by himself for several years and published several popular books on constitutional medicine (Ch'ae, 1993). Some biomedical doctors interested in KM or Sasang medicine formally entered KM schools to get the official license to practice them, whereas some others dealt with KM as a part of complementary and alternative medicine.

Fourth, KM doctors are more flexible than other groups. Whereas some KM doctors do not admit Sasang medicine into their clinical practice, some others actively use it. Several surveys (Kim, Lee and Kim, 2006; Kim, Lee and Lee, 2009; Jang, Baek and Lee, 2013; Jang, 2017) have been conducted to investigate the current use of Sasang (constitutional) medicine among KM institutions. Different surveys showed that approximately 38.8% to 62% of KM clinics and hospitals provide constitutional medical service with other traditional medical services.[20] By contrast, very few KM practitioners answered that they use the constitutional

[19] Those issues include KM doctors' use of (bio-)medical devices such as ultrasonic devices, computerized tomography (CT), magnetic resonance imaging (MRI) for clinical practice, or the inclusion of certain KM treatments and techniques in the national health insurance (Jang, 2018). For detailed cases of the conflicts between those two groups, see Ma and Lynch (2014).

[20] In the surveys, the questionnaires defined the constitutional medical service as "the medical service which includes Sasang or Eight constitutional medicines and provides individually customized diagnosis, treatments and preventive guidelines" (Jang, Baek and Lee, 2013:44).

medical service only, for example, 3% in 2008 (Kim, Lee and Lee, 2009:1505). During my fieldwork, I could observe that many KM doctors used Sasang medicine in a hybrid form with other styles of KM (details of this will be discussed in Chapter 6).

Fifth, the group of SCM (Sasang Constitutional Medicine) specialists is regarded as the most specialised practitioners in Sasang medicine from a legal point of view. Since the first KM specialist qualifying examination in Sasang medicine accredited by the government took place in 2002, the number of specialists in SCM has become 148 as of 2016. 148 is not a large number when compared to the whole number of KM doctors in the same year, which was 23,460, or the whole number of KM specialists in eight disciplines, 2,739 (Han'guk'anŭiyakyŏn'gam palganwiwŏnhoe, 2018:228-9). This group formed the Society of Sasang Constitutional Medicine (SSCM). Active members of this society usually consist of professors and hospital residents, not KM doctors from private clinics. This group is more interested in the institutionalisation and scientisation of Sasang medicine, hoping Sasang medicine to become more incorporated into the National Health Insurance System. Also, researchers from a large government-funded KM research institute are closely working with professors for scientific research of Sasang medicine. They are especially focusing on scientising constitution diagnosis by developing statistic algorithms and diagnostic (Lee, Li and Kim, 2010).

In short, Sasang medicine is understood differently according to diverse interests and expectations from different social contexts. First, the perception of classifying people into certain types according to their personalities or temperaments is the interest of many Korean people and Sasang medicine is particularly known to the general public as providing such information, inclusive of dietary guidelines for well-being. Furthermore, the term *ch'ejil*

(constitution) is widely known to Korean people and is even easily combined with words from various fields. Second, Korean intellectuals have shown interest in Sasang medicine because of its unique philosophical roots and its applicability to wider fields such as politics or psychology, in many cases to develop a new methodology based on Korea's uniqueness. Third, biomedical doctors generally have sceptical attitudes towards Sasang medicine as they regard Sasang medicine not to be grounded in science. However, a few biomedical doctors became passionate supporters and re-entered university to obtain the KM licenses. Fourth, KM doctors have diverse views on Sasang medicine, from sceptical to eclectic or impassioned views. Fifth, SCM specialists are KM doctors who had hospital training in Sasang medicine. They represent the institutionalised Sasang medicine and are generally interested in the scientisation or systematization of Sasang medicine and the further inclusion of Sasang medical practice into the national health insurance system to improve the authority and social status of SCM specialists. In this way, understandings and practices of Sasang medicine are multiple.

Among these, this thesis focuses on the last two groups - i.e. KM doctors and SCM specialists. It is because this thesis sees KM doctors and KM doctors with the speciality in Sasang medicine as main actors for the contemporary practice of Sasang medicine. It is also because this thesis regards KM practitioners are very unique actors and it is difficult to find similar cases in other cultures, particularly in the West.[21] Nonetheless, this thesis is well aware that various social groups described above are actively engaged and negotiating together to make the social meanings of Sasang medicine. Sasang medicine should be also studied in the

[21] This is based on the unique position and status of KM in the dual medical system. In this system, Korean medicine is recognised as one of the conventional medicines in South Korea, along with biomedicine. Complementary and Alternative Medicine (CAM), which Korean medicine would be included in this category in the West, belongs to another category in South Korea. Hence, the medical culture in South Korea is different accordingly from that in the West.

perspective of the interplay of various social actors - which includes the general public or patients – but I reserve this task for future research.

1.3. Scholarly Foundations of the Research

The Anthropological Literature on Asian Medicines

Since the 1970s, not a few anthropologists have researched on Asian medicine.[22] At the initial stage of the development of medical anthropology as an independent discipline, anthropologists became interested in investigating Asian medical systems through a comparative perspective (Kleinman *et al.*, 1975; Leslie, 1976). The concept of medical pluralism, widely discussed in the earlier books in the 1970s, is more in-depth examined in the cases of Taiwan (Unschuld 1976; Kleinman, 1980), and Japan (Lock, 1980; Ohnuki-Tierney, 1984) in the 1980s. In the meantime, the first English translation of an introductory textbook of traditional Chinese medicine was introduced with explanations of its theory (Sivin, 1987).

Anthropologists were interested primarily in the epistemological aspects of Asian medicine. Leslie and Young (1992) investigate whether Asian medical systems are coherent bodies of knowledge or heterogeneous and syncretic accretions of speculation and practice and whether these traditions are inextricably rooted in local conceptual systems or are transferrable

[22] The review of research on East Asian medicines is here limited to English-language sources. It mainly covers book-length monographs foundational to medical anthropology and its more recent developments rather than journal articles or chapters in edited volumes.

to other settings. Hsu and Barrett (2008:349) reinforces this view explaining that "they [medical systems] had a long history, a large archive of theoretical and clinical treatises, a codified materia medica, and they distinguished, as does scientific medicine, between diagnostics and treatment". In addition to this, the institutionalisation or modernisation process of Asian medicines also becomes worthy of study, for example, the modernisation of the education system in China (Taylor, 2005). These interests emerge as the investigations of traditional Chinese medical knowledge as a practice (Farquhar, 1994), different styles of knowing in various social relations (Hsu, 1999), and medical practice in plurality and synthesis (Scheid, 2002). Also, the clinical encounter of Chinese medicine is examined in more detail (Zhang, 2007). Since the 2000s, transnationality and globalization become an issue in the field of the anthropology of Asian medicines. For example, the transformation of medical theory, techniques, and concepts in terms of their movement away from the context of their production (Hsu and Hog, 2002; Alter, 2005; Stollberg and Hsu, 2009; Zhan, 2009; Scheid and MacPherson, 2012; Lei, 2014; Scheid and Lei, 2014; Smith, 2018).

Anthropological studies on Asian medicines have primarily concentrated on Chinese cases except for the initial studies on Japan. Still, some other studies have looked at other cultural areas such as India, Vietnam, and Tibet. The modernised Ayurveda is examined from a transnational and postcolonial perspective (Langford, 2002), and Vietnamese medicine is illuminated as 'Southern medicine' which is distinguished from Chinese medicine as well as Western medicine (Monnais, Thompson and Wahlberg, 2012). On the other hand, Tibetan medicine is investigated in terms of transformations of Tibetan medicine in transnational settings (Pordie, 2008); professional Tibetan medical physicians' and institutions' appropriations and engagements with biomedicine and scientific research, and how translations

between the scientific epistemologies of Western and Tibetan medical and scientific ways are made and debated (Adams, Schrempf and Craig, 2011); how contradictory trajectories of modernisation and cultural preservation are negotiated in the response to the requirements of intellectual property regimes (Saxer, 2013); questioning the issue of efficacy by examining the tension between social ecologies of knowledge and practice and the dynamics of "translational science" in the context of globalization (Craig, 2013); and the work of medical practitioners and of medical houses on the geographic and socio-political margins of Tibet's medical establishment in Lhasa during the times of medical revivalism (Hofer, 2018).

The Status quo *of Research on Contemporary Korean Medicine*

There is no anthropological monograph on Korean medicine, but a few historical, sociological, and anthropological doctoral dissertations on Korean medicine exist. Hyo-Je Cho (1999) extensively and meticulously traces the professionalization of Korean medicine in the 20th century. Focusing on the history of health policy and the integration of Korean medicine into the National Medical Insurance in South Korea, he describes the function and position of the profession of Korean medicine and its cooperative or conflicting relationship with other health professions such as pharmacists (*ibid*:35). He also examines the institutionalisation of the educational settings of Korean medicine (*ibid*:219). This explains the professionalisation of Sasang medicine in general, but Cho did not directly trace the trajectory of Sasang.

Jongyoung Kim (2005) examines how the hybridization process of Korean medicine entails multiple constructions of knowledge, identity and community. His multi-sited fieldwork in private clinics, hospitals, and laboratories of Korean medicine reveals vivid examples of hybridization. He uses the concept of hybridization as a combining or mixing process between

different cultural resources and entities. Furthermore, he explains that hybridity indicates a break or rupture from a linear origin, as well as the multiplicity and the heterogeneity of components in a given entity (*ibid*:3). He emphasizes that hybridity does not refer to the incorporation of "all elements" of the combining cultures; rather, it denotes a "particular coupling" among elements. For example, the hybridization of Korean medicine and science is the association between "empirical aspects" of Korean medicine and the materiality of laboratory practice (*ibid*:3). In other words, in the laboratory setting, it can be said that the clinical and experiential aspects of Korean medicine are accommodated in the system of knowledge production as laboratory science to meet standardised landscapes of global knowledge. However, the directionality of the hybridization process may vary according to the dispositions of players in their fields. For instance, as Kim illustrates, in a clinical setting the practice of a Korean medical doctor could be more autonomous than that of scientists in a laboratory because the aim of the discretion does not fit into a standard protocol of therapeutics, but treats subjectively-experienced illnesses of patients (Kim 2005:112;173). This point can be well depicted in the examples of scientific research and the local private practice of Sasang medicine. Hybrids are everywhere, but the quality of hybridization differs according to the characteristics of the settings.

Covering a broad period of time from 1600 to 1945, Soyoung Suh (2006) historically examines how Koreans have represented their tradition of medicine and how these claims have been modified since the 17th century. She argues that during those 'indigenous' medical learning moved from defining itself with a 'universal' Chinese tradition to a confrontation with biomedicine in the context of nationalism and colonialism since the early 20th century, and to repositioning itself as an aspect of national heritage in the postcolonial setting of independence

after World War II (*ibid*:8). This is also linked to this thesis's critical approach of 'making Sasang medicine to a national medicine'. The intellectuals, especially in the early 20th century, intended to make the history and culture of Korea independent from others and used Sasang medicine for this purpose.

From the viewpoint of Science and Technology Studies, Eunjeong Ma (2008) deals with Korean medicine in postcolonial Korea from 1948 to 2006. She examines how practitioners of Western and Korean medicine have tried to either expand or defend their jurisdictional boundaries to control resources over markets for their services and with government policies. She points out that the clash between the two knowledge systems is based on their different colonial and post-colonial histories, specifically how postcolonial scientific and medical knowledge is made in the process of building a nation-state.

As we will see, Ma's logic can also be applied to the strategy of Sasang medicine for arguing its distinctiveness. The boundary between Sasang medicine and 'Korean medicine' is negotiated when Sasang medicine becomes the 'national medicine', and it becomes a professionalised discipline. If Sasang medicine becomes the former, national medicine, Sasang medicine is identified with Korean medicine, whereas Sasang medicine is separated from professionalised KM when it becomes the latter, i.e. a professionalised discipline. This is because of the paradoxical aspects of Sasang medicine originated from its history of institutionalization.

In addition there are two anthropologists and one sociologist who have written their doctoral theses on KM since 2010. As one of the few medical anthropologists who has consistently investigated Korean medicine in contemporary Korea, Taewoo Kim (2010) provides a view that the Korean medical world consists of two sectors: the official sector and

the practical [private-practice] sector. According to him, the official sector includes schools of Korean medicine, university-affiliated KM hospitals, and non-university affiliated KM hospitals. On the other hand, the practical sector incorporates private KM clinics run by Korean medicine doctors and academic societies where the transmission of Korean medicine happens outside the KM schools (*ibid*:31). Kim also introduces the transmission of knowledge in the KM schools (*ibid*:44). By doing so, he disentangles as two distinctive issues: standardisation and biomedicalisation in the curricula. He first explains that standardised knowledge is reinforced by the standardised formats of in-class tests and the state license examination. Furthermore, he points out that the standardised knowledge for modern institutions is unable to contain some core aspects of traditional medicine such as "experience" and "virtuosity" which are important factors of traditional medical practice as Farquhar (1994), Hsu (1999) and Lei (2002) argue. In terms of biomedicalisation of the curricula, secondly, he analyses the reason why the significant portion of biomedical contents reflects the hegemonic position of biomedicine South Korea (*ibid*:47). After introducing these critical approaches to the institutionalised sector, he devotes more space to investigating the practical sector to find more 'real' landscapes of Korean medicine, which is similar to Hsu's (1999:88-104) investigation on the personal transmission of knowledge and practice of Chinese medicine as well as Scheid's (2002:161;184-185) observation of *guanxi* (particularistic exchange relations 关系). Kim's (2010) research points out that there are different styles of practice between the official sector and the practical sector, and these different logics are also applied to my analysis of the two different settings: the school and the private clinics. This thesis further intends to examine which actors caused this difference and how it happened.

Seonsam Na (2015) deals with a series of intergenerational conflicts which occurred

in the community of Korean medical doctors in 2012. Like Kim (2010), he discusses the biomedicalisation of the curricula in KM schools. He points out an education in KM schools has a strong emphasis on biomedical elements (*ibid*:78). He also mentions some tensions and conflicts in the Korean medical community between the 'classicists' (or fundamentalists), who have a strong emphasis on the medical classics for their identity formation, and the 'integrationists', who show more adaptive attitudes towards biomedical disciplines. Along with Na (2015)'s analysis of various opinions and attitudes of KM doctors, this thesis goes further to KM doctors constituting the world of Sasang medicine and explores their diverse views and interpretations of the classical texts of Sasang medicine with hybridized medical techniques.

Most recently, In-Hyo Park (2017), a medical sociologist, researched the relationship between Korean medicine and biomedical doctors in clinical practices in which they are mutually involved with their patient management under the name of 'Western-Korean Cooperative Treatment' (WKCT 洋韓方協診). To do so, he conducted fieldwork in the WKCT hospitals in Busan, South Korea's second-most-populous city on the Southeast tip of the Korean peninsula. He classifies the hospitals into four types: a medium-scale KM-oriented hospital, a large-scale KM-oriented hospital, a medium-scale biomedicine-oriented hospital and a large-scale biomedicine-oriented hospital. He finds that the WKCT in those hospitals is 'parallel treatment', rather than 'cooperative treatment' in terms of its actual meaning because the physicians send their patients to their counterpart for additional diagnoses or therapies through the request of referral/consultation and receive the results of such medical actions. He also observes that KM doctors' WKCT requests to biomedical doctors are usually conducted for 1)biomedical inspection to confirm their patients' diagnosis, 2) acute patient care and intense pain control, and 3) uptake of biomedical technicians such as physiotherapists whereas

biomedical doctors' WKCT requests to KM doctors are usually conducted for 1) relief of symptoms and pain control for non-fatal yet intractable chronic diseases such as chronic musculoskeletal diseases, 2) additional treatments for irreversible diseases with sequels in the chronic phase such as after-effects of stroke, and 3) management for uncurable or end-state diseases such as terminal cancers (*ibid*: 7-8). He finds that biomedical doctors do not have any concrete KM knowledge. In contrast, KM doctors' biomedical knowledge based on their learning experience at KM schools and clinical experience in WKCT hospitals plays a central role in connecting KM and biomedical doctors in the process of the WKCT. He also analyses that KM doctors' necessity to utilize biomedical knowledge in WKCT hospitals makes them more dependent on biomedical doctors' medical actions. He points out that the superiority of biomedicine and biomedical doctors over KM and KM doctors is reinforced in the process of the WKCT in clinical practices (*ibid*:10). His research shows an 'asymmetrical coexistence' of KM and biomedicine in the hospital setting. However, as he indicates, this situation was relatively limited to the hospital setting. When Korean people think of KM doctors, they imagine KM doctors working in private clinics, whereas biomedical doctors generally regarded as working in hospitals. This situation and perception lead to the recent strategy of the AKOM - the Association of Korean Medicine [Doctors] - to make the role of KM doctors as primary health care providers (Choi, 2019).

Overall, although there is no monograph on Korean medicine published as a book for Anglophone readers in anthropology, there have been a number of doctoral theses on Korean medicine written in English including historical, sociological, and anthropological approaches since the 1990s. I have discussed those of Cho (1999), Kim (2005), Suh (2006), Ma (2008), Kim (2010), Na (2015), and Park (2017). They have focused on the professionalisation and

hybridizing practices in Korean medicine; political and epistemological conflicts between WM doctors and KM doctors, and conflicts between different groups in the KM community; diverse KM practices in the private sector; and various styles of practices at different levels of cooperation between KM and WM in hospital settings. All of them demonstrate various and evolving aspects of Korean medicine in history and different social dimensions.

1.4. Thesis Argument

Theory

This thesis bears in mind Kleinman (1980)'s argument on "medicine as a cultural system" (24) or a "health care system as a concept not an entity" (25). Kleinman explains that medicine as a cultural system is a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions. Hence, illness, the responses to it, individuals experiencing it and treating it, and the social institutions relating to it are all systematically interconnected (24). He also argues, like other cultural systems, a health care system needs to be understood in terms of its instrumental and symbolic activities. Those activities are influenced by particular social institutions (e.g., clinics, hospitals, professional associations, health bureaucracies), social roles (e.g., sick role, healing role, interpersonal relationships (e.g., doctor-patient relationship, patient-family relationship, social network relationships), settings of social interaction (e.g., home, doctor's office), economic and political constraints, and many other factors, including, most notably, available treatment interventions and type of health problems. The health care system is organised as a special portion of the

social world through the interaction of these variables. It is the nexus of adaptive responses to the human problems created by sickness, and as such, the issue of "efficacy" is central to it (26-27). This thesis accepts Kleinman (1980)'s perspective of "medical system" as a theoretical framework in that it involves interactions of various actors from individuals to social institutions. Sasang medicine can be regarded as a system to some extent comparing to other traditional medicines in other cultures which do not have a consistent theory (at least in a textbook level or in terms of sharing same classical texts as a theoretical basis), educational, research, or regulatory institutions.

However, just viewing medicine as an organised system has some limitations. Last ([1980]2007) provides a different view of emphasising the importance of "knowing about not knowing" of traditional medicine in a society. His point is that anthropologists, sociologists, and health educators alike have assumed that "systems of medical knowledge" held by indigenous peoples and by Westerners alike are generally uniform and consistent (Littlewood, 2007:ix). In other words, he argues that the term "medical system" is not an appropriate word to unravel the complexities of inconsistent and multi-layered practice and knowledge. Instead, he suggests the term "medical culture" for all things medical that go on within a particular geographical area (Last, 2007:2). In this respect, this thesis puts more weight on "medical culture" than "cultural system" as a more useful theoretical tool to observe intricate social phenomena in the world of Sasang medicine.

This thesis intends to go further: then how should we account for the culture of medicine in a society? To do so, this thesis engages Pierre Bourdieu's (1977, 1984) attempt to locate culture in the disposition, habitus and taste, which were used for pursuing the project of a 'praxeology', similar to 'practice theory'. In other words, this thesis aims to trace and analyse

different habitus and tastes of diverse groups of people in three different social settings of the world of Sasang medicine. This thesis will illuminate different social practices of the people, which embody different habitus by manifesting different tastes of knowledge and things: such as classical texts, diagnostic and treatment tools, and therapeutic techniques.

Then what are specific characteristics of the concept of habitus and what would be the benefits of using it as a theoretical framework? Analysing Bourdieu's academic legacy from the perspective of (linguistic) anthropology, Hanks (2005:69) explains that habitus concerns reproduction of the regularities immanent in practice. The stability of the habitus is not expressed in rules, which Bourdieu rejects, but in habits, dispositions to act in certain ways, and schemes of perception that form individual perspectives along socially defined codes (ibid.). Hanks adds that through the habitus society is impressed on the individual, not only in mental habits, but even more in corporeal ones.

According to Hanks (2005:69-71), the concept of habitus can be further developed along three lines of thought. The first is the Aristotelian idea of the hexis, which Bourdieu treats as the individual disposition that joins desire (or intention) with judgment (or evaluation). The second is the phenomenological idea of habituality and "corporeal schema", which implies a critical shift from disposition to embodiment. The third line is the approach developed by the art historian Erwin Panofsky (1951, cited in Hanks 2005), who expanded the scholastic concept of habitus to cultural production in medieval civilisation, explaning habitus as 'mental habit' which later Bourdieu appropriates as embodied habituality by positing the body, not the mind, as the "site" of habitus. These three aspects need to be considered when referring to habitus, to be distinguished from other terms such as habits, or customs. Furthermore, the concept of 'taste' can be also understood in this context as an aspect of the habitus. In a sociological perspective,

taste is generally defined as an individual or collective intersubjective preference for dietary, design, cultural and/or aesthetic patterns (Bourdieu, 2010[1984]). Hence, taste as social and cultural phenomena affects social relations between people and objects.

Practice theory, which this thesis intends to engage in, also stands in this philosophical context. According to Reckwitz (2002:249), practice theory treats practices as the 'smallest unit' of social analysis. Reckwitz explains that 'practice' is "a routinized type of behaviour which consists of several elements, interconnected to one other: forms of bodily activities, forms of mental activities, 'things' and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge" (ibid.:250). In this sense, a practice represents a pattern which can be filled out by a multitude of single and often unique actions reproducing the practice. The single individual – as a bodily and mental actor – then acts as the 'carrier' of a practice. A practice is thus a routinized way in which bodies are moved, objects are handled, subjects are treated, things are described, and the world is understood (ibid.). In this way, the 'body' becomes an important concern as a social practice is the product of training the body in a certain way (ibid.:251). Objects are also necessary components of many practices because carrying out a practice generally means using particular things in a certain way. For example, writing, printing and media 'mould' social practices. They enable and limit certain bodily and mental activities, certain knowledge and understanding as elements of practice (ibid.:252).

In this theory of practices, 'fields', where the practices are played, are also worth for consideration. A field is "a form of social organisation with (a) a configuration of social roles, agent positions, and the structures they fit into and (b) the historical process in which those positions are actually taken up, occupied by actors (whether individual or collective)" (Hanks,

2005:72). Hanks (2005:73) explains that any field is a space of "strategic possibilities". Pertinent speaking and discourse production are ways of taking up positions in social fields. Speakers have somewhat logical trajectories over the course of which they pursue various values, which are formed by the field.

The three medical fields of Sasang as practised in a university, a research institute, and private clinical settings were chosen as fieldwork sites because I paid attention to them as the main medical fields of KM doctors for knowledge production and innovation in institutionalised Korean medicine [as well as Sasang medicine].[23] Those medical fields are also generally referred by KM doctors or Korean media as the tripod contributing to the formation of modern Korean [and Sasang] medicine: i.e. education (*kyoyuk* 教育), research (*yŏn'gu* 研究), and clinical practice (*imsang* 臨床). Although it seems that the practices in the three settings pertained to these three purposes respectively, there were significant overlaps. Moreover, each of the three settings in the Korean medical world is affected by three social processes: institutionalisation, scientisation, and diversification. The thesis examines the entanglements, negotiations, dislocations in these processes between KM doctors performing Sasang medicine.[24] This thesis is the result of a medical anthropological project for investigating the processes.

[23] This is also in line with Young's (1978:118) analysis on the production of medical knowledge in particular social formations, Hsu's (1999:240) investigation on styles of knowing in different social contexts, and Scheid's (2002:54) multi-sited fieldwork for comparisons of different perspectives to an emergent object of study whose contours, sites, and relationships are not known beforehand.

[24] This idea of multi-sited ethnographic research is influenced by Hsu's (1999) fieldwork in a narrow side street of old houses (p.25) [secret transmission], a ground floor of a provincial government hostel (p.90) [personal transmission], and a TCM college [standardised transmission] as well as the investigations of diverse voices of agencies in Chinese medicine (Scheid, 2002) and in Ayurveda (Langford, 2002). Furthermore, in line with

The Argument

This thesis poses the question: how did Sasang medicine become 'successful' in the KM world and the Korean public sphere? Specifically, how did a medical theory and practice from the geographical and epistemological periphery in the Korean peninsula become 'Sasang medicine', which is recognised as a relatively medical tradition that became involved in the mainstream of the KM world of South Korea? For answering this question, I propose to examine the term constitution *ch'ejil* very closely and do so from three different perspectives.

I argue that practices surrounding *ch'ejil* were linked to questions of institutional, scientific and clinical legitimation. I will hence discuss *ch'ejil* in the light of its (social) efficacy. By social efficacy I mean as the collective ability to produce a desired or intended result, specifically in terms of to what extent a certain mechanism could show its competence in a given society to rationalise its logic of practice. I will show that process of empowering Sasang medicine accompanied transformations of practices in different social settings, which directly or indirectly had to do with practices of *ch'ejil.*

To demonstrate these transformations of Sasang medical practices, this thesis presents three propositions. First, the combination of the term *ch'ejil* and Sasang medicine resulted in making Sasang medicine distinctive from other sub-disciplines of Korean medicine and establish itself in the institutionalised education setting. Second, it enabled researchers to proceed with scientific research projects in the research institute by intersecting epistemological boundaries of disciplines. Third, it catalysed the processes of innovating KM practices in the private-practice sector. These are the main concerns which this thesis intends

Marcus's (1995:100), I emphasize that the fieldwork in each setting is not separated from each other.

to deal with, providing ethnographic cases. The ethnography in this thesis does not just stay to prove the propositions but also aims to depict tensions and conflicts inherent in past and present transformations. In doing so, this thesis will also illuminate the changing/changed habitus and tastes of diverse actors obviously emerged in different settings which were engaged in those transformations.

Methods and Ethics

This thesis aims to take a form of ethnography, i.e. writing about the people in the world of Sasang medicine. To do so, I did participant observation as the main research method. In other words, as an ethnographer, I studied with people practicing Sasang medicine in the field of Korean medicine in South Korea during the eighteen-month fieldwork. I met the people, I talked with them, I asked them questions, I listened to their stories, and I watched what they did, (as nicely said by Ingold's (2014:386). I also joined in when necessary and appropriate. Participant observation is a combined practice of the engagement of participation and the detachment of observation. Furthermore, this thesis follows what Ingold (2014:387) elaborates on the process of participant observation: ontological commitment and education. He points out that observation ultimately requires an intimate coupling, in perception and action, of observer and observed, accompanying ontological commitment (ibid.). Also, he argues anthropology is a practice of education, and a practice of exposure which pulls us from any position or perspective we might adopt (ibid.:388). In doing so, throughout the fieldwork and participant observation I was ontologically committed to the people I met and was educated by them, being exposed from my world to their world(s). Other technical research methods such

as archival or historical studies are used in this thesis but also followed this ontological trajectory, to complement the ethnographic research.

This thesis is based on multi-sited fieldwork in South Korea from March 2017 to August 2018. The different fieldwork settings consist of (a) a standardised higher educational KM institution, (b) a scientific research project in at the national research institute of KM, and (c) private KM clinics. They all are about Sasang medicine, but they are differently constituted. In this way, I regard settings of a school, a hospital, a research institute, and a private clinic as being in relationship with each other for the promotion/continued practice of Sasang medicine in contemporary South Korea. The three settings can be tied to three purposes of medical knowledge: education, lab-based research, and clinical practice. Although in all three settings the practices pertained to all three purposes, there were significant overlaps. Moreover, each of the three settings in the Korean medical world is affected by three social processes: institutionalisation, scientisation, and diversification. The thesis examines the entanglements, negotiations, dislocations in these processes between KM doctors performing Sasang medicine.[25]

The focus of the fieldwork on the school setting was on participant observation in a series of lectures on Sasang medicine at the Hanguk University School of Korean medicine and the clinical training on Sasang medicine at the school's affiliated hospital, which I did for the two semesters of the year. The lecture was generally held three hours per week while the

[25] This idea of multi-sited ethnographic research is influenced by Hsu's (1999) fieldwork in a narrow side street of old houses (p.25) [secret transmission], a ground floor of a provincial government hostel (p. 90) [personal transmission], and a TCM college [standardised transmission] as well as the investigations of diverse voices of agencies in Chinese medicine (Scheid, 2002) and in Ayurveda (Langford, 2002). Furthermore, in line with Marcus's (1995:100), I emphasize that the fieldwork in each setting is not separated from each other.

clinical training happened on two days, all day, in two semesters. I conducted in-depth interviews with the professor in charge of the lecture of Sasang medicine, a training doctor of Sasang medicine and around ten students in the clinical training, as well as having daily conversations with many more students. During that time, I also was a regular visitor at a private clinic of a retired professor of Sasang medicine in his 80s, Professor Lee. He was the founder of the department of Sasang medicine at Seoul University College of Korean medicine, which is the oldest department of Sasang medicine in South Korea. He was regarded as the significant person who contributed to the institutionalisation of Sasang medicine in Higher Education and interacted with many prominent figures in the history of Sasang medicine in the late 20th century. During weekly visits, which lasted almost a year (totalling almost 40 visits), I interviewed him for over 4 hours at a time and heard of a wide variety of stories on Sasang medicine that happened during his life. I mention him as I consider his impact particularly remarkable for education. Regarding my research on institutionalised Sasang education, I also attended two major academic conferences on Sasang medicine. Participants for those meetings were all KM doctors; however, they had different backgrounds. Most participants in the academic conferences were professors, specialists and residents of Sasang medicine working in hospitals.

Furthermore, I also participated in a weekly text-reading seminar which I attended for about ten months. It focused on reading Yi Chema's philosophical text, *the Manuscript of Study* (*kyŏkch'igo* 格致藁). In comparison with the academic conferences which I attended, all members in the text-reading seminar were KM practitioners working in private clinics. I observed them in conversation, participated in learning and teaching processes, and sometimes had informal interviews with them. Also, I visited several private KM clinics known as treating

patients with Sasang medicine, in order to investigate varieties of medical experience among doctors. I interviewed around sixteen KM doctors practicing Sasang medicine in private clinics as well as observed doctor and patient interactions during the examination and treatment sessions in ca. 10 clinics. I also subjected myself to many forms of therapy in many of the private clinics visited insofar as I was deemed competent and capable.

Finally, I conducted participant observation in a national research institute of Korean medicine daily, Monday to Friday, 9 to 6, for three months. I was permitted a desk in one of its research centres called the Mibyeong research centre, where two specialists in Sasang medicine and three KM doctors formed a research group with other 10 researchers from different academic backgrounds. I could communicate freely with researchers in the centre who were working on scientisation projects of Sasang medicine. I followed research projects they were working on, joining in two business trips, weekly official meetings, and unofficial meetings that were held frequently. I conducted informal interviews when necessary.[26] Besides, casual chats with researchers during lunch time or coffee time were also important opportunities to get to know their habitus and practices of research on Sasang medicine.

My research[27] involved the audio recording only with permission from the participants. The audio-recorded participants of this research included: the 5th and 6th year students of Korean medicine at Hanguk University who took the class and the clinical training of Sasang medicine; a training doctor of Sasang medicine and a professor of Sasang medicine at the

[26] The names of all participants being mentioned in the thesis are pseudonymized to protect them from being identified. So are the names of the institutions, although geographical names and explanations are genuine.

[27] It obtained ethical approval of my field research by the University (Ref. No.: SAME_C1A_17_002).

university-affiliated hospital; 15 doctors of Korean medicine in private clinics; ca. 15 researchers at the national research institute of Korean medicine. I did not undertake systematized surveys or standardized questionnaires because I was concerned about my interlocutors' feeling of being objectified by them. I rather paid more attention to individual characteristics and nuanced differences revealed in narratives or even serendipities according to various situational contexts. I conducted formal interviews only with the KM doctors and not with patients since this research primarily targeted arguably most active and prevalent actors of Korean medicine in the legitimate settings, that is, KM doctors. For doing so, I also observed KM doctor-patient encounters in clinics. Patients were happy to grant oral permission to observe their interactions with doctors. They often came to private clinics with biomedically diagnosed disease names and KM doctors made clinical decisions based on their experience in East Asian medicine (inclusive of Korean and Sasang medicine).

As for my positionality, I myself am a trained KM practitioner who is a graduate of a KM school and holds a master's degree in the history of Korean medicine. I have experience in not only clinical practice but also research work at a research institute. Although I was not involved in the scientisation work on Sasang medicine, I could see and interact with researchers at neighbouring departments working on various scientisation projects on Sasang medicine as well as Korean medicine. My knowledge and experience from those circumstances affected to understand the worlds of Korean medicine and Sasang medicine.

1.5. Outline of the Thesis

Chapter 1. Introduction aims to illuminate flexible and sophisticated attributes of the KM practice. This chapter firstly takes a view that Korean medicine or Sasang medicine are not homogenous entities but assemblages. This attempt is achieved by locating the two on the studies of medical anthropology and the history of Korea. In detail, chapter one provides the background of the study by depicting contemporary medical diversities in South Korea. Drawing on Korea's unique healthcare system called "dual medical system" (*ŭiryo iwŏnhwa ch'egye* 醫療二元化體系), this chapter also demonstrates how Korean medicine has been legalised and has attained the equivalent social status with biomedicine. Examining previous studies on Asian medicines, chapter one discusses various medical landscapes in the KM world which analytical tools are raised by some anthropologists. By doing so, this chapter sets main targets of this thesis: the different modes of Korean medicine in different settings. These medical fields are generally based on what has previously been described as the official sector, inclusive of the education and research sub-sectors, and the private practice sector.

Chapter 2. Historical and Theoretical Explorations of Constitution in Sasang Medicine explore how "Sasang Medicine" was constructed in the recent history of ca. 150 years. Practitioners of Sasang medicine actively engaged with ongoing discourses, technologies, and societies throughout its history. This chapter will present the historical trajectory of medicine in formation as "Sasang medicine". To do this, I first consider several different names for Sasang medicine. Notably, as mentioned before, the word *ch'ejil* (constitution 體質) did not appear in Yi Chema's writings, nor did Lee call his medicine *Sasang ŭihak* (Sasang medicine

四象醫學). As we will see, the term "Sasang Constitutional Medicine (*Sasang ch'ejil ŭihak* 四象體質醫學)" is a late invention, which was made in the mid- or late 20th century. It is currently the official term used by the most significant academic society of Sasang medicine when referring to Sasang medicine. Hence, by investigating historical records and articles, I delve into how those similar but somewhat different notions were combined and how the newly invented terms expanded, or restricted meanings of the terms traced to Yi Chema.

Chapter 3. Meeting with Professor Lee: the chŏngshin *(Spirit* 精神*) of Sasang medicine* reports on a series of conversations with Professor Lee, a retired professor of Sasang medicine from Seoul University. He was regarded as a living witness of the institutionalisation of Sasang medicine and has participated in many events and interacted with many historical figures regarding Sasang medicine. This chapter firstly introduces his life and academic career. His academic career was inseparable from the institutionalisation of Sasang medicine in the school and hospital settings as he was the founder of the department of Sasang medicine in the oldest KM school. Secondly, this chapter deals with the teachings I received from Professor Lee, which happened during my visits.

Chapter 3 aims to guide readers to the world of Sasang medicine, of an experienced expert. It will be combined with the bird's eye perspective on the Sasang medical knowledge presented in Chapter 2. This chapter thus leads readers to understand the most 'authoritative' form of the practice of Sasang medicine in the institutionalised KM world. The teaching from Professor Lee covered from history and philosophy to diagnosis and treatment of Sasang medicine. However, it was not the same with textbook instructions. It was based on his own understanding of classical texts and clinical experience. Therefore, it was not systematic, but

more like an ongoing and never-ending narrative. Continuously reading this chapter and following ones, readers will notice that the teaching from Professor Lee, the authoritative teaching of Sasang medicine, resonated with different voices in different social settings described in subsequent chapters.

Chapter 4. Learning Sasang Medicine at the Level of University Education provides ethnographic accounts on Sasang medicine in the classroom and hospital settings. The ethnography explores how Sasang medicine is taught in a KM school, which provides both classroom and hospital teachings. The standardised education of Sasang medicine was provided with other KM subjects in the 5th and 6th years of a 6 year training course. Moreover, in the hospital, the department of Sasang constitutional medicine was installed alongside others of KM as well as those of Western-style medicine. This institutionalised platform was certainly different from when Sasang medicine was traditionally practised outside the school and hospital system. It was observed that these different environments in the school and the hospital gave different roles to Sasang medicine.

The standardised textbook of Sasang medicine was used during classroom teaching. However, there was still a strong emphasis on understanding the founder's life and thoughts and his seminal texts. Students were required to memorise various sentences and paragraphs from the seminal texts. In the hospital education, more technological devices and more standardised tools, e.g. diagnostic tools, or questionnaires, were engaged during the learning process of Sasang medicine. Students were also required to perform doctor-patient role-play as a part of the Objective Structured Clinical Examination (OSCE). By the students who played the role of a doctor, those clinical encounters were interpreted in the category of Sasang medical

terms, views, and perceptions. Through observing this process, I explored how the constitutions were made in role-play.

Chapter 5. Experimenting with Sasang medicine is based on the ethnographic fieldwork conducted in a national research institute of Korean medicine. Unlike standardised education, the research setting differed in terms of the social background of the researchers and the nature of the technology used. For example, in the team in which I conducted participant observation, there were specialists of Sasang medicine alongside researchers from other disciplines such as the nursing sciences, genetics, and statistics. Being senior to other researchers, the specialists of Sasang medicine played a central role in establishing research plans. It seemed they had 'core knowledge' or a 'core technology' to proceed with the research projects. In many cases, researchers made or suggested research hypotheses and discussed viability with other researchers such as statisticians. Because disciplines of science are highly specialised, researchers from those backgrounds sometimes worked independently. However, at a particular stage of their research, they had to consult with their superiors or advisors who were KM doctors. Some researchers occasionally expressed complaints about the unviability of some research projects such as the integration of Sasang medicine with genetics. This chapter also discusses underlying conflicts and the negotiation of knowledge within different paradigms.

Chapter 6. Practising Sasang medicine focuses on the clinical practice of Sasang medicine in the private and practical setting. It aims to explore how different clinical interpretations coexist within and outside the circle of Sasang medicine. It presents a medico-scape called *rok'ŏl* (local), which consisted of relatively autonomous private clinics and enabled diverse clinical practices of Sasang medicine that were endorsed based on practitioners'

practical purposes. This chapter provides ethnographic examples of variability in the interpretation of Sasang medicine: the first is striving for authority among the various lineage-based practitioners; the second deals with competing for legitimacy by discussing whether a creative interpretation of the Sasang medical theory could be an 'innovation'; and the third is about combining Sasang medical knowledge with other bodies of knowledge – anatomical/biomedical information and analytic psychology - for clinical practicableness. Therefore, this chapter demonstrates various ways of knowledge production and its modes of existence in the world of Sasang medicine.

Conclusion elaborates the discussion of "what *ch'ejil* (constitution) is" in Sasang medicine, how it was understood, different, and transformed in each setting. As will have become evident by then, *ch'ejil* played an important role in raising the legitimacy or "efficacy" of Sasang medicine. Specifically, this will have been shown by examining how Sasang medicine became known in Korea and how it was institutionalised in the Korean healthcare system; how it is distinguished from other forms of Korean medicine; how the authoritative form of Sasang medicine is established; how the authoritative form is reflected or created in the standardised education and in the bioscientific research setting, and whether there are any conflicts or negotiations among different actors; and how different styles of Sasang medical practice exist in the private setting, which is more flexible to diverse practices compared to the standardised official setting.

Chapter 2. Historical and Theoretical Explorations of Constitution in Sasang Medicine

This chapter discusses the different notions of 'constitution' (*ch'ejil* in Korean transcription; 체질 in Korean; 體質 in Chinese characters) in Sasang medicine. To do so, this chapter traces historical and theoretical trajectory of Sasang medicine in formation. In other words, this chapter poses two questions. First, how did Sasang medicine, which emerged from a peripheral region of the Korean peninsula, become included into the official Korean medical curriculum? Second, how is it possible that Sasang medicine has a different medical framework than others on the Korean peninsula? Answering these questions, this chapter aims to illuminate how the conception of constitution was transformed and influenced by various factors. Furthermore, this chapter critically examines the formation of Sasang medicine. This will be achieved by arguing that the term "Sasang medicine" was made not by Yi Chema himself but by his disciples and followers, and that the emergence of Sasang medicine in the Korean public sphere was possible because of prevailing discourse in society in the 1930s with the integration of foreign theories such as the ABO blood type theory.

2.1. Sasang Medicine as a Distinctive Medical Culture

Yi Chema and His Academic Background

To understand the context of the emergence of Sasang medicine, it is worth investigating the background of the person hailed as its inventor and founder. Yi Chema[28] (李濟馬; 1837-1900), whose pen-name was *tong-mu* (literally, a warrior of the East; 東武), was from a central city in the north-eastern part of the Korean peninsula, Hamheung, which had long been discriminated against and marginalized in Chosŏn Korea. Suh (2013:444) explains that the northern part of the Korean peninsula was a political and cultural margin, whereas influential families and key figures in academia and politics were mostly southerners. Furthermore, it is known that Yi Chema was born as an 'illegitimate son' (*sŏŏl* 庶孼) to a *yangban* (兩班) family.[29] This condition brought many restrictions to his entry to government service; he could do so after initially beginning his career in the military. After retirement in 1898, he opened a private clinic in his hometown and treated patients until his death in 1900 (Koh, 2019:10).

Yi Chema, as an individual, had never connected to a major network of politics, scholarly learning, or medicine. He gained medical expertise neither by passing the state examination nor by belonging to a family of famous physicians. It is known that Yi Chema's self-study, his many years long accumulated experience in his hometown, and his scholarly

[28] There are also other expressions when referring to his name in English. The most known are 'Lee Jema', 'Lee Je-ma' or 'Yi Che-ma'. In line with the McCune-Reischauer romanisation system and the official way to write the Korean surname '이' (李) in English, this thesis uses 'Yi Chema' as the romanisation of '이제마' (李濟馬).

[29] *Yangban* is the term designating the entire landholding class. It is the highest social class of the rigidly hierarchical class system in the Chosŏn dynasty (1392-1910) of Korea, which is composed broadly of four classes: *yangban*, *chungin* (intermediate class 中人), *sangmin* (common people 常民), and *ch'ŏnmin* (lowborn people 賤民). The class of yangban alone was entitled to take civil service examinations and was exempt from military duty and statute labour. However, if one was *sŏŏl* from a *yangban* family, one was not fully recognized as *yangban* and faced many restrictions and discriminations, such as restrictions on taking civil service examinations (See Lett (1998:14-32) for the details of the Yangban tradition and the Chosŏn dynasty).

dialogue with an unknown teacher helped him make extraordinary achievements in medicine. Yi Chema's marginal and relatively modest background is contrasted with that of another prominent medical figure in Korea, Hŏ Chun (許浚; 1539-1615) who worked as a court physician and received unconventional support from a royal family (Suh, 2013:444). The general view of Yi Chema is that he practiced and wrote medicine as a self-taught doctor on the margins of society (ibid.).

Yi Chema's personal history and his intellectual background are not very well known. Suh (2013:442) supposes Yi Chema's conception of Sasang might be ascribed to his study of the *Mencius*, to Chosŏn elites' Neo-Confucian pursuit of human nature, or to Yi Chema's exposure to emergent Confucian ideas at that time, later called "Practical Learning" (*shirhak* 實學).[30] Yeo (1998:28) elaborates on those different views in detail. He firstly points out Sasang medicine has the uniqueness of having absorbed the strong influence from Confucianism and emphasizes a certain Confucian ethical directionality. He explains that before the emergence of Sasang medicine in the late 18th century, traditional Korean medicine only had a relationship with Confucianism in terms of the social aspects of medical practice, but medical theory was not considered to relate in any way with Confucianism in its internal logics. Yeo emphasizes the close connection that Sasang medicine made with Confucianism not only externally, but also internally. Neo-Confucianism in the Chosŏn dynasty was the ideology of the rulers and this strongly affected the common people at that time. However, at

[30] Seth (2016:222) explains that *shirhak* or "Practical Learning" is a modern term used to categorize a number of thinkers who had different concerns of critical scholarship emerged in the seventeenth and especially in the eighteenth century of Chosŏn Korea. They had a lively intellectual curiosity in a wide variety of areas, yet they shared a desire to correct social and political injustices.

the same time, Neo-Confucian learning in Chosŏn also transformed significantly due to ongoing controversy. The most representative one, Yeo (1998:30) argues, is the controversy on the transcendental and intrinsic nature of the Principle (*i* 理). There was confrontation between the view of 'seeing the Principle as being transcendent' – the dualism of the Principle and the Vital Force (*igiiwonron* 理氣二元論) – and another view of 'the principle that patterns the universe' (that is, *i* 理) as being not in a transcendent and dominating relationship to the material aspects of the Universe (that is, *ki* 氣) but immanent to its existence – the monism of the Principle and the Vital Force (*igiilwonron* 理氣一元論) (Yeo, 1998:30). However, the discussion of the transcendence versus immanence of the Principle developed not only in terms of the Discourse of Cosmology (宇宙論), but also in terms of the Discourse of Human Nature (心性論). This interest in the Discourse of Human Nature became the most characteristic feature of Neo-Confucianism in the Chosŏn dynasty.[31]

As time went by, the concept of *i* became more internalised in the late period of Chosŏn.

[31] One of the characteristic examples of the discussion on human nature was a debate known as the Four Beginnings and Seven Feelings (四端七情論) (Yeo 1998:30). Neo-Confucian scholars understood that human nature conventionally consisted of the Seven Feelings: joy (喜), anger (怒), grief (哀), fear (懼), love (愛), hate (惡), and desire (慾) which might not always be good; whereas a natural goodness argued for by Mencius (372-289 BCE) was seen in the disposition for compassion (惻隱之心), shame and dislike (羞惡之心), yielding and deference (辭讓之心), approving and disapproving (是非之心) which could be transformed into the fundamental virtues of humanity (仁), righteousness (義), propriety (禮), and wisdom (智). The issue of the debate was whether one side of human nature is governed by goodness and another by feelings that may not necessarily be good, or if human nature is one and good (Seth, 2016:189).

Yeo argues that Yi Chema's medicine, which emerged in the late Chosŏn Dynasty, needs to be understood in view of this philosophical transformation (Yeo, 1998:30). Neo-Confucianism of Chosŏn particularly emphasized the aspect of self-cultivation, and thus, it focused more on the theoretical discussion of human nature (*shimsŏng* 心性) rather than on the art of national governance (*t'ongch'i* 通治). This emphasis was associated with the strong influence of the book *Mencius* on Neo-Confucianism in Chosŏn, because the *Mencius* dealt with the issues of the mind and human nature in detail. Yeo points out that the influence of the *Mencius* was reflected in Yi Chema's Sasang medicine, which began from the same point: discussions on human nature and feelings (Yeo, 1998:33).

Yeo (1998:31) introduces another view which argues Yi Chema may have been part of the group of 'scholars who studied practical matters' (*shirhak-cha* 實學者) in the late Chosŏn Dynasty. That is, Yi Chema's critical attitude to the then prevailing ideology – that is, Neo-Confucianism – was related to the attitude of Chŏng Yakyong (丁若鏞; 1762-1836).[32] Quoting an argument by Yi Ŭlho, a renowned scholar in Korean philosophy and Sasang medicine, Yeo describes that the philosophical background of Chŏng Yakyong is not Neo-Confucianism (*shin yuhak* 新儒學) but Original Confucianism (*wŏnshi yuhak* 原始儒學) (Yeo, 1998:31). Yi Ŭlho argued Chŏng Yakyong's point of view was distinctive in terms of focusing on practical matters

[32] Chŏng Yakyong, a preeminent philosopher and prolific writer, warned against the danger of any excessively narrow approach to moral cultivation, chiefly Neo-Confucianism in the Chosŏn dynasty. He emphasized people differ and, accordingly, that a specific formula which works for one person or one group may not work as well for others (Baker, 1999:199).

rather than on abstract concepts. Yi Ŭlho also saw Yi Chema's philosophical background as that of an Original Confucianist. It helped Yi Chema to avoid the doctrinal catechism of Neo-Confucianism in the late Chosŏn Dynasty (Yeo 1998:31). In this context of emergent practical Confucianism, it can be assumed that Yi Chema's philosophy and medicine stood on the realistic and reformative side against the society in his time.[33]

In addition to Yeo, the historian of science and medicine in Korea, Yi (2016) has undertaken extensive research on Yi Chema's learning. Yi pays attention to Yi Chema's style of writing. Analysing one chapter from *Donguisusebowon* (*Prolonging the Life and Preserving the Origin in Eastern Medicine* 東醫壽世保元), he argues that during the intellectual upheaval at the end of the 19th century, Yi Chema took a 'forward-looking' attitude, rather than 'the principle of revering the old' (*sanggojuŭi* 尙古主義) (Yi, 2016:39). According to Yi, the reason why Yi Chema was able to present medical thinking and practice very different from the predecessors was because he was able to go beyond the traditional epistemological framework. He did this by historicizing the knowledge and practice of East Asian medicine. In general, the authority of the classical/canonical text was superior to texts conveying an individual physician's experience before the 20th century. The principle of being attentive to the present[34] was also contained in the classical texts, which enabled the dynamic

[33] Yeo (1998:31) warned that this view is based on the unproved presupposition that 'practical learning' should be based on Original Confucianism and this view is uncritically adopted by followers of Sasang medicine. During my fieldwork, I also observed similar attitudes from some of my interviewees, who argued Sasang medicine is a new medicine distinctive from others in the past.

[34] For example, there are maxims of "grasp the patterns [of disorders] with facing the season/time" (臨時參證) or "a doctor should be attentive [to the situation and symptoms of the patient]" (醫者意也) that were emphasized to KM doctors when reading classical texts.

understanding of the tension between text tradition and current experience.[35] Thus, it led to the emergence of different methods of medical thought and practice, depending on time and region. For example, the Warm disorder current of learning (*wenbing xuepai* 溫病學派) in China and the Ancient Formula Current (*kohoha* 古方派) in Japan developed their own medical traditions amid these intellectual tensions (ibid.; see Hanson, 2011 and Trambaiolo, 2014). Finally, a third reason why Yi assumes Yi Chema's thinking happened outside the tradition of Chosŏn's Neo-Confucianism is that Yi Chema used Confucius' words in his writings but their wording is quite different from the common usage of Confucius sayings in other books used at the Chosŏn court (Yi, 2014:212). Yi Chema did not clarify the new definitions of these words in his books. Instead, he developed his own unique style of writing, which is schematic multi-layered. It had the effect that contemporary readers cross-refer within the text to find out the meaning of the terms and concepts he used to express his thoughts and intentions (ibid.:210-11).

In sum, I presented two viewpoints by Yeo and one by Yi regarding the question of how the foundation of Yi Chema's philosophy and medicine was different from former ones. Although many aspects of Yi Chema's life and academic background are not known, it seems certain that Yi Chema's philosophy and medical thought originated outside the orthodox Confucius tradition at the Chosŏn court. At the geographical and socio-cultural margin of the intellectual influence, Yi Chema engaged with the Confucian debates in his own way. This

[35] As for experience in the East Asian context, Farquhar (1994:2) explains that experience (*jingyan* in Chinese transliteration; 經驗) is more historical, collective, and discursive than the individualistic life narratives that the English word experience connotes. In addition, describing a case of a senior doctor in Chinese medicine, Hsu (1999:99) clarifies the doctor claimed to have not only his 'own experience', but also his knowledge of the classics, and the 'experience of the ancients'.

provided the foundation for him to create the conception of Sasang, or so called *ch'ejil* which encompasses Confucius' virtues as well as bodily attributes relevant to medicine. This connection between Confucius' virtues and bodily medical attributes was new to the history of Korean medicine.

Yi Chema's Rearrangement of Classical Medical Texts

Investigating the philosophical aspects of Yi Chema's thoughts is far beyond the focus of this thesis. Rather, to help readers understand the outline of Sasang medicine in later chapters, this section tries to briefly explore how Yi Chema rearranged classical medical texts to build his own medical culture.

It is generally known that the idea of people's constitutional difference is first seen in the *Yellow Emperor's Inner Canon* (*Huangdi neijing* 黃帝內經) (Lu, Yoo, & Lee, 2010:251).[36] The chapter of *Connecting with Heaven* (*Tongtian* 通天) in the *Divine Pivot* (*Lingshu* 靈樞) introduced the Five Appearances among People (*wutairen* 五態人). Although it explained five types of people with the terms of *Taiyin* people (太陰之人), *Shaoyin* people (少陰之人),

[36] For the details of the *Huangdi neijing*, see Hsu's (2010:4) succinct but comprehensive explanation: "the *Huangdi neijing* is generally considered the earliest and most important canonical work of Chinese [and Korean] elite medical knowledge. … It is to be assumed that several books by this title were in circulation in antiquity and that the earliest version of the extant compilation probably dates from the first century CE (Unschuld, 2003:5), which in its extant form is the heavily revised edition from the Song dynasty (960-1279 CE) (Sivin, 1993). In its extant form it consists of two books, *Suwen* (the Basic Questions) and *Lingshu* (the Divine Pivot), but the same materials are organised differently in the *Huangdi neijing Taisu* (Grand Basis)."

Taiyang people (太陽之人), *Shaoyang* people (少陽之人), and *Yinyang*-balanced people (陰陽和平之人), it was limited in portraying their [physical or observed] shape (*qizhuang* 其狀) only.[37] Meanwhile, there was another chapter of the same book which introduced constitutional difference. The chapter of *Twenty-five people of Yinyang* (*yinyang ershiwuren* 陰陽二十五人) in the *Divine Pivot* provided another five types of people based on the theory of the Five Phases (*wuxing* 五行). The five original types of people were introduced as people with the forms of Wood [木形之人], Fire [火形之人], Earth [土形之人], Metal [土形之人], and Water [水形之人]. Each of these are divided into four subcategories, therefore twenty-five types in total when added to the five original types (Kang & Im, 1998:139). However, it is claimed by scholars of Sasang medicine that Yi Chema commented on the *Divine Pivot* that barely discusses the principle of the viscera (*jangri* 臟理) and just centred on the appearances of the people. It merely made reference to the different types of people according to the five phase theory (Koh *et al.*, 2008:61-62).

It is known that Yi Chema studied not only the *Inner Canon*, but also creatively

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[37] The related passage is as follows: "黃帝曰, 夫五態之人者, 相與毋故, 卒然新會, 未知其行也, 何以別之. 少師答曰, 衆人之屬, 不如五態之人者, 故五五二十五人, 而五態之人不與焉. 五態之人, 尤不合於衆者也. 黃帝曰, 別五態之人奈何. 少師曰, 太陰之人, **其狀**黮黮然黑色, 念然下意, 臨臨然長大, 膕然未僂, 此太陰之人也. 少陰之人, **其狀**清然竊然, 固以陰賊, 立而躁巆, 行而似伏, 此少陰之人也. 太陽之人, **其狀**軒軒儲儲, 反身折膕, 此太陽之人也. 少陽之人, **其狀**立則好仰, 行則好搖, 其兩臂兩肘, 則常出於背, 此少陽之人也. 陰陽和平之人, **其狀**委委然隨隨然, 顒顒然, 愉愉然, 瞭瞭然, 豆豆然, 衆人皆曰君子, 此陰陽和平之人也." (emphasized by the author)

adopted the categorizations and the symptoms in the *Treatise on Cold Damage* (*Shanghanlun* 傷寒論).[38] Although overlaps are found in terminologies they used, Yi Chema did not follow the pathological patterns according to the Six Warps (*yukkyŏng pyŏngjŭng* 六經病證)[39], rather he re-classified symptoms in the *Treatise on Cold Damage* into his own category of the four types centred on human differences. This was possible because he prioritized 'people' (*inmul* 人物), while Zhang focused on 'patterns' (*chŭng* 證) of being ill. Four types of people were identified as *soŭmin* (少陰人), *soyangin* (少陽人), *t'aeŭmin* (太陰人), and *t'aeyangin* (太陽人), and each reflected the dissimilar nature of human physiology, strength and weakness of the visceral system, uneven senses of morality, and the ups and downs of emotional characteristics[40] (Suh, 2013:438-9). In addition, in "Treatise on the Origin of Medicine"

[38] The *Shanghanlun* is attributed to a historical person Zhang Zhongjing, governor of Hunan Province in the second century A.D. The set of ideas embodied in this work formed a medical tradition distinguished from another medical tradition by the *Huangdi neijing* (Agren, 1986:212).

[39] According to Agren (1986:216-7), unlike the *Huangdi neijing*, the *Shanghanlun* does not make of any channel system in the recognition of signs and symptoms. The *Shanghanlun* merely knits together *status praesens* with an appropriate drug combination. Symptomatological change is followed day by day during the course of a disorder - usually an infectious disorder caused by external pathogenic tendencies. The phenomena of disorder were followed longitudinally in time, and their successive manifestations made the targets for drug interventions. The penetration of external pathogens is analysed in a highly characteristic fashion by dividing it into six stages named the Six Warps (*liujing* 六經). The Six Warps were named by the sixfold ying-yang terminology, with no connotation of channel or acupuncture. The constellation of symptoms in each stage is called *taiyangbing* (太陽病), *yangmingbing* (陽明病), *shaoyangbing* (少陽病), *taiyinbing* (太陰病), *shaoyinbing* (少陰病), and finally *jueyinbing* (厥陰病), in the order in which the symptoms become serious.

[40] As for the ups and downs of emotional characteristics, for example, Yi Chema explains Taeyang person has sudden anger and deep sorrow (暴怒深哀); Soyang person has sudden sorrow and deep anger (暴哀深怒); Taeeum person has profligate pleasure and deep joy (浪樂深喜); Soeum person has profligate joy and deep pleasure (浪喜深樂). For more details, see the *Treatise on the Four Beginnings* (四端論) of the *Donguisusebowon*

(*ŭiwŏllon* 醫源論), a part in *Donguisusebowon*, Yi Chema reclassified symptoms of *taiyinbing*, *shaoyinbing*, and *jueyinbing* as symptoms of *soŭm* people; symptoms of *shaoyangbing* as symptoms of *soyang* people; symptoms of *taiyangbing* and *yangmingbing* as symptoms of *soŭm* people (Koh *et al.*, 2008:62). Suh (2013:439) indicates that Yi Chema's classification of people and his recomposition of symptoms also reflect his observation of Korean people and clinical experience, in addition to the influence of the numerology of four from the Mencius.

Morevoer, Yi Chema claimed he had adopted several prescriptions from the *Treatise on Cold Damage*, reaching 37. He also quoted medical case histories (*ŭian* 醫案)[41] from the *Treatise*. It is claimed that 66 out of 137 medical case histories in the book were from the *Treatise*. This shows that the *Treatise* had a big impact on the theory of disorders in *Donguisusebowon* (Koh *et al.*, 2008:62). Not only the *Treatise*, Yi Chema's seminal book quotes various classical texts not only from Chinese ones such as the *Book of Saving People* (*Huorenshu* 活人書), the *Mirror of Ancient and Modern Medicine* (*Gujin yiguan* 古今醫鑑), the *Introduction to Medicine* (*Yixue rumen* 醫學入門), but also from Korean ones such as the *Assembled Categories of Medical Prescriptions* (*Ŭibang yuch'wi* 醫方類聚) and the *Treasured Mirror of Eastern Medicine* (*Tongŭi bogam* 東醫寶鑑). Based on those materials, Yi Chema developed his own idea of concepts of disorders and prescriptions. According to Suh

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of 1901.

[41] *Ŭian* or *yi'an* (in Chinese pinyin) is individual records of the diagnosis and treatment of a single patient by a single physician (Cullen, 2001:297). For examples of medical case histories in Late Imperial China, see Cullen (2001), and Andrews (2001), and for a detailed history, see Furth, Zeitlin and Hsiung (2007).

(2013:439), Yi Chema highlighted how his own prescriptions were built on past knowledge of herbs. For instance, Yi Chema first picked up 23 formulas from the *Treatise*, which would work for those who belong to the Soeum people, then 13 formulas from the above books by the Song, Yuan, and Ming physicians were added. Finally, he suggested his own 24 prescriptions, by adding or subtracting herbs according to his Sasang constitutional framework. For example, if Cinnamon Twig Decoction (*guizhitang* 桂枝湯) was prescribed by Zhang Zhongjing, Cinnamon Twig Plus Aconite Accessory Root Decoction (*guizhi fuzitang* 桂枝附子湯) was designed by Li Chan (李梴), and, lastly, Yi Chema's own solution was built on by adding milkvetch root or ginseng to the older formulas. By doing so, he introduced Astragalus, Cinnamon Twig, and Aconite Accessory Root Decoction (*huangqi guizhi fuzitang* 黃耆桂枝附子湯) or Ginseng, Cinnamon Twig, and Aconite Accessory Root Decoction (*renshen guizhi fuzitang* 人蔘桂枝附子湯) which are suitable for Soeum people. In this way, Yi Chema introduced more than 100 prescriptions in total and put them into the category of Sasang constitutions.

Suh (2013:440) points out that Yi Chema's organizing principle is partly consonant with the author of the *Treasured Mirror of Eastern Medicine* Hŏ Chun's emphasis on the interaction between the 'surface' (表) sign and the 'interior' (裏) root. Not only the organizing principles, but also textual components reflect Yi Chema's reliance on Hŏ Chun. Yi Chema never directly mentioned the *Treasured Mirror*, but most of Yi Chema's Chinese originals were actually constructed through sentences in the cold (寒) section of the *Treasured Mirror.* In fact,

all of Yi Chema's Chinese references were already examined in that section. Even some of Yi Chema's sentences are much closer to those in the *Treasured Mirror*, which were arguably modified by Hŏ Chun, than the Chinese originals. Valuing Hŏ Chun is also seen in a chapter of *Donguisusebowon*, juxtaposing Hŏ Chun with other great Chinese physicians in history. By employing 'Eastern medicine' (*tongŭi* 東醫) in his title, Yi Chema alluded that the lineage first originated with Zhang Zhongjing was then mediated by Hŏ Chun and was to be succeeded by Yi Chema himself, not just revering the old (ibid.:441).

In sum, Yi Chema's thoughts and use of terms certainly had origins from classical medical texts. In particular, Yi Chema consulted Hŏ Chun's interpretation of *shanghanlun* which emphasized the interaction between the 'surface (表)' sign and the 'interior (裏)' root (Suh 2013:440). In other words, it can be said that Yi Chema inherited Hŏ Chun's medical thoughts and the conception of the body. However, he went further by incorporating his own idea of the constitutions based on his innovative interpretation of Confucianism, which was selectively gathered from philosophical streams of thoughts at that time. By doing so, he devised his original thought of constitutions which could respond the issue of the moral body as well as the medical body at his times.

2.2. The Formation of Sasang Medicine: From the Margins to the Mainstream of Korean Medicine

2.2.1. The Formation of 'Sasang Medicine' as a Term

This part explores how 'Sasang Medicine' is constructed, in the aspects of its use of terms such as 'Sasang', 'Sasang medicine' and 'Constitutional Medicine' (*ch'ejil ŭihak* 體質醫學). Notably, the word *ch'ejil* (constitution 體質) did not appear in Yi Chema's writings, nor did Lee call his medicine Sasang medicine. According to Shin (2006:152), it is likely that the term Sasang medicine was not popular until the 1910s, which is ten years after Yi Chema's death.

In 1914, a magazine of traditional Korean medicine titled *Hanbang ŭiyakkye* (*The World of East Asian Medicine* 漢方醫學界) introduced the outline of four constitutional types of human beings under the title of "A Theory that Human Beings are Originated from the Four Types" (*Inyusasangsŏl* 人由四象說):

> If one is born according to the four types: greater yang (*t'aeyang* 太陽), greater yin (*t'aeŭm* 太陰), lesser yang (*soyang* 少陽), and lesser yin (*soŭm* 少陰), is the beautiful or the ugly of one's physique the same? No. Is the big or the small the same? No. Is the generous or the fierce of one's character the same? No. Is the keen or the dull of one's character the same? No. The big or the small of one's ear and nose, the long or the short of one's eyes are never the same. Nor are the viscera of humans. … Our entrails are not the same in size, and a doctor should give a different prescription to each patient. If only doctors would give medicine according to the four types, all the diseases would be cured. Yi Chema revealed for the first time what previous medical men had

never found out (Kang Won-hu 1914:33).[42]

As seen above, the concept of Sasang medicine was explained although the term "Sasang medicine" was not explicitly used. The first manuscript which used the term Sasang medicine was *Explanations for Sasang Medicine* (*Sasang ŭihagŭi haesŏl* 四象醫學의 解說) by To Ŭnkyu (都殷珪; ?-1940). The manuscript was published in the *Monthly Magazine of the Association for Researching Eastern and Western Medicine* (*Tongsŏ ŭihak yŏn'guhoe wŏlbo* 東西醫學研究會月報) from January 1924 to September 1925 (Shin 2006:153). The Association for Research Eastern and Western Medicine (*Tongsŏ ŭihang yŏn'guhoe* 東西醫學研究會) was the representative association of KM practitioners at that time and To Ŭnkyu was one of the most active members who often contributed articles on Sasang medicine to its magazine (Huang, 2017:170; Kim, 2013:22). Considering that the author was the physician who came from the same region with Yi Chema (Kim, 2013:22), it is likely that there was a regional tradition of calling the medicine "Sasang medicine".

The term "sasang medicine" later encountered a remarkable linkage with another term "constitutional medicine" (*ch'ejil ŭihak* 體質醫學). In 1933, Yi Ŭlho (李乙浩; 1910-1998), a student at Kyŏngsŏng Pharmaceutical College (京城藥學專門學校) of colonial Korea, published an article arguing *sasangŭihakŭn ch'ejirŭihak* (Sasang Medicine is constitutional

[42] Quoted in Shin 2006:152.

medicine) in the *Magazine of the College Alumni Association* (*Gyowu hoeji* 校友會誌) (Shin 2006:154). According to Shin (2006:154), medical discussions of constitution were very popular at that time. Many newspaper articles and magazines introduced information such as "a certain constitution is connected with a certain disease; a certain constitution a certain character." In this context, constitution was related to the four types from the ABO blood type theory, which was regarded as the latest scientific discovery and crucial evidence of constitutional theory at that time. Yi Ŭlho used the concept of constitution to associate Sasang medicine with the ABO blood type theory to justify it to the modern intellectuals and general public. At this point, it would be necessary to examine how the ABO blood type theory was imported to Korea and how it was used to legitimize the existence of Sasang medicine in detail as it illuminates some clues on the colonial origin of the term 'Sasang Constitutional Medicine'.

2.2.2. A Three-fold History of the ABO Blood-type Theory and Sasang Medicine[43]

The Birth of the ABO Blood-type Theory in the West

In general the ABO blood-type theory is traced to Karl Landsteiner (1868-1943). The determination of the ABO blood types is regarded as a milestone in the development of surgery since the 19th century. The development of safe transfusion methods by the determination of the ABO blood types had to the innovation by eliminating the problem of bleeding during

[43] This section is an attempt to integrate discussions by Robertson (2012) on the appropriation of Western blood research in imperial Japan, Jung (2012) on the blood research in imperial Japan and its influence in colonial Korea, and Shin (2006) on the nationalistic acceptance of Sasang medicine in colonial Korea.

surgeries. Intermingled with the social atmosphere at that time, Landsteiner's discovery of the ABO blood types soon stimulated people's imagination on ethnology. For example, German internist Emil von Dungern (1867-1961) was interested in the origin, evolution, and heredity of the blood types of mammals after discovering that most mammals have blood type B except for chimpanzees and humans who mostly have A-type blood. In 1910, he discovered the heritability of the A, B, O and AB blood groups with the assistance of Polish serologist Ludwik Hirszfeld (Robertson, 2012:97).

Ludwik Hirszfeld (1884-1954), a student of von Dungern, developed a hypothesis that blood types evolve from type B to type A and attempted to verify it through blood-type grouping on existing races and ethnicities. Originated from this hypothesis, he conducted an experiment and published an article in the Lancet. Its title was: "Serological difference between the blood of difference races: the result of researches on Macedonian Front" (ibid.; Hirszhfeld & Hirszfeld, 1919:675-9). In this article, he presented the "Biochemical Race Index" as a coefficient of differences in blood type distribution among different races or ethnicities. Based on the hypothesis that type A is a more evolved form than type B, he conjectured that in reality the blood type distribution of race and ethnicity would increase the frequency of appearance of type A among Caucasians and would be more frequent for type B among peoples of colour. Then he argued that the results of the investigation were as he had predicted. His research strongly implied that the Biochemical Race Index could be used as an identifier of ethnic groups (Jung, 2012:524). In effect, after Hirszfeld's study, research on the blood types have made the distinction of race/ethnicity more precise, while seeking the applicability of the Biochemical Race Index in anthropology, criminology, and psychology. For instance, by gathering the results of blood type studies at that time, the Vienna-born American

anthropologist Reuben Ottenberg (1882-1959) further refined the grouping system of the blood types (ibid.) and was awarded Karl Landsteiner Memorial Award from the American Society of Blood Banks for "distinguished pioneering contributions to blood banking and hemotherapy."[44]

Hence, Hirszfeld's study had a great impact on the Western academia as a new scientific basis for justifying the hierarchical order of races which established colonial rule as 'natural'. Although the hypothesis that Hirszfeld set when he created the Index of race was completely rebutted by subsequent researchers such as Ottenberg, the Biochemical Racial Index remained and became the 'global standard' which supported the scientific justification of blood racism (Jung, 2012:527).

The ABO Blood-type Theory in Japan

Then how was the ABO blood-type theory transmitted to Japan and how was it transformed? It is regarded that the first research in Japan on the blood types was conducted in 1916 which discussed the relationship between natural and cultural temperament and blood type by physician Hara Kimata (1882-1922), who had studied in Germany with the doctor of internal medicine Emil von Dungern (1867-1961) (Robertson, 2012:97). When Ottenberg proposed that the "races" of the world could be classified into six categories on the basis of the pattern of distribution of the A, B, and O blood types, which six groups were European, Intermediate, Hunan, Indian-Manchurian, African-South Asian, and Pacific-American, he grouped the

[44] For the list of the recipients, see http://www.aabb.org/about/awards/Pages/recipientspast.aspx

Japanese in the Hunan category along with the Southern Chinese, Hungarians, and Romanian Jews. This view was challenged by the German-trained Japanese geneticist and physician Furuhata Tanamoto (1891-1975) by arguing that the Japanese and central Europeans - minus the Jews - should form one group (ibid.). Furuhata's proposal gained a lot of publicity in Japan at that time whereas it was ignored by Ottenberg. In a similar vein, scholars in the Japanese medical world, who investigated the blood types of Japanese people, encountered the question whether to locate Japanese people in Hirszfeld's categorization of races and ethnicities. They had ambiguous attitudes towards the science of eugenics which was pervasive in the West at that time and beyond.[45] They were hesitant to apply Hirszfeld's categorization to their investigation of the blood-type distribution in Japan because the investigation could reveal that Japan might be a country of 'coloured' people (Jung, 2012:528). Especially, the research on the efficiency of soldiers' work according to their ABO blood types showed that soldiers of type B, which was known as 'inferior', had much more appropriate aptitudes for military duties. This result made Japanese scholars be sceptical about the racial differentiations done in the West. They rather would use them to identify individuals' characters and how to dispose them into appropriate places by referring to the ABO blood types (ibid.:531).

Meanwhile, the public had developed a huge interest in the blood grouping. During the period of Japan's intensified imperialist aggression in Asia (1930-1945), Furuhata regularly contributed articles in newspapers which topics ranged from practical information on blood donation to blood-type character analysis (Robertson, 2012:98). In addition to Furuhata's public relations efforts to popularize the blood type theory, the sensationalistic publications and radio broadcasts of the social psychologist Furukawa Takeji (1891-1940) played a big role for

[45] Cf. See Dikötter (2015) on a Chinese case.

the popular culturalization of the blood-type theory (ibid.). Furukawa enthusiastically promoted the notion of a connection between blood type and personality. He simplified prevailing scientific theories about the racial distribution of blood types and melded them with an eclectic mix of psychological concepts, a combination which proved seductive to the general public. Practical applications of Furukawa's thesis followed. In 1930, for instance, a new blank for recording one's blood type was added to job application forms in the belief that such information would help to evaluate a candidate's employment potential (ibid.). In sum, the Japanese medical world was reluctant to regard the Biochemical Race Index as a decisive criterion for proving racial superiority, as in the West. Instead, they paid more attention to investigating people's social characters relating to the ABO blood types. Meanwhile, the attitude to relate blood type and personality prevailed among the general public as well as the medical world in Japan. This transformed trend of the blood typing influenced colonial Korea.

The Naturalisation of Japanese ABO Blood-type Theory in Colonial Korea, and Its Relationship with Sasang medicine

In Korea, the ABO blood type theory was introduced in the 1920s. The blood-type grouping was regarded as cutting-edge medical science at that time and was readily used for justifying the discrimination of races and ethnicities (Jung, 2012:514). It was promoted primarily in colonial medical research and educational institutions such as the college of medicine at Kyŏngsŏng Imperial University (京城帝國大學), Kyŏngsŏng Medical College (京城醫學專門學校), and Severance Medical College (Severance 醫學專門學校). Especially, the Department of Forensic Medicine at Kyŏngsŏng Imperial University, which had a strong

identity of ‘social medicine’, executed systematic investigations on the blood types. Established in 1929, the Department of Forensic Medicine was backed by a significant amount of funding from Japanese institutions compared to other departments in the university. The Department conducted systematic investigations in 1930 on the distribution of the blood types of Korean people for four years. In 1934, it extended the research focus to people of Northeast Asia such as Manchuria, Inner Mongolia and constructed extensive databases on it. In doing so, it pioneered the field of the ‘anthropology of blood types’ (血液人類學) in collaboration with the Department of Anatomy at the same university, which was trying to statistically verify the differentiation and hierarchy of races and ethnicities by measuring biometric information of the Japanese and the other surrounding ethnic groups (ibid.:515).

Following this trend, the discussion of *ch’ejil* (constitution 體質 체질) was very popular in the public sphere. According to Shin (2012:6), newspapers and magazines at that time were full of the information such as “what kind of constitution is likely to have certain diseases, what kind of constitution has certain characters”. In particular, the discovery of the ABO blood types, which postulated four different types, was recognised as a welcome basis for a constitutional theory (Shin, 2012:6). Studying at Kyŏngsŏng Pharmaceutical College (京城藥學專門學校), Yi Ŭlho (李乙浩; 1910-1998) was at the intersecting point between the colonial concerns and the public interests in the blood-type research. As well as a beneficiary of modern medical education, he had an interesting background of being taught Sasang medicine from an apothecary Ch'oe Sŭngtal who was known to treat Yi Ŭlho’s tuberculosis and

tried to distribute Sasang medicine.[46] In 1933, Yi Ŭlho published an article titled "Sasang medicine is constitutional medicine" in the *Magazine of the College Alumni Association* (*Gyowu hoeji* 校友會誌) (Shin, 2006:154). In the article, he argued that there seemed to be many similarities between the ABO blood grouping theory and Sasang medicine in that the former's relating four different personalities was similar to the latter's having a theory of four types and four kinds of *sŏng-jŏng* (nature-emotion 性情) (Yi Ŭlho 1933:8 in Shin, 2012:6). Furthermore, he compared four types of Sasang medicine – the lesser yang type (i.e. *soyangin* 少陽人), the lesser yin type (*soŭmin* 少陰人), the greater yin type (*t'aeŭmin* 太陰人), the greater yang type (*t'aeyangin* 太陽人) – to psychological characteristics of four blood types such as the sanguine temper (type B), the melancholic temper (type A), the phlegmatic temper (type O), and the choleric temper (type AB), respectively (Yi Ŭlho 1933:23-4 in Shin 2006:154).[47] He took a critical attitude toward the existing Korean and Western medicines being not far from symptomatic treatment, which did not consider the cause of diseases, that is, people's characteristics. By doing so, he insisted that Sasang medicine was at the apex of traditional Korean medicine and urged it could surpass both of existing Korean and Western medicines which in his views were unaccomplished (Shin 2006:155). As mentioned earlier, Yi

[46] This information on the relationship between Ch'oe Sŭngtal and Yi Ŭlho was obtained from an interview in July 2017 with Professor Lee, the main figure of the ethnography in Chapter 3.

[47] I could not check the original sentences of Yi Ŭlho's article in 1933. In his later work in the 1990s, he stepped back from arguing the close relationship between the ABO blood-type theory and Sasang medicine. He wrote: "given that the blood types are also classified into four types, it has been of great interest to see if there is any correspondence between the ABO blood-type grouping and Sasang medicine. Although there are some similarities in terms of explaining body structures or personalities, it has been confirmed that they do not correspond at all. I don't think we need to insist on this, as it is a statistical fact that many scholars have experienced in research." (Hong & Lee, 1995[1973]:392).

Ŭlho had educational backgrounds of both studying at a Western pharmacy school in a higher educational setting and with a practitioner of Sasang medicine in a private setting. Hence, he was in-between the science of the colonial gaze and the science of public interests. His argument of Sasang medicine as a constitutional medicine was a breakthrough in that it overcame the colonial rhetoric of derogating traditional theories and yet used a logic of science from the colonial authority at the same time.

2.2.3. Relating Sasang Medicine with Korean Nationalism

There is another noteworthy example of how Sasang medicine came to be part of the institutionalised Korean medicine and attracted public interest. In the 1930s, Cho Hŏnyŏng (1900-1988), a distinguished man of letters, was one of Korea's intelligentsia who paid attention to Sasang medicine. He graduated from the Department of English Language and Literature at Waseda University in Japan and served as the president of the Tokyo chapter of *Shin'ganhoe* (The New Trunk Association 新幹會), a Korean nationalist organization founded in 1927 which encompassed both of Korean socialist and nationalist factions and maintained a unilateral independence movement until their confinement in 1931. After the confinement, he came to Korea and developed his own understanding of Korean medicine, then published several books about Korean medicine, mainly for the general public rather than for experts and practitioners of Korean medicine (Baik, 2019:122). His life trajectory could be regarded as an exemplar of nationalists in this period. According to Breuilly (1985:156), anti-colonialism is one of the main forms of nationalism, and resistance to imperial power can be looked at in

terms of how it led to modifications in the collaborator system. That is, it is about how 'modern elites' succeed in detaching the indigenous political elements from the colonial regime until they eventually formed a united front of non-collaboration against it (ibid.:160). Likewise, Cho Hŏnyŏng, a college-educated elite, wrote several articles on Korean medicine in a famous magazine called the *New East Asia* (*Shindonga* 新東亞)[48], which was written in Korean language[49], and actively engaged in founding an academic journal titled *Eastern Medicine* (*Tongyang ŭiyak* 東洋醫藥). In the first issue of *Eastern Medicine*, he argued that "Korean scholars who want to know oriental medicine (*hanŭi* 漢醫) cannot but learn *Sasang* Medicine as a matter of common sense as the theory was created in Korea" (Cho Hŏnyŏng 1935:151-7; in Shin 2006:155-6). By doing so, he aimed at escaping from the worship of China, which many of Korean medicine scholars persisted in doing, as well as in obtaining the status of a Korean uniqueness as a national identity against the Japanese imperial power.

Similar to Yi Ŭlho, Cho Hŏnyŏng's nationalistic attitude on Korean medicine did not exclude Western biomedical knowledge, which was rather different from traditionalists of Korean medicine. Suh (2017:77) explains Cho Hŏnyŏng competently employed biomedical

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[48] The *New East Asia* (founded in 1931) is the monthly magazine of the Dong-A Daily News (東亞日報). The preface of the first issue of the Dong-A Daily News implies the use of the term Dong-A (East Asia 東亞) to "recognise the rights of each nation". The original text is as follows: "特히 東亞에 在하야는 各民族의 權利를 認定한 以上의 親睦團結을 意味하며 世界全局에 在하야는 正義人道를 承認한 以上의 平和聯結을 意味함이라" (The Dong-A Daily News 1st April, 1920).

[49] The official language of colonial Korea was Japanese. As Anderson (2006:44-45) argues, print-language and print-capitalism play a role to form imagined communities, which use of Korean language contributed to establish Korean nationalism in this context.

examples to demonstrate that experts in traditional Korean medicine were far from being ignorant and old-fashioned. For example, based on his knowledge of anatomy and physiology, Cho Hŏnyŏng explained moxibustion and heat-acupuncture therapy were described as effective because of the interaction of white and red blood cells and digestive enzymes (ibid.).[50] This kind of integration between traditional medicine and Western biomedicine can be seen in neighbouring countries such as Japan and China. In Tokugawa Japan (1603-1868), for example, the Current of Ancient Learning (*kogakuha* 古學派) arose as a politically aware nativist intellectual endeavour, to oppose the Zhu Xi (1130-1200) brand of syncretistic Confucianism that was the state philosophy during the Tokugawa shogunate (Agren, 1986:217). Under the influence of this political and cultural atmosphere, a series of physicians known as the Ancient Formula Current (*kohoha* 古方派) rejected Chinese metaphysics to such a degree that channels, the Five Phases, and, in the end, even systematic ideas of the *Shanghanlun* such as yin and yang were discarded (ibid.). Agren points out that the *kohoha* tried to replace the older heuristic theories with Western medicine that gained momentum in the late eighteenth century (ibid.).[51] Meanwhile, Scheid (2001:375) notes that a professor of Chinese medicine who

[50] There is an interesting difference between Cho Hŏnyŏng and Yi Ŭlho, although both were intellectuals with higher education and advocated Korean medicine in general as well as Sasang medicine. According to Park Yunjae (2007:134), Cho Hŏnyŏng did not emphasize the Five Phases while he praised the Yin-Yang theory with engaging biomedical physiology and pathology. On the contrary, Yi Ŭlho embraced the Five Phases theory. Park analyses that Yi Ŭlho encountered the limitation of Western medicine while he was attending the college of pharmacy so that he had much more affection to the whole theories of Korean medicine, unlike the integrationists (ibid.). During the fieldwork, I also found that Yi Ŭlho had a lineage of Korean medicine (especially Sasang medicine) in addition to his official education career as a pharmacist and it strongly affected his attitude onto Korean medicine.

[51] Lock (1980:64) also analyses the reason why Japanese doctors in the *Kohoha* were encouraged to be pragmatic and experimental rather than devoted to classical theory and practice: first, since Todo Yoshimasu and later his son were leaders of one of the most important and influential factions during the Edo period (1603-1868), their reductionistic approach became widely accepted. Second, for most doctors, access to the limited editions of the comprehensive classical texts was impossible, and many of them did not read well. Finally, the raw materials necessary to perform a full range of classical East Asian medicine were rarely available. She also points out this

claims that he knows Western medicine and uses it to enlarge his personal understanding of disorders, without however showing much interest in biomedical information beyond disease names or basic diagnostic data such as blood pressure, blood sugar levels, or liver function tests. This could be expressed as an attitude of frequently using rhetorical phrases such as "Western medicine says … but Chinese medicine says …" (ibid.). In this case, biomedical knowledge played a role as providing legitimacy for Chinese medicine. As seen in examples of Agren (1986) and Scheid (2001), those practices are also related to a certain kind of nationalistic attitude, whether they are political, cultural, and anti-colonial, because they are based on the distinction between the self and otherness at the nation-state level as well as the individual level.

Overall, the term "Sasang medicine" was made not by Yi Chema himself but by his disciples and followers. Furthermore, the term of "constitution" or "constitutional medicine" was derived not from the debates in the texts of traditional Korean medicine, but from the discourses prevailing in society in the 1930s, with the integration of foreign theories such as the ABO blood type theory. It appears that Korean intellectuals found nationalistic ideas in Sasang medicine and tried to establish it as a nationalist pride to resist Chinese and Western powers during the period of political turmoil (Shin, 2006:161). Also, the combination between "Sasang" and "constitution" left room for future practitioners and scholars to make a compound "Sasang constitutional medicine (*Sasang ch'ejil ŭihak* 四象體質醫學)," to expand the boundary of Sasang medicine, and to not just remain as a traditional discipline.

Meanwhile, the clinical usefulness and effectiveness of Sasang medicine played a role

enhanced diversity, competition, and innovation in medical practice, trends which are still at work today in Japan.

that Sasang medicine could maintain its way of practice among practitioners during the first half of the 20th century. As Shin (2006:150) points out, Yi Chema's medical book was published seven times throughout the span of fifty-some years which is incomparable with other Korean medical books during the same time. Followers of Sasang medicine furthermore published many medical books which were more systematic and practical for the practice of Sasang medicine. Although some practitioners of Korean medicine regarded Sasang medicine as heresy, the repeated publication of Yi Chema's book and a variety of books detailing applied issues show the practicality of Sasang medicine not only for Korean intelligentsia but also for many practitioners of Korean medicine. Consequently, Sasang medicine acquired citizenship in both the public and the medical domain.

2.3. Summary

Sasang medicine has been continuously made to be adjusted to social and cultural conditions over time, regardless of whether the initiator was the founder or his followers. In the time of the founder, it was influenced by the legacy of the Confucian debates, particularly focused on the human nature and the numerology of four from the *Mencius*. The founder's clinical experience also affected to reclassify and reorganise existing medical knowledge from classics such as the *Treatise of Cold Damage* and *Donguibogam*. 'Sasang medicine' was also actively transformed by nationalistic movements in the Japanese colonial period in the early 20th century. Notably, Sasang medicine was finally given its name *sasang ŭihak* (Sasang medicine) and the concept of *ch'ejil*, which was not mentioned by the founder, was attached to

the explanatory model of Sasang medicine. By doing so, Sasang medicine gained a foothold for entering the mainstream of the Korean medicine circle as well as the mainstream intellectual society at that time.

Chapter 3. Meeting with Professor Lee: The *chŏngshin* (spirit 精神) of Sasang Medicine

This chapter explores a way of 'knowing (institutionalised) Sasang medicine', from a perspective of a renowned practitioner of Sasang medicine. This chapter especially deals with the meeting which I had with Professor Lee, a retired professor of Sasang medicine from Seoul University College of Korean Medicine (hereafter SUKM). He was known as a legendary figure who made great contributions to institutionalise Sasang medicine in higher education. The subject of Sasang medicine in the school curriculum was categorised to be 'clinical'.[52] However, during the interview, Professor Lee underlined Yi Chema's philosophy as more than clinical practice.[53] Professor Lee emphasised a thorough understanding of Yi Chema's writings, which encompassed not only practical knowledge of medicine but also complicated Confucian concepts. Meanwhile, Professor Lee also had experience of practicing biomedicine with a license that he was given in a special social situation (see 3.2). This enabled him to practice Sasang medicine in the KM hospital and to mobilise Western medical devices such as CT scans, which were state-of-the-art medical equipment in Korea in the late 1980s. This accordingly

[52] Under the existing system, it can be said that the KM curriculum consists of basic subjects and clinical subjects. The basic subjects include biology, chemistry, classical Chinese, medical history, classics, anatomy, physiology (KM/WM), pathology (KM/WM), acupoint studies (經穴學), herbology, etc, whereas the clinical subjects embrace internal medicine, acupuncture and moxibustion medicine, psychiatry, paediatrics, ENT, etc. This arrangement of KM subjects in the curriculum will be further explained in Section 4.1.1 of Chapter 4.

[53] Professor Lee's viewpoint contrasts with Farquhar (1994:1)'s observation in that Professor Lee emphasized 'philosophy' more than 'practice' in Sasang medicine. Farquhar's question was "How do [Chinese medicine] doctors know which statement [in classical medical texts] is correct?". She reported that invariably the answer was "We take experience [*jingyan*] to be our guide," or "We take practice [*shijian*] to be the main thing." The teacher in the KM school, as we will see in Chapter 4, hovered somewhere in between.

gave him pride and authority as a hospital doctor. However, Professor Lee's competence in Western medicine was seldom mentioned among his achievements of institutionalising Sasang medicine in KM hospitals. Instead, the authenticity of Sasang medicine, which lays the emphasis on the classical texts and the philosophy of Yi Chema, occupied the main space for legitimising Sasang medicine. By examining Professor Lee's life, teaching, and clinical practice, this chapter discusses this paradoxical observation regarding the institutionalisation of Sasang medicine.

This chapter borrows some analytical frameworks from previous studies. First of all, Hsu's (1999) analysis of the personal transmission of knowledge suits the setting dealt with here. She introduces her interlocutor mentor Zhang, a learned doctor of Chinese medicine who "seemed to have retained values and habits of Chinese medical learning that elsewhere had been abolished" (ibid.:88) after the socialist state was established in 1949. Analysing Zhang's mode of interpreting classical texts, Hsu describes different modes of interpretation: the indirect mode of interpretation, the authoritative mode, the justificatory mode, the mode achieved by recourse to everyday life, and the creative mode (ibid.:105). Notably, mentor Zhang interpreted the classical texts as 'scriptural' not 'historical', which would reflect the understanding of the text at the time it was composed. Hsu's project aimed to develop an understanding of how knowledge acquisition affected the quality of the knowledge learned. Her interest was to show how the same concepts *qi, yinyang, shen,* and others, taught in different ways in different settings, were imbued with different meanings and used to express different forms of authority, entailing different attitudes to knowledge. She attempted to develop a comparative gaze on knowledge, its sociality and its 'epistemic virtues', a project which Daston and Galison (2006) have since brought to perfection. Scheid 's (2002) example

of Professor Zhu also provides an analytical framework to explore the meeting with Professor Lee. Professor Zhu's example is more focused on the synthesis of various actors' contribution to an established medical routine. As a professor of Chinese medicine, Professor Zhu dealt with Western medicine as well as Chinese medicine, and added/deducted herbs from certain formulas based on diverse theories from different currents of Chinese medicine that Professor Zhu ingeniously synthesized (ibid.:134-163). In this point of the 'mangle' of practice (Pickering, 1995:21-7), as Scheid (2002:44-46) quotes for his investigation of Chinese medicine, Professor Lee's practice will be also discussed in the conclusion section.

I started my fieldwork in South Korea in March 2017. As I myself was a graduate of a Korean medical school, it looked more feasible to conduct anthropological research if the first contact points were the 'visible' and official institutions or organizations: schools of Korean medicine and academic societies of Korean medicine. Therefore, to find my field sites, along with asking my colleagues or teachers of Korean medicine for help, I searched websites on internet and found a KM school as a candidate for the initiation of my field work. Fortunately, a professor of Sasang medicine at Hanguk University College of Korean Medicine (hereafter HUKM) admitted me as an observer in his classes, which will be described in detail in Chapter 4. He also suggested to meet the current president of *Sasang ch'ejil ŭihak'oe* (the Society of Sasang Constitutional Medicine 四象體質醫學會 사상체질의학회; hereafter SSCM) and to attend their regular academic conferences. Following his suggestion, I attended a spring conference held in late March 2017 in order to see the current issues and concerns of the SSCM.

3.1. The Spring Conference: Tensions in the SSCM

The spring conference venue was at a hotel located in the very centre of the capital, Seoul, and was very close to the city hall and the central railway station. The conference's theme was on "How to Expand the Insurance Benefits for Sasang Constitutional Medicine" (*Hanŭihak kŭbyŏ hwaktae pangan*: *sasang ch'ejil ŭihak pumun chungshimŭro* 한의학 급여확대 방안: 사상체질의학 부문 중심으로). This one-day conference comprised two sessions with seven presentations by professors and a government official who was working at the National Institute for Health Insurance Review and Assessment Service, followed by a panel discussion. There were around 12 round tables in the conference hall, and 8 to 9 people sat around each round table. I settled myself in a seat near a table in the back. It seemed that senior and important personnel were sitting in the front and centre, whereas junior professors and doctors-in-training were at the back and side. In terms of the order of progress, it was just like any other conference of Korean medicine I had attended. Then I saw an old gentleman in the front who made some comments after the panel discussion. His comment lasted for almost 10 minutes. What was interesting in his remark was that he emphasised the distinctiveness of Sasang medicine. He said,

> The current attempt to cover Sasang medical practices with the National Health Insurance ignores the difference between Sasang medicine and *chŭngch'i ŭihak* (pattern-treatment medicine 證治醫學). **Sasang medicine is constitutional medicine** which is based on the theory of *sajang sabu* (four viscera [*zang*] and four bowels [*fu*] 四臟四腑), not that of *ojang yukbu* (five viscera [*zang*] and six bowels [*fu*] 五臟六腑). With the theory of four *zang* and four *fu*, Sasang medicine treats patients by focusing just on the most weakened *zang* among the Lungs, Spleen, Liver, and Kidneys. There are only about 100 prescriptions in Sasang medicine. Therefore, there are only about 30 prescriptions per each constitution except for the *Tae-yang* people (太陽人) for which there are only 2 prescriptions. Only few people understand this. People say that we just need to follow the medical system and its policy, but

> we should not do so in that way. There is also *chejil uihak* (constitutional medicine 體質醫學 체질의학) in China[54], but it is based on the theory of five *zang* and six *fu.* So is *pal-chejil uihak* (eight-constitution medicine 八體質醫學 팔체질의학). **Practitioners of Sasang medicine should treat several disorders with one prescription** [according to patient's constitution], rather than using one prescription for each disorder. (emphasised in bold by the author)

The proposition that "Sasang medicine is constitutional medicine" was the rhetoric firstly used by Yi Ŭlho in the 1920s as discussed in Chapter 2. However, whereas Yi Ŭlho had resort to the scientific value of Sasang medicine, Professor Lee here used the proposition to demarcate Sasang medicine and other types of East Asian medicine. To do so, he instantiated the physiological theory of Sasang medicine, which was about Four Viscera and Four Bowels to show that Sasang medicine has a different physiological theory from others, such as the Five Phases theory in TCM or the three doshas doctrine in Ayurveda. This was a contrast to Yi Ŭlho's strategy, which intended to incorporate the discourse of the ABO blood type theory.

It seemed clear that the old gentleman was opposing the implementation of the national health insurance for Sasang medicine, which was the main theme at the conference. Most presenters and discussants in the conference had been talking about how to integrate Sasang medical practice into the National Health Insurance system. Another middle-aged professor who was sitting next to him added some comments thereafter.

> It is very important what *Lee wŏnjangnim* (President Lee; the name of honour when Professor Lee was the president of the SUKM hospital) points out. I understand that President Lee (*Lee wŏnjangnim*) concerns the difference in paradigms between Sasang medicine and pattern-

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[54] The seed for a constitutional theory in Chinese medicine can be found in Sections 64 (陰陽二十五人) and 72 (通天) and of the *Divine Pivot* (*Lingshu*, 靈樞). However, according to Wang et al (2017:2), a complete theoretical system was not established at that time and the constitutional theory of TCM was first defined in 1978. It compiled discourses of basic concept, constitutional classification, constitution and pathogenesis, constitution and treatment, and other aspects of the constitutional theory of TCM (ibid.). Professor Lee was also aware of this trend within TCM in the late 20th century.

> treatment medicine (*chŭngch'i ŭihak* 證治醫學 증치의학). Nowadays we are in a state that medical systems decide which strands of medical knowledge should exist. Therefore, the new legislation in the medical system affects and transforms the existing knowledge. In this regard, I highly appreciate that *pyŏngjŭng* (pathological patterns 病證) of Sasang medicine are included as U-codes in the KCD (Korean Standard Classification of Diseases and Cause of Death).[55] Likewise, I think that the effort to be included in the national health insurance should be made together with maintaining the distinctiveness of Sasang medicine.

For me, his comment seemed to be providing a compromising proposal to the panellists and the audience. He tried not to lose the politeness to the senior professor and at the same time he wanted Sasang medical practice to be covered by the National Health Insurance and Sasang medical disorders to be included in the international clinical practice references such as the International Classification of Diseases (ICD). By doing so, it seemed he was trying to minimize the conflict between the senior professor and other members of the SSCM. Meanwhile, a younger professor on my table spoke in a low voice to his students sitting next to while Professor Lee was talking in the front.

> He [Professor Lee)] starts with the same words again. It [using prescriptions according to constitutions] should be proven, but it has not been done yet. He is just mentioning a theory, but we should make use of proven [i.e. evidence-based] treatments.

I realized that there were some tensions in the SSCM, maybe between different generations, institutions, and practice styles. In this regard, at the same time, I felt that I would

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[55] The KCD is a classification system of diseases to enable the storage and retrieval of diagnostic information for clinical, epidemiological, and quality purposes (Lee, 2016:110). All licensed medical practitioners in South Korea must input diagnosis names to the system to get reimbursement from the national health service finance. The 'U-code' was originally designated for special purposes including 'unspecified' diseases in the ICD (International Classification of Diseases), but in South Korea the U-code category has also contained disorders of Korean medicine. Before 2009, Korean medical doctors could only use the disorder names in the U-code category for reimbursement. However, since disorder names of Korean medicine were subcategorised into the KCD which only included biomedical disease names, Korean medical doctors are required to use biomedical disease names when diagnosing patients. For the detailed history for the transformation of the disorder classification system in Korean medicine, see Lee (2016).

need to meet the retired professor, who might be at the centre of issues within Sasang medicine. Hence, with the help of Professor Jeong, who played a role as a facilitator of my research during my fieldwork, I made an appointment to meet Professor Lee.

3.2. The Biography of the Institution Builder

It was three months after the conference when I met Professor Lee again, because I had to conduct my fieldwork in a KM school outside Seoul. I contacted him after my fieldwork at the school had become more settled. On 2nd of June 2017, Professor Jeong and I went to Professor Lee's clinic in Seocho-gu of Seoul, where he was running his private clinic after his retirement from his university in 2006. The district which his clinic was located in was one of the most expensive neighbourhoods in Seoul, South Korea. His clinic was inside a block filled with relatively old and small buildings whereas glamorous skyscrapers formed the skyline on the main street surrounding the area. In contrast to many Korean medical clinics nowadays in commercial buildings (Kim, 2005; Kim, 2010), his clinic was in an two-story old house often called *yang-ok-chip* (Western-style house 양옥집), built in an architectural style that prevailed in the 70s-90s (Im, 2011:450) (see Figure 3.1). At first, I thought Professor Lee was living on the first floor of the house while running his clinic on the ground floor of the house as some senior and affluent Korean medical doctors do. However, later he said that he was renting out the first floor to tenants, while he was living with his wife in another very affluent area of a neighbouring district.

Figure 3.1. Professor Lee's Private Clinic in Seocho-gu, Seoul. Photo by the Author.

It was 1pm when we arrived at Professor Lee's clinic to have lunch together in a nearby Korean restaurant where he was a regular. During the lunch, Professor Lee told us about his personal history: he entered Seoul's College of Eastern Medicine and Pharmacy (*tongyang ŭiyak taehak* 東洋醫藥大學) - the predecessor of SUKM - in 1959 as the top student of the entrance examination. While he was attending the KM school in the early 1960s, Sasang medicine was not included in the school curriculum. When he was in the second year in 1961, the May 16 military coup happened, and the military government ordered all schools to close for a while. During this period, he and his friend wandered around about five clinics of Korean medicine in Seoul which were renowned for Sasang medicine to find a good teacher. They finally found one place and became apprentices of the same practitioner, Mr. Choi. According to Professor Lee, Mr. Choi was not a licensed Korean medical doctor but *hanyakchongsang*

(herbalist 韓藥種商 한약종상).[56] Mr. Choi learned Sasang medicine from a certain person when he was in prison due to being involved in the independence movement during the Japanese colonial period. Professor Lee and his friend sat behind their teacher while Mr. Choi was seeing patients. This is how they learned the way he diagnosed the patients' constitutions and prescribed medicines. When Professor Lee visited Choi's pharmacy, he copied Choi's books which seemed related to Sasang medicine.[57] Among them were the *Manuscript of Study* (*Kyŏkch'igo* 格致藁) and the *Record for Illuminating the Good* (*Myŏngsŏllok* 明善錄). After Professor Lee graduated from the school and passed the Korean Medical Licensing Examination, he got a short-term training in Western medicine at Seoul National University College of Medicine before he got dispatched to a remote area as a public health physician (*kongŭi* 公醫) for military service. He worked there for about two years, then he came back to the SUKM to pursue a master's degree in [Sasang] constitutional medicine (*ch'ejil ŭihak chŏn'gong* 體質醫學專攻). By earning a master's degree in 1967, he became one of the two graduate students who majored in Sasang medicine for the first time. According to Professor

[56] Herbalists (*hanyakchongsang* 韓藥種商) had usually practiced traditional medicine as well as selling herbal drugs. However, the range of their prescriptions was restricted by the law. People could become herbalists by passing the national qualifying examination. However, the examination has not been conducted since 1983, and their role has partly become absorbed to those of KM doctors and pharmacists. It has been practically replaced by that of pharmacists of Korean medicine (*hanyaksa* 韓藥師 한약사) after 1994 (Kim, 2006:543-7).

[57] Compare with Hsu (1999): 'Zhang presented this passage on a piece of paper in beautiful handwriting and asked us first to copy it into our notebooks. The handwritten text in our notebooks took on a personalised form. It stood and was to be understood for itself' (108). Although Professor Lee mentioned he did not learn much of Sasang medicine from Choi, the description of this scene, which was narrated several times among his juniors and official interviews, seemed not just a physical activity of the transcription of books, nor a copy of the information, but the transmission of the authenticity in Sasang medicine, by inscribing the books to make his clinical practice more sedimented with the medical lineage.

Lee, his supervisor did not know much about Sasang medicine, although he had established the course for Sasang Constitutional Medicine in the graduate school.[58] During his graduate study, Professor Lee also learned classical Chinese from a former lecturer of classical Chinese (*hanmun* 漢文 한문) at the College of Eastern Medicine and Pharmacy.[59] Professor Lee went to the private institute twice a week after setting up his own clinic. At the institute, Professor Lee memorized[60] ancient texts as essential, what he recalled "from the Four Books and Three Classics (*sasŏ samgyŏng* 四書三經)[61] to the *True Treasures of the Old Writings* (*komunjinbo*

[58] Professor Lee said that his supervisor, Professor Ro, intentionally added the term *chejil* (constitution 體質) because he wanted to relate Sasang medicine with other *constitutional* medicines in other cultures and make Sasang medicine universal to the world. For example, Professor Ro had published a book titled "Constitutional medicine and Diseases" in 1970 which was written in English. In the book, he called Sasang medicine (四象醫學) a constitutional medicine and defined constitution as a certain physiological tendency from birth, which is derived from a functional difference in the internal organs (Ro, 1970:8).

[59] The lecturer was running a private institute for classical Chinese after the expulsion from a university due to his involvement in the pro-democracy movement against the military government. This private institute later developed as one of the most famous institutions in the country for providing a traditional learning of classical Chinese.

[60] Hsu (1999) demonstrated that rote learning was "the main path to the profound knowledge of a senior doctor (102). The emphasis of memorization in Professor Lee's early learning of medicine might intend to contribute to the legitimatization of his virtuosity in Sasang medicine.

[61] The Four Books are comprised of the *Great Learning* (*Taehak*, 大學), the *Analects* (*Nonŏ*, 論語), the *Mencius* (*Maengja*, 孟子), and the *Doctrine of the Mean* (*Chungyong*, 中庸). The three Classics consist of the *Book of Odes* (*Shigyŏng*, 詩經), the *Book of Documents* (*Sŏgyŏng*, 書經), and the *Book of Changes* (*Yŏkkyŏng* 易經). The Four Books and Three Classics were regarded the seminal documents for Confucian education in the Chosŏn Dynasty.

古文眞寶)”[6263]. He said the learning of East Asian classics at that time helped him understand the philosophy of Sasang medicine in the years that followed.[64]

On the other hand, Professor Lee also mentioned that his career was related to Western medicine.[65] He once explained, after the short-term (bio-)medical training from the Seoul National University College of Medicine, he could perform simple surgeries such as appendicectomy. Acting as a public health physician during his military service, he also performed birthing procedures, which is not considered to be in the area of a KM doctor's practice these days. After he finished the military service, he acquired a special license for Western-style medical practice in a limited area (限地醫師免許 한지의사면허). He said that the acquisition of this license in Western medicine and the experience as a public health physician played a big part in becoming a staff member of the newly-established *Chungp'ung*

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[62] The *Old Writings as True Treasures* was an anthology of ancient Chinese poetries originally written during the Song dynasty of China. The book was transmitted to the Korean peninsula and developed as a distinct edition. It had been widely used to educate young learners of classical Chinese since the Chosŏn dynasty. It was generally recommended that learners of classical Chinese should learn the Four Books first and the *True Treasures of the Old Writings* later, considering the level of learning (Han'gukchŏngshinmunhwayŏn'guwŏn, 1991:484-5).

[63] Learning these books meant to learn the foremost virtues to be a Confucian 'gentleman' (*junzi* 君子). The detail of the books required for reading might be slightly different between China and Korea as seen here.

[64] It is in a similar vein to 'understanding Chinese medicine'. Hsu (1999) introduced a saying of Chinese intellectuals outside the TCM college, 'If you really want to understand Chinese medicine, you have to be able to read classical Chinese' (93). Professor Lee's learning of classical Chinese was also for understanding East Asian philosophy (especially Confucianism) as well as improving the reading ability of classical texts.

[65] During the interview, his career in Western medicine was mentioned relatively late, compared to his study of Sasang medicine and the East Asian classics. It was at one of the last visits of him that he showed me a certificate of the short-term Western medicine education from the SNU college of medicine, which was issued decades ago. It was treated differently. He took it out of a box kept under his desk or bookcase. This contrasted with his KM license, specialist certificate of Sasang Constitutional Medicine, and other honours related to Sasang medicine which were clearly seen on the walls of his clinic.

(stroke 中風 중풍) centre at the SUKM hospital in 1974.[66] The *Chungp'ung* centre became very famous in the 1980s. It was the first institution in the country which aimed to treat *Chungp'ung* patients with *hanyangbang hyŏpchin* (Korean-Western Cooperative Treatment 韓洋方協診 한양방협진). Professor Lee told me that many patients with stroke directly came to the centre instead of going to Seoul National University Hospital, which was the most prestigious hospital in the country. The stroke centre bought a CT (Computerized Tomography) machine in 1989, the first equipment imported to South Korea. Therefore, Professor Lee could treat patients using CT images when none of the other hospitals in the country had CT machines yet. Professor Lee told this to me several times and it seemed he was very proud of it.

According to Professor Lee, he was very good at seeing patients, as he not only treated disorders but also built a good rapport with patients. He was a doctor who saw most patients at the centre. When he was on the ward round, patients who were consulting different doctors in charge asked questions and listened to him because he was kind and warm to them. Moreover, even residents from other departments peeked in to see how he treated patients and which prescriptions he used because they considered Professor Lee's treatments worked better than other professors' ones. On the strength of this kind of popularity, an independent department of Sasang medicine could be installed in the hospital in 1986. In 1989, the department started running a clinic of Sasang medicine in the hospital and recruited hospital staffs as well as

[66] The subject of Sasang medicine for undergraduate students of Korean medicine started to be taught since 1996, when the College of Eastern Medicine and Pharmacy merged with Seoul University. Several non-tenured professors had taught Sasang medicine until Professor Lee took up the tenured position as a lecturer in Sasang Medicine in 1976 (The Society of Sasang Constitutional Medicine, 1999:190).

training doctors. In 2002, when the law on professional qualifications of specialists in Korean medicine was enacted, Sasang medicine was also included. Nowadays, nearly 8-10 specialists in Sasang medicine complete their training from KM hospitals every year. Many of the professors of Sasang medicine in each hospital were students of Professor Lee or were influenced by him.

Furthermore, numerous famous elders in the history of Sasang medicine had mingled with him or formed part of the same group in the past. When I asked questions about whether he knew certain KM practitioners famous for Sasang medicine, Professor Lee immediately narrated their brief personal information and characteristics, as if he had been asked such questions many times before. However, except for a few, he described most of them as not fully aware of *Sasang uihak* (Sasang medicine). He emphasized "the correct knowing of Sasang medicine" (*Sasanguihak-eul jedaero ihaehaeya* 사상의학을 제대로 이해해야).

> Once you are set in the right direction, you don't need to learn from someone or do something more. You can just do it [Sasang medicine] by yourself. It is enough to examine the responses of a patient after using some prescriptions. You don't need to use all prescriptions.

This indicated the importance of understanding the 'principle' (*wŏlli* 原理 원리) or 'spirit' (*chŏngshin* 精神 정신) of Sasang medicine if one aimed to be a practitioner of Sasang medicine. What was interesting for me was that Professor Lee did not mention about clinical apprenticeship or standardised learning methods. It can be compared with Farquhar (1994), Hsu (1999) and Lei (2002)'s analyses of Chinese medicine as knowing practice/experiential practice. Farquhar (1994) underlines a Chinese notion *jingyan* (經驗), or *kyŏnghŏm* (경험) in

Korean, is ‘more historical, collective, and discursive than the individualistic life narratives that the word experience connotes’ (2). Furthermore, Hsu (1999:98) notes that having *jingyan* is a speech act, implying popularity among patients due to clinical efficaciousness acquired by the doctor through medical practice. On the other hand, Lei (1999) points out that traditionally *jingyan* was mostly read as a verb compound, which meant in the medical context, “through testing and being confirmed” (334). I thought this utterance might be relevant to explaining Professor Lee’s own learning of Sasang medicine. Although he got or transcribed classical texts of Sasang medicine from some elders, he often told me that it was like self-learning (*tok'ak'* 獨學 독학) for him to learn Sasang medicine. He claimed he did not belong to any medical lineage of Sasang medicine and just studied Yi Chema’s writings by himself. He also mentioned that the experience of seeing many patients[67][68] in the hospital helped him verify the effectiveness of Sasang medicine. He thereby reinforced the view that Sasang medicine could be learnt through self-learning by observing many patients’ changing conditions in the hospital setting. I considered that Professor Lee’s remarks also show some aspects of *jingyan* or *kyŏnghŏm*: Yi Chema’s *kyŏnghŏm* is mediated by his writings and is tested and confirmed through Professor Lee’s medical experience.

After the lunch, I asked Professor Lee to teach me Sasang medicine. He assented to

[67] During my fieldwork, several interlocutors also testified that Professor Lee had the largest clientele while he was working at the SUKM hospital.

[68] Chinese doctors measured their achievements by counting the number, the distance travelled, the status of their clients or humaneness (Hsu, 1999:97). In terms of this criteria, Professor Lee’s case met almost all the factors described: he had the largest clientele in the hospital; treated patients from all over the country, even Koreans from overseas; treated high-ranking ones including performing constitution diagnosis of some Presidents of South Korea as a presidential advisory doctor; and was known for a humane and kind KM doctor among patients in the hospital.

my request and said he could provide some "principles" of Sasang medicine which many students and practitioners could miss easily. Expressing my gratitude, the first encounter ended with agreeing a date for the next meeting.

3.3. A Phone Call from Professor Lee: The *Spirit* of Sasang Medicine

A couple of days later, around at 2.30 pm, Professor Lee rang me. It seemed his initial purpose was to reconfirm the next appointment, but the call soon became a lecture of Sasang medicine. First, he wanted to know to what extent I had already learned Sasang medicine in terms of a proper genealogy of teachers. He asked about my academic background: the Korean medical school which I attended; who was the professor who taught Sasang medicine to me at that time; and why I got interested specifically in Sasang medicine although I pursued my study in the history of medicine after my graduation of a KM school.[69] Then he said,

> If you study Sasang medicine in the department of the history of medicine, although you tasted a little bit of Sasang medicine in your undergraduate course, that is not 'real' Sasang medicine.[70] That is the concept of Sasang from the *Treatise on the Five Forms of People*

[69] At the first meeting I introduced myself as a doctoral student in medical anthropology (*ŭiryo-illyuhak* 醫療人類學 의료인류학) after studying the history of Korean medicine, but it seemed that he did not quite understand what medical anthropology was. As an academic discipline, *medical anthropology* was not widely known in South Korea, let alone *anthropology*. Hence, he initially remembered me as a doctoral student in the history of Korean medicine. During a later visit to attend his teaching, however, he said, "Sasang medicine is *illyuhak* (人類學 인류학) indeed!". I understood, in this case, *illyuhak* meant 'the study (學) for humanity (人類)'.

[70] It would be worth noting that Hsu (1999:105) also wanted to learn 'real' Chinese medicine from Zhang, a learned doctor of Chinese medicine. She regarded him as "having retained values and habits of Chinese medicine

(*ot'aeillon* 五態人論) in the *Inner Cannon* (*Naegyŏng* 內經)[71] based on the theory of Five Phases (*o-haeng*, 五行). I was once an examiner of a master's student from the Department of the History of Medicine who wrote his dissertation on Sasang medicine. However, he did not refer to the theory of the four viscera and four bowels (四臟四腑). In the department, there is no one who could think in the mode of the theory of four viscera and four bowels and teach it. The same applies to professors in the other basic medicine departments. They just know *O-haeng* (the Five Phases 五行) but don't know Sasang (the Four Images or Four Constitutions). They don't know Sasang medicine either because they don't do clinical work. You seem curious about Sasang medicine and about learning it but there has been no one there to teach you Sasang medicine so far.

He subsequently emphasized the "core" (*haekshim* 核心) of Sasang medicine:

At the initial stage of learning, you may be confused about the difference between Sasang medicine and pattern-treatment medicine (*chŭngch'i ŭihak* 證治醫學). I'll teach you to grasp some principles of Sasang medicine, then you can learn it by yourself. Yi Chema did not just focus on treating disorders but intended to maximize the inherent life phenomenon (*naejaejŏk saengmyŏng hyŏnsang* 內在的 生命現象) to overcome morbid patterns. That is preserving the Original qi (*wŏn'gi* 元氣). This is why the term *powŏn* (Preserving the Origin 保元) is added to the title of his book, *Donguisusebowon*. It does not aim to treat one disease per one prescription, but its focus is on maximizing the Original qi to treat disorders without damaging the Real Number of the Life Pulse (*myŏngmaek-shilsu* 命脈實數). … Therefore, people are classified into four constitutions according to the qi of Qi-fluid (*kiaek-chi-gi* 氣液之氣) and the qi of Water-food (*sugok-chi-gi* 水穀之氣) and those two are divided into Loosening and Tightening in the Internal and External body parts (*naeoe-wansok* 內外緩束) and Ascending and Descending in the Upper and Lower body parts (*sangha-sŭnggang* 上下升降). This is the basis for the constitution theory by Yi Chema. The concept of *powŏn* is different from that of *yangsaeng* (Nurturing the Life 養生) as it implies the concept of *myŏngmaek-shilsu* (the Real Number of the Life Pulse 命脈實數). Yi Chema introduced completely new terms which are not seen in pattern-treatment medicine (證治醫學).[72]

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learning that elsewhere had been abolished" (ibid.:88).

[71] This means the contents in Section 72 [*To Penetrate Heaven* 通天] of the *Divine Pivot* (*Lingshu* 靈樞). For details, see Unschuld (2016:650).

[72] Professor Lee frequently used the term "pattern-treatment medicine" (證治醫學) to refer to established Korean medicine as distinct from Sasang medicine. This term could be defined temporally and spatially: it indicated both established medicine before Sasang medicine became created in 1894 and conventional KM practiced outside the

The phone call from Professor Lee can be summarized in two ways. First, it seemed that he wanted to know whether I was a right person who he would transmit the knowledge of Sasang medicine. For this reason, he wanted to know which medical lineage I adhered to in the field of Sasang medicine. If I learned 'Sasang medicine' from another medical lineage, which would not be 'real' Sasang medicine from Professor Lee's point of view, then I would not be a 'right' person to be taught by him.[73] As he said in later interviews, it would be rather better that I did not have any knowledge of Sasang medicine.

Second, based on the condition of being a suitable person, even if ignorant, Professor Lee considered that the given person could grasp the completely new concepts of Sasang medicine. To him, this meant that Sasang medicine was evolved in complete separation from conventional Korean medicine. The term such as 'the Real Number of the Life Pulse' was an entirely new concept hardly seen in any classical texts before Yi Chema's writings. And the concepts of Loosening and Tightening in the Internal and External body parts (*naeoe-wansok* 內外緩束) and Ascending and Descending in the Upper and Lower body parts (*sangha-sŭnggang* 上下升降) were elaborated upon in Yi Chema's writings on the physiology of the

field of Sasang medicine today. This term encompasses not only the *bianzheng lunzhi* (pattern differentiation and treatment determination 辨證論治) of Traditional Chinese Medicine (Farquhar, 1994; Scheid, 2002; Karchmer, 2004; Zhang, 2007), but also the method of causing treatments to correspond with certain patterns [證治] in *Shanghanlun* (傷寒論) or *Donguibogam* (東醫寶鑑).

[73] This experience reminded me of the phrase '非人不傳' (If he is not the (right) person, do not transmit (the knowledge)' which was originally from "余聞得**其人不教**，是謂失道，**傳非其人**，慢泄天寶" in Chapter 69 (氣交變大論) of the *Basic Questions* (*suwen* 素問).

body, although each directional movement of qi existed in the previous medical discourses. For these two reasons, the Sasang medical body could be apprehended by me: the pure state of mind to accept new teaching, and the knowledge of Sasang medicine as distinct from other KM knowledge. However, paradoxically, the term like the inherent life phenomenon (*naejaejŏk saengmyŏng hyŏnsang* 內在的 生命現象 내재적 생명현상) was never mentioned in any of Yi Chema's writings. It was evidently Professor Lee's own word.[74] This term paralleled with another term *naejaejŏk chayulsŏng* (intrinsic autonomy 內在的 自律性 내재적 자율성), which Professor Lee used several times in other interviews.

This was the third time that Professor Lee's talked about Sasang medicine to me. Every time he mentioned Sasang medicine, it seemed like there was only one single authentic way to learn it, from his point of view. Hence, I decided to listen to his story and his explanations of Sasang medicine as much as possible.

3.4. Professor Lee's Introduction to Sasang Medicine

The following day, after that very long telephone call, I visited Professor Lee's clinic at 10am. On Wednesdays he was not running his clinic. Therefore, he asked me to come on that day. When I entered the clinic on the ground floor, there was thus no one in the waiting room. The arrangement of the facilities was not very different from that of other Korean medical clinics I

[74] For example, I have never heard the term in the later interviews with other practitioners of Sasang medicine.

visited (see Figure 3.2). The clinic consisted of a waiting room, a consulting room, and a storehouse for making/decocting prescriptions and storing processed herbs. In the consulting room, there were some decorations behind his chair that conveyed the authority of Professor Lee. On the left side, for instance, a letter of encouragement in 1995 from the 14th South Korean president referred to the president's compliments for Professor Lee's efforts to scientise Korean medicine. This was awarded when Professor Lee was working as the president of the SUKM hospital. On the back side, there was a frame which contained an Order of Civil Merit from the government and a letter of appointment as a medical adviser for the 16th president of South Korea. These were remarkable honours which I did not see in any other KM clinics.

Figure 3.2. Waiting Room in Professor Lee's Clinic (left) and Consulting Room (right).
Photo by the Author

Whenever I visited him, even if he only had an appointment with me, Professor Lee generally dressed up with a neat shirt with a tie even during the hot summer season of Korea. I felt this was different from the attitudes of many KM practitioners. He later explained about his motive, mentioning that "Wearing clothing neat and tidy" (*ŭigwan-jŏngje* 衣冠整齊) was a teaching of Yi Chema. Moreover, whenever I visited him, he prepared some biscuits, fruits

and rice cakes, which made me feel like I was a grandson who visited his grandfather to listen to his story.

This part aims to demonstrate Professor Lee's introduction to Sasang medicine in three aspects: Professor Lee's emphasis on classical texts, his demarcation and integration of different strands of knowledge, and his hybrid clinical practice. In other words, it can be said: a certain proficiency of dealing with diverse classical texts mattered for establishing the authority of Sasang medicine; an expertise formed by clinical experience to distinguish Sasang medical practice from other similar clinical practices was required to establish the authenticity of Sasang medicine which was indispensable for remaining as an independent discipline; nonetheless, hybrid between conventional Korean medicine, biomedicine and Sasang medicine was observed in his clinical practice. These aspects of Professor Lee's account will be discussed below.

Textuality as a Source of Medical Authority

During my private tutorials, several texts were mentioned as important writings to understand the philosophy of Yi Chema. I found his emphasis on classical texts, i.e. Yi Chema's writings in this context, important in that they play as cornerstones for establishing the discipline of Sasang medicine, in terms of providing principal terms, theories, and treatment methods. The earliest work Professor Lee mentioned was the *Record for Illuminating the Good* (*Myŏngsŏllok* 明善錄) by Han Sŏkchi (韓錫地; 1709-1791). This author died before Yi Chema (1837-1900) was born. There was a story that Yi Chema encountered the *Record for Illuminating the Good*

(See '1' in Table 2.1) when he was staying in an inn at age 30. Each page of the book had been stuck on the wall of this room. When he read those pages, he was very glad that the author's thought resonated with his own, which was very different from the mainstream neo-Confucian thinking at that time. Based on this story, some professors and scholars valued Han Sŏkchi's work for understanding Sasang medicine as well as Yi Chema's philosophy. On the contrary, Professor Lee emphasized that Yi Chema did not emulate Han Sŏkchi as a model but had developed his own way of thinking and thereupon found that Han's thought was very similar to his. He said that Han's book insisted on the teachings of Mencius. However, since the *Record for Illuminating the Good* did not deal with medical knowledge at all, Professor Lee argued learners of Sasang medicine do not need to read the *Record for Illuminating the Good* (See 'A' in Table 3.2). Namely, from Professor Lee's point of view, to pursue the origin of the philosophy of Sasang medicine was not necessary to understand Sasang medicine.

Table 3.1. Yi Chema's Writings and Relevant Sources

No.	Year of completion	Year published	Title of the book	Note
1	1787	1940	*Myŏngsŏllok* (*The Record for Illuminating the Good* 明善錄)	It was written by Han Sŏkchi (韓錫地1709-1803). Yi Chema's disciple, Han Tuchŏng (韓斗正 1880-?) published it in 1940 (Bang, 2001:2)
2	1880-1893	1940	*Kyŏkch'igo* (*The Manuscript of Study* 格致藁)	It was originally a written manuscript, but Han Tuchŏng officially published it with appendices (*the New Compilation for Helping the Multitude* 濟衆新編, and some extracts from the posthumous work) in 1940. There is another version of the manuscript transcribed in 1930, with no appendices (Song *et al.*, 2006:169).
3	Between 1882-1892 (estimated)	1951 (transcribed) 1985 (published)	*Donguisusebowon Sasangch'obon'gwŏn* (*Prolonging the Life and Preserving the Origin in Eastern Medicine: the First Draft of Sasang* 東醫壽世保元	Its completion year is estimated between 1882 and 1892. After Yi Chema's death, it was kept by his disciple Ch'oe Kyŏmyong (崔謙鏞 ?-?). Kim Kuik (金九翊 1880-

No.	Year of completion	Year published	Title of the book	Note
			四象草本卷)	1969)[75] came to visit him from China and transcribed the text and bequeathed his student Son Yŏngsŏk (孫永錫 1944-). Son published the text as an appendix of the book titled *Choŭihak* (*Korean minority medicine in China* 朝醫學) in 1985 (Lee and Song, 1999:77).
4	1894	1940 (transcribed) 2001 (published)	*Donguisusebowon Kabobon* (*Prolonging the Life and Preserving the Origin in Eastern Medicine: the Kabo edition* 東醫壽世保元 甲午本)	The original text of *Kabobon* does not exist. There are two editions of *Kabobon*.[76] One is a transcription of 1940 kept by a grandnephew of Yi Chema (open to the public in 2000). Another is kept in the National Assembly library of Korea (transcribed in 1940, discovered in 2003). The Society of SCM restored the first edition and published it in 2001 (Han and Park, 2001:95).
5	1900 (the year of Yi Chema's death)	1901	*Donguisusebowon Shinch'ukpon* (*Prolonging the Life and Preserving the Origin in Eastern Medicine: the Shinch'uk edition* 東醫壽世保元 辛丑本)	After Yi Chema's death in 1900, his followers collected and combined the new version and the old version of *Donguisusebowon*, and published them in woodcuts in 1901 (Han and Park, 2001:95).
6	Around the time of Yi Chema's death - before 1918	1940	*Changsŏgak tongmuyugo* (*The Posthumous Work of Tongmu*[77]*: the Changsŏgak edition* 藏書閣 東武遺稿)	This is a collection of Yi Chema's various literary works, which included Yi Chema's poems, appeals, letters, travel essays, aphorisms, etc. The compiler is not clearly known but is presumed to be Han Tuchŏng (Yi, 1999c:7, 22).
7	?	1966 (in North Korea)/ 1999 (in South Korea)	*Pogŏnsŏng tongmuyugo* (*The Posthumous Work of Tongmu: the Pogŏnsŏng edition* 保健省 東武遺稿)	It mostly included contents of the classification of medicinal herbs according to Sasang constitutions and disorders. It was inherited as a transcription and was published as a mimeograph by the Ministry of Health in North Korea in 1966. It was passed to South Korea and was published in 1999 (Yi, 1999b:3).

[75] For his life dates and books about Sasang medicine, see Son (2006).

[76] https://mediclassics.kr/books/183

[77] Tongmu (東武) is the pen name of Yi Chema.

Table 3.2. Yi Chema's Writings and Relevant Sources Referred/Used by Professor Lee

	Title	Year of completion	Note (Professor Lee's comment)
A	*Myŏngsŏllok* (*The Record for Illuminating the Good* 明善錄)	1787	Professor Lee commented it shares similar viewpoints with Yi Chema's philosophy, but Yi Chema was not influenced by this book. Professor Lee noted that Yi Chema accidentally encountered the book and there were just many similarities with his thought.
B	*Kyŏkch'igo* (*The Manuscript of Study* 格致藁)	1880-1893	Professor Lee commented it contains the essence of Yi Chema's philosophy
C	*Donguisusebowon Sasangch'obon'gwŏn* (*Prolonging the Life and Preserving the Origin in Eastern Medicine: the First Draft of Sasang* 東醫壽世保元 四象草本卷)	Between 1882-1892 (estimated)	Professor Lee showed me some sentences from this book mentioning various concepts in this book which were not in other editions of *Donguisusebowon*.
D	*Donguisusebowon Kabobon* (*Prolonging the Life and Preserving the Origin in Eastern Medicine: the Kabo edition* 東醫壽世保元 甲午本)	1894	Professor Lee only showed me one sentence from the back cover of this book.
E	*Donguisusebowon shinch'ukpon* (*Prolonging the Life and Preserving the Origin in Eastern Medicine: the Shinch'uk edition* 東醫壽世保元 辛丑本)	Completed in 1900 (the year of Yi Chema's death) and published in 1901.	Professor Lee showed me some sentences of this edition to explain some concepts which were not in other editions.
F	*Ŏnhaengnon* (*The Treatise of Words and Deeds* 言行論)	Around the time of Yi Chema's death - before 1918	It is a part in *the Posthumous Work of Tongmu: the Changsŏgak edition.* Professor Lee showed me this part of the above book when explaining the difference between the philosophy of *the Book of Changes,* which was about the Heavenly Supreme Ultimate (天太極) and that of Yi Chema, the Supreme Ultimate of the Heart (心太極).
G	*Chihaengnon* (*The Treatise of Knowing and Action* 知行論)	1880-1893	It is a part of *the Manuscript of Study.* Professor Lee showed this part when explaining Yi Chema's important concept of *Chihaeng* (Knowing and action 知行).
H	*Obongnon* (*The Treatise of the Five Blessings* 五福論)	Around the time of Yi Chema's death - before 1918	It is a part in *the Posthumous Work of Tongmu: the Changsŏgak edition*
I	*Kyojap'yŏngsaengjam* (*Aphorisms for Instructing Children for Their Whole Lives* 敎子平生箴)	Around the time of Yi Chema's death - before 1918	It is a part in *the Posthumous Work of Tongmu: the Changsŏgak edition.*

Table 3.3. Yi Chema's Writings Referred/Used in the Classroom/Hospital Education

	Title	Note
Ⅰ	*Donguisusebowon shinch'ukpon* (*Prolonging the Life and Preserving the Origin in Eastern Medicine: the Shinch'uk edition* 東醫壽世保元 辛丑本)	Professor Han usually used sentences from this edition. Students were required to memorise many words/sentences/parts of this edition.
Ⅱ	*Donguisusebowon Sasangch'obon'gwŏn* (*Prolonging the Life and Preserving the Origin in Eastern Medicine: the First Draft of Sasang* 東醫壽世保元 四象草本卷)	It was recognised as an auxiliary textbook in the classroom learning but rarely mentioned by Professor Han.
Ⅲ	Some parts of *the First Draft of Sasang*, and *the Posthumous Work of Tongmu* (both editions) were summarised in tables in the textbook and the clinical handbook. But they were barely mentioned by both of the professor and the resident in class.	

Tables 3.1, 3.2, and 3.3 show the lists and explanations on Yi Chema's writings and relevant sources. The demonstrations of the writings are three-layered. That is, Table 3.1 indicates all of the 'classical texts' of Sasang medicine which are mostly the founder's writings and an earlier work. Table 3.2 shows Yi Chema's writings – including specific parts of certain writing - referred to by Professor Lee during my interview with him. I also added notes on Professor Lee's evaluation of each work. It shows Professor Lee's act of dealing with classical texts to create the discipline of Sasang medicine. Table 3.3 demonstrates Yi Chema's writings referred or used in the classroom or hospital education, which will be elaborated in Chapter 4. Comparing these three tables, readers can see how 'classical texts' are utilized for different purposes, i.e. establishing the discipline, and providing standardised education of Sasang medicine.

Professor Lee also emphasized *the Manuscript of Study* (*Kyŏkch'igo* 格致藁) written by Yi Chema between 44 and 57 years of age (1880-1893). He valued *the Manuscript* because it demonstrated how Yi Chema understood and summarized Confucianism in his own way.[78] It contained the essence of Yi Chema's philosophy before *Donguisusebowon*, he said. In that

[78] For example, Yi Chema wrote a section called *yuryak* (*the Summary of Confucianism* 儒略) in *the Manuscript of Study*. See 3 and B in Tables 3.1 and 3.2.

book Yi Chema classified the Confucian virtues into four basic categories: affairs (事), heart (心), body (身), and thing (物).[79] Each of the four categories also has four extremities (四端) like: Appearance, Word, Vision and Hearing (貌言視聽) for the four extremities of the affair (事四端); Learning, Inquiring, Thinking and Discerning (學問思辨) for the four extremities of the heart (心四端); Bending, Releasing, Receiving and Stretching (屈放收伸) for the four extremities of the body (身四端); Will, Courage, Concern, and Intention (志膽慮意) for the four extremities of the thing (物四端). Like the Five Phases (*o-haeng*, 五行), those principles are multi-dimensional from moral values like Benevolence, Justice, Courtesy and Wisdom (仁義禮智); to economic and social status like Wealth, Nobility, Impoverishment and Humbleness (富貴貧賤); to physical activities and the action of consciousness or perception as shown above. Moreover, the concepts of the one (一) and the ten thousand (萬) were contrasted throughout the book by meaning the one means 'self' (*na*) in comparison to the ten thousand as 'collective self' (*woori*). Professor Lee emphasized that the heart and the body (心身) could become a

[79] The first two sentences of the first chapter in the *Manuscript of Study* start with explaining the four extremities: The thing inhabits in the body; the body inhabits in the heart; the heart inhabits in the affair. One thing is to halt; one body is to behave; one heart is to sense; one affair is to determine (物宅身也, 身宅心也, 心宅事也. 一物止也 一身行也 一心覺也 一事決也).

controller of affairs and things (事物) through the philosophy of Yi Chema in *the Manuscript of Study*. In other words, human being is not just the existence which gets influences from the nature, as described in previous Eastern philosophical writings.

Professor Lee repeatedly emphasized certain concepts in Sasang medicine. Interestingly, many of the concepts were not in the most famous version of the seminal text, *Donguisusebowon* published in the year of *shinch'uk* (1901; 辛丑年), also called as *shinch'ukpon* (辛丑本, see '5' and 'E' in Tables 3.1 and 3.2). Those terms were in another version of that book, called *the First Draft of Sasang* (四象草本卷) written between 1882-92 (estimated, see '3' and 'C'). Although *the First Draft of Sasang* was regarded as the basis of the 1901 edition, the book had a very different structure, and some key terms are only seen in this book. Professor Lee said that it was at a late time that he encountered those concepts in *the First Draft of Sasang* as the book became known in South Korea only after the 1990s. The original manuscript of *the First Draft of Sasang* was kept by a physician, a Chinese Korean in Yanbian, China. The physician testified that he inherited it from his teacher who went to Hamheung in North Korea in 1936 to meet the best pupil of Yi Chema and transcribed Yi Chema's several writings including *the First Draft of Sasang.* It came to be known to practitioners of Sasang medicine in South Korea since the physician published a book containing *the First Draft of Sasang* in Yanbian in 1985 (Yanbian joseonjok jachiju minjok uiyak yeonguso 1985). Professor Lee estimated that the concepts were early ideas of Yi Chema and worth following. The structure of *the First Draft of Sasang* consists of three parts: Seeking the Origin of Human Beings (原人), Pathological Changes (病變), and Formulas (藥方).

Professor Lee especially emphasized that the part of Seeking the Origin of Human Beings is most valuable and said that it is not necessary to read the other two parts as those are also given in the 1901 edition.

Another earlier edition of *Donguisusebowon* that was emphasized by Professor Lee was the Kabo edition (*kabobon* 甲午本), which was published in the year of *kabo* (1894 甲午年; see '4' and 'D' in Tables 3.1 and 3.2). Unlike *the First Draft of Sasang*, he did not mention the contents of the Kabo edition in detail, except for the two sentences: "Under great concentration, there is where the way of changes exists; between the moments of turning one's hand over, the art of war seemingly resides" (潛心之下, 其有易道存焉. 反掌之間, 似乎兵法寓矣). I noted that these sentences were on the back cover of the book. Professor Lee particularly emphasized two words in these sentences: the way of changes (易道) and the art of war (兵法). Relating these two concepts, he explained that Yi Chema devised a new principle of the Supreme Ultimate of the Heart (心太極) and a new viewpoint of comprehending the passage and transmutation of disordered patterns. Moreover, he insisted that Yi Chema used the terms such as slight or serious importance (*kyŏngjung* 輕重), forward and reverse shifts (*sunyŏk* 順逆), lesser or greater urgency (*wan-kŭp* 緩急) based on Yi Chema's experience of military tactics, i.e. the art of war. In the medical context, those terms were used to indicate the strategies of treatment for diagnosing and treating disorders.

The *Treatise of Words and Deeds* (*Ŏnhaengnon* 言行論; see '6' and 'F' in Tables 3.1 and 3.2), a part of *the Posthumous Work of Tongmu: the Changsŏgak edition*, was what Professor Lee also mentioned several times during his teachings. This treatise was not particularly related to Sasang medicine, but Professor Lee emphasized that it teaches how to live in the sense of Yi Chema. *The Treatise* was a writing by Yi Chema which was not published by him, but by one of his disciples, Han Tuchŏng (韓斗正, 1880-?). He effected that *the Treatise* be included in the appendix called *the New Compilation for Helping the Multitude* (*chejung shinp'yŏn* 濟衆新編) of *the Manuscript of Study* (see '2').

During the teachings, Professor Lee introduced me to another piece of writing in *the Posthumous Work*, the *Aphorisms for Instructing Children for Their Whole Lives* (*kyojap'yŏngsaengjam* 敎子平生箴; see '6' and 'I' in Tables 3.1 and 3.3), which was written at age 47. *The Aphorisms* were not directly related to medicine but were instructive remarks for Yi Chema's two sons. In *the Aphorisms*, Yi Chema gave advice to his two sons, based on their Sasang constitutions. Especially he emphasized the aspects of intention (*shimsul* 心術) and talent (*chaenŭng* 材能) of each constitution. For instance, Yi Chema explained that the first son, Yong-hae (龍海, 1859-1922) was a Soeum person (*soŭmin* 少陰人) and therefore he had to discard the intention of not 'being jealous of people's wisdom' (*t'uhyŏn* 妬賢) and of

not 'being desperate' (*chagi* 自棄) to live until eighty years of age.[80] By contrast, Yi Chema said to the second son, Yong-su (龍水, 1872-1936)[81], was a Soyang person (*soyangin* 少陽人) and that he had to develop the talent of being fond of the classics and learn that he was to be a hero (*hogŏl* 豪傑).[82] Professor Lee insisted that the contents of *the Aphorisms* can be summarized into the sentence at the beginning: "Be less greedy and diligent in action; seek wisdom when you become entangled in affairs. When wisdom prevails, the heart becomes alive; when greed prevails, the heart gets harmed" (寡慾力行 遇事求知, 知多心活 慾多心傷).

Professor Lee also emphasized that Yi Chema devised the Five Blessings (*obok* 五福) in the *Treatise of the Five Blessings* (*obongnon* 五福論; see '6' and 'H' in Tables 3.1 and 3.2) in the *New Compilation for Helping the Multitude* are different from the other five fortunes which were traditionally known.[83] These are: longevity (*su* 壽), beautifying the heart's intention (*mishimsul* 美心術), being fond of reading books (*hodoksŏ* 好讀書), reserving family properties (*kasan* 家産), and handling the world (*haengse* 行世). Professor Lee said

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[80] The original text is as follows: "勇(少陰初名熊圭後改龍海)之狀貌有壽骨而有夭氣無妬賢自棄之心則克享八壽有妬賢自棄之心則難望四十(自棄之心欲爲雞口自私自高之心也)"

[81] For the life dates of Yi Chema's sons and Yi Chema's pedigree, see Park (1996).

[82] The original text is as follows: "謹(少陽初名龍岩後改龍水)之狀貌有貴節而有賤趣有好古向學之誠則能爲豪傑無好古向學之誠則終作賤夫"

[83] The Five Blessings which were traditionally known are: longevity (*su* 壽), wealth (*pu* 富), health and peace (*kangnyŏng* 康寧), love of virtue (*yuhodŏk* 攸好德), and peaceful death (*kojongmyŏng* 考終命).

that those virtues from Yi Chema imply the sociality of any person. In other words, blessings were not limited to individuals, but expanded to the making of harmonies in society.[84] According to Professor Lee, "handling the world" was meant to give back one's knowledge and experience to society. In this context, Professor Lee quoted a sentence from *the First Draft of Sasang*: "Enjoying one hundred blessings together with longevity" (*paekpogigyŏmsu* 百福而兼壽).[85] This means that longevity ensues when sharing blessings with others.

As seen above, in terms of dealing with the classical texts, Professor Lee referred mostly to sentences or parts from specific texts written by Yi Chema. Apart from *Donguisusebowon Shinch'ukpon* (edition of 1901), he did not suggest that I need to read all of them. In this sense, Professor Lee used the parts of the texts as 'scriptural' rather than 'historical' sources (see Hsu 1999:102, based on Waley, 1934:13). The characters of the classical texts could be classified into the three types.

First, *the Record for Illuminating the Good* and *the Manuscript* were more philosophical than others. Professor Lee introduced *the Record for Illuminating the Good* as a source which might be relevant to Yi Chema's thinking but did not elucidate in the contents in detail and told me it was not necessary to read the text for learning Sasang medicine because it

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[84] Professor Lee's remarks in this paragraph might be comparable to the concept of the 'body ecologic' by Hsu (1999:78-83). She explains, "the notion of the 'body ecologic' provides a framework for an analysis that includes the concerns of people in their interaction with the natural environment" (80). She also adds that "the notion of the 'body ecologic' highlights the idea of mutual resonance between macrocosm and microcosm and the continuities between the inside and the outside of the physical body" (82).

[85] This phrase is from the sentence following. It contrasts with the "one blessing" from the Daoist practice: 賢人之力 學以欲察理 而洽身先物 抑損揚益 開物成務七八九十壽者 百福而兼壽也. 老氏之閑靖 外欲害己 退處窮僻 戒虧保盈 遺世獨立 一百零壽者 一福而高壽也.

was not written by the founder. The *Manuscript* was important because it was written by Yi Chema and could play a role as a mirror to explore his philosophy. However, during the teaching, Professor Lee only mentioned the most basic concepts, Affair-Heart-Body-Thing (*sa-shim-shin-mul* 事心身物), through which to see the world like *yinyang wuxing* (陰陽五行). Moreover, there was no detailed explanation about how to relate these concepts with others such as the four viscera (i.e. Lung-Spleen-Liver-Kidney 肺脾肝腎), the four emotions (i.e. Sorrow-Anger-Joy-Pleasure 哀怒喜樂), or the four types of people (i.e. Taeyang people, Soyang people, Taeeum people and Soeum people 太陽人, 少陽人, 太陰人, 少陰人). I thought of those points while having conversation with him, but I could not ask him just following him and felt I might look impolite to his interpretation and guidance for learning Sasang medicine. This could be explained as Professor Lee's authoritative mode of interpretation (Hsu 1999:116). I felt that there was tacit agreement of not asking critical questions for learning his understanding of Sasang medicine.

Second, according to Professor Lee, recognising the three different editions of *Donguisusebowon* – i.e. *ch'obon'gwŏn* (written between 1882 and1892), *kabobon* (written in 1894), and *shinch'ukpon* (published in 1901) - meant to understand Yi Chema's original intentions for devising Sasang medicine better. Especially, the 'philosophy' parts from previous editions were useful. Meanwhile, only the most recent version was recommended to search for clinical prescriptions.

Third, some parts of Yi Chema's other writings were introduced to me especially when they were relevant to moral virtues which could enlighten readers, students, practitioners, or

patients. Without taking recourse to the standardised textbook of 2004 written by the professors of Sasang medicine,[86] Professor Lee used these texts to teach the principles of Sasang medicine to me. For me, exploring the intertextuality, in other words, navigating diverse sentences and phrases from diverse texts, looked an important skill of pursuing the authentic learning of Sasang medicine and at the same time a way of showing medical authority.

Professor Lee's Style of Medical Practice: Segregation and Combination

As seen above, Professor Lee emphasized the basic principles of Sasang medicine. Because he was not just a philosopher or a philologist but a medical practitioner, I became curious about how, based on those thoughts, he sees patients. Whenever I asked him to show me his clinical practice, he said two things:

> I don't see many patients in this clinic. And many of them are patients whom I treated when I was in the hospital. Sometimes they send me their family, friends, or relatives. So, there is nothing special to see here (in the private clinic). The hospital setting is better for learning the clinical practice of Sasang medicine.

or more rarely, he would say:

> You are not really prepared to learn clinical practice (of Sasang medicine from me). If necessary, you can use prescriptions of Sasang medicine on yourself or close people. Then you can ask me clinical questions.

[86] Although he sometimes used printed versions of his PowerPoint files and his own notes about certain concepts of Sasang medicine, almost all the sentences were from Yi Chema's writings, especially the three editions of *Donguisusebowon*, i.e. *The First Draft of Sasang* (*ch'obon'gwŏn*), *Donguisusebowon Kabobon* (edition of 1896), and *Donguisusebowon Shinch'ukpon* (edition of 1901).

I could understand the first reason because Professor Lee spent most of his time for the clinical practice of Sasang medicine at the SUKM hospital. In the hospital, he mostly treated patients with sequelae of stroke (*chungp'ung-huyujŭng* 中風後遺症 중풍후유증), and the treatment might be constructed with physical therapies or nursing care, alongside his diagnosis and prescriptions. It seemed he thought clinical practice in the private clinic is limited comparing to the one in the hospital setting in terms of the systematic approach and interventions from various medical personnel to patients. However, as for the second reason, I could not exactly understand what he meant. I was not sure whether it was because I was not a resident of Sasang medicine in a KM hospital, or because he thought I was not fully aware of the essential writings of Yi Chema yet. This reminded me of his criticism that not a few KM doctors were just interested in how to use Sasang prescriptions which could be instantly applied in practice and not in knowing the principles. As I felt that he was providing those reasons for indirect expression of refusal, I could not ask further about the reason why he was reluctant to teach me clinical practice of Sasang medicine.

During his teaching, he warned practicing Sasang medicine without a clear understanding of its *wŏlli* (principles 原理 원리) or *chŏngshin* (spirit 精神 정신). He criticized the clinical practice without those understandings for destroying the authenticity of Sasang medicine. In other words, he often used the term *sŏkkŏjap* (a state of being sundry 섞어잡) as a depreciative term to describe the mixed forms of Sasang medical practice and other medical practices. For instance, he criticized the clinical practice of a renowned senior Korean medical practitioner in that the senior practitioner used prescriptions from *chŭngch'i ŭihak*

(pattern-treatment medicine 證治醫學 증치의학) such as a Four Substances Decoction (*samul-t'ang* 四物湯) for certain Sasang constitutions. Although the senior practitioner had published a book including the term 'sasang' in its title, Professor Lee said the senior practitioner's medicine was not proper Sasang medicine. For the same reason, Professor Lee also took a critical attitude on the eight-constitution medicine (*p'al-ch'ejil ŭihak* 八體質醫學 팔체질의학). He disapproved of efforts to affect a theoretical integration between the constitutional theory and the five *zang* and six *bowels* theory.

Rather than demonstrating his clinical practice of Sasang medicine to me, Professor Lee told me some stories. Most of them were about how he treated patients when he was at the hospital, and some of them were clinical cases which he had treated in his private clinic. While telling stories about his clinical experiences, he related them to the "principles" of Sasang medicine. For example, he repeatedly emphasized the concept called *naejaejŏk chayulsŏng* (the intrinsic autonomy 內在的 自律性 내재적 자율성). The direction of treatment in Sasang medicine should aim to maximize this intrinsic autonomy in the body, he said. The term *chayulsŏng* (autonomy 自律性 자율성) or *naejaejŏk chayulsŏngŭi kŭktaehwa* (the maximization of the intrinsic autonomy 내재적 자율성의 극대화) do not appear in any writings by Yi Chema. Nor did I hear these terms during my fieldwork in other private clinics. They appeared to be the expression of Professor Lee's own understanding of Sasang medical experience. He explained that human beings in Sasang medicine are the autonomous existence which is responsible for their health, longevity, destiny, and good or bad luck. It seemed that

Professor Lee also expanded the meaning of “the autonomous” in the relationship between internal organs of the body, as he added the term “intrinsic” (*naejaejŏk* 內在的). He especially linked the “intrinsic autonomy” (內在的 自律性) to the concept in *the Manuscript*, the Real Number of the Life Pulse (*myŏngmaek-shilsu* 命脈實數), which appeared in *the First Draft of Sasang.* According to Yi Chema’s theory, every person was born with the functional deviation between the internal organs, which decided a certain constitution of a person.

Overall, Professor Lee took a position of rejecting other interpretations of the classical text, the concept of the constitution, or the mix of other traditional doctrines and treatments. This was read to make clear demarcations to be distinguished from other similar clinical practices and to get a proper legitimation as an independent academic discipline. Although it looked somewhat paradoxical, his strategy of combining the modern term and the traditional concepts was a metonymical approach to make traditional concepts more sensible. This process was fulfilled by the use of words such as “intrinsic autonomy” to express the general physiology of Sasang medicine, based on Professor Lee’s own personal understanding and experience which was tied to a social and cultural context. That is, it is very likely that Professor Lee was influenced by certain biomedical discourses (e.g. theories on autonomous nerve system) at a certain time just as Yi Ŭlho was influenced by a prevailed scientific discourse in the 1920s of Korea. Even though Professor Lee claimed the authenticity of Sasang medicine which could be distinctive from other medical frameworks, this can be an example that the development of traditional doctrines is influenced by contemporary biomedical theories, i.e. a case of coevolution.

An Auto-Ethnographic Note on Constitution Diagnosis: A Hybrid Practice

When I decided to do fieldwork on Sasang medicine, I already heard that there were some controversies on the "objectivity" (*kaekwansŏng* 客觀性 객관성) of the constitution diagnosis. Opponents of Sasang medicine, whether they were KM doctors or not, criticized that there was not a standard and objective way to diagnose the four constitutions. Therefore, whenever I visited practitioners of Sasang Medicine, I tried to see how they diagnosed Sasang constitutions. In the case of Professor Lee, I also asked how he diagnoses patients' constitutions. He firstly said the hospital setting helped him grasp patients' constitutions as he could observe inpatients' physiological phenomena such as digestion and excretory process, characters, and changing responses to Sasang medical prescriptions. This comprehensive observation made it possible for him to diagnose constitutions more accurately. Secondly, he said he used an acupuncture method known as the T'aegŭk acupuncture (*t'aegŭk ch'imbŏp* 太極鍼法 태극침법) as his diagnostic technique.[87] Because he did not show me his clinical practice in his private clinic, I asked him to diagnose my own Sasang constitution.

He let me lie down on the bed in the consulting room. He thus required me to roll my

[87] The *T'aegŭk* acupuncture (太極鍼法) was devised by a KM physician Yi Byŏnghaeng (李炳幸; 1906-1974) and introduced in one of his books titled *the Repeated Polish of the Original Stream in the Way of Acupuncture* (*Ch'imdo-wŏllyu-jungma* 鍼道源流重磨) in 1974 (Lee, 1974; Kim, 2011). Inspired by Yi Chema's Sasang medical theory, Yi Byŏnghaeng identified certain acupoints for each Sasang constitution. In detail, this method uses acupoints on the Heart channel (心經) as Yi Chema emphasized the Heart above other organs. Moreover, certain acupoints which have the attributes of the Five Phases (五行) are applied to each Sasang constitution according to the Sasang constitutional relation of the sizes of each organ.

shirt and trouser sleeves on the right side up above my elbow and knee. He then applied acupuncture on *Sohae* (HT-3 少海), *T'aeyŏn* (LU-9 太淵), *T'aegye* (KI-3 太溪), *Samŭmgyo* (SP-6 三陰交) and *T'aebaek* (SP-3 太白). While needling, he spun [*yŏmjŏn* 捻轉] and pushed and pulled [*chesap* 提揷] the handle of the needles several times.[88] At the same time, he asked me to move my left arm and leg and to feel whether they move with ease. He also asked me to breathe deeply and to feel whether my nose was all cleared up and my vision became clear, and whether I felt comfortable. He performed abdominal diagnosis (*pokchin* 腹診) to check whether my rectus abdominis muscle became smooth, while asking whether I could sense the growling sounds from my intestine. He added that if I heard the growling sounds then it was a good sign as it proves peristalsis of the intestine and the smooth circulation of qi between the upper and lower parts of the body. When he asked me about my sensations, I could not feel all changes at the same time as my attentiveness was on those points in which needles in. Moreover, I could not gauge the dramatic change of my body as I usually do in my everyday life. After needling and checking my bodily condition for about 10 minutes, Professor Lee removed the needles and said he would give another set of acupuncture treatment to me. Then he gave acupuncture on different acupoints on the right side of my body: *Hapkok* (LI-4 合谷), *Shinmun* (HT-7 神門), *T'aech'ung* (LV-3 太衝), *Choksamni* (ST-36 足三里), *T'aebaek* (SP-3 太白). During the second session, apart from needling into different acupoints, he used

[88] This technique is usually for reinforcing or reducing qi (補瀉), or for obtaining qi (得氣).

the same techniques of spinning and pulling and asked the same questions. I did not feel any dramatic changes this time. He said this was perhaps because I was not a kind of person who is very sensitive and is not familiar with being treated by acupuncture. The growling sounds, which both Professor Lee and I could hear, sounded a bit clearer in the first session.

After finishing the acupuncture session on both sides, Professor Lee explained that the first session was for diagnosing a So-yang person and the second one was for a So-eum person. Based on the responses during the diagnosis, he said that it seemed like I am a so-yang person. Then he also said my physique shows an example of So-yang type: the distance between the navel and the symphysis pubis is relatively short; the distance between the iliac crests are shorter than the shoulder width. Moreover, he said that my slight curly and dry hair could be also an indicator for So-yang type whereas shiny hair is usually for So-eum type. The dry skin on my legs, he said, was a sign for the lack of yin qi, which So-yang type persons usually have. He also commented on my attitude during the acupuncture session.

> So-yang people are likely to fear needling. When I needled you, I felt some sweat on my left palm. This is typical of the character of So-yang type persons. They tend to think about the things which haven't happened yet. Before I even needled you, you were already apprehensive about what would happen if being needled.

As seen above, Professor Lee's practice of constitutional diagnosis was hybrid rather than being authentic. Namely, a novel acupuncture technique, which was not mentioned by Yi Chema, was used for a diagnostic purpose. Furthermore, his way of observing and identifying my bodily responses after the needling were also not mentioned in the classical texts, as well as the work by the inventor of the acupuncture method.[89] This insight was attained from his

[89] The inventor only mentioned "becoming effective" (*p'alhyo* 發效) when a needling was made to a correct acupoint according to Sasang constitutions (Lee, 1974:348). He did not specify the conditions or symptoms of

prolonged clinical experience and made a hybrid with knowledge from classical texts.

3.5. Summary

From many visits to Professor Lee's clinic, I could learn the history of institutionalisation of Sasang medicine, the major concepts and theories, the emphasis on classical texts and their specific parts, and the way of constitution diagnosis, from Professor Lee's perspective. Based on this experience, I could find three paradoxes in his teachings: first, the emphasis of authenticity based on the classical texts with his biomedical expertise; second, the paradox between the emphasis of spirit/philosophy and the experience; third, the melange of his clinical practice in the constitution diagnosis.

First, Professor Lee's achievement as a practitioner of Sasang medicine looked impressive but also somewhat unusual compared to other Sasang specialists. His arguments sometimes sounded contradictory. On the one hand, he displayed an episode with Mr. Choi that accentuated adherence to a certain lineage of Sasang medicine and was proof for authenticity, but on the other hand, he told me that he did not have a proper teacher of Sasang medicine and emphasized self-study based on enough understanding of the "principles". Understanding these "principles" or "spirit" was possible through the full familiarity of Yi Chema's classical texts and the guidance from a mentor. Clinical experience with many patients provided sources of experience (*kyŏnghŏm* 經驗 경험) for his clinical reasoning in Sasang medicine. According

becoming effective.

to him, the hospital culture played an essential role to enable him not only to verify his competence in Sasang medicine to himself[90] and to other practitioners and patients, but also to assess his treatment on a regular basis. However, paradoxically, his initial employment to the hospital was possible by learning biomedicine from a biomedical school and getting some clinical experience and qualification as public health physician (*kongŭi*). This aspect made him be proud of using the state of art diagnosing devices such as CT, which initially became available in the early 1970s and was capable of finding or showing weighty knowledge of the anatomical body (Saunders, 2008:97-101; Joyce, 2008:56). He also integrated some biomedical terms such as *chayul shin'gyŏnggye* (autonomic nerve system 自律神經系 자율신경계) into his narratives of Sasang medicine. Such complex and somewhat contradictory mixture of his practice seemed to reflect the social world he lived in. It also showed the paradoxical reality of the academic society of SCM, dealing with maintaining the concepts and philosophy and absorbing the recent trend from Western medicine, as I saw at the spring conference.

Second, as for the paradox between the emphasis of principles/spirit and experience, Sivin (1995:182-88)'s explanation on text and experience gives some clue to examine. By analysing Chunyu Yi's cases from historical records accomplished the 2nd-1st century BC, he scrutinizes the description of the transmission of texts and divides it into the following actions: receiving texts, reading them, getting a feel for them, and practicing them. According to him, receiving texts is a formal process which begins only after one has been "serving" the master

[90] See Hsu (1999:96) on a form of self-persuasion.

as a disciple for some time.[91] In other words, it means being ritually transmitted and taught. In this sense, Professor Lee's transcription of Yi Chema's classical texts during the apprenticeship from Mr. Choi means "receiving texts" from the founder, mediated by Mr. Choi. Then young Professor Lee read (*ikta* 읽다) them, which action means studying and memorising (ibid.:182). After that process, "getting a feel for them" becomes an issue. Sivin (ibid.) explains this step is composed of "comprehend" (*jie* 解) and "verify" (*yan* 驗). In Professor Lee's case, this is also linked to the last stage of "practicing" which means "trying out", "success/succeed" or "efficacy". Therefore, this means for Professor Lee to try out, verify, and experience the clinical effectiveness of Sasang medicine in the clinical setting. In this regard, Professor Lee's somewhat paradoxical remarks on the texts, spirit, and experience of Sasang medicine could be understood as a sequential practice of learning which even happened two thousand years ago in East Asia. In other words, it can be understood in terms of that the principles/spirit and experience are not dichotomous but a continuum of a ritualistic process.

Third, relating to the paradox that Professor Lee's mixed practices in the constitution diagnosis, Hsu (1999:127) indicates that personal knowledge of classical texts was transmitted by means of exegesis and interpretation, those terms seemed to play a role not as expository but as interpretive variables. That is, although he emphasised classical texts, phrases, and terms, Professor Lee's practice for the diagnosis of constitutions was combinatory as he integrated other methods – such as the T'aegŭk acupuncture or physical examination methods. This

[91] For instance, Hsu (1999:100) introduces a case of making a master-disciple relationship. The master said, "The training of a disciple takes nine years: three years for the master to evaluate his disciple, three years for the disciple to reconsider his choice of master and the last three years for the master to transmit the essential knowledge". Hsu (1999:101) emphasises, a disciple, unlike a student, was expected to know and accept all aspects of his master's personality, based on his personal choice.

melange of practice was possible because of Professor Lee's creative interpretation of classical texts based on his accumulated clinical experience. This could be also explained as a coevolutionary development of Sasang medicine interacting with outer discourses such as other medical theories and techniques including biomedicine. In this process, the conceptual practice of *chejil* was constructed by Professor Lee's own intention and diverse agencies he engaged.

Chapter 4. Learning Sasang Medicine at the Level of University Education

This chapter discusses Sasang medical education in a Korean medical school (hereafter KM school) and its teaching hospital. At the time of my fieldwork, the university was aiming to provide a standardised education for students in Korean medicine, and after their graduation had them pass the national licensing examination to become KM doctors.[92] There had been a nationwide tendency to study highly standardised textbooks compiled by professors at KM schools. Furthermore, the KM curricula in all KM schools were evaluated and accredited by a government-credited institute called the Institute of Korean Medicine Education and Evaluation (IKMEE). The IKMEE standardised the principles or competencies to be taught at KM schools. The education of Sasang medicine at the KM schools was also under this influence. A standardised textbook written by professors of Sasang medicine was used as a main material for the classroom learning in all the KM schools. This standardised mode of learning was also considered a form of 'scientific' learning.[93] Especially various 'scientific' devices,

[92] It is generally perceived that students pursue to obtain the KM license to practice Korean medicine once they are admitted to KM schools. In effect, all the students I met during my fieldwork at the KM school took their life as a KM doctor for granted after graduation. For reference, the pass rates for the KM national licensing examination were 95.7% in 2018, 96.6% in 2019, and 96.6% in 2020 (Min, 2020).

[93] Hsu (1999:2) indicates that the standardised mode of transmission [in Chinese medicine] is generally considered a form of 'Westernisation', 'modernisation', or 'professionalisation', although it is in no way specific either to Western culture or to modernisation. Regarding Sasang medicine in the standardised education, this part is basically in line with Hsu's idea of 'modernisation', 'professionalisation', and 'Westernisation'. However, this part also tries to demonstrate an interesting example of traditional medicine in the standardised mode of transmission persisting its own way of learning which could be even distinguished from other standardised KM subjects, such as 'internal medicine of KM', 'gynaecology of KM' or 'neuropsychiatry of KM'. Whereas the textbooks of the other KM clinical subjects explain biomedical diseases and corresponding KM disorders in parallel, that of Sasang medicine and its class more relied on classical texts. This aspect will be further discussed in this chapter.

systematized document forms were engaged with in the hospital training. However, I could observe many kinds of diversity even in the standardised educational settings. First, each of the universities which incorporate KM schools was established in distinct social and cultural contexts. Second, the teaching staff of Sasang medicine could be identified almost as a kin group, namely a specific Sasang medical lineage. Third, it was observed that students' attitudes towards Sasang medicine were different from each other although they took the same standardised class. Not only showing disinterest in the subject, some of them also exhibited interest in other kinds of Sasang medicine, which were different from the professor's view of authentic Sasang medicine. Thus, this chapter argues that even in the standardised and scientific mode of learning there was a unique logic of practice and a conscious effort to maintain 'authentic' Sasang medicine.[94] Said logic practice also contributed to Sasang medicine managing to exist among the specialised units in a hospital setting, such as internal medicine, gynaecology, paediatrics, neuropsychiatry, etc. This chapter traces the paradoxical coexistence of such adaptation and resistance to the standardised learning in the education of Sasang medicine at university level.

4.1. The Exterior Aspects of Learning

Institutionalised KM Learning at University Level

[94] By 'authenticity' regarding Sasang medicine, I mean it is based on following aspects: certain emphasis on the relation to the founder, specific ways of dealing with/interpreting classical texts, specific ways of clinical practice. Its cases are also described in detail in Chapter 3.

At the time of my fieldwork in 2018-19, there were twelve schools of Korean medicine in the country (Figure 4.1).

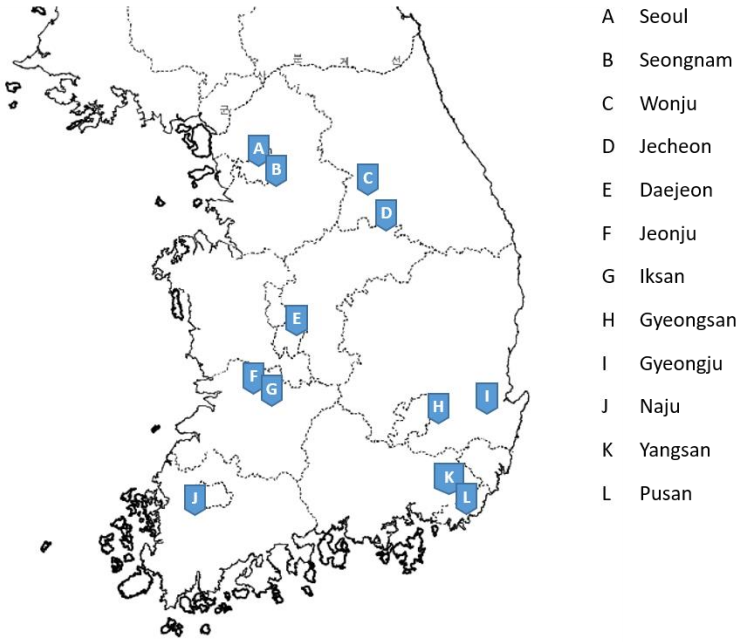

Figure 4.1. Locations of the KM schools in South Korea[95][96]

The origin of the education of Korean medicine in modern institutional setting traces back to the establishment of the Tongje Medical College (同濟醫學校) in Seoul in 1904. The petition for its establishment was made by court physicians and the institution was recognized by King Gojong (r. 1863-1907) (Namil Kim, 2011:59). However, within three years it was

[95] School names are anonymised.

[96] The years of establishment of the KM schools are like follows: A (1948), G (1972), I (1979), H (1980), E (1981), L (1987), C (1988), F (1988), B (1990), E (1992), J (1992), and K (2008) (Han'guk'anŭiyakyŏn'gam palganwiwŏnhoe, 2018:21).

closed due to the abdication of the King. During the Japanese colonial period (1910-1945), there was no longer government's effort to establish educational institutions for Korean medicine, but KM practitioners had continuously opened accredited institutes to educate subsequent generations (ibid.). In 1948, after liberation, the Tongyang Academy (*Tongyang taehakkwan* 東洋大學館), which provided four-year courses for humanities and Korean medicine, was established and later renamed as Seoul College of Korean Medicine (서울漢醫科大學) in 1951 and the College of Eastern Medicine and Pharmacy (東洋醫藥大學) in 1955. In 1964, the institution was raised to the status of proving a six-year course of Korean medicine along with biomedical schools, which was divided into a two-year preparatory/pre-med course (*yegwa* 豫科) and a four-year main/medical course (*pon'gwa* 本科), and it was merged to Seoul University in 1965 (ibid.:60). By doing so, the KM education became entirely incorporated into the university education as the nation's university system was renovated. Since then, new KM schools have been established almost for each province in the country, followed by the establishment of the first national KM school in 2008.[97]

Compared to other medical schools such as schools of Western (or bio-) medicine and Dentistry which most national universities had, one of the main characteristics of the KM schools was that the majority of them belonged to private universities. The one exception was

[97] Therefore, when I refer to a 'KM school' (*hanŭigwa-taehak* 韓醫科大學), it naturally postulates that the KM school exists as a 'college' (*tan'gwa-taehak* 單科大學) in the university system such as 'college of medicine' (*ŭigwa-taehak* 醫科大學; (bio-)medical school), 'college of engineering' (工科大學) or 'college of humanities' (人文大學).

the Pusan National University College of Korean Medicine which was the newest established in 2008. In addition to such support from the government, during the fieldwork I could find that not a few schools of Western medicine and dentistry were installed in universities founded by Christian missionaries or their churches, whereas it was the Buddhist and Won-Buddhist[98] organisations which established KM schools in their universities. I thought it was not just coincidental. Some successful KM doctors also established KM schools, same as successful biomedical doctors did. Today each KM school has at least one or more affiliated KM hospitals for clinical training of KM students as well as internist and trainee doctors to be KM specialists in one of the eight KM specialities.

As for the characteristics of the standardized KM curriculum in the school setting, Hyunkoo Kim (2016) explains that there are three kinds of epistemological differences in the curriculum: Eastern philosophy and medicine; Western biomedicine; and hybridized Korean medicine. KM students learn subjects related to Eastern philosophy and medicine such as classical Chinese, Chinese medical literature reading, medical history, medical classics, and medical theories of various masters. Western biomedical subjects are also taught, namely Biology, Embryology, Biochemistry, Histology, Anatomy, (Western) Physiology, Pathology, Immunology, Pharmacology, etc. Subjects in these two epistemological threads are mostly taught to 1st to 4th year KM students. On the other hand, subjects related to hybridized Korean medicine are mainly taught to 5th to 6th year students. Those subjects look similar with biomedical subjects such as Internal Medicine, Neuropsychiatry, Ophthalmic &

[98] Won Buddhism was founded by Pak Chungbin (朴重彬; 1891-1943) (aka Sot'aesan 少太山) in 1924. It can be regarded either as a syncretic new religious movement or as an offshoot of Korean Sŏn (Zen 禪). For details, see Pye (2002).

Otorhinolaryngology, Dermatology, Gynaecology, Paediatrics, etc. However, most of them have prefix of *hanbang* ([the way of] Korean medicine 韓方 한방) in their titles, although students or professors often omitted it in casual conversations among them when referring to those subjects. Looking into the contents of those textbooks, they are quite different from KM classics in terms of styles of writing and knowledge. They are also different from biomedical textbooks in that the KM textbooks provides paralleled explanations and treatments of Korean medicine to biomedical diseases and pathological changes, in the principle of 'diagnosing with Western medicine and treating with Korean medicine' (*yangjin-hanch'i* 洋診韓治 양진한치). In Korean medicine, as in traditional Chinese medicine (TCM) (Karchmer, 2010), clinical reasoning prevails in terms of so-called *pyŏngjŭng-ronch'i* (pattern differentiation and treatment determination 辨證論治 변증론치)[99]. Han (2013) explains the KM textbooks had imported the *pyŏngjŭng-ronch'I* system from TCM since the late 1970s.

Interestingly, Sasang medicine is probably the only subject which had much relevance to the epistemology of Eastern medicine and philosophy, as taught to the 5th and 6th year students, rather than being biomedical, or hybridized (Kim 2016:111). It does not use pattern differentiation and treatment determination (*pyŏngjŭng-ronch'i* 辨證論治) nor biomedical disease classification. During the fieldwork, I could encounter the perception that Sasang medicine was regarded as 'traditional' (*chŏnt'ongjŏgin* 전통적인) but at the same time

[99] Scheid (2002) considers 'patter differentiation and treatment determination' as one of the defining practices of contemporary Chinese medicine. Almost the same trend was seen in the textbooks of the other clinical subjects in the KM curriculum, except for Sasang medicine.

'clinical' (*imsangjŏgin* 임상적인) which meant to be learned (*paeuda* 배우다) after learning other Eastern philosophy and medicine subjects.

The School: Hanguk University College of Korean Medicine

To investigate the education of Sasang medicine and the making of constitutions in a standardised setting of Higher Education, I conducted fieldwork at Hanguk University College of Korean Medicine (hereafter HUKM) in Ilsan, Gyeonggi province. My fieldwork at the school was comprised of participant observation of learning and teaching in the classroom and in the hospital; shadowing a training doctor and students during clinical training; and informal interviews with students, the training doctor, and professors of Sasang medicine. To do this, I commuted there on average twice a week for 8 months in 2017. It took around one and half hours by bus from Seoul. The HUKM's Ilsan campus was a recent one which was built beginning in 2009, compared to the university's other two campuses in Seoul and in Gyeongju which were established in 1906 and 1978 respectively. Hanguk University has a long history and has a strong relationship with Buddhism in Korea. Its beginning was to educate Buddhist monks, and it was still running a Department of Buddhist Studies along with more than 70 majors throughout the university.[100]

Because of the University's founding spirit in Buddhism, the University opened its second campus in 1978 in Gyeongju, Gyeongsangbuk-do, acknowledging the importance of

[100] http://encykorea.aks.ac.kr/Contents/Item/E0016246. Retrieved on 1st July 2019.

this city for Buddhism. Gyeongju was the capital of the ancient kingdom of Silla (新羅 57BC-935AD) in which Buddhism was the official state religion. The city was full of famous Buddhist temples, pagodas, ancient tombs, traditional tile-roofed houses and museums storing ancient remains. It was designated as the limited development district, so that building heights in the area were restricted by law for example. Hence, the University's Gyeongju campus was located in the outskirts of the city. The University founded the school of Korean medicine in 1978 and its teaching hospital of Korean medicine in 1983. Afterwards the University also founded the school of Western medicine in 1985, and its hospital in 1991 in Gyeongju. Students at the HUKM were mainly taught in Gyeongju before the establishment of the Ilsan campus in the late 2000s, which included newly-built KM and WM hospitals on site.

Ilsan, unlike Gyeongju, was *shindoshi* (new/planned city 新都市 신도시). It was a relatively recently developed area by the government in Goyang city in the 1990s, to alleviate housing shortages in the city of Seoul. The residential area of Ilsan had luxurious detached house zones as well as many high-rise apartment complexes. The city also had the largest international exhibition centre of the country, and several notable general hospitals such as the national cancer centre. As a result of the state's support for urban development, Ilsan *shindoshi* attracted upper-middle and upper class Koreans. The Hanguk University Ilsan Medical Centre was established in the outskirts of this new town in 2005, with 1,000 beds and 28,000 square meters of floor space. It claimed that the medical centre operated 'the world's first state-of-the-art digital medical information system that integrated Western and Korean medicines. The University built not only WM and KM colleges but also colleges of Pharmacy and Biosystem in the Ilsan campus. Accordingly, it was christened the Ilsan campus "*Paiomedi k'aemp'ŏsŭ*

(Biomedi-campus)". Apart from the Ilsan Medical Centre, the University was running other hospitals in Gyeongju and Bundang, Gyeonggi Province. In Gyeongju, the hospital incorporated WM and KM clinics, whereas the Bundang hospital was a KM-centred one called *hanbang byŏngwŏn* (Korean medicine hospital 韓方病院 한방병원) in Korean. Like Ilsan, Bundang was a new town in the Seoul Capital Area which was developed in the early 1990s and was famous for being one of South Korea's wealthiest and highest developed areas. The establishment of these hospitals in the two areas were meant to attract the upper-middle or upper class Koreans who were interested in their health and wellbeing.

The HUKM at Ilsan accommodated students from the 4th year to 6th year, after spending their first three years at Gyeongju. Whereas students learned *basic* subjects in Gyeongju, they learned *clinical* subjects in Ilsan. In the Ilsan Campus, the building of the school of Korean medicine was adjacent to the Ilsan hospital, just across the street. On the north side of the hospital, there was another building for the college of Western Medicine. Together with the school of Korean medicine, the 9-storey-building housed the University Business Incubator Centre with its small offices of venture companies (see Figure 4.2). The learning spaces were on the third, fourth and fifth floors, and consisted of lecture theatres, a library, study rooms, professors' offices, laboratories, etc. The lecture theatres were located on the same storey, so that KM students from different years would have to take classes on the same floor. Each lecture theatre could accommodate around 90 students which comprised the yearly number of freshers.

Sasang medicine was mainly taught to 5th and 6th year students, (Han'guk hanŭiyak

yŏn'gam palganwiwŏnhoe, 2018).[101] It basically consisted of classroom teaching and clinical training in the hospital. Classroom teaching occurred for two to three hours once a week, whereas clinical training lasted all day once a week. The classroom accommodated all of the students in a same-year cohort which amounted to around 70 to 80, while students split into several groups which amounted six to seven students for clinical training. During my fieldwork, two teachers, Professors Mok and Han, were involved in teaching Sasang medicine to the students.

Figure 4.2. The Building of Hanguk University of Korean Medicine in the Ilsan Campus. Photo by the Author.

[101] During my fieldwork in 2017, Professor Han said that there was a series of special lectures on Sasang medicine to the 4th year students in the second semester (i.e. from September to December). However, he said that the course was usually taught by an external lecturer who ran his/her own clinic. As it was an exceptional case not recorded in the official curriculum, I decided not to discuss it in my research.

The Teachers

Professors Mok and Han basically had two roles at the HUKM. Firstly, they were teachers who taught Sasang medicine to students of the HUKM, through two hours of classroom lectures and approximately four hours of clinical training per week. Secondly, they treated patients as well as taught trainee KM doctors at the department of Sasang Constitutional Medicine at the affiliated hospitals: Professor Mok was based at the Bundang hospital and Professor Han was at the Ilsan hospital. These two roles were basic requirements for professors of 'clinical' subjects. It was contrasted to the case of professors of 'basic' subjects. For instance, professors who taught medical classics such as the *Yellow Emperor's Inner Canon* (*Huangdi neijing* 黃帝內經), the *Treatise on Cold Damage* (*Shanghanlun* 傷寒論), or the *Treasured Mirror of Eastern Medicine* (*Donguibogam* 東醫寶鑑)[102] did not have requirements of treating patients in affiliated hospitals, although some classical texts not only included theoretical contents but also clinical treatments such as herbal prescriptions or acupuncture methods.

Professor Mok, Head of the SCM department, graduated from Seoul University College of Korean Medicine. After the graduation with acquiring the KM license, he got

[102] These three books were generally regarded as 'classics' to learn Korean medicine, along with Yi Chema's *Donguisusebowon* (東醫壽世保元). Particularly, in the standardised KM education, *Huangdi neijing* is generally taught in the class for 'classics' (wŏnjŏn 原典 원전) as it is regarded as having 'theories', and *Shanghanlun* is mainly dealt with in the class for KM pathology (*hanbang-byŏngnihak* 韓方病理學) as it demonstrates pathological processes. On the other hand, *Donguibogam* is generally considered as 'clinical', but learning it is not dealt with in an independent class as *Donguisusebowon* for Sasang medicine. Instead, the prescriptions and phrases from *Donguibogam* are rather scattered in the textbooks of various clinical subjects compared to *Donguisusebowon*.

residency training of SCM at the university-affiliated hospital, supervised by Professor Lee. Simultaneously, he entered the graduate school of Korean medicine at Seoul University and obtained a PhD of SCM. He had served as the president of the Society for Sasang Constitutional Medicine and as the director of the Bundang KM hospital. He came to Hanguk University in 1994 when the university opened a hospital of Korean medicine. At that time, the KM hospital only had departments of KM Internal medicine (韓方內科), KM gynaecology (韓方婦人科), KM paediatrics (韓方小兒科), Acupuncture and Moxibustion (鍼灸科), KM psychiatry (韓方神經精神科), and KM Otorhinolaryngology (韓方眼耳鼻咽喉科). Therefore, he was initially involved in the department of Internal medicine of Korean medicine as SCM doctors were at the Seoul University Hospital before the SCM department was installed.[103] He was known as devoting himself to researching on classical texts and Yi Chema's biography and philosophy as well as working on clinical research. In the interview with Professor Lee, he told me that it was Professor Mok who worked on Yi Chema's biography in the current way. It was known that he completed the chronological table of Yi Chema included in the textbook by combing through relevant local gazettes and anthologies of local aristocrats. Moreover, Professor Mok translated Yi Chema's the *First Draft of Sasang* (*sasang-ch'obon'gwŏn* 四象草本卷) from classical Chinese to Korean and published it in 2002. The *First Draft of Sasang* was emphasised by Professor Lee during the conversations containing many philosophical and inventive ideas (see Tables 3.1 and 3.2 in Chapter 3). Professor Lee mostly used Professor Mok's translated

[103] When his teacher Professor Lee was beginning clinical practice at Seoul University College of Korean Medicine Hospital, there was no department specialised for Sasang Medicine. For this reason, Professor Lee worked in the department of Internal Medicine of Korean Medicine instead.

version to show me the sentences in the book. Along with the 'standardised' textbook of Sasang medicine, the translation was used as the auxiliary textbook for the class.

The younger professor Han came to the School in 2004. He graduated from the HUKM. He got residency training of SCM from Professor Mok in the Bundang hospital and gained a PhD in SCM. When he finished his residency training, he started working in the HUKM hospital in Gyeongju. After the Ilsan hospital was established, he came to Ilsan and took the professorship of SCM then. He seemed to be very enthusiastic in researching Sasang medicine. Together with Professor Mok, he investigated the relationship between Buddhism and Sasang medicine. When I met him in his office for the first time, he kindly gave me the books which were the results of his research. He said that he could find some "clues" on the relationship between Buddhism and Sasang medicine from Yi Chema's writings although they were few. Also, he researched to what extent Buddhist practice like mindfulness or contemplation affects emotional changes according to Sasang constitutions. Moreover, he conducted a collaborative study with a professor of Plastic Surgery at the same hospital on a facial diagnosis of constitutions based on accumulated photographic facial data. Besides his main research projects, he often appeared on television to provide health information to the public. While conducting the fieldwork, I saw him several times being interviewed in his office and when visiting him, he sometimes mentioned his appearance on the broadcast. He once told me that it was important to decide which TV programs to appear in because it affected the public image of KM doctors and the discipline of Korean medicine. For instance, he talked about that he appeared several times in a popular TV program titled "Ask Anything (*muŏshidŭn murŏboseyo* 무엇이든 물어보세요)" broadcasted by the Korean Broadcasting System (KBS). In the program he gave information about not only Sasang medicine but also Korean medicine and

dietetics. He explained that the reason why he decided to appear on television was that there were some “unverified” KM doctors who were just keen to advertise themselves to sell their products rather than providing useful information to the public.

Hence, the brief biographies of the professors of Sasang medicine demonstrates several points. First, those show how Professor Lee’s academic legacy affects a new department of Sasang medicine in another KM school. Second, the two professors have different emphases on Sasang medicine: the senior has more interest in laying strong academic foundation for Sasang medicine by researching on classical texts whereas the junior has more in scientific research and expanding the social impact of Sasang medicine as a specialist. These two contrasting attitudes surely affected students learning Sasang medicine in the standardised setting.

The Training Doctor: A Student Teacher

There was a player positioned between the teachers and students: a training doctor. During the clinical training, I followed the training doctor, Dr. Park, who was in the residency program of SCM in the Ilsan hospital. At the time of my fieldwork, Dr. Park was the only training doctor of SCM in the Ilsan hospital, whereas there were two in Bundang. Dr. Park graduated from Won University College of Korean medicine. After her graduation, she did her medical internships in a private hospital, which provided the internship program only due to its size. Thereafter she applied for the residency program of SCM at the Hanguk University hospital of Korean medicine in Ilsan. Compared to Professors Mok and Han, who decided early to get the training of SCM when they were still college students, she decided to apply for this position

during her internship to have more clinical guidance and to get a certificate of KM specialist. She confessed that she was not very interested in SCM before applying for the residency program. She also said that she was not planning to remain in the university-affiliated hospitals as a fellow or in academia. For this reason, she did not attend graduate school for further degrees, which many other training doctors did.

As for her daily routine as a training doctor of SCM, she came to the office of the hospital by 8 am. After receiving a briefing from an intern by 8.20 am, she did a ward rounding until 9 am. From 9 am to 12 pm, she assisted Professor Han's clinical practice in the outpatient clinic, which included the practice of moxibustion or cupping, or performing the SCM diagnosis with the SCAT (Sasang Constitutional Analysis Tool) in the KM comprehensive examination room. After lunch, she again assisted the professor's clinical practice and treated acupuncture to patients in the wards until 5 pm. By 5.30pm she briefed the patient's current conditions, medications or treatments provided, and other necessary information to an intern on call that night. During semesters, she had to allocate time for teaching and supervising students in the clinical training. Otherwise, she needed to work on writing research articles which were conditions for the completion of the residency program whenever she had time.

As for her job in the hospital, as well as in the school, Dr. Park had three roles. First of all, like a teaching assistant to Professor Han and a teacher to KM students, she had to prepare and carry out SCM clinical training plans. Unlike the classroom teaching, teaching from the training doctor took up more amount of time than teaching from the professor. She had to supervise students almost six hours on every Tuesday during the semester. Whereas the professor's teaching was more crucial to transmit the core knowledge of SCM, the training doctor's teaching was rather practical or about the general knowledge needed in the hospital,

such as teaching how to write a progress note of a patient from the SCM perspective. Second, she was required to write and publish journal articles to fulfil the conditions to get certified as an SCM specialist. She sometimes told me about her experience on clinical research she did in the past, evaluating which one was good and which one was bad. In consultation with Professor Han, she formulated research questions, performed clinical research, or wrote case reports, and submitted to peer-reviewed academic journals, usually to the journal of SCM, to publish the research results. In contrast with such research activity, she also showed me a book she was reading for 'self-studying' SCM. The book was about explaning the meaning and providing commentaries onto the main texts of the classical SCM book. She told me the book was very helpful to better understand Sasang medicine. In addition, she praised another book for KM internists which explained medical practices performed in hospital settings. The book included: how to perform diagnostic examination, how to write medical records, how to analyse medical statistic data, how to manage inpatients in wards, frequently used herbal prescriptions and acupuncture methods, etc. Those were the skills required to be a good KM hospitalist. Third, as a practitioner in the hospital, she had to treat patients alongside Professor Han, although Professor Han always made important clinical decisions and she usually followed his treatment plans such as routine acupuncture treatments, frequently checking patients' health conditions, and primarily responding to patients' complaints.

Overall, the training doctor's role here seemed close to the role of an apprentice rather than just a student, in so far as, despite the standardised setting, the atmosphere could be quite intimate and focused on mimicking the teacher's practice (as described in Hsu (1999:100-102) for example). However, as seen above, unlike the professors Mok and Han, her aspiration to be a specialist of Sasang medicine was to secure a better position than just a general KM

practitioner. In a break, she once told me dissatisfiedly that elders of the society of Sasang medicine required training doctors to show more committement to Sasang medicine. At that point, I felt that there was some generational gap between Dr. Park and the professors. It seemed the lack of commitment was not her fault but was because of the institutionalised culture.

The Students

Unlike the teachers, who were very committed to Sasang medicine, students at the HUKM learnt Sasang medicine as one of the many clinical subjects. Despite of the distinctiveness of its doctrine and practice, the subject of Sasang medicine in the school curriculum seemed to be an aspect of the body of knowledge of 'Korean medicine'. Students of the school were taught in two campuses of the University according to their school year: the year of 1st to 3rd in Gyeongju and that of 4th to 6th in Ilsan.[104] In Gyeongju, they were mainly taught pre-clinical or basic subjects. Those subjects could be divided into three categories: Eastern Philosophy and Medicine such as *Classical Chinese, History of Eastern Philosophy, Medical History,* or *Medical Classics*; Western Biomedicine such as *Biology, Biochemistry, Anatomy, Physiology* or *Pathology*; and Hybridised Korean Medicine[105] such as *Introduction to Korean medicine* or

[104] The school years at the HUKM were divided into the two categories: *Yegwa* (preparatory/pre-med course 豫科) from the first year to the second year and *Pon'gwa* (main/medical course 本科) from the third year to the sixth year. Therefore, students were generally called *Yegwasaeng* (students in the pre-med course 豫科生) or *Pon'gwasaeng* (students in the medical course 本科生).

[105] The subjects of 'hybridised Korean medicine' can be explained as subjects for systematised education of Korean medicine in the subject-oriented and standardised curriculum, by systematically rearranging phrases or parts from classical texts for expositions of concepts, or rearranging KM disorders and treatments in parallel with corresponding biomedical diseases and explanations. For more details on the characteristics of 'hybridised Korean medicine', see Hyunkoo Kim (2016:79-100).

KM Physiology. On the contrary, in Ilsan, they were mainly taught clinical subjects more focused on hybridised Korean medicine: such as the five visceral systems[106] of KM Internal Medicine, KM psychiatry, KM paediatrics or KM Gynaecology. The subject of Sasang medicine was also taught in the clinical course along with the hybridised KM subjects. Hence, students naturally regarded Sasang medicine as 'clinical' even though professors read the classical texts written by Yi Chema. It was contrasted with other text-reading classes which were regarded as 'basic'.[107]

Whereas students from the first to the fifth year took most classes at the school lecture theatres, students in the sixth year received clinical training at two university-affiliated hospitals in Ilsan and Bundang. For example, if students got training in the Ilsan hospital on Mondays and Tuesdays, then they got training in the Bundang hospital on Thursdays and Fridays in the same week. There was a shuttle bus for the students which ran between the two hospitals. Because of limited capacity, the university could not accommodate all the students. Hence, many students I met during the fieldwork were living in private accommodation both in Ilsan and Gyeongju. Some others were living with their parents in the Seoul area, and commuting to the Ilsan campus. The student numbers in the fifth and sixth years, whom I observed for fieldwork, were 74 and 84, respectively. Among them, female students were 20 out of 74 and 31 out of 84. In terms of their age, I found that most of them were under 25 but

[106] Internal medicine of the Five Systems consists of: Internal medicine of the Liver system (肝系內科), Internal medicine of the Heart system (心系內科), Internal medicine of the Spleen system (脾系內科), Internal medicine of the Lung system (肺系內科), Internal medicine of the Kidney system (腎系內科).

[107] For example, the classes reading *Huangdi neijing* or *Shanghanlun* were regarded as 'basic'. Also, professors or lecturers who teach those subjects were not generally involved in the hospital practice and expected to do research only, except they were adjunct faculty working in private clinics.

often encountered students in their 30s and more. In those cases, students already had bachelor's degrees and even some work experience. They applied to the school to become a KM doctor because it has a record of high job satisfaction. In terms of the social background of students at KM schools, it is worth noting that recent news articles reported there has been a tendency that high school graduates from wealthy districts in the country occupied a large percentage of the successful candidates of schools of biomedicine, dentistry, and Korean medicine (Ahn, 2012; Sohn, 2013; Song, Cho and Sohn, 2020).

Whether to get a training in a hospital or not was one of the important issues for students' job prospects after graduation. If a student chose to get the hospital training, he or she had to spend one year as an internist and another three to be a specialist in a certain discipline. Apart from that, students tended to work as an apprentice in private clinics to get enough clinical experience. The final destination was usually opening their own clinic unless they obtained the very desirable position to work as an attending doctor in a hospital. During my fieldwork, I could have opportunities to have interviews on this issue with students while in clinical training at the hospital. Some students were interested in hospital life. A student told me that she was fascinated by Professor Han's insight, adeptness, and virtuosity in Sasang medicine. Besides, she confessed that she was deeply impressed by the charm of the prescription management according to the exquisite Sasang medical analysis of pathological patterns, which she did not realise during the lectures of Sasang medicine in the classroom. However, she told me that she did not come to the conclusion to have residency training in the department of Sasang Constitutional Medicine (SCM) because she still had time to experience cultures in other departments during the clinical training. There was another student who was interested in getting residency training in KM hospitals. It seemed that she wanted to learn

'integrated' clinical practice cooperated with the biomedical departments and was interested in getting the status of a specialist which would make a distinction with general KM practitioners. However, rather than the department of SCM, she said she was more interested in other departments such as KM ophthalmology, otolaryngology & dermatology or KM gynaecology because they seemed to more sizeable in terms of faculty members and patients. As a female student, her preference of KM departments as a potential speciality is corresponding with Jeong and Lee (2015)'s research on 6th year-KM students' perception of the preference of hospital specialities by gender. In the research, male students favoured rehabilitation medicine, acupuncture and moxibustion medicine, internal medicine whereas female students favoured gynaecology, paediatrics, and ophthalmology, otolaryngology & dermatology (ibid.:220). SCM was also one of the departments preferred by female students, but the preference was lower than aforementioned departments (ibid.:221).[108]

On the other hand, there was a student who was sceptic about the usefulness of the standardised Sasang constitution analysis tool. He told me that there were many greater masters of Sasang medicine in the private setting. Instead of getting training in a hospital, he said he would like to learn from them. He also mentioned about the work condition of the hospital training to be a specialist, which was very hard compared to working as *pu-wŏnjang* (vice director 副院長 부원장)[109] in private clinics. He said he does not want to be under a harsh

[108] The research analyses that such gender disparity of preference for certain speciality is because of the patriarchal culture in each department and female doctors' work-family double burden. Furthermore, the research points out that the high preference of gynaecology and paediatrics is because there is social expectation that female doctors would be good at dealing with women's illness and social/psychological capability of caring children. The preference of dermatology was also because more female patients come and visit the department of KM dermatology, especially for cosmetic reasons (Jeong and Lee, 2015:219).

[109] Because there are not many KM doctors in private clinics, usually one to five at most, being a 'vice director' is not having a high position in the setting. Rather, being at the position is generally regarded as a temporary

condition of residency like military discipline from senior doctors. Rather than being in a bureaucratic organisation like hospitals, he would choose a more liberal atmosphere like working in a private clinic. The salary of the residency program was also a reason why he did not want to get into the program as he will be able to have more opportunities to make more money if he works in private clinics.

There was another student who told me that she did not want to get hospital training, although she showed very keen interest in Sasang medicine. Unlike the aforementioned students who were in their mid-20s, she aged over the mid-30s and had a PhD degree in a medical field. Like other mature students, she was interested in clinical and practical treatments which could be directly used just after graduation. She had already heard of Sasang medicine and got interested in it before she attended the lectures on Sasang medicine in her fifth year. Hence, using her vacations in her fourth year, she attended external lectures held by experienced KM doctors who practised Sasang medicine in private clinics. However, she told me that she lost her interest in Sasang medicine for a while after those experiences. It was because the teachers did not give direct answers when she asked questions on Sasang medicine. They just said she would know if she kept studying it and built up her experience. Nonetheless, she said she kept trying to learn from various other masters or academic groups outside the university, including *p'al-ch'ejil ŭihak* (Eight-Constitution Medicine; ECM 八體質醫學). Although the mainstream ECM practitioners argued that ECM is different from SCM and cannot be mixed together, she thought ECM and SCM could be linked. It seemed that she found her way of diagnosing constitutions and prescribing treatments. However, this kind of fusion

course to build up clinical experience and eventually open his/her own clinic. For detailed explanations on the position in private KM clinics, See Section 6.3.1.

of horizons could not be accepted in the hospital setting which emphasised the disciplinarity of SCM in the name of professionalisation and standardisation. As expected, she did not show interest in hospital training.

The Textbook and the Handbook: Between Classroom Learning and Clinical Training

Sasang medicine in the school curriculum had a standardised textbook written by professors of Sasang medicine from all of the twelve KM schools in the country. The first edition of the textbook was published in 1997. The preface, written by Professor Lee, pointed out the situation of the day that "many people still try to understand Sasang medicine from the perspective of *kijon-ŭihak* (conventional medicine 旣存醫學 기존의학)" [110] (SSCM, 1999:56). Therefore, the purpose of the textbook was "to overcome 'the problem of the understanding'" and "to provide the 'standardised' way of education" (Chŏn'guk hanŭigwadaehak sasangŭihak kyoshil, 2005:4). In doing so, the contents of the textbook covered *ch'ongnonjŏk wŏllip'yŏn* (the chapter for the general fundamentals of Sasang medicine 總論的原理篇) and *ŭihagironp'yŏn* (the chapter for the medical theory[111] 醫學理論篇) (see

[110] "*kijon-ŭihak* (conventional medicine 旣存醫學)" was another expression of *chŭngch'i-ŭihak* (pattern-treatment medicine 證治醫學) in Professor Lee's words.

[111]. Following Boyer (1990:24-45), Hsu (1999:124) speaks of traditional notions as 'empty' and seems vague to the novice who has no experience in medical practice. However, their meanings become be very specific and precise with growing experience. That is, the words may become increasingly polysemous with practitioner's experience. In this context, such 'empty concepts' are rarely defined by denotation in the classical texts, they acquire their denotational meaning in medical practice. To highlight that knowledge can have different status and purposes, Hsu (1999) distinguishes more religiously oriented attitudes to knowledge as a 'doctrine' which she from a scientific 'theory' in modern medicine. This mode of learning usually requires reading the classical phrases or sentences by heart. For this reason, classical texts were often written in "poetical style" (Langford, 2004:119),

Table 4.1 for details of the table of contents of the textbook). In 2004, the revised and enlarged edition was published and its preface explained that the new edition included the edited contents of the *First Draft* (四象草本卷) and the North Korean edition of the *Posthumous Work of Tongmu* (東武遺藁) which were newly discovered at that time (ibid.:3). Furthermore, the new edition included the classical texts and the modern Korean translation of *Donguisusebowon* in the last part of the book to help students "to understand [the classical texts] better" (ibid.). Apart from this textbook, in the HUKM, the Korean translation of the *First Draft of Sasang* which was translated by Professor Mok, was designated as an adjunct textbook. During the first semester of the classroom teaching, however, I barely saw that the book was in actual use, although I could see many students purchased and carried the book. In the classroom teaching, Professor Han mostly used his PowerPoint materials to deliver his talk, sometimes referring to the contents of the textbook itself. On the other hand, Professor Mok mostly used the classical text part of the textbook to lecture on "Treatise on the Origin of Medicine" (醫源論), a chapter of *Donguisusebowon* which Yi Chema explained the history of East Asian medicine in his own viewpoint.[112]

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to help the embodiment of the texts. Langford (2004) explains, "verse acts as a mnemonic and organizing vehicle carrying the sound-substance of medical wisdom into the mind of the reciter and listener, writer and reader. The rhythms of poetic texts were evidently designed to enhance memorization, recital, and even comprehension" (120). Therefore, learning classical texts aims to go to deeper levels of knowledge. On the contrary, the standardised textbook amasses vast amounts of knowledge (ibid.). Langford (2004:126) points out that signs of illness or health are separated from narrative accounts and translated into quantities. Hsu (1999:127) comes to the conclusion, that somewhat paradoxically, didactical explications and explanations in standardised form likely hinder the creative medical interventions that can be achieved by rote learning. She presents a traditional doctor's conviction that the memorisation of texts by imitation and repetition will eventually lead to a culturally recognised "revelation" (*wu* 悟) of "just knowing" (ibid.:222).

[112] For the particular introduction and the English translation of "Treatise on the Origin of Medicine", see Yi (2016).

Apart from the textbook, there was a handbook for the clinical training of Sasang medicine. The handbook comprised of two volumes and Sasang medicine existed as one of the six parts in total in the second volume. Other clinical subjects such as Acupuncture Medicine, Rehabilitation Medicine, Paediatrics, Ophthalmology and Otolaryngology, and Dermatology were in the same volume. Compared to the textbook of SCM, the handbook quoted other books and articles as well as the textbook. It also used more tables, diagrams, and photos. Tables and diagrams were usually used to summarise or systematize the contents of the classical texts or the textbook; and pictures were mainly used to indicate exact body parts for the body type measurement. As for treatments, the handbook introduced a list of the frequently-used prescriptions in the department of SCM at the HUKM hospital, and another list of powdered herbal extracts of Sasang prescriptions covered by the National Health Insurance (see Table 4.1 for the details of the table of contents of the clinical handbook). Along with the herbal treatment, acupuncture methods like T'aegŭk acupuncture (太極鍼法)[113] and Sa-am acupuncture (舍菴鍼法) were introduced as ones used in the SCM department. It was noteworthy in this context that Yi Chema rarely even mentioned acupuncture treatments in his writings. Clearly, the Tae-geuk acupuncture was later invention which could be used in relation with Sasang medicine (Lee, 1974).[114] The inclusion of the Sa-am acupuncture method, which is known to rely on the theory of Five Phases, seemed the department's contradictory adaptation for clinical practicality. The Sasang textbook, however, kept a critical attitude to those acupuncture

[113] T'aegŭk (lit. Supreme Ultimate 太極) acupuncture was first introduced in a book *Ch'imdowŏllyujungma* (*the Repeated Polish of the Original Stream in the Way of Acupuncture* 鍼道源流重磨) by Lee Byŏnghaeng in 1974 (Lee, 1974).

[114] For the details of its logic and practice, see Section 3.4.3 of Chapter 3.

methods. The textbook explained, the theories used in those acupuncture methods "rarely considered the difference between existing *zangfu* (臟腑) concept and *zangxiang* (state of the internal organs 臟象) of the Sasang *zangfu* theory" (Chŏn'guk hanŭigwadaehak sasangŭihak kyoshil, 2005:337). By contrast, the handbook did not include those critical remarks and just contained the two acupuncture methods because they were used in the current clinical practice of Sasang medicine in the hospital. This contradiction showed the difference between the textbook and the handbook, one was for authenticity and authority, the other for practice.

Clearly, the textbook for classroom teaching and the clinical handbook for clinical training had different purposes. These different purposes organised different structures of knowledge in Sasang medicine. The textbook focused more on establishing the 'systematic' structure for the disciplinarity of Sasang medicine, although it still embraced the classical texts as an important part of the content of the textbook and the teaching. The clinical handbook, on the other hand, paid more attention to the practical use in the hospital setting, even including somewhat contradictory therapeutic methods for the clinical practice. In doing so, factors of dealing with Sasang *ch'ejil* – e.g. diagnosis or treatment – were differently constituted.

Table 4.1. Comparison of the Tables of Contents of the Textbook and the Clinical Handbook of Sasang Medicine

The Textbook of Sasang Medicine	The Clinical Training Handbook at the Department of SCM
Part 1. The Background of Sasang Medicine	**Part 1. The Understanding of the Principles of Sasang**
1.1. The Life of Yi Chema and the History of Sasang Medicine	1.2. The Life of Yi Chema
1.3. The Philosophical Background of Sasang Medicine	1.2. The Classical Texts of Sasang Medicine
1.4. The Medical Historical Background of Sasang Medicine	1.3. The Basic Principles of Sasang Medicine
Part 2. The Basic Principles of Sasang Medicine	**Part 2. The Constitution Diagnosis**
2.1. The Basic Concepts of Sasang Medicine	2.1. The Outline
2.2. The Discussion on the Nature and Life of the Heaven and Human	2.2. Somatic Morphology and Physical Comportment
2.3. The Visceral State of the Sasang Persons	2.3. Appearance and Manner of Speech
Part 3. The Discussion on the Sasang Viscera and Bowels	2.4. Observation of the Heart
3.1. General Discussions	2.5. Basic Patterns
3.2. The Difference between The Viscera-Bowels Theories of Pattern-Treatment Medicine and Sasang Medicine	2.6. Questionnaires
3.3. The Rules of the Viscera-Bowels Theory	**Part 3. Therapeutic Principles of Pathological Patterns and Life-Nurturing**
3.4. The Organisation and Functions of the Viscera and Bowels	3.1. The Discussion on the Pathological Disorders of Sasang Persons
Part 4. The Discussion on the Pattern Differentiation of Sasang Constitutions	3.2. The Discussion on the [Sasang] Drugs
4.1. The Outline	3.3. Songs on the Qualities of Drugs
4.2. The Conditions for the Pattern Differentiation of Constitutions	3.4. Foods
4.3. The Classification of Constitutions	3.5. The Discussion on the Life-Nurturing

4.4. The Comparison between the Constitutions with Difficulty in Differentiation	**Part 4. Clinical Applications**
4.5. The Spirit of Yi Chema's Pattern Differentiation	4.1. Frequently Used Sasang Prescriptions
4.6. The Characteristics of Each Sasang Constitution	4.2. Acupuncture Methods for Sasang Persons
4.7. *The First Draft of Sasang*	
4.8. A Study on the Methods of Constitution Diagnosis by Doctors from Later Generations	
Part 5. The Discussion on Pathological Disorders	
5.1. The Relationship between Sasang Medicine and Shanghanlun	
5.2. The General Principles of the Discussion on the Pathological Disorders of Sasang Persons	
5.3. The Discussion on the Pathological Disorders of Soeum Persons	
5.4. The Discussion on the Pathological Disorders of Soyang Persons	
5.5. The Discussion on the Pathological Disorders of Taeeum Persons	
5.6. The Discussion on the Pathological Disorders of Taeyang Persons	
Part 6. Constitutions and Life-Nurturing	
6.1. The Methods of Life-Nurturing according to Nature-Emotion based on the Heart	
6.2. The Methods of Life-Nurturing according to Knowing-Doing based on the Body	
6.3. The Methods of Life-Nurturing according to [Constitutional] Diets	
Part 7. Other Discussions on Constitutions	

7.1. The Study on Constitutions in Eastern and Western Medicines	
7.2. Constitutional Pulses and Acupuncture Methods	
Part 8. The Discussion on Sasang Formulae	
8.1. The Discussion on the Sasang Drugs	
8.2. The Discussion on the Sasang Formulae	
8.3. The Discussion on the Sasang Prescriptions	
Part 9. Clinical Applications	
9.1. Miscellaneous Disorders	
9.2. Internal Bodily Elements	
9.3. External Bodily Elements	
9.4. Gynaecology	
9.5. Paediatrics	
Part 10. The Korean Translation of *Donguisusebowon*	
Part 11. *Donguisusebowon*	

4.2. Learning Sasang Medicine in Classroom

Assimilating the Founder: Establishing the Boundaries of the Discipline

To conduct participant observation for the classroom learning of Sasang medicine, I participated in classroom lectures for the 5th-year students as an auditor/ethnographer from March to June 2017. The classes were held in a lecture hall which could accommodate around 80 people. In the hall, there was a whiteboard and a screen for an LED projector at the front side, and there were several television screens hanging from the ceiling at the rear sides, for students at the back to see words and pictures on slides. During my field work, I could see some students were stacking books, textbooks of other subjects on their desks, and some at the back row seemed doing assignments even after the lecture started.

In the first lecture of Sasang medicine, Professor Han started by briefly introducing the structure of the classes of Sasang medicine in the first semester. The whole classes for 16 weeks of the first semester would be divided by two professors: Professor Han would teach for the first 12 weeks and Professor Mok would teach for the last four weeks. Professor Han then asked the students to understand the existence and identification of constitutions in an embodied way. After a moment's thought, he told the students that they would need to form a group of nine which were expected to make a presentation about Sasang medicine each week just before the professor's lectures of each week start. When the students just listened to his remarks, he emphasised that students would need to form groups right away. "Right now?" The students seemed puzzled and did not know what to do. A little later, the professor smiled and said, "You stand still if I do nothing. I will give you a condition that the group which succeeds to be formed first will present at the very last whereas the last group formed will be the first to

present." Then the students started to speak loudly and actively sought other members to form groups. After about 15 minutes, the list of groups was finally complete and was handed over to the professor. The professor added, "While you were forming groups, some of you spoke louder to assiduously find other members and some others just passively hoped for their names to be called by their friends. Through this, we can see that there is a wide variety of dispositions. Sasang medicine is a discipline which examines these differences."

Furthermore, Professor Han emphasised the importance of the founder of Sasang medicine, i.e. Yi Chema. At the end of the first lecture, Professor Han said, "[Through this series of lectures,] Yi Chema is what you need to meet. You need to meet him through reading the original texts [written by him]." The curriculum also fitted into knowing about the founder's life trajectory and thoughts, especially in the lectures of the first semester. Understanding the terms and theories of Sasang medicine was meant to understand the founder's intention. The lectures in the first semester dealt with the 'philosophical' aspects of Sasang medicine whereas in the second semester the lectures covered the 'medical' aspects, that is, pathological patterns of constitutions (體質病證). Understanding the historical and philosophical contexts of the founder's life and thought was important to understand the meaning of terms, concepts, and theories of Sasang medicine.[115] For instance, Professor Han spoke of Yi Chema's life like this:

> Yi Chema lived during the periods of the kings of Hŏnjong (1834-1849), Ch'ŏlchong (1849-1863) and Kojong (1863-1897) of the Chosŏn dynasty. He was born in Hamhŭng, a remote city in the north of the Korean peninsula. He moved to the capital in his 40s and devoted

[115] This can be compared to the case of learning biomedicine. Good and Good (1993:97-98) explains that learning the language of (bio-)medicine consists not of learning new words for the common-sense world, but the construction of a new world altogether, and learning names is getting into linguistics or semiotics of things. One different point between learning biomedicine and learning Sasang medicine is that teachers in biomedical schools regard biomedical terms as "the lingua franca of medicine" (ibid.:97), whereas teachers of Sasang medicine does not. The teachers of Sasang medicine in the class regarded Sasang medicine as another medical framework in a different realm from Korean medicine.

> himself to medicine in his hometown Hamhŭng after serving as a military officer for about twenty years. He started studying medicine with the emergence of his chronic disease. He did not particularly have any teacher. By wandering around in Hamgyŏng province and Manchuria, he became broad-minded and free-thinking, different from most intellectuals at the centre of the country. He was not a person who shared the opinions that prevailed in the capital at that time. He used medicine as an effective medium to realise ethical practice.

This biographical sketch highlights the uniqueness and distinctiveness of Sasang medicine, particularly if compared to the conventional Korean medicines developed in the middle of the country or the centre of the academic and philosophical stream. Furthermore, it supported the view that his philosophical idea, which induced the formation of the physiological theory in Sasang medicine, was not influenced by Neo-Confucianism which flourished in the middle or the southern parts of the country. Professor Han continued:

> Yi Chema saw the harmful consequences of Neo-Confucianism [as a political ideology and epistemology] in his day and, [like a real revivalist (see Leslie (1976))], tended to study Confucius and Mencius. His making of the conceptual alignment of Sorrow-Anger-Joy-Pleasure (*ae-no-hŭi-rak* 哀怒喜樂) is from the Four Extremities (*sadan* 四端) in the *Mencius*, not from the Seven Emotions (*ch'ilchŏng* 七情) [which were mentioned in other East Asian medical classics][116]". The contrast with the *Book of Changes* (*I Ching* 易經) was also mentioned: "while there is a divergence from the Supreme Ultimate (*t'aegŭk* 太極) to the two opposing principles (*yangŭi* 兩儀) or yinyang (*ŭmyang* 陰陽), the Four Images (*sasang* 四象), the Eight Trigrams (*p'algwae* 八卦), and the Sixty-four Hexagrams (*yukshipsagwae* 六十四卦) in the *Book of Changes*, Yi Chema enumerated from the Supreme Ultimate, yinyang to Affair-Heart-Body-Thing (*sa-shim-shin-mul* 事心身物), which was meant to Sasang. He did not go to the eight trigrams or further.

Lastly, Professor Han explained that the purpose of the Sasang medical practice was different from some kind of the Daoist tradition: "The eventual purpose of Yi Chema's thought

[116] For detailed discussions of the Seven Emotions as parts of the human psycho-physiological process, see Zhang (2007:64).

is to become a sage (*sŏngin* 聖人) by cultivating one's body (*sugishin* 修其身) and establishing one's fate (*ipkimyŏng* 立其命)." This was close to the Confucius way rather than that of the Daoist.

Hence, by featuring the originality of Yi Chema's thought and Sasang medicine, he intended to draw boundaries between Sasang medicine and conventional medicine (*kijon-ŭihak* 旣存醫學) or pattern-treatment medicine (*chŭngch'i-ŭihak* 證治醫學), and between Sasang philosophy and Neo-Confucianism, which was the philosophical foundation of the old regime in the Chosŏn Dynasty. This demarcation provided Sasang medicine with a new epistemological space to establish its own identity and enabled it to get new designations such as "medicine of inherited traits" (*p'umsu-ŭihak* 稟受醫學), "medicine of heart and physique" (*shimshin-ŭihak* 心身醫學), "medicine of different constitutions" (*ch'ejil-ŭihak* 體質醫學), and "medicine of different socialities" (*sahoe-ŭihak* 社會醫學) (Chŏn'guk hanŭigwadaehak sasangŭihak kyoshil, 2005:4). As has been shown so far, in the process of learning Sasang medicine, assimilating the founder's thought and practice throughout his life was regarded as a required course to fully understand what Sasang medicine is and how to apply it.

Emphasis on Philosophy and Basic Doctrine: Thinking with the Classical Texts

Then how would students assimilate the founder? The founder already died in 1900 so that getting apprenticeship education from him was impossible. Even the medical lineage from the

founder was not clear and seemed to have not continued in contemporary South Korea.[117] As mentioned before, according to Professor Han, 'meeting the founder' was possible by reading the classical texts written by the founder. He used the phrases from the original texts in his PowerPoint slides. The range of the original texts was not just limited to the sentences in the most seminal book, *Donguisusebowon* of 1901 (*shinch'ukpon* 辛丑本); it also included the philosophical writings as well as the precursor manuscripts such as the *Manuscript of Study* (*Kyŏkch'igo* 格致藁) and the *First Draft of Sasang* (*Sasang-ch'obon'gwŏn* 四象草本卷). Professor Han, for example, explained the concept of Sasang using Yi Chema's philosophical writing, the *Manuscript of Study*.[118]

> Sasang medicine has its core concepts of *sasang* (Four Images 四象), that is, Affair (*sa* 事), Heart (*shim* 心), Body (*shin* 身), Thing (*mul* 物); and Nature and Emotion (*sŏngjŏng* 性情), that is, Sorrow (*ae* 哀), Anger (*no* 怒), Joy (*hŭi* 喜), Pleasure (*rak* 樂). Affair-Heart-Body-Thing (*sa-shim-shin-mul* 事心身物) appeared in the *Manuscript of Study* (*Kyŏkch'igo* 格致藁) but not in *Donguisusebowon* [of all editions].

When explaining Affair-Heart-Body-Thing, Professor Han showed the sentence from the *Manuscript of Study* saying "A thing resides in a body, a body resides in a heart, and a heart resides in an affair (物宅身也, 身宅心也, 心宅事也)" on the PowerPoint slide. Also, interpreting the classical Chinese sentence in modern Korean, he provided some examples for students' better understanding. As for the relationship between the body and the thing, for instance, Professor Han asked students to imagine that 'the body was meeting with the thing',

[117] For the detailed description of tracing the medical lineage of Yi Chema, see Jung (2013:347-380).

[118] For the years of completion and years of publication of Yi Chema's writings, see Table 3.1 in Chapter 3.

like the body ‘sits’ on the chair, or like the body ‘reads’ the book.[119] Another example was a story of a gorilla which eats a banana. “If the banana is a ‘thing’, the gorilla would be a ‘body’, and if an idea of eating bananas is a ‘heart’, then the eating event would be an ‘affair’.” In this way, he argued that all phenomena could be explained with the conceptual framework of *Sa-shim-shin-mul*, which was devised by Yi Chema. Hence, *Sa-shim-shin-mul* referred to the most representative ones of human life and activity.

Many parts of the textbook also used the classical texts to support their systematised explanations of the concepts and theories. This was frequently shown when explaining the concepts appeared in the Sasang Structural Theory (*sasang-gujoron* 四象構造論) part of the textbook. During the class, Professor Han often read classical texts from the textbook to explain . For instance, he read the first sentence of *Donguisusebowon* of 1901 like below:

> 天機有四 一曰地方 二曰人倫 三曰世會 四曰天時. 人事有四 一曰居處 二曰黨與 三曰交遇 四曰事務 (Committee for the textbook of Sasang medicine, 2005:633).
>
> *Ch'ŏn'gi* (heavenly affairs) consists of four aspects. The first aspect is *Chibang* (the earth’s squareness), the second is *Illyun* (human relations), the third is *Sehoe* (generational meetings), and the fourth is *Ch'ŏnshi* (the heavenly times); *Insa* (human affairs) consists of four aspects. The first aspect is *Kŏch'ŏ* (knowing the proper place to reside), the second aspect is *Tangyŏ* (establishing group responsibilities), the third aspect is *Kyowu* (associating with others one on one), and the fourth is *Samu* (fulfilling one’s mission and work) (Wagman, 2017:32-33).

The words like *Ch'ŏn'gi* (heavenly affairs 天機) or *Insa* (human affairs 人事) were crucial theoretical terms of the philosophy of Sasang medicine but were unfamiliar to the students because they had not appeared in Chinese or other Korean medical classics which the

[119] This explanation can be interpreted not only as a physical contact between the body and the thing, but also as bodily perception of the thing.

students learnt before. Therefore, the teacher explained the meaning of the words based on the expository commentaries in the textbook. "*Ch'ŏn'gi* is a comprehensive reference to all the environmental factors that always exist around us and affect human life. *Insa* refers to characteristic elements of behavioural patterns in human life." Then he added his interpretations of the terms in the sentences like "Among the four aspects of *Ch'ŏn'gi*, *Chibang* (the earth's squareness 地方) is the most basic. This is the very basis of existence, which can be understood as a concept that is almost consistent with nature. *Illyun* (human relations 人倫) is the concern of human relationships which forms ourselves such as ethics, morals, or communal norms" (cf. Committee, 2005:88-89).

Professor Han also mentioned the connections to the blood-type theory. He explained that only in Japan the blood types were related to psychological characteristics and that has also influenced Korea. However, different from the blood-type theory, Yi Chema related the psychological characters to the virtues of the Four Extremities (*sadan* 四端). This correspondence was derived from Confucius' thought, not from the blood types. The professor emphasised, "therefore the clarity of constitution classification became problematic in practice because it is difficult to 'measure' as it originated from philosophy".

To explain the distinctiveness of the four constitutions, the professor asked a question. "Is it spring now?" The students could not readily answer. "It is March, but it feels like winter these days. Then isn't there spring? No. Spring still exists."[120] The professor continued.

[120] In traditional East Asian lunisolar calendars, there are 24 terms of *Chŏlgi* (twenty-four solar terms 節氣). According to this system, spring begins at *ipch'un* (the beginning of spring 立春) which is on 4 Feb. Therefore, the professor's remark implies that it is spring although the current weather is still cold like winter.

“Likewise, constitutions exist as well. However, they are often concealed by education or edification of human nature, and the changes of circumstances and lifestyle. So, we need to consider those factors when identifying constitutions.”

In summary, Professor Han explained the life story of Yi Chema and his philosophy, by emphasizing phrases from his writings. Illuminations on the founder’s life can be understood as history as “re-enactment of past experience” (Collingwood, 1946:282). By learning about Yi Chema’s life, students were required to envisage the reality as the founder did it. By doing so, Professor Han intended students to go closer to the founder’s thought and the ‘authenticity’ of Sasang medicine. Moreover, throughout the classes, as Hanks (1989:119) indicates, the classical texts played a role as a form of cultural capital, as a mode of naturalizing and familiarizing social realities, and as an instrument of authority. In other words, Yi Chema’s texts were often more influential than sentences from the standardised textbook and any other recent articles. The classical texts also played a role as a medium which bridges the social and medical realities in the founder’s time and in the present. Furthermore, the presentation of the texts during the classes intensified not only the authority of the founder, but also that of Professor Han’s interpretations on the classical texts with his figure of speech, which were similar to that of Professor Lee and his students. By doing so, Professor Lee’s emphasis on the classical texts was embedded in the standardised classroom education.

4.3. Learning Sasang Constitutional Medicine in Hospital

As mentioned before, the clinical training of Sasang medicine happened in university-affiliated

hospitals in Ilsan and Bundang. Although most of clinical practice of Korean medicine (KM) was happening in KM clinics (*hanŭiwŏn* 韓醫院 한의원), most of the KM clinical training of was taking place in KM hospitals (*hanbang byŏngwŏn* 韓方病院 한방병원).[121] Unlike most KM clinics, normally run by KM doctors only, KM hospitals were usually in a form of 'cooperation'[122] with Western medicine (WM) doctors and WM clinics in the same unit. For instance, the Ilsan hospital included WM and KM outpatient clinics as well as WM and KM wards in the same building (see Figure 4.3). However, they were on separate floors. Whereas the WM outpatient clinics were located on the first and second floors, the KM outpatient clinics were on the third floor. When I visited the hospital, the former was relatively more crowded than the latter. In addition to the outpatient clinics, the KM inpatient ward with 71 beds was on the fifth floor, separated from the other WM wards on the other floors, open to patients of all of the KM departments on the same floor. As for the SCM department[123] in the Ilsan hospital, the outpatient clinic of SCM was located on the third floor, along with other KM departments. It consisted of a consulting room, and a treatment room shared with the KM paediatrics department which was next to the SCM department. In the treatment room, I saw there were around 6 beds for KM treatments such as acupuncture, moxibustion, etc. In addition, the SCM

[121] As of 2016, 282 out of 14,142 KM institutions were KM hospitals, while the rest of 13,860 institutions were KM clinics (The Yearbook of Traditional Korean Medicine Publication Committee, 2018:232).

[122] In the hospital, this was expressed as the term *yanghanbang hyŏpchin* (the Western-Korean Cooperative Treatment 洋韓方協診). For the detailed process about the cooperative treatment between WM and KM, see Park (2017).

[123] The term SCM is the abbreviation of Sasang Constitutional Medicine (*sasang ch'ejil ŭihak* 四象體質醫學). As mentioned in Chapter 3, the hospital department and the graduate school education included the word '*chejil*' (constitution 體質) in their subject titles, whereas the undergraduate education persisted in using Sasang medicine (*sasang ŭihak* 四象醫學).

department was in charge of managing the KM comprehensive examination room (*hanbang-jonghapkŏmsashil* 韓方綜合檢查室), where patients were sometimes consulted for the constitution analysis (*ch'ejil bunsŏk* 體質分析).

This hospital culture was significantly different from that of private KM clinics. Borrowing Jewson (2009)'s terms, Sinclair (1997:42) explains 'hospital medicine' was based on the concept of normality, and on systematic statistical associations being made between external symptoms and internal lesions found at anatomical dissection after death. And in 'hospital medicine', the sick poor who were treated there became 'cases', adopting a role of the passive and uncritical patient in the face of incontestable medical knowledge. He points out that, not only did the new knowledge fundamentally alter relationships between patients and doctors, 'hospital medicine' also created new relationships between doctors themselves: between hospital doctors and general practitioners, between senior and junior hospital doctors, and between students and hospital doctors. For this reason, the hospital was a good locus to observe how the social practice of Sasang medicine were reorganised, specialised, and systematized.

As mentioned above, I embarked on fieldwork for the SCM clinical training at the Ilsan hospital at the beginning of March 2017. It was the beginning of the new academic year. I shadowed students in the sixth year – the last year for the bachelor of KM course. They had the clinical training throughout almost the year. There were totally 13 clinical subjects for clinical training. Generally students had clinical training one subject per a week, two days in the Ilsan hospital and the two other days in the Bundang hospital. The clinical training of SCM, which I observed, started with a general orientation at the main auditorium of the hospital. The

orientation was attended by the sixth year students wearing formal suits with white lab coats, an attire that was required throughout the clinical training. The whole student body of 84 people would be divided into 13 groups, with 6 or 7 students forming one group. Each student group would get the clinical training of SCM for one week: Monday and Tuesday in Ilsan, and Thursday and Friday in Bundang.[124] On Wednesdays, students were often required to attend special lectures or took exams. After that week assigned to the SCM clinical training, they would get clinical training in other departments on other subjects than SCM throughout a semester (16 weeks in total). The SCM training for the first semester would be about learning how to diagnose constitutions and in the second semester students would be about to treat a mock patient by role-plays. In the first semester, the students would be learning the body-shape measurement (*ch'ehyŏng ch'ŭkchŏng* 體形測定) and the facial measurement (*anmyŏn ch'ŭkchŏng* 顔面測定).

Figure 4.3. The HUKM Hospital in Ilsan. Photo by the Author

[124] I conducted fieldwork in the Ilsan campus because of its relative proximity to other schedules such as interviewing Professor Lee and visiting KM clinics in various locations.

As for the daily plan, the clinical training usually began at 8.30 am and ended at 5.30 pm. On the first day of training in the first semester, students were required to gather in front of the training doctors' office by 8.30 am and attended a lecture by Dr. Park, the training doctor. The lecture consisted of learning four factors for the constitution diagnosis: Somatic Morphology and Physical Comportment (*Ch'ehyŏng-gisang* 體形氣像)[125], Appearance and Manner of Speech (*Yongmo-sagi* 容貌詞氣)[126], Observation of the Heart (*Shimjŏk-kwanch'al* 心的觀察), and Basic Patterns (*Sojŭng* 素證)[127]. Students were expected to be aware of those factors in advance because they already learned about related knowledge from the classroom learning in the fifth year. The lecture was intended to teach how to enact those diagnostic viewpoints into the practice in real situations. Dr. Park asked students to read out sentences in the constitution diagnosis part of the handbook, which included the four factors, then proceeded the exercise (see Table 4.2 for the detailed schedule of the SCM clinical training in the first semester).

For the first factor, Somatic Morphology and Physical Comportment, the clinical handbook first presented the related classical texts and then introduced two methods: the five-bodyline measurement and the eight-bodyline measurement. Dr. Park gave a brief

[125] Lee (2010:93) explains Somatic Morphology and Physical Comportment as "a passive method of observing the physical attributes in order to discern the constitutional type of a given individual the differences in external appearances that arise from the differences in the internal organ scheme due to the deviation in *Sŏngjŏng* (Nature and Emotion 性情) of *Aenohŭirak* (Sorrow-Anger-Joy-Pleasure 哀怒喜樂)".

[126] Lee (2010:94) explains Appearance and Manner of Speech as: "an active method of observing the physical attributes in order to discern the constitutional type of a given individual; includes the facial features and manner of speech".

[127] Lee (2010:75) defines Basic Patterns in Sasang medicine as: "patterns observed commonly or usually in an individual". They are distinctive based on one's Sasang constitution.

demonstration of the two methods and each student, in turn, practised the five-bodyline measurement in an empty ward. Back in the office, they photographed their front and side faces to input to the computer to perform the facial constitution analysis, which was related to the second factor: Appearance and Manner of Speech. They were also required to review research articles on basic patterns to perform role-playing in the afternoon. After lunch, they moved to the PK room and filled in another questionnaire on basic patterns and the PBL (Problem-Based Learning) report form, preparing for role-playing. Students were expected to work in pairs to perform doctor-patient role-playing. The guide of role-playing was to demonstrate the procedure of diagnosing a patient's constitution, and the role-playing was supposed to be video-recorded to be submitted to Professor Han. When they finished preparing to role-play, they called Dr. Park to watch their plays and got brief feedbacks and comments from her. In the morning of the second day, they gathered in the KM examination room to experience *sŭk'aet* (SCAT: i.e. the Sasang Constitution Analysis Tool), which was a standardised tool to diagnose Sasang constitutions. This time, their faces were photographed by a professional camera in a standardised setting, they recorded their voices for the voice analysis, and answered a personality-related survey. They also experienced the Digital Infrared Thermal Imaging (DITI) in the room, which visualises and quantifies changes in skin surface temperature. In the afternoon, they went to Professor Han's outpatient clinic and got detailed feedbacks and comments on their role-plays.

In the second semester, the SCM clinical training was more inclined to clinical application. The clinical training lasted for two days as it was the last time although on the morning of the second day there was no schedule for students. In the morning of the first day, students gathered in the PK [abbreviation of 'polyclinic'] room – where computers were

allocated to each student for assignments and self-study – by 8.30 am and were required to fill in a case report form (CRF) of themselves, referring to papers distributed in advance. In the afternoon, students had a practice of filling out a medical record of their pair in the group and performed doctor-patient role-playing. This time focused on how to treat a patient based not only on their constitution but also on pathological patterns. This role-playing was also video recorded by students, and the recording files were submitted to Professor Han. In the afternoon of the second day, they went to Professor Han's outpatient clinic and got feedback and comments on the role-playing. Besides, students could sometimes observe Professor Han's clinical practice when he was seeing patients (see Table 4.3 for the detailed schedule of the SCM clinical training in the second semester).

Table 4.2. A Schedule of the SCM Clinical Training at the Ilsan hospital in the 6th Year: 1st Semester, One Week

Time	**Day 1 (Monday)**	**Place**	**Day 2 (Tuesday)**	**Place**
8.30 am	Gathering in front of the training doctors' office		Gathering in front of the KM Examination Room	
8.30-9.30	Lecture by the Training doctor	The training doctors' office	Experiencing the SCAT	The KM comprehensive examination room
9.30-10.30	Practising the body measurement	A hospital ward	*Ditto*	*Ditto*
10.30-11.30	Photographing faces, putting the points on the faces, filling in the Basic Pattern Questionnaire (素證說問紙)	The training doctors' office	*Ditto*	*Ditto*
1.30-3.30pm	Filling in the PBL Report Form (PBL 記錄紙) and preparing for role-playing	The PK room	Clinical apprenticeships (Subgroup 1)	The outpatient clinic
3-5.30pm	Role Playing (Doctor diagnoses patient's Sasang Constitution)	The PK room	Clinical apprenticeships (Subgroup 2)	The outpatient clinic

Table 4.3. A Schedule of the SCM Clinical Training at the Ilsan Hospital in the 6th Year: 2nd Semester, One Week

Time	Day 1 (Thursday)	Place	Day 2 (Friday)	Place
8.30 am	Gathering in the PK room		*No Schedule*	
8:30-11:30am	Filling in a case report form (or CRF)	The PK room	*No Schedule*	
1-3pm	Filling in a medical record form, preparing for role-playing	The PK room	Clinical apprenticeships (Subgroup 1)	The outpatient clinic
3-5.30pm	Role-playing (Doctor prescribes patient's medicine)	The PK room	Clinical apprenticeships (Subgroup 2)	The outpatient clinic

Spaces and Spatialized Works in the Hospital

Unlike classroom learning, the SCM clinical training used various spaces in the hospital. First, wards were the first place that students encountered when they started clinical training. Wards 51 and 52 on the fifth floor were mainly assigned to KM inpatients, and KM students in the clinical training went around the area. Of course, other people, professors, training doctors, internists, nurses, patients and carers appeared in the same area, with different purposes and tasks. When students encountered professors, training doctors, or internists on the corridor of the wards, they briefly but politely bowed to their seniors. If they encountered other fellow students, some students made a playful look to others because of their unfamiliar costumes of wearing formal dresses with white coats and awkward attitudes, while others just passed by with no greetings, not wishing to draw the attention of their seniors.

The training doctors' office was another place of learning. During my fieldwork, three

training doctors from the departments of SCM, paediatrics, and neuropsychiatry were sharing one office. Each of them was the only training doctor in their department, whereas 'big' ones such as the department of KM Internal Medicine or that of Acupuncture and Moxibustion medicine had several training doctors. Each of the three training doctors took their own desk, bookshelf, and other office devices. There were also a big tables and chairs to accommodate a group of students for a small conference or lecture. Although the office was located on the same floor with the fifty-one/fifty-two wards, the area was separated from the wards, with an iron door that could restrict public access. In the morning of the first day, students came to the office and attended a lecture given by the training doctor of SCM, Dr. Park.

Apart from the training doctors' office, there was the PK room for students' self/group work in a separate but neighbouring area. There were desks and desktop computers for a group of students which made them work during the afternoon of the first day. While students were working by themselves, Dr. Park went in and out of the room twice: 1) to give an instruction to how to fill out the Basic Pattern Questionnaire (*sojŭng-sŏlmunji* 素證說問紙) and the PBL (Problem-Based Learning) Report Form (*p'ibiel-kirokchi* PBL記錄紙) and how to prepare the role-playing; 2) and to give feedback to the students on their role-playing.

The KM comprehensive examination room (*hanbang-jonghapkŏmsashil* 韓方綜合檢查室), which was usually used by training doctors to perform medical examinations for patients, was open for students when learning how to 'analyse' Sasang constitutions by using a standardised and systematised program, the SCAT (Sasang Constitutional Analysis Tool).[128]

[128] During my fieldwork in the hospital, Professor Han emphasized the SCAT was only for the 'analysis' of Sasang

The SCAT comprised of various devices: a camera set to take photographs for the facial analysis, a microphone for the voice analysis, measurement tools such as a tapeline for the body measurement, and a computer to record and analyse responses for a questionnaire and to see the results. The room was located on the same floor with the professor's outpatient clinic, so sometimes Professor Han consulted Dr. Park for an SCM examination of a patient. During the clinical training, students came into this room and listened to a description of the operating mechanism and how to use it. Then they took part in the diagnosis process and checked out the results through the computer screen. The professor came to the room only when important patients visited him or there was a problem with using the tool.

Lastly, the outpatient clinic was the place where students met the professor during clinical training. It was located on the second floor, together with other KM departments. The room for the SCM outpatient clinic was primarily for the professor to see patients but in the afternoon of the second day of clinical training students were allowed to enter the room and listened to Professor Han's talk. Although the time was allocated for students, the status of students was ambiguous in the outpatient clinic. When patients came to see the professor, as Sinclair (1997:200) indicates in his study of medical students in clinical training at the UCL hospital in London, students were barely acknowledged officially in the doctor-patient relationship. This also applied to Ilsan. Sometimes they were able to observe the professor treat patients; however, at other times, for privacy reasons, they were required to go out in the corridor and to sit in the chairs. They were warned to be quiet especially while waiting in the corridor.[129] When the professor had no patient, they could enter the room and got feedback on

constitutions, not 'diagnosis'. He said that the final diagnosis of Sasang constitutions should be decided by a SCM doctor himself, referring to the results from the SCAT.

[129] In terms of this, Sinclair (1997:200) explains, "Ward rounds are by far the most frequent setting for clinical

their recordings of role-playing. Like this, compared to the classroom learning, many places and various materials were involved in the hospital learning. Some students said to me that they often felt overwhelmed and lost because of the very complicating hospital system.

In summary, as we examined above, the hospital setting consisted of various spaces which had functions for specialised works, not just for treating patients but also for training students. Each actor – i.e. the professor, the training doctor, students, and even devices – had a specific role in the hierarchy of the bureaucratized educational culture in the hospital. Especially, the moving line and tasks for students were closely managed compared to the classroom learning. Likewise, the knowledge and practice of Sasang medicine were more rigidly dealt with in the systematically organised setting. This usually appeared in the forms of 'cases' or 'data' and they were preferred to be expressed in 'tables', 'diagrams', 'pictures', or 'numbers' which were believed to be more objective. However, there were also makeshift decisions based on experience and intuition. These were shown not only by the professor, the senior, but also the juniors such as the training doctor or students. These makeshifts sometimes complemented the rigidly systematized hospital learning, but also sometimes collided with or even overrode it. The following sections will demonstrate the examples in detail.

The Standardised Diagnosis

In this part, I would like to describe the issue of the standardised diagnosis of Sasang constitutions, which was taught in clinical training. As explained before, various standardised

teaching, being therefore the typical official frontstage of the clinical years."

and quantified methods were used for analysing Sasang constitutions, and these devices substituted practitioners' perception with quantifiable data. As Kuriyama (1999:168) indicates, sensing a certain object is not just objectifying it but perceiving it, and this entails the process of interpretation and knowing. In other words, according to Lei and Lin (2012:106), the very idea of gazing (*wang* 望) demands the viewer's active participation in making sense of something that is not readily comprehensible. In this way, the way of diagnosing Sasang constitutions could be different from the idea of mirroring the reality out there without any involvement of human subjectivity. This problem was exposed to clinical training. For example, students were sometimes confused with the inconsistencies between their own diagnoses and the SCAT's final analysis results, or between each analysis result such as the voice analysis and the facial analysis. Furthermore, there were times when Professor Han did not agree with the results from the SCAT, especially the accuracy of the facial analysis. He stood for the discordances the first few times, however, once the discordance continued, he said to Dr. Park that they would need to consult with the manufacturer, the national research institute of Korean medicine in terms of the issue of inaccuracy. Professor Han finally called a researcher from the national research institute to come to the hospital and asked him to examine the program. The researcher said they recently changed an algorithm on the colour recognition so Professor Han and Dr. Park would need to use a clear colour chart to be used in front of the subject's face to let the program recognise the colour distribution of the face better. Apart from purchasing a new colour chart, Professor Han and Dr. Park re-checked and confirmed the distance from the camera and the chair on which a subject sits, and also re-adjusted the scale next to the colour chart to gauge the size of a face correctly.

This example shows the judgement of the standardised tool never overrode the expert's

experience and sense. This phenomenon even caused the distrust of the SCAT from some students. Rather than the SCAT, some students preferably admired Professor Han's virtuosity and adeptness of Sasang medicine. This can be associated with the notions raised by Farquhar (1994:168) and Hsu (1999). Farquhar defines 'virtuosity' as "a form of experience that links practice to history and practitioners to knowledge" (Farquhar 1994:2). Likewise, Professor Han's virtuosity, which links practice to history and him to knowledge, mostly based on the interpretation of the classical texts, surpassed the authority of the numerical machines in the hospital.

Training doctor's Instruction and Students' Following

It was the session for practicing the body measurement method for constitution diagnosis in the morning of the first day of clinical training. After Dr. Park asked a group of students to read about the five body-part measuring method in the handbook, Dr. Park and the students moved to an empty ward for practice. Dr. Park let a student lie on the bed and demonstrated how to measure the body parts in practice. Then she asked each student to measure another student's body parts. Although the measuring process and the device were standardised, they still required skilled body techniques. For instance, when measuring distances of the five body parts with a Martin-type sliding calliper, students firstly had to be familiar with using the measuring device. In addition, they had to set a proper point on the body parts, which were three-dimensional so that it was more difficult to measure the distance than doing so on two-dimensional planes. Because of that, students repeatedly continued trial and error. They sometimes asked Dr. Park, "is it correct to set the upper flank as the ending point of the first

line? Is this the correct point?", or they talked to each other, "Isn't it too tight?", "There is no difference between the lines. Strange.", "You should set the point at the outer line of the bone, not at the inner line, otherwise he becomes *T'aeyangin* (Taeyang person 太陽人; which hardly ever comes out according to the teaching). When students continuously failed to measure the 'correct' distance between certain points, Dr. Park hinted the tips for the five body-part measurement of constitution diagnosis,

> *Soŭmin* (Soeum person 少陰人) can be decided when the fourth and the fifth lines become rapidly widening as the line goes down, being based on the third line. *Soyangin* (Soyang person 少陽人) is decided when the second line is the longest. *T'aeŭmin* (Taeeum person 太陰人) is suspected if every line exceed 30 centimetres. The lengths of the five lines are similar. *T'aeyangin* (Taeyang person 太陽人) is a person whose first line is the longest. His body shape is typically like a reverse triangle.

Based on the training doctor's advice, students started not just to measure each body part, but also to compare the lengths of each part. That is, they started to investigate the 'patterns' of the body. In doing so, they developed body techniques of properly measuring each body part, and a way of seeing the ratio of each length. However, although the sliding calliper which was capable of measuring up to one-hundred centimetres was used, it seemed that such accuracy was not important for fostering intuitive intentionality of seeing 'patterns' of the lengths. In this context, the body-shape measurement (*ch'ehyŏng ch'ŭkchŏng* 體形測定) of the SCM diagnosis can be compared with the physical examination in biomedicine. As Sinclair (1997:202) points out, the techniques of the examination were frequently and sometimes repeatedly taught, and students were urged to practise them again and again. The difference between physical examination and the body measurement was that physical examination aimed for recognising 'abnormal signs' of diseases from the normal, whereas the body measurement

of the SCM diagnosis aimed for recognising and 'picking up [meaningful and useful] patterns' (*chipchŭng* 執證) from the normal to identify a particular constitution.

The standardisation of the SCM analysis also emphasized certain aspects of the diagnosis process. Those comprised quantifiable parts such as the shape of faces and bodies, the quality of voices, and the multiple-choice questions. The standardised SCM analysis did not consider the active participation of healing during the diagnosing process and the intersubjective matters. Interestingly, Professor Han mentioned these in the teaching at the outpatient clinic. He said that the ability to identify a specific 'pattern' was more important than just reading the results of the analysis. Furthermore, he often ended up with the teaching session, saying "why don't you confirm the constitution diagnosis trying out administering some Sasang herbal medicines?", rather than merely concluding that someone belonged to a particular constitution. This approximation of meaning[130] seemed like the room which Professor Han wanted to leave for the active participation between the practitioner and the patient. However, he did not disregard the importance of the standardised diagnosis tool. As Lei and Lin (2012:116) argue, the tool played a role in "the creation of values". Active participation was crucial for Professor Han, but that was a covert thing. The overt thing which should be shown in the hospital was modernised, scientised, and systematised Sasang constitutional medicine. This double sided aspect will be further demonstrated in the following parts.

[130] I borrowed the term 'approximation of meaning' from Pritzker (2014:71). Although she used the term to explain that the translation of the original Chinese terms needs to be more familiar and useful for audiences in a different cultural context, here I used the term to indicate the approximated decision making in the constitution diagnosis process because practitioner's diagnosis can also be interpreted as a 'translation' of patient's symptoms. Thus, instead of concluding with a single diagnose term, Professor Han left room for negotiation with patients in terms of administrating a Sasang medical decoction and observing patients' responses.

Professor's Feedback on the Standardised Diagnosis Practice and Students' Responses

In the first semester, students visited Professor Han in his consulting room in the afternoon of the second day of the clinical training. During the afternoon, Professor Han gave feedback to the students about their performance of the constitution diagnosis. Students sometimes could observe Professor Han's clinical practice when patients visited the office. However, there was not much time like that, and Professor Han occasionally even asked students to stay away from the clinical encounter because of patients' privacy. Some fortunate student groups could see how Professor Han treated patients, but some others couldn't. Hence, the session in the afternoon for the clinical apprenticeship mostly consisted of the conversation between Professor Han and students. Compared to the classroom learning, the topics of the conversation were more about clinical issues; and students asked more questions when they met the professor in a small group.

During the sessions, Professor Han mainly emphasized three things. Firstly, he said that it would be important to know *p'aet'ŏn* (patterns) displayed from the body. One day, a student asked about how to diagnose a given person's constitution when the four diagnostic factors were not consistent. It meant that his diagnosis of his peer resulted in a Soyang person considering his voice (*sŏngŭm* 聲音), but also a Taeeum person considering his somatic morphology and physical comportment (*ch'ehyŏnggisang* 體形氣像). Professor Han explained that students would need to differentiate *sojŭng* (basic patterns 素證) from *chŭnghu* (symptoms 證候). He instantiated that *chŭnghu* could mean the state of diarrhoea, whereas

diarrhoea as *sojŭng* would be an indicator of bodily disorders (*pyŏngjŭng* 病症) getting worse. In this case, his mention of *sojŭng* sounded like knowing about physiological or pathological tendency towards a certain state of the body.

Related to the explanation on 'patterns', Professor Han mentioned about the process of *chipchŭng* (picking up patterns 執證). When a student asked whether he could diagnose someone with "a well-developed waist (*yowijiipse-sŏngjang* 腰圍之立勢盛壯)[131]" as a Taeeum person, he warned him not to rely on only one factor such as somatic morphology and physical comportment (體形氣像), which is the easiest to grasp, but to comprehensively consider all the four factors to pick up certain patterns for the constitution diagnosis. He stressed that "for this reason, the constitution diagnosis actually takes a long time". Furthermore, he added, "then how can you do pick up patterns? If you regard showing a feminine tendency as a character of Soeum person, you should examine whether the given person shows *t'uil-chi-shim* (the tendency of isolate themselves from others[132] 偸逸之心). In other words, you should consider *tendency* and *pattern*. After that, you should observe *hangshim* (Constant Mindset 恒心)."[133] This meant that students need to know how to relate

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[131] This phrase appears in the *Treatise on the Pattern Differentiations of People with Sasang* (四象人辨證論) of *Donguisusebowon* of 1901. The English translation for this phrase is from Wagman (2016:340).

[132] This English translation is from Wagman (2016:76).

[133] Lee (2010:85) explains *hangshim* as "the mental propensity (under tension) to always advance (*chin* 進), lift (*kŏ* 擧), remain (*chŏng* 靜), or stay (*ch'ŏ* 處), related to the Nature (*sŏng* 性) manifestations, and the mental propensity (under tension) to always lean toward femineity (*cha* 雌), masculinity (*ung* 雄), guarding (*naesu* 內

characteristics of a certain Sasang constitution described in classical texts to psychological, physical, physiological, or pathological manifestations of a person in reality.

In this way, similar to the classroom education, he gave special importance to thinking with classical texts (*wŏnmun* 原文) even when performing clinical practice. When describing his subject's body shape, one student confused a phrase from classical texts between *yoch'u-ji-gise* (腰椎之起勢) and *yowi-ji-gise* (腰圍之起勢), which correct expression was *yowi-ji-ipse* (standing momentum of the waist 腰圍之立勢). This mistake was probably derived from the confusion with *noech'u-ji-gise* (rising momentum of the crest 腦頙之起勢) from the previous sentence of the classical text, because of its similar pronunciation. Then Professor Han rebuked the student, "Remember the classical texts correctly. Then you could say based on them. Memorize the texts and think about clinical clues from the memorization."

Reversely, he also showed his way of interpreting classical texts. When explaining the difference between Soeum and Soyang persons in terms of the face shape, he said, "the classical texts say the face of a Soeum person is like a sheep, whereas that of a Soyang person is like a horse. [I interpret that] the face of a sheep is not merely long, but oval. On the contrary, that of a horse is like spindle-shaped. An oval face like a sheep can be seen as having an inverted triangle shape with a narrow lower jaw, while a spindle-shaped face like a horse can be seen as a triangle." He even emphasized classical texts not just for helping clinical decision-making, but also for ruminating them from clinical experience. When telling about a student's

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受), or conquering (*oesŭng* 外勝) related to the Emotion (*chŏng* 情) manifestations."

constitution, he said, “you need to think about your Sasang constitution in the pattern of a Soyang person. Try out medicines for the Soyang person and think about why you could/could not belong to that type. And go back to classical texts and think about the reason why the clinical clue is like that.” In this sense, classical texts were the frame of reference which the clinical reality and experience should be aligned with.

The Role Playing

The role playing session was the last task for the students doing the clinical training of Sasang medicine. Students were required to perform doctor-patient role play for 10 to 15 minutes. The role play was video-recorded by other group members and the recorded file was to be submitted to Professor Han for feedback at the clinical apprenticeship session on the following day. In terms of the allowed time for the role play, i.e. 10 to 15 minutes, not a few students felt that the time was too long. One student said, “I think we cannot do it in full for 15 minutes. Let’s make a plot in advance.” Likewise, role-playing inevitably entailed emplotment in their therapeutic communication for role-playing. It was also about building illness narratives which were in/between the colloquial and the medicalised worlds (cf. Mattingly, 1994; Kleinman, 1980, 1988, 1991). As students were not adequately trained and not experienced practitioners, they sometimes had difficulties how to represent medical terms or colloquial expressions of pain in the conversations. Furthermore, the conversations between the professor and students on the role-playing revealed how the issues raised before were studied, collided, and negotiated. The following parts discuss these issues by demonstrate ethnographic cases from the role-playing session.

a) Preparation

In advance of the role playing, students were required to fill in two forms: the Case Report Form (*chŭngnye-girokchi* 證例記錄紙) and the Medical Record Form (*chillyo-girokpu* 診療記錄簿). The former was intended for each student to record their case. If a given student did not have any symptoms or problems at the moment, she/he was allowed to write about fictional illness/symptoms based on their reading of case reports in peer-reviewed journals which were provided in advance. However, it had to be more or less congruent with what was described in classical texts or sets of symptoms or problems which they learned from the class. The latter was for students to record medical information observed from a simulated patient, whom would be played by a paired student. A student in charge of playing a patient was also primarily expected to talk about his/her own symptoms or problems but was allowed to simulate as a patient if they did not really have them. Yet, it was not allowed to just follow sets of symptoms displayed in the published case reports. Students had to develop their own pathological case even using their life experience if necessary. The Case Report Form was used before the role playing for students to learn how to write a case report, which was a very important item for the KM intern education in the hospital.[134] On the contrary, the Medical Record Form was intended to be filled during the role playing to record a patient's symptoms/problems (see Figure 4.4).

The items required to be filled in the Case Report Form consisted of C/C (chief

[134] Dr. Park, the training doctor of SCM, once told me that she was angry at an intern because he made mistakes in writing a case report. It sounded that it would be very important to write a case report accurately for good and accurate communication between an intern, a training doctor, and a professor. Meanwhile, the Medical Record Form was usually filled by a professor or rarely a training doctor who were in charge of the outpatient clinic.

complaint), O/S (onset), PI (present illness), *pokyong-yangmul* (details of current medication), SH (social history), PH (past history), FH (family history), ROS (review of systems), and *sojŭng* (basic patterns 素證). On the contrary, the Medical Record Form included: Name, Age, C/C, O/S, PI, PH, FH, *t'ongjŭng-buwi* (painful area 痛證部位), *pok-chin* (abdominal diagnosis 腹診), *maek-chin* (pulse diagnosis 脈診), *sŏl-chin* (tongue diagnosis 舌診), *ch'ojin-sogyŏn* (opinion on the first medical examination), *ch'ejil-chindan* (constitution diagnosis 體質診斷), and *chindan mit ch'iryo kyehoek* (diagnosis and treatment planning).

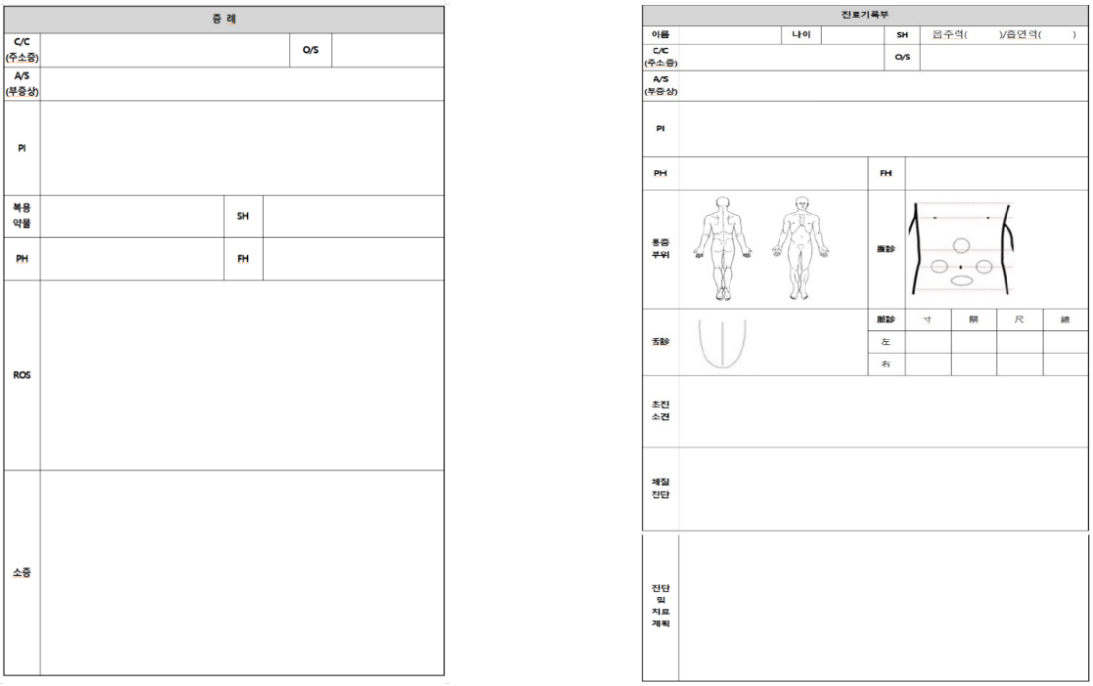

Figure 4.4. The Case Report Form and the Medical Record Form for the PBL (Problem-Based Learning) to be Filled by Students during the Clinical Training[135]

[135] cf. Ohnuki-Tierney (1984:119) introduces a questionnaire to be filled out at drugstores in order for a pharmacist to choose an appropriate *kampo* medicine. Scheid (2002:99-103) also compares various kinds of

To role play, they formed a pair and shared the roles of a doctor and a patient. While a student acting a patient performed based on his/her case report form, a student acting a SCM doctor had to write on the Medical Record Form. As mentioned earlier, although students learnt symptoms and treatments of Sasang medicine, they had to set a specific model of disorders and narratives which had certain spatiotemporal aspects limited by social and cultural dimensions. To help this process, students were also given some case report papers mostly written by training doctors of SCM who experienced real cases. When filling in the Case Report Form, students were basically required to write about their own disorders or discomforts as if they reported their illness to other practitioners of Sasang medicine. Thereafter, the Medical Report Form was written by the other students who acted as a doctor as if they saw patients and ordered treatments for them. Because they had not had any experience about the doctor-patient role play before, they initially looked confused and hesitated to perform. Some students said, “do we need to write communication scripts and memorize them?” or “we should not reveal that we are pretending to be a doctor or a patient”. It was a tacit rule that students had to use plain words and narratives of symptoms when playing as a patient. As it was not disclosed in the instruction of playing as a patient. a few students still used specific KM or Western medicine terms which they learnt in the classroom when playing as a patient. However, many of the students were sensible enough to catch the meaning of ‘playing’. They tried to make their experience of illness or pain done to fit into the Sasang medical categories. The selection of diseases was conferred by the case report articles they read. Since most of the papers provided dealt with to skin disorders, many of the students talked about atopic dermatitis, acnes, or herpes zoster (shingles), etc.

clinical record in China.

b) A Role Play between Students Hwang and Park

Students Hwang and Chang were relatively old among the students, compared to other students in the group whose average age was in the mid-twenties. Especially, Hwang, aged 35, often played a role as a decision-maker of his group when they had to make some small decisions, although they had another student as an official group leader which was normally taken by a young male student or very occasionally taken by a mature female student. During the clinical training, for example, Hwang sometimes instructed other students in his group about how to measure the body parts – how to use the Vernier calliper, on which part they had to put it to measure the length - or what to do for writing reports, when the training doctor was not with them. On the other hand, compared to other young students, he sometimes seemed not to faithfully follow instructions for students. I assumed that he might think himself as already too 'experienced' to follow every basic and trivial procedure. Interviewing mature students, I found that many of them were more motivated in learning Korean medicine, because in many cases mature students had relatively rare opportunities to get hospital training or clinical apprenticeship in private clinics to enhance their clinical skills after their graduation. For this reason, many of them actively participated in private KM learning communities [136] inside/outside the school. Their interests in the clinical practice was very evident during the clinical training. Student Hwang was also following this logic of practice.

[136] Alongside the official KM curriculum from KM schools, many students were involved in private KM learning communities. These communities sometimes intended for studying medical classics such as *Shanghanlun* or *Donguibogam*, or for acquiring specific therapeutic skills such as Sa-am acupuncture (*saam-ch'imbŏp* 舍菴鍼法), pharmacoacupucture (*yak-ch'im* 藥鍼), or Chuna (Pushing and Pulling 推拿) therapy. The common goal of those kind of private communities was usually to enhance clinical capability and regarded as more practical than the school curriculum. Those communities existed in the HUKM, but also had branches in other KM schools in many cases. Furthermore, this logic of practice continued after students graduate. Many KM doctors were usually active to form or take part in such communities alongside the official academic societies (cf. see Taewoo Kim (2010)).

For the role play, Hwang, playing as the doctor, started with asking patient's name and age. Then when Hwang asked about main complaints, Chang, the patient, firstly told the disease name: "I have *atopy* - a colloquial expression of atopic dermatitis- on my neck and shoulders as well as my head". Hwang led Chang to explain about the symptoms he had, indicating the lesions. "I can see the scratches on your skin". At that moment Hwang asked since when Chang had those symptoms, Chang talked briefly about his story. He got the symptoms when he was 20, while preparing for the university entrance exam. Then he added his appraisal, "I think it's because I was under much stress at that time". After this, a somewhat interesting issue was discussed. Hwang started the conversation,

> Hwang: So, did you go to a Western medical hospital or other hospitals at that time?
>
> Chang: I went to a dermatologist in the neighbourhood.
>
> Hwang: So you went to the dermatologist and were diagnosed with atopic dermatitis?
>
> Chang: Yes, I did.
>
> Hwang: I see. Then did you get some treatments when you went to the dermatologist?
>
> Chang: Yes.
>
> Hwang: An ointment?
>
> Chang: No, pills.
>
> Hwang: I see. Do you remember the name of the pills?
>
> Chang: It was Evoprim.
>
> Hwang: Ah, Evoprim. It's derived from evening primrose oil. So you can use the pills for atopic dermatitis. How long had you taken those pills?
>
> Chang: I guess for about two months.
>
> Hwang: Did the symptoms improve with taking the pills?
>
> Chang: Yes, they did.
>
> Hwang: Then it got better after you entered the university? [Chang: Yes.] And when did it get worse?
>
> Chang: It got better but got worse again when I was under stress from my workplace since September 2015.

As seen in the above role play, the student playing the patient said he did not directly get KM treatments. Instead, he went to see a local dermatologist first, and was given the biomedical diagnosis of atopic dermatitis, and came to the KM clinic with the diagnosis when the WM treatment was not effective. For this reason, the KM doctor had to be well-acquainted with the WM diagnosis names and their treatments as well as those of KM. By doing so, the KM doctor had to get trust from the patient and to guide the patient to the KM treatments, which were expected to be more effective than the previous ones. This narrative flow was seen in role plays of many other students. Furthermore, it was a reflection of the many case reports given to them for reference. In this way, the role play session was a reflection of the reality in the KM world and at the same time they were internalizing the social or moral norms of the process which were not taught in the classroom teaching of Sasang medicine.

After this conversation, Hwang started asking about patient's Social History, Associated Symptoms, Present Illness, Past History, and Family History, which were listed on the Medical Record Form, with filling in the form. Those procedures were followed by the Doctor's explanation on the constitution diagnosis. Hwang explained:

> Regarding your height, weight, and body shape, your shoulders and thorax are more developed than your lower body. [Chang: Um…] In this case, with your body type, it can be said that you are *yangin* (yang person 陽人), such as *soyangin* (Soyang person 少陽人) or *taeyangin* (Taeyang person 太陽人). And your face tends to look a little red. [Chang: Yes.] Also, your jaw tends to be more angular than ordinary people. [Chang: Yes.] Uh, now I can see that your personality is much like… You aren't timid, are you? [Chang: No, I am not.] Yes, I guess that you were good at expressing yourself while you were working at your company? [Chang: Yes, I think I easily express myself to others.] And do you often lose your temper? [Chang: I think I am a bit sensitive, but also sometimes lose my temper] Yes. When looking at your temper and appearance, I could say you are close to *soyangin.* [Chang: I see…]

This part showed Hwang's clinical reasoning through the principles of Sasang medicine. Following the instructions, he considered the patient's body shape, personality and

temper. Certain attributes such as the upper, redness, angularness, and extroversion were linked to the property of *yang*. It seemed that students were not likely to diagnose as *taeyangin* because Yi Chema's *Donguisusebowon* mentioned that the proportion of *taeyangin* was the smallest.[137] What was interesting for me was that after this narrative of constitution diagnosis, Hwang brought another narrative to explain patient's symptoms. Hwang continued:

> In this case, it's actually important for *soyangin* to have a good bowel movement for not having disorders. [Chang: Ah, I don't go to the loo frequently.] Yes, therefore this is not necessarily a matter of constitutions. So your symptom is getting worse because of stress. [Chang: Yes.] Korean medicine calls this state of cumulative stress as *kanul-gich'e* (liver constraint and qi stagnation 肝鬱氣滯). It means that stagnated qi resides in the liver. [Chang: Yes.] So that qi should be dispersed. I felt the stiffness and tension of your rectus abdominis muscle when I performed abdominal diagnosis. [Chang: Yes.] Clearly. And through the pulse diagnosis, I felt that the liver pulse was sunken (沈), sunken and wiry (弦), which was like the string of *gayageum* - Korean-style zither with twelve strings. [Chang: Yes.] This can be seen as the problem of *kanul* (liver constraint 肝鬱).

Here Hwang used the term *kanul-gich'e* (liver constraint and qi stagnation 肝鬱氣滯), which was not a Sasang medical term but was from the established KM. His reasoning was from the observation that the patient's bowel movement was normal according to the criteria of *soyangin.*[138] Because the patient's bowel movement was okay, Hwang thought that the patient had no problem with constitution-related disorders and the current symptoms of *atopy* were not related to his constitution. Hence Hwang turned around to the established diagnosis and treatment system in Korean medicine and used the pattern differentiation *kanul-gich'e*

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[137] In *Donguisusebowon* of 1894 (甲午本) and of 1901 (辛丑本), Yi Chema indicated that only 3-10 out of 10, 000 people were a Taeyang type (Lee, 1997:260).

[138] This is based on a sentence in *Donguisusebowon* of 1901: "Regular bowel movement is a sign of overall health and lack of illness for *soyangin*" (少陽人 大便善通則 完實而無病) (Wagman, 2016:345).

which he might have learned in other subjects of the curriculum. Once the diagnosis was decided, the treatment followed it accordingly. Hwang explained about the treatment plan:

> Hwang: When you're working, try to get less stress. I am going to give you an acupuncture treatment which releases liver constraint.
>
> Chang: How often do I come to visit a week?
>
> Hwang: Because you are busy, you only have to come twice a week. [Chang: Yes.] And if you can afford it, it would be good to use *yak* ({herbal} medicine 藥) because it is a chronic disorder. [Chang: Yes.] Constitution should be reformed gradually. Of course getting rid of stress is the first thing. [Chang: Yes.] Second is to learn a regimen (養生法) which fits into your constitution, this is the best way. So I suggest this is the fundamental way to treat your disorder. Therefore I recommend you take the medicine about twice a day, on a cycle of about three weeks.
>
> Chang: Can I change my constitution then?
>
> Hwang: No, I am not changing your constitution. I am just saying that you can have the most ideal condition for your constitution. [Chang: Yes.] So if you want, I am going to give the medicine from today. [Chang: Yes, please] I think you should now take acupuncture treatment first. (*pretending to point out the treating room at one side*) So over there… [Chang: Yes, I see.]

In this way, the role play ended. Because Hwang used the diagnostic method of the established KM system, the use of herbal medicine and acupoints had to follow it, which was the prescription of relieving *kanul* (liver constraint 肝鬱). At the same time, he also tried to prescribe a specific regimen according to the constitution diagnosis of Sasang medicine as the fundamental way to treat the disorder, namely, foods which have qualities of sourness (*san* 酸), bitterness (*ko* 苦), coolness (*ryang* 凉) and coldness (*han* 寒) such as raw vegetables and

seafood.[139] In this way, while treating the patient, Hwang jumbled Sasang medicine and established Korean medicine at his discretion. This was different from many other students' cases, which mostly used Sasang medical diagnosis and prescriptions only. I became very curious about what Professor Han would say about Hwang's play.

c) Discipline in Interdisciplinary Practice

On the following day, students Hwang and Chang went to Professor Han's outpatient clinic for Clinical Apprenticeship. It was in the very last sequence of the clinical training of Sasang medicine in the second semester. When we entered the room, Professor Han was reading the Case Report Forms and the Medical Record Forms which Hwang and Chang had filled in the day before. A few minutes after he started reading the documents, Professor Han began talking to the students. He firstly referred to the way that the students wrote on the forms. For example, he pointed out that the students should have distinguished the chief complaints and symptoms from the diagnosis names and disorders. According to this, Hwang's writing of "atopic dermatitis" in the C/C section had to be replaced with "itching sensation" on certain parts of

[139] More on this, the textbook of Sasang medicine introduced beneficial foods such as barley, read bean, mung beans, cabbage, cucumber, lettuce, burdock, pumpkin, eggplant, watermelon, strawberries, banana, oyster, shrimp, lobster, pork, beer, iced products etc. Also, harmful foods were introduced: Welsh onion, garlic, pepper, ginger, pepper, chicken, deer meat, goat meat, honey, ginseng, etc (Chŏn'guk hanŭigwadaehak sasangŭihak kyoshil, 2005:321; Koh, 2019:59). Koh (2019) also introduces social life management for each Sasang type. For example, Soyang persons are active and passionate but hasty and careless. They have warm hearts. They are not calculative but tend to help others in need. They have a strong sense of justice. They are active in their social lives and love to stand out in the presence of others. However, Soyang persons have a tendency to neglect themselves and their families. They have a tendency to exaggerate themselves in the presence of others. They like to impress others by clothing themselves in expensive materials [*kyosa* 嬌奢], and they have strong sexual desires [*hosaek* 好色], which may result in them neglecting their family. Sexual desires are not confined to enjoying sexual intercourse, but more broadly refer to an extravagant lifestyle that is not appropriate for one's income. To avoid these problems, Soyang persons should simplify and minimize their lives [*kanyak* 簡約] to stop extravagant overspending (60-61).

the body. Professor Han also explained about the difference between Past History and Social History, as the students appeared to be a little bit confused about it. After that, Professor Han finally asked Hwang about his decision of the constitution diagnosis and the treatment.

Professor Han: Which constitution did you diagnose the patient with?

Hwang: I diagnosed the patient with *soyangin* (a Soyang person).

Han: And the treatment is?

Hwang: I originally intended to use prescriptions of Sasang medicine. But I thought his symptom was not particularly about the constitution problem because the patient's bowel movement was okay. Instead, I thought it was the symptom derived from continuous stress, so I did not use Sasang prescriptions.

Han: Oh, dear. What are you talking about?

Hwang: So.. I thought he was *soyangin* but there was no problem from the constitutional view. So I gave prescriptions according to *pyŏnjŭng* (pattern differentiation 辨證).

Han: Did I tell you to do the Sasang constitution diagnosis and treatment like that?

Hwang: No.. There was no mention about it, but..

Professor Han: What do you mean by "there's no problem from the constitutional view"?

Hwang: That is… (he couldn't continue to talk.)

Han: I don't understand at all. "There's no problem in constitution"….

Hwang: Yes, because the patient's bowel movements were okay, which meant *taebyŏn-sŏnt'ong* (good bowel movement 大便善通), I thought this case had the sign of *wanshil-mubyŏng* (overall health and lack of illness 完實無病)…

Han: Then should you give prescriptions or not?

Hwang: So… the prescription… was according to his symptoms…

Han: Does the person have illness or not?

Hwang: He has illness, but…

Han: He has illness, but there's no problem with his constitution?

Hwang: The illness is… because it's not *sojŭng* (basic patterns 素證) …

Han: Is the constitution only about the basic patterns?

Hwang: That is.. *atopy* did not happen in his early ages, but just happened after his 20s because of stress…

Han: There's *atopy* of adults.

Hwang: Yes, I thought so. So in terms of the basic patterns, I thought there was no anomaly

when he was born so that he was just a healthy *soyangin*… Sorry.

Han: What are you talking about? If he is a healthy *soyangin,* he should not have no illness.

Hwang: But he got ill because of the stress…

Han: Doesn't *soyangin* get any stress?

Hwang: Yes, they have. So I tried to match the stress with Sorrow-Anger-Joy-Pleasure (哀怒喜樂) [in Sasang medicine], but I had nothing in my mind. Hence, I tried to give a prescription to relieve liver constraint according to the pattern differentiation but recommended a regimen for *soyangin*…

Han: I am saying because you are doing what you should really not do!

Hwang: Sorry.

Han: Then why are you diagnosing him as *soyangin*? You could just diagnose as *kanul* and treat accordingly, couldn't you? You could just say *atopy* has itching sensation, and it's caused by stress, and it can be seen as *kanul,* so I'll treat him accordingly. Why are you talking about constitutions? If you are to do like that, you should go to the departments of Dermatology (of KM).

Professor Han looked a bit irritated due to Hwang's play, especially his jumbled practice. He explained,

Han: You should be aware of that the patient's symptom of *atopy* existed for a long time, around for 5 years. So your prescription of *shiho-gyeji-t'ang* (Bupleuri Radix and Cinnamomi Ramulus Decoction 柴胡桂枝湯) might be insufficient for treating that symptom. But it goes to different directions when thinking of constitutions. Prescriptions of constitutions are not just for treating *kanul* or itching. *Taebyŏn-sŏnt'ong* (good bowel movement 大便善通) is just an indicator. So the fact that the Soyang person has the basic pattern of good bowel movement means one's disorder is not serious, and one could be treated by the prescriptions described in the book. It does not mean that one has no disorder. If there is the heat pattern to the patient, then it can be associated with *hyunggyŏk-yŏlchŭng* (heat pattern in the chest-diaphragm 胸膈熱證) of a Soyang person. Then you could consider *yanggyŏk-sanhwa-t'ang* (Diaphragm-Cooling Fire-Dissipating Decoction 凉膈散火湯).

He also said, "the aim of the clinical training is to try to choose Sasang prescriptions and set a treatment plan according to the Sasang medical theory. Otherwise you should have

gone to dermatology or surgery clinics [of Korean medicine].” In the setting of professionalised Sasang medicine, Professor Han’s view was definitely right. However, during my fieldwork in private clinics or *rok’ŏl* which will be discussed in Chapter 6, I found that not a few KM doctors were performing jumbled practice of Sasang medicine, like Hwang. It seemed that Professor Han was aware of the situation outside the school and that might be the reason why he became angry not just at Hwang, but also at those practitioners who do *sŏkkŏjap* (i.e. jumbled practice).[140]

4.4. Discussion

This chapter examined how Sasang medicine was presented and educated in a university setting. It was done by exploring how Sasang medicine was taught in the classroom and hospital settings, and how the concept of *ch’ejil* was depicted in those settings. The university education of Sasang medicine could be characterised as standardisation, as it used the standardised textbook, the clinical training handbook, and quantified materials and technologies. Looking at its education as a part of the KM curriculum, whereas in the biomedical curriculum learning basic sciences, anatomy or other clinical subjects form the knowledge of biomedicine as a whole (Good and Good, 1993), Sasang medicine in the curriculum emphasized a separate body of knowledge and system. As seen in the conversation between Professor Han and student Hwang, the inclination of independence became intensified in the hospital culture, where professionalised specialities existed. The more the field of SCM emphasized its disciplinarity,

[140] This kind of jumbled practice was also Professor Lee warned in my interview, as discussed in Chapter 3.

the more its medical notions and objects became separate from other KM fields. However, as seen above, there were even hybrids and struggles between Sasang medicine and other KM streams in the standardised system of SCM. Hence, this chapter reveals conflicts and negotiation among diverse medical values and techniques. The notion of *ch'ejil* was not only choreographed by various actors such as the professor, the training doctor, mechanic devices and quantified programmes in the standardised setting, but also showed evident interrelated cross-over with other settings.

Chapter 5. Experimenting with Sasang Medicine

This chapter deals with Sasang medicine in a research setting. This chapter particularly explores how the main conception of Sasang medicine, *chejil* (constitutions 體質 체질) was enacted in a research team of the National Research Institute of Korean Medicine (NRIKM), the only government-funded research institute devoted to the scientisation of Korean medicine. This will be examined in two aspects of the social networks and epistemological discourses, according to the inside and the outside of the team. Before describing these issues in earnest, this chapter will firstly look into the historical and epistemological context of scientisation in Korean medicine. Based on this context, the research setting will be described. Then the main issues will be examined.

5.1. Scientisation in Korean Medicine

Contexts of Scientisation in East Asian Medicines

Scientisation of East Asian Medicines[141] has always been related to social and political values in history. As Lei (2014:141) points out, the word 'scientise', a verb form of science, is rarely used in English, whereas 'scientise' is a word used daily in modern Chinese, Japanese and Korean. This means that a state of 'science' is a certain level that they need to achieve with

[141] In this thesis, the term 'East Asian Medicines' encompasses Chinese medicine in China, Japanese medicine in Japan, and Korean medicine in Korea; otherwise specific notifications are made.

things they already have, like civilisation. Not only in China, but also in Korea the concept of scientisation has served as a tool to reconcile the conflict between scientism and cultural nationalism. The project of 'scientizing East Asian medicines' served as a crucial innovation in negotiating with the universalist conception of modernity.[142]

Farquhar (1994:14) presents that advocates of continuing or expanding support for Chinese medical institutions have had to cobble together nationalist, socialist, scientific and modernizing values and link them to central characteristics of the profession and its knowledge. In other words, discourses on knowledge and practice in the People's Republic of China have been intensely political. Meanwhile, Taylor (2005:87) points out that in countries such as Singapore, Hong Kong and Taiwan, the development of Chinese medicine has been much freer and less regulated than it has been in Communist China. However, it does not mean that Chinese medicine in those countries was an independent object free from social and cultural contexts. Still, it has common characters in terms of the relationship between tradition and modernity.

The term 'scientisation' has been often expressed and understood with other words designating similar values. Hsu (1999:168) introduces that TCM teachers claimed to be ''standardising' (*guifanhua*), 'modernising' (*xiandaiua*), 'making scientific' (*kexuehua*), and 'systematising' (*xitonghua*) Chinese medical knowledge and practice. She adds that 'Westernising' (*xifanghua*) was not importantly mentioned, although the importance of the West – on a technological, institutional, and ideological level – cannot be overlooked. Hsu (1999:168) contends that it is not merely the practice of biomedicine in China which has had

[142] See Lei (2014:142) for the case of Chinese medicine.

an impact on TCM, but also Western scientific thought and practice in general and other ideologies of modernity such as nationalism, Marxism, and materialism. For example, the history of Chinese medicine could be presented as a history of scientific progress (Hsu 1999:172). This kind of epistemological coupling was also expressed as a social practice during my fieldwork, when the team aimed to set a new research agenda.[143]

Epistemological Topographies of the Scientisation of Korean Medicine

It can be said that scientisation of Korean medicine means conducting the act of 'scientific research' on Korean medicine and making it more 'rational' to be accepted by modern society. However, even this 'scientisation' process has epistemological topographies. In other words, it has diverse epistemic directionalities which have been formed throughout the history of Korean medicine in the 20th and 21st centuries. Lee (2010)'s analysis well describes such topographies of the discourses surrounding the scientisation of Korean medicine. Since the 20th century, Korean medicine has experienced unprecedented transformation in terms of the encounters with Western biomedicine, the modern state, and colonial and Western powers. In the meantime, the mottos of modernisation, scientisation, systematisation and standardisation have dominated the discourses around institutionalised Korean medicine. These mottos have been widely used by KM doctors internally as well as external agencies such as the government, biomedical doctors, scientists, or the general public (ibid.,759).

[143] For details, see the *Formulating Future Directions* section in this chapter.

Lee (2010) introduces three stances on the scientisation of Korean medicine. First, there is a stance from some people that adopts the concept of 'science' in a narrow sense. In this case, 'science' means natural sciences. In this vein, proponents of this view argue that Korean medicine becomes 'unscientific' and Korean medicine should not have the equivalent legal and social position with Western biomedicine, which is believed to be based on natural sciences. This view is linked to the claim that Korean medicine should be abolished from the modern health care system. However, some of them are interested in the 'effectiveness' of Korean medicine in clinical practice, although they think Korean medicine is unscientific. They regard that the effectiveness of Korean medicine is not from its 'theory', but from its 'experience' which was accumulated during over thousand years (cf. Lei, 2002 on a similar context in China). Hence, if there are effective treatments recognised by 'experience' for thousand years, they think those shall be researched scientifically to identify their mechanism. This is the logic of the scientisation in their argument. In this logic, 'theories' of Korean medicine are to be exhaustively excluded. Instead, they focus on the clinical effectiveness of treatments in Korean medicine such as herbal drugs and acupuncture treatment (cf. Lei, 1999 on how experiments excluded TCM doctors from the effectiveness of TCM treatments).

Second, there is a group of people who think that Korean medicine is a rational knowledge system, applying the concept of 'science' in a broad sense. This group of people claims that natural sciences are not enough to analyse the organism as a holistic and comprehensive entity so that they claim Korean medicine will lose its identity if it is analysed by natural sciences. Nonetheless, some of them also agree that Korean medicine in the premodern period had some irrational knowledge and techniques. Therefore, they think Korean medicine should be distinguished from 'folk remedies', and also think its knowledge should be

consistently systematised with reinterpreting its terms in modern ones. In this awareness, statistical methods are often important to show the clinical effectiveness of Korean medicine in an objective way. This group of people prefers to say 'modernization' of Korean medicine rather than 'scientisation' (Lee, 2010:761).

Third, Lee (2010:762) reports that there are people who have twofold attitudes to the scientisation of Korean medicine. They contend that Korean medicine is 'science' in a broad sense but also agree the scientisation of Korean medicine with natural science. Instead of just arguing "Korean medicine is science", they pose a weakened argument that "Korean medicine has scientific characters". This is a view that Korean medicine has potentially scientific factors, although it is difficult to say the whole aspects of Korean medicine belong to science. Therefore, they try to identify what the scientific characters in Korean medicine are. They especially try to show scientific characters in the 'theories' of Korean medicine. It is because they believe the theories are related to the characteristics of Korean medicine and the clinical effectiveness.

Therefore, the discourses of the scientisation of Korean medicine emerged in the 20th century have diverse directionalities which have different positionalities and goals. These diverse views have affected to establish the scientisation projects on Korean medicine. This mixture of views shows that even the scientisation process is not unilinear but consists of multiple voices.

The Scientisation of Korean Medicine as Institutional Object and Historical Moment[144]

[144] The expression of this heading is inspired by one from Farquhar (1994)'s chapters: "Chinese Medicine as Institutional Object and Historical Moment".

Nowadays, the mainstream research trends in the scientisation of Korean medicine aim to investigate the effectiveness and safety of Korean medicine treatments. Not only KM doctors, but also researchers in other fields such as biomedicine or pharmacy are also involved in those projects. Lee (2010:762) argues that these trends were originated from thoughts emerged in the Japanese colonial period in the early 20th century. For example, Cho Hŏnyŏng (1901-1988), a renowned intellectual, politician, and proponent of Korean medicine, explained Korean medicine by using the knowledge of biomedicine and natural sciences. He also tried to demonstrate the theory of Korean medicine was scientific in some sense.[145]

In terms of the infrastructure for the scientisation of Korean medicine, it gathered momentum when masters and doctoral courses of Korean medicine started to be installed in the oldest KM school in 1960s. After then, experimental research gradually became one of the major research methods for the study of Korean medicine. Specifically, as more KM schools newly got established since the 1980s and the number of graduate students in the KM schools increased accordingly, laboratory studies on Korean medicine also became invigorated. However, experimental research did not become the most used research methods at that time. Still, except for the masters and doctoral theses, many publications produced from professors and researchers in the KM schools relied on analysing classical KM texts for their research at least until early 1990s (Lee, 2010:762).

The establishment of the National Research Institute of Korean Medicine (NRIKM) was another big momentum for the scientific research on Korean medicine. Specifically, the

[145] See Section 2.2.3. *Relating Sasang Medicine with Korean Nationalism* for more details about his background and claims.

start of ‘the research support project for the development of Korean medicine’ (*hanŭihak palchŏn yŏn'gujiwŏnsaŏp* 韓醫學發展研究支援事業) in 1997 played a significant role to change the atmosphere. With this project, the way of securing research funds from external funders by promoting research proposals has become common. This affected the experimental research method to be given a lot of weight. Furthermore, the CAM (Complementary and Alternative Medicine) boom in the West also contributed to the turn to the experimental research method in the world of Korean medicine (Lee, 2010:762).

Hence, most research projects initiated from government-funded research institutes focus on the development of new drugs using medicinal herbs, instead of paying attention on the theories of Korean medicine. They also aim for industrialisation as well as scientisation. The assessments of those projects are being done by counting numbers of articles published on so-called SCI (Science Citation Index) journals or patents (Lee, 2010:762). This kind of direction is almost consistent with the way of the CAM research in the West. It is because the government-funded KM research projects aim at the CAM market in the West and the World as well as the domestic market.

The Scientisation of Sasang Medicine

The scientisation of Sasang medicine is on a similar trajectory with that of Korean medicine in general. The installation of the Department of Sasang Constitutional medicine at a graduate study level played a major a role to produce publications of experimental research on Sasang medicine in the early days. The SCM (Sasang Constitutional Medicine) department at Seoul University School of Korean medicine, the oldest KM school, was the place which led the

research on Sasang medicine. According to Lee, Kim and Lee (2012:60), it was 2007 when the NRIKM started to produce more research outputs on Sasang medicine than Seoul University. It was related that the so-called "Yi Chema project"[146] was initiated at NRIKM in 2006.

Before the Yi Chema project, the research on Sasang medicine at the NRIKM started in 1997. The project at that time was about the relationship between Sasang constitutions and genetics (Lee, Kim and Lee 2012:60). It was followed by subsequent projects such as the construction of the "constitution information bank" in 2001 (Yoon *et al.*, 2001), and the "construction of the constitution clinical database and the objectification of the constitution diagnosis" in 2005. These research projects further developed in the Yi Chema project with massive funding. Lee, Kim and Lee (2012) classified the trends of the SCM research at the NRIKM into four categories: 1) surveys on the current status of SCM; 2) SCM clinical studies; 3) correlation studies on Sasang constitutions and genetic characters; 4) studies for the development of measuring devices for diagnostic quantification.

First, as surveys on the current status of SCM, Lee, Kim and Lee (2012:61) introduce review articles which researched on the markets of traditional medicine or constitutional medicine in South Korea and was about previous SCM studies. They particularly report SCM clinical researchers' opinions that "it was difficult to perform objective constitution diagnosis" by proposing it as the preferential research field.

Second, Lee, Kim and Lee (2012:62) divide the SCM clinical studies to four categories:

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[146] The official title of the project is "*Chŏnt'ong ch'ejirŭihage kibanhan chindan mit yangmul ch'iryo shisŭt'em kaebal* (Development of Diagnostic and Herbal Drug System based on Traditional Constitutional Korean Medicine)" (Kim, 2009). However, it is more widely known as the "Yi Chema project" to the general public through mass media.

1) investigating clinical characteristics according to Sasang constitutions; 2) developing diagnostic tools for the constitution diagnosis – mostly questionnaires; 3) discovering SCM therapeutic techniques and drugs; 4) constructing the constitution information bank. In this category, researchers at the NRIKM firstly worked on identifying clinical characteristics of Sasang constitutions, especially physical characteristics such as width, length, circumference, thickness of the body. Moreover, various personality test tools such as the Minnesota Multiphasic Personality Inventory (MMPI) or the Temperament and Character Inventory (TCI) were considered to relate to them with the psychological conditions of Sasang constitutions. Besides, several studies were performed to investigate constitutional characteristics such as perspiration, body mass index (BMI) or gender. In doing so, various versions of the questionnaire for Sasang constitution classification (so-called QSCC) were developed and continuously revised. For constitution diagnosis, these questionnaires were often used with other diagnostic tools considering other factors such as voice or physical shape. As for the research on clinical treatments according to constitutions, the majority of studies focused on drugs, which investigated pharmacological responsiveness of drugs onto Sasang constitutions, safety issues, and the properties of a drug itself. Studies on constitutional acupuncture treatments were relatively few. Lee, Kim and Lee (2012:64) analyse that it might be because acupuncture theory was not clearly set based on the Sasang principles.

Third, the research team at the NRIKM tried to relate the SCM theory with systems biology. For this, the team collaborated with other research groups not only in the country, but also in foreign countries such as Vietnam (Kim and Pham, 2011) or the UK (Kim, 2015). They also established the constitution information bank (*ch'ejil chŏngbo ŭnhaeng* 體質情報銀行) to store various genetic information of the constitutionally confirmed subjects. The information

was gathered in various collaborating institutions throughout the country. Keeping updating the information in the bank, they aimed to develop and improve constitution diagnosis algorithms (Lee, Kim and Lee, 2012:64).

Fourth, as mentioned earlier, the issue of 'objective constitution diagnosis' was pointed out by SCM researchers, as well as KM doctors. They also regarded that questionnaires were not perfect to secure objectivity and reproducibility of the constitution diagnosis. Thus, the research team conducted studies on the quantification of the constitution diagnosis, focusing on the measurement of pulse, tongue qualities, facial shapes, voice qualities, etc (Lee, Kim and Lee, 2012:65-6).

To sum up, it can be said that the scientisation projects on Sasang medicine started from various aspects of what would be regarded as 'scientific'. In so doing, the scientisation projects were approached by various subdisciplines of science such as biology, bioengineering, or statistics, and their discursive results, in terms of seeing from a perspective of established scientific disciplines, were arranged in the name of the 'research of (Sasang) constitutions' (*ch'ejil yŏn'gu* 體質硏究 체질연구). Such process of reassembling will be further discussed in this chapter by providing ethnographic episodes.

5.2. The Research Setting

The NRIKM as a Location of Scientisation for National Prosperity

It was during the hot summer days in early June of 2018 when I started my fieldwork at the

National Research Institute of Korean Medicine (NRIKM). After packing my luggage in Seoul, I headed to Daejeon, the city where the institute was located. The NRIKM was one of the government-funded research institutes located in 'Daedeok Innopolis' of Daejeon, a metropolitan city in central Korea. The construction of Daedeok Innopolis was planned in the early 1970s, during the reign of President Park Chung-hee (1917-1979; in office 1962 – 1979).

President Park Chung-hee's attitude on science and technology is shown in his calligraphy given to the Korean Institute of Science and Technology (KIST), the first government-funded research institute, for commemorating the 10th anniversary of its establishment in 1976: *kwahag-ipkuk kisul-charip* (rely on science to establish the state, rely on technology to establish autonomy 科學立國 技術自立). This meant that government-funded research institutes were given a mission for modernisation of the nation (Moon, 2008:278).[147]

The case of the NRIKM was quite unique compared to other major or bigger government-funded research institutes for science and technology. The establishment of the NRIKM was ignited by the request from KM doctors and the government allowed it as a conciliatory gesture after the social conflict between pharmacists and KM doctors in 1993 (Park, 2015).[148] At that moment, KM doctors requested the establishment of a KM department at the

[147] According to Moon (2008), promoting science and technology was not the main interests of the Korean government until the late 1950s despite of Korean scientists' stress on the promotion of science and technology and the construction of research institutes and related administrative government bodies shortly after the liberation in 1945. It was a momentum that the US proposed to Park's government that they would support the construction of a research institute of science and technology. Moon (2008:265) analyses that the US's support of the establishment of the KIST had the cost aspect that the Korean government sent South Korean troops to the Vietnam War.

[148] For the details of the social and historical aspects of the conflicts between KM doctors and pharmacists, see Cho (2000).

national medicine centre, a national research institute for Korean medicine, and a government department solely devoted to the promotion of Korean medicine. All of the requests were realised in 1991, 1994, and 1997, respectively (Kim, 2019:113-127). At the time of establishment, the NRIKM was affiliated with the Ministry of Health and Welfare. However, its jurisdiction was transferred to the Ministry of Science and Technology in 2006, two years after the relocation of the institute from Seoul to the Daedeuk Innopolis in 2004. Since the NRIKM moved to Daejeon, it has expanded largely, in terms of the number of researchers and the amount of funding. As of 2020, there are a total of 331 staff members in the NRIKM[149] of the main campus in Daejeon and its two branches in Naju and Daegu. Also, its annual budget is 63.177 billion KRW (approximately 41.76 million GBP), almost 40 times more than that of the initial period in 1994.[150]

Nowadays the NRIKM plays an important role for the scientific research on Korean medicine. The majority of the government's funds for the scientific research on Korean medicine goes to the NRIKM and the institute often distributes some of those funds to other research labs and groups in universities, hospitals, or other research centres. The NRIKM also plays as a national hub of traditional medicine in the international society. For example, as of 2020, the NRIKM is designated as a WHO collaborating centre and sends researchers to international meetings which focus on quality and safety of raw materials, manufactured products, and medical devices in traditional medicine. The institute also frequently interacts

[149] http://www.alio.go.kr/popReportTerm.do?apbaId=C0291&reportFormRootNo=2020. Retrieved on 7th February 2021.

[150] http://www.alio.go.kr/popReportTerm.do?apbaId=C0291&reportFormRootNo=31501. Retrieved on 7th February 2021.

with foreign research institutes on traditional medicine or integrative medicine in Europe and the US as well as in China and Japan. Furthermore, the institute is associated with a government organisation to support the fellowship program on the "Modernization of Traditional Medicine" which introduces the scientific research results of Korean medicine to government officials or researchers from some Asian or African countries such as Bangladesh, Bhutan, Cambodia, Kazakhstan, Laos, Mongolia, Vietnam, Sri Lanka, Uzbekistan, Ethiopia or Uganda.

In terms of the research on Sasang medicine, the NRIKM gained media attention for the initiation of the so-called 'Yi Chema project' in 2007, which aimed for the scientisation of Sasang medicine. Many newspaper articles said that this ten-year project with the funding of almost 100 billion KRW (approx. 66 million GBP) was designated as one of the top-brand projects by the Ministry of Science and Technology which were bestowed to most ambitious research projects from government-funded research institutes of science and technology (Lee, 2007). On the contrary, the project also stirred up the opposition especially from the side of biomedical doctors, criticizing that the government funds the fanciful research. I thought that the NRIKM would be an interesting place to investigate the scientisation projects on Sasang medicine because it was where a great deal of research capacity was concentrated, and it seemed to be a good case to observe diverse debates surrounding the scientisation projects. For these reasons, I contacted a researcher who was a specialist of Sasang Constitutional Medicine at the NRIKM and started my fieldwork in his team. Particularly, I was interested in observing how the constitution was interpreted in the research setting.

The Places at the NRIKM

When I conducted my fieldwork at the NRIKM in 2018, there were five buildings with a recreation ground in the NRIKM campus of Daejeon. Those five buildings were: the Dasan Building, the Guam Building, the KM Standards Centre, the Laboratory Animal Research Centre, and the Dormitory/Cafeteria Building. The Dasan Building was the oldest and mainly accommodated administrative offices and strategy departments.[151] The Guam[152] Building, on the other hand, was a relatively new one with a modern exterior. It housed most research divisions at the NRIKM. The KM Standards Centre Building was the most recent one and housed the KM standard centre which was established in 2013. The Laboratory Animal Research Centre housed animals necessary for lab experiments at the NRIKM. During my fieldwork, I sometimes saw researchers moving a trolley which was carrying boxes that seemed to have laboratory animals in them. In addition to research and administrative facilities, the NRIKM housed a KM history museum and a KM science museum in the Guam Building, and an herbarium in the KM standard centre building. There were also some artworks carved or painted on the walls of the buildings. For example, passing through the buildings, one could see a mural on the front wall of the Laboratory Animal Research Centre, depicting a series of

[151] Dasan or Tasan (茶山) is the penname of Chŏng Yakyong (丁若鏞, 1762-1836). He is known as one of the greatest thinkers and polymaths of the late Chosŏn period, wrote highly influential books about philosophy, science, and theories of government. In the media, he is often expressed as 'Da Vinci of Chosŏn (or Korea)' (Hwang, 2012). This is often linked to a perception of his achievement as a national symbol of scientific and technological creativity and innovation.

[152] The name of the building comes from a prominent doctor's penname. Guam or Kuam (龜巖) is the penname of Hŏ Chun (許浚, 1539-1615). Hŏ Chun is famous for his book, *Donguibogam* (Treasured Mirror of Eastern Medicine 東醫寶鑑, published in 1613), which is arguably the most famous medical book in the history of Korean medicine.

historical paintings of medicine in Korea (see Figure 5.1). The sign in front of the building introduced its title as *onko-ch'angsin* (Creating the new by revising the old 溫故創新). The title was a variation of a phrase *onko-chishin* (Learning the new by revising the old 溫故知新) originally from the Analects of Confucius.[153] It was modified by a former NRIKM president to use it as a motto for the institution. The mural paintings portrayed some historic scenes in Korean history or myths. From the left, in chronological order, the paintings depicted the mythical founder of the Korean nation, the three-legged crow, a deer-hunting archer of the Goguryeo kingdom, several sculptures, pagodas, buildings or books which symbolize 'creative achievements' of Korea, portraits of Hŏ Chun and Yi Chema, the double-helix structure of DNA and the world map.

It seemed that the institute was led by a very strong nationalistic motif. Also, it seemed like that the nationalistic motif was entrenched in pursuit of the scientisation of Korean medicine. However, in everyday lives during my fieldwork at the NRIKM, I could see some researchers who did not like these artworks. They told me it did not look good or even looked ridiculous. I heard from one researcher that another big artwork hung on a wall of one building which displayed a traditional body had been pulled down because of its 'ugliness'. Otherwise, many other researchers said they did not much care about the artworks because of their busy working schedules.

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[153] The term *onko-ch'angshin* is also known as a combined word between *onko-chishin* (溫故知新) and *pŏpko-ch'angshin* (creating the new with following the old 法古創新) (Kim, 2012). It is known that *pŏpko-ch'angshin* first appeared in a writing of Pak Chiwŏn (朴趾源; 1737-1805) (Jeong, 1999), who has been regarded as one of the famous scholars of the so-called "Practical Learning" (*shirhak* 實學) in the late Chosŏn dynasty (Haboush, 1999:72).

Figure 5.1. A Mural on the Front Wall of the Laboratory Animal Research Centre. Photo by the Author

At the time of fieldwork in 2018, there were seven departments for research. They were the KM Fundamental Research Division, the Clinical Research Division, the KM Convergence Research Division, the K-herb Research Centre, the KM Application Centre, the KM Standards Centre, and the Mibyeong Research Centre.[154] According to the institute's publicity brochure introducing those departments, the KM Fundamental Research Division was

[154] The names of the departments at the NRIKM in Korean and Hanja (the Korean name for Chinese characters 漢子) words are as follows: *hanŭi-giban-yŏn'gubu* (韓醫基盤硏究部), *imsang-yŏn'gubu* (臨床硏究部), *hanŭiyak-yunghab-yŏn'gubu* (韓醫藥融合硏究部), *k'eihŏbŭ-yŏn'gudan* (K-Herb硏究團), *hanŭi-gisul-ŭngyong-sent'ŏ* (韓醫技術應用센터[中心]), *hanŭi-gisul-p'yojun-sent'ŏ* (韓醫技術標準센터[中心]), and *mibyŏng-yŏn'gudan* (未病硏究團).

in charge of research on basic theories and knowledge of Korean medicine as well as development of source technologies in medical engineering; the Clinical Research Division was conducting clinical studies of Korean medicine; the KM Convergence Research Division was working on the development of herbal medicine and herbal substances for treatment of targeted diseases; the K-herb Research Centre was performing investigation and preservation of herbal medicinal resources as well as research on theories and application for herbal medicine formulation; the KM Application Centre was doing research on prescription of Korean medicine and commercialization of herbal medicine and applied materials; the KM Standards Centre was working on projects related to standardisation on Korean medicine technology and was also working closely with the World Health Organisation as a collaborating centre for the development of national policy and R&D strategy on Korean medicine; and the Mibyeong Research Centre was working for the establishment of a health care platform based on Korean medicine and development of disease prevention and management services.

When I firstly saw the organization chart of the institute, I could not find which research team was working on Sasang medicine, or constitutions, because they were not in the titles of the departments. After contacting a SCM specialist at the institute, I realised that, during the term of a former president of the NRIKM, his group worked as the Constitutional Medicine and Diagnosis Research Group. Then that group had split to several subgroups and currently he was working with some of his previous team members and other new researchers from other departments.

From the Yi Chema Project to the Mibyeong Research

The Yi Chema project already ended when I visited the NRIKM in 2018. However, most of the core researchers involved in the project were still working in the institute. As mentioned earlier, they were more or less dispersed in different research groups, otherwise some of them were working in same research teams with different titles. It was because the departments were often reshuffled in time for the inauguration of a new president of the institute or other important issues.

The official title of the Yi Chema project was the "Development of Diagnostic and Herbal Drug System based on Traditional Constitutional Korean Medicine (*Chŏnt'ong ch'ejirŭihage kibanhan chindan mit yangmul ch'iryo shisŭt'em kaebal*)". This project consisted of several subprojects and each of them had goals as follows: the construction of the database of constitutional information, the identification of the biological characteristics of the constitutions and the development of the constitutional health index measurement technique, and the development of constitutional drugs.[155] Each subproject was carried out by a group of

[155] The details of the research goals described in the report are as follows:

A. To establish a multi-institute cooperative clinical research network and Constitutional Information Bank through constitution cases. Also we are planning to apply the DNA, EBV Transformation in searching for constitutional heredity and excavating constitution related genes.

B. To understand genetic basis of SCM and then develop modernized SCM system, we aim to genotype Korean samples collected by SCM diagnostic system and then perform genome-wide association analyses to identify genetic variants associated with SCM itself or SCM-related phenotypes. Using the information, we aim to develop SCM diagnostic system based on genetic information.

C. Discover gene loci through linkage analysis and analyse the heritability related to constitution-determining factors, including Sasang constitution.

D. To develop the tool and the system for constitution diagnosis by analysing the clinical, biometrical, and biomedical information. To identity the genetic elements that are associated with constitution through genetic studies including family analysis. To define the effect of genetic risk factors for chronic, late-onset,

researchers and each group had their own disciplinary focus such as bioinformatics or bioengineering. Interestingly, it was observed that many group heads were KM doctors with PhD degrees.[156] For instance, I found that there were unofficial designations of research groups out of convenience: *kigit'im* (the team for medical devices) and *imsangt'im* (the team for clinical research). The former was led by a KM doctor with a PhD in SCM who also studied engineering before his study of KM, and the latter was led by a KM doctor with the SCM speciality and a PhD in SCM. After the Yi Chema project was terminated, they still proceeded similar projects with different project titles. One example was the team for clinical research changed its name to the Mibyeong Research Centre (*mibyŏng yŏn'gudan* 未病研究團).

The term *mibyeong* (not yet ill 未病) was originated from a phrase "[the sages] did not treat those already ill, but treated those not yet ill" ([聖人]不治已病治未病) of the medical classic *Huangdi Neijing* (the *Yellow Emperor's Inner Canon* 黃帝內經)" (Unschuld and Tessenow, 2011:57). The centre took the term inputting the interpretation of *mibyeong* as "a condition that is not a disease, but suffers from discomfort in daily life due to physical, mental and social stress or exhibits abnormalities in the boundary area between the normal and the pathological during examination".[157] Furthermore, the centre related the term to other medical

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or metabolic disorders on differential constitutional background. To construct a database system with the information on the constitution related medicines (Kim, 2009:19).

[156] In many cases, KM doctors with PhD degrees attended their graduate courses in KM schools, although there were a few exceptions. Some other KM doctors at the NRIKM studied in various academic disciplines such as natural science, science policy, neuroscience, or public health in non-KM graduate schools.

[157] https://blog.naver.com/kiompr/220536047350. Retrieved on 7th February 2021.

concepts such as: pre-clinical phase, health grey zone, health weakness status, and medically unexplained symptoms.[158] Bunkenborg (2014)'s study of 'subhealth' overlaps at this point. He points out that the discourse of subhealth (*yajiankang* 亚健康) in China first emerged in the 1990s (ibid.:132). Furthermore, he observes that Chinese authors of *Subhealthology* (亚健康學) regarded the tradition of regulating the "not yet ill" as the antecedent of subhealth within Chinese medicine (ibid.:136). According to Bunkenborg (2014), "*mibyeong*" and "subhealth" were initially different concepts, but scholars of Chinese medicine applied the idea of "not yet ill" to subhealth evaluation of diagnosing a disorder that is about to or will very likely occur even before the body exhibits any clear symptoms or signs of disease (137).

Similar to this logic, team members of the Mibyeong centre used the term "subhealth" as the English translation of "*mibyeong*" when writing research papers in English. For example, the head of the Mibyeong centre contributed an interview article about introducing *mibyeong* to a newspaper likening it to subhealth which has symptoms such as uncomfortable feeling of fatigue or pain (Hwang, 2014).

Furthermore, the Mibyeong Research Centre made slack epistemological room of *mibyeong* to engage the concept of the Sasang constitutions, even though the term was not mentioned in the classics of Sasang medicine, i.e. Yi Chema's writings listed in Table 3.1 of Chapter 3. In a research article on the trends of the Mibyeong research in China, Japan, and Korea, Lee, Li and Kim (2010) characterized that the Mibyeong (*weibing* in Chinese) research in China as the state-driven national project since 2008 while the Mibyeong (*mibyou* in

[158] https://blog.naver.com/kiompr/220536047350. Retrieved on 7th February 2021.

Japanese) research in Japan as biomedicine-integrated quantification by biomedical doctors. On the other hand, the Mibyeong research in Korea was still not very active until 2010. Analysing that Japanese biomedical doctors used the concept of the "constitution (體質)", they suggested that Sasang medicine could contribute to the Mibyeong research in Korea (ibid.:32). In the Mibyeong Research Centre at the NRIKM, this suggestion was realised by linking traditional concepts of *mibyeong* and (*Sasang*) constitutions, although they were not directly related to each other in the classical texts. They were linked to each other through mostly biomedical operations such as collecting data on coldness/heat, sleep, diet, or activity level.

Another example was expressed in a writing by the head of the clinical research team arguing "Large-scale KM cohort should be urgently constructed".[159] In this writing, he argued that governmental/institutional support should be made to link cohort KM characteristics – constitutional characters or heat/cold characters - to the existing cohort studies implemented by the government and the biomedical side. He also suggested that the KM cohort studies should develop more common indicators to connect with other cohort studies implemented by the government. By doing so, he foresaw that after all "the prevention and management of *mibyeong* could get sound evidence". In this process, Sasang constitutions were reduced into some biological data.[160] It appeared as though the Mibyeong research was an evolved or hybridized form from the "constitution research" (*ch'ejil yŏn'gu* 체질연구). There was

[159] https://blog.naver.com/kiompr/220866955083. Retrieved on 7th February 2021.

[160] This process of reducing Sasang constitutions into biometric data will be further examined in detail later.

certainly a continuum between those two kinds of research. I felt it would be interesting to delve into the connecting point.

The Mibyeong Research Centre

When I started the fieldwork at the Mibyeong research centre (*mibyŏng yŏn'gudan* 未病研究團)[161], the main office of the team was located on the ground floor in the north wing of the Guam building, but a researcher of the team told me that department reorganisation would take place in a few months in line with the inauguration of the institute's new president. The centre consisted of the main office, the head's office, the clinical document storage room, and the Mibyeong lifestyle lab. During my fieldwork at the NRIKM, the team moved their office to the Dasan Building. The new office included all those places in the one area just with partitions. There I was offered a desk prepared for a postdoctoral researcher.

There were almost 20 researchers in the team.[162] Five of them were KM doctors. The head, Dr. Ryu[163] was a SCM specialist as well as a PhD in Korean medicine with a focus on SCM. The other four were: Dr. Ku was also a SCM specialist and held a PhD in SCM. He joined the NRIKM in 2009. Dr. Bae was a KM doctor but was not a SCM specialist. He held a

[161] As of 2021, the current department structure of the NRIKM is different from which I was doing my fieldwork at the NRIKM. Nonetheless, in this thesis, I use the names of the departments which existed during my fieldwork.

[162] One researcher, who was a web designer and worked for constructing project websites, left work during my fieldwork. She was one of the youngest in the team and told me she wanted to find a better place for her career.

[163] All names which appeared in this chapter are pseudonyms.

PhD of Korean medicine with a focus of KM physiology. He did not have a training in a KM hospital. He originally worked in another team at the NRIKM and joined the team later. Dr. Min was a specialist and a PhD, both in KM rehabilitation. She also worked for another team at the NRIKM but joined the team when the department reorganisation happened. On the other hand, Dr. Koh was a specialist in KM internal medicine. He was not the youngest, but the latest KM doctor to join the team due to his military service at a military hospital for three years. He told me that he joined the team to research on coldness-heat patterns of Korean medicine, not Sasang medicine. As my fieldwork progressed, he once confessed that he was not interested in Sasang medicine and even felt a bit sceptical about it. Apart from the KM doctors, there were researchers with various academic backgrounds such as public health, nursing sciences, bioinformatics, biochemistry, statistics, computer science, and traditional Chinese medicine.

Team members continued meeting with and separating from different members in the team according to their particular subprojects. For example, some researchers – a bioinformatician and molecular geneticists formed a subgroup to perform a project on genomics; a KM doctor contacted a statistician to discuss probability of certain analysis in clinical trials; nurses trained as clinical research coordinator formed a group to educate KM residents for cohort study training at collaborating KM hospitals. Although they were working for 'Mibyeong research', it seemed like they were doing their discipline-specific professional research that corresponded to their fields when looked at closely.

Work Routines at the Mibyeong Research Centre

The team members were usually mobilized based on subprojects of a bigger project. Big

projects normally progressed for one to three years. In case of even bigger projects, like the Yi Chema projects which proceeded almost for 10 years, they had to submit a mid-process report and be evaluated by internal or external committees every three years or so. Team members took overseas or domestic business trips to attend international/domestic conferences, or to contact collaborating agencies such as experts in foreign/domestic research institutes, universities, hospitals, or clinics. They also attended or held meetings with government officials, university professors, researchers at private institutes, executives of the KM association, etc. Those external activities constructed the social network of the research projects and intensified the impact of the projects. Another important task was producing research outcomes such as publishing research articles. I felt that almost every researcher in the team was very enthusiastic and even sometimes looked overwhelmed with producing many quality publications. In many cases, the quality depended on whether it was published on the "SCI journals", or how high the Impact Factor of the journal was. As Latour and Woolgar (1986:51) pointed out in their fieldwork in a lab of the Salk Institute, here in the NRIKM "inscription devices" were also operating, which were transforming pieces of matter into written documents. In the Mibyeong Research Centre, their work was transformed to words, sentences, or graphs in project reports or research articles. I could reversely track their activities from the written work or from comparing the two.

As for the daily or weekly routines of the team members, most of their working time was spent in the main office. Each researcher had their own desk and computer usually neighbouring other researchers working together for a subproject. It looked like some researchers (e.g. bioinformatician or molecular geneticist) had high-performance computers to optimize their work. For example, one molecular geneticist told me that her computer was

much more expensive than other computers in the office because she had to analyse genetic sequences. Molecular geneticists also used computers in the Mibyeong lifestyle lab which seemed to be optimized for genome sequencing only.

In terms of group meetings, there were several types of meetings in the team. Firstly, the head, who was working in a separate office, often called several researchers of a subproject to his room and had small meetings. The head sometimes came to a certain researcher's place for discussion or directives. Researchers often gathered in a researcher's place and discussed issues on their projects. Secondly, the team had a regular meeting called "book club" usually once a week unless it was difficult to set a time when most of the researchers got together. A book to read was usually decided by the head based on his consideration of what would be good for team members to read together. During my fieldwork, they read three kinds of books: *Genetic Variation and Diseases* by Lee Jong-geuk, *Epidemiology* by Leon Gordis, and *The Sapiens: A Brief History of Humankind* by Yuval Noah Harari. Usually two researchers presented the summaries of each chapter of the books each time. It was followed by questions or discussions among the researchers and final remarks from the head researcher. Attending the book club meetings, I observed that they were the intended times for researchers from different academic backgrounds to communicate with each other. Otherwise they would only focus on their own fields. The head hoped to enlarge the project on genomics so that he wanted other researchers to have more knowledge about it. It was the same with epidemiology. Furthermore, he thought that reading a 'big history' book such as *The Sapiens* would motivate his team members for interdisciplinary research as well as satisfying his personal academic interest. However, I found that many other researchers in the team were not as enthusiastic as the head researcher except for a few. Unlike the two meetings described before, there were more

informal meetings in the office such as a coffee break or a lunch break. In these times, the head and senior researchers did not show up and the researchers had more private conversations. As many of them were in their 30s, they talked about their unstable status in the institute (as some of them were in temporary position), how to get an affordable house, how to educate their young children, etc. I also joined their conversations and sometimes shared my thoughts as well as listening to their stories.

5.3. Social and Epistemological Relations of the SCM Research

A Business Trip to a KM Hospital: Qualifying Quantifications

In this part I demonstrate how the Mibyeong[164] research team members worked to construct a KM biobank. I do so, first, by describing a business visit of some NRIKM researchers to a KM hospital. Researchers whose specialities were in public health and nursing science instructed KM consultants and trainee doctors in the hospital how to collect human data for the construction of the KM data or constitution centre, which is a Korean medical version of a biobank. I trace what kind of data was collected in such biobanks and how it was related to the concepts of 'KM' or 'constitution'. I provide an example of the research networks Mibyeong researchers used, how they educated other researchers in collaborating institutions, and what

[164] As explained earlier, *mibyeong* (not yet ill 未病) is a term originated from the *Inner Canon's* famous phrase "[the sages] did not treat those already ill, but treated those not yet ill" (Unschuld and Tessenow, 2011:57).

kind of data they aimed to collect for the biobank. Among the latter belonged to questionnaires for quantification. I intend to illuminate how the negotiated term of 'constitutions' (*chejil* 體質) was formed in this setting.

As outlined in Chapter 2, the notion of constitution – or what Yi Chema demonstrated about the attributes of being different between humans – was primarily based on abstract Confucian philosophy although it was supported by more concrete medical concepts and theories borrowed from Korean medical traditions. However, after documenting the above quantifiable variables, such as vital signs or systematised questionnaires, that Mibyeong researchers collected for the KM biobank, I contend that the concepts of *chejil* or *mibyeong* in the KM tradition becomes shaped by following the logic of the regulatory power in the institutions of modernity and the nation-state.

It was not long after I started fieldwork at the Mibyeong research centre of the NRIKM in early June 2018. One day, Dr. Ryu suggested I join a business trip to a KM hospital in Jecheon, North Chungcheong Province. It was meant to instruct researchers of collaborating centres how to construct a KM databank. The contingent consisted of Dr. Nam who held a PhD in public health, Ms. Yin with a master's degree in nursing science, and Ms. Na who worked on the management of electronic case report forms (eCRF). We met at the Daejeon station for a two-hour train ride to Jecheon. The KM hospital, situated in the city, was affiliated with Jecheon University College of Korean Medicine. Its local team consisted of a professor of KM internal medicine, two trainee doctors, and a research assistant.

The training started at 11.30am. Dr. Nam firstly presented 'the protocol overview of the KM cohort in the second year of the project, 2018'. As she explained, the project was for

collecting ‘predisposing factors’ such as the participants’ genetically-based, constitutional and cold/hot or coldness/ heat information[165] alongside ‘risk factors’ such as sleeping, dieting, physical activity, or other lifestyle habits. The project aimed to predict the probabilities of chronic disorders such as cardiovascular disorders and metabolic syndromes, and physical conditions in terms of quality of life rankings or a score of *mibyeong*. The number of participants recruited into the project was expected to be 2,500 in total, for three consecutive years from 2017 to 2019. It was to include 200 staff members of Jecheon university and 300 of Daejeon university as well as 2000 citizens in Daejeon. In Jecheon university with its two teaching hospitals in the province, 100 participants were to be recruited in 2018 and follow-up observations were required for the 100 participants collected in the previous year. Dr. Nam asserted that the ultimate goal of the project was to form the groundwork of ‘KM Big Data’. It would consist of KM cohorts in planned regions and workplaces, electronic medical records (EMR) from the clinic, and personal health records (PHR). In Jecheon University, the local team was expected to collect data in two categories: the first category was concerned with instrument measurement which included anthropometric measurements, vital signs, grip strength, sphygmogram, heart rate variability, body composition and blood test data. The second consisted mostly of questionnaires asking for sociological information, lifestyle habits, sleep/stress, diet, quality of life, constitution diagnosis and frequency of the use of medical institutions. She highlighted that blood test performed for this project would be same as usual blood test in ordinary medical institutions, except that participants would fill out a consent form for the project. This showed the characteristics of the ‘KM data’, which were not only derived

[165] This is information about how many cold patterns (寒證) or heat patterns (熱證) participants have. In the team, those patterns were regarded as indicators of prevention management for patients’ disorders (Bae *et al.*, 2016:18).

from traditional philosophy, but also based on modern epidemiological indicators.

Dr. Nam's presentation was followed by Yin's and Na's presentations. Their presentations were more practical and described the hierarchical structure of the project. Yin explained the general methods and precautions regarding the KM cohort research which would be performed in that year. She described how to get the consent form for the research, how to input information to the eCRF, and how to manage and store records and documents for clinical research. During the presentation, she highlighted that the researcher's signature part in the consent form should be filled by a *KM doctor*, not nurses or other researchers. It was a moment in which I felt that the division of labour for the KDC construction project was arranged centring around KM doctors.[166] Na's presentation was about how to input information in the eCRF on the specially-designed website, which was built by the *Mibyeong* research team to collect the clinical data from collaborating centres in various regions throughout the country in real time via the internet. It was about how to organise collected data in a standardised form without noise or error. This trend continued to the afternoon session. Yin and Na gave demonstrations on how to collect, input and store the data, and inspected whether the local

[166] Yin's emphasis reminded me of Freidson (1970)'s explanation on the relationship between the physicians and 'paramedics'. He explains: "the term 'paramedical' refers to occupations organized around the *work of healing* which are ultimately controlled by physicians. Physician control is manifested in a number of ways. First, much of the technical knowledge learned by paramedical workers during their training and used in their work tends to be discovered or enlarged upon or at the very least approved of by physicians. Second, the tasks performed by paramedical workers tend to assist rather than replace the focal tasks of diagnosis and treatment. Third, paramedical workers tend to be subordinate, in that their work tends to be performed at the request or "order" of, and is often supervised by, physicians. Finally, the prestige assigned to paramedical occupations by the general public tends to be less than that to physicians. These characteristics are such that the paramedical occupations may be distinguished from established professions by their relative lack of autonomy, responsibility, authority, and prestige" (48-9). During my fieldwork at the NRIKM, KM practitioners' decision and permission were usually at the top of the hierarchy of the division of labour. Also, I observed that a large proportion of supporting workers or paramedics for the collaborative projects were females, whereas principal researchers for the projects were dominantly males (cf. Frankenberg, 1980; Davies, 2007).

researchers performed these tasks in a standardised way of measuring body shapes, temperatures, mechanized pulse waves, heart rate variations, and so on. The *data* presented in the training were all about numerical values.

On that day after we came back from the business trip, I could get a paper-version of the CRF which was used for the training and saw many questions written on it. Many aspects of life, from quality of life and living habits to pathological conditions, were *quantified* in Question & Response format. Most answers were required to be ticked on a three to five-point scale. What was interesting for me were questions regarding constitution diagnosis and other KM terms included in the CRF such as *mibyeong*, *hanyŏl* (coldness and heat 寒熱)[167], *hŏul* (depletion and constraint 虛鬱)[168], *sujok-naengjŭng* (syndrome of feeling cold in hands and feet 手足冷症), and *ŏhyŏl* (stagnant blood 瘀血)[169]. Questions regarding constitution

[167] Here, *hanyŏl* was used as a compound word of *hanjŭng* (cold patterns 寒證) and *yŏlchŭng* (heat patterns 熱證), just denoting a parallel symmetry between the two. This concept was devised for a questionnaire to diagnose whether a patient has cold or heat patterns. The concept is different from classical meanings of *hanyŏl* such as either "chills and hot flushes" or "intermittent coldness and heat" (For an illuminating discussion of its wide range of classical meanings, see Hsu (2010:188)). It was similar to the relationship between *yin bing* (yin disorder 陰病) and *yang bing* (yang disorder 陽病).

[168] This new combination of depletion and constraint came from the awareness that fatigue and stress, which would be characteristic symptoms of *mibyeong,* could be derived from those factors (Baek, Lee, *et al.*, 2015:12). It will be further examined in the next section.

[169] According to Jeon, Woo and Jeong (1989:95), the term Stagnant Blood (瘀血) first appears in *Shanghanlun* (*Treatise on Cold Damage* 傷寒論) and *Jingui yaolue* (*Essential Prescriptions from the Golden Cabinet* 金匱要略), but not in *Huangdi neijing* (*Yellow Emperor's Inner Cannon* 黃帝內經). Hsu (1999:221) makes an elaboration on Stagnant Blood (瘀血), with Phlegm (痰). Both referred to a process of stagnation and were postulated processes in the body which were detected by excretions, signs outside the body, such as Phlegm on the tongue or Clots in the menstrual blood. They gave rise to many different disorders and have recently become classified among the Disease Factors in traditional Chinese medicine (ibid.:221). It is almost same in Korean medicine. There are favoured concepts by KM doctors to cover extensive symptoms of a body. However, I could

diagnosis, *mibyeong*, Coldness and Heat, and Depletion and Constraint were expected to be filled by patients or research participants, whereas questions regarding the syndrome of feeling cold in hands and feet and Stagnant Blood were to be filled by KM doctors (see Figures 5.2 and 5.3). Questionnaires for patients consisted of plain words which could be considered as illness, while those for KM doctors included specific KM terms such as *t'aehwang* (yellow coat of the tongue 苔黃), *maekpu* (floating pulse 脈浮), *kich'e-hyŏrŏ* (Qi stagnation and blood stasis 氣滯血瘀), which requires the interpretation process of symptoms by KM doctors.[170] Namely, questionnaires for patients intended to record self-reported symptoms and were later interpreted by KM doctors, whilst questionnaires for KM doctors were to record answers which were already observed and interpreted by them. In the case of the questionnaire for the constitution diagnosis, it was answered by a subject, but the final decision was made by two KM doctors – which form was also in the CRF. It seemed that these expert opinions were to complement the reliability of the questionnaire (see Figure 5.4).

To sum up, the business trip was to build a huge institutional object, the Korean Medicine Data Centre. It was managed by the hierarchical structural order between research institutions and clinical care institutions, e.g. the NRIKM – KM hospitals. Those networked social institutions were expected to be mobilised by empowered KM specialists. In other words,

not see any 'questions regarding Phlegm' during my fieldwork at the NRIKM. It might be because "Phlegm had the strength of being extremely vague" (ibid.:221)", whereas Stagnant Blood provides relatively easier symptomatic and visual indicators to make a quantified questionnaire.

[170] For reference, Farquhar (1994:205) provides a perspicuous diagram of what she called *zheng*1 (signs), *zheng*2 (symptoms), and *zheng*3 (syndromes-therapy) in various verbal layers of the clinical encounter of Chinese medicine.

the hierarchical structure transformed the role of KM doctors from a practitioner in doctor-patient relationships to a decision maker or a manager in the bureaucratic medical system. Furthermore, the data flowed the circuit of the order were mostly quantified in numbers. Patients' information was collected by self-reporting questionnaires or KM doctors had to systematize or quantify their observations of patients to fit into standardised categories in questionnaires. In this process, several traditional concepts such as *hanyŏl* (coldness and heat), *hŏul* (depletion and constraint), or *mibyeong*, which appear in classical medical texts, were reinterpreted, reclassified, or recombined with other concepts – even biomedical concepts. To what follows will be further examinations of these questionnaires.

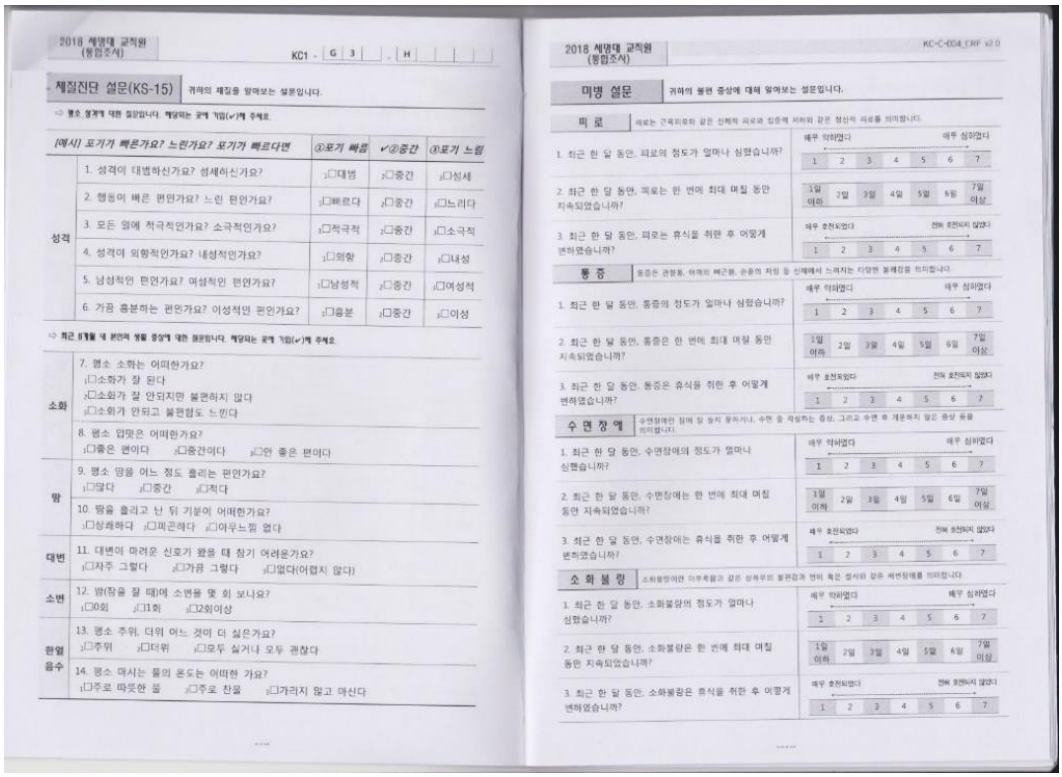

Figure 5.2. The Constitution Diagnosis Questionnaire and the Mibyeong Questionnaire

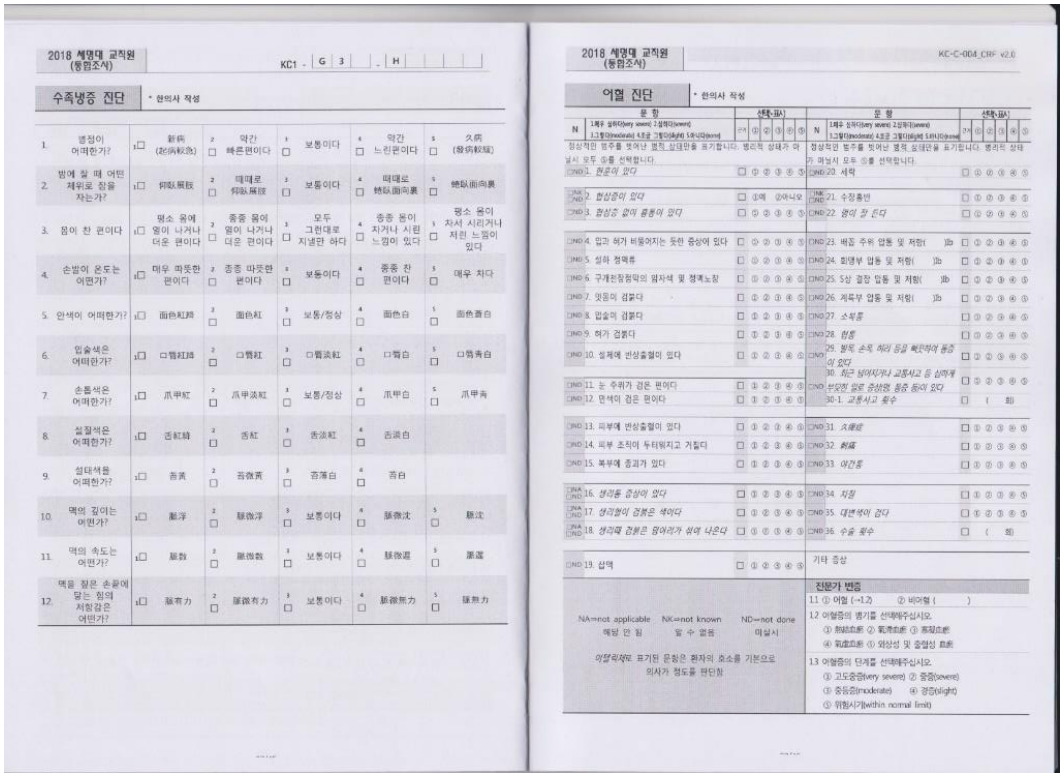

Figure 5.3. The Cold Hands and Feet Questionnaire and the Stagnant Blood Questionnaire

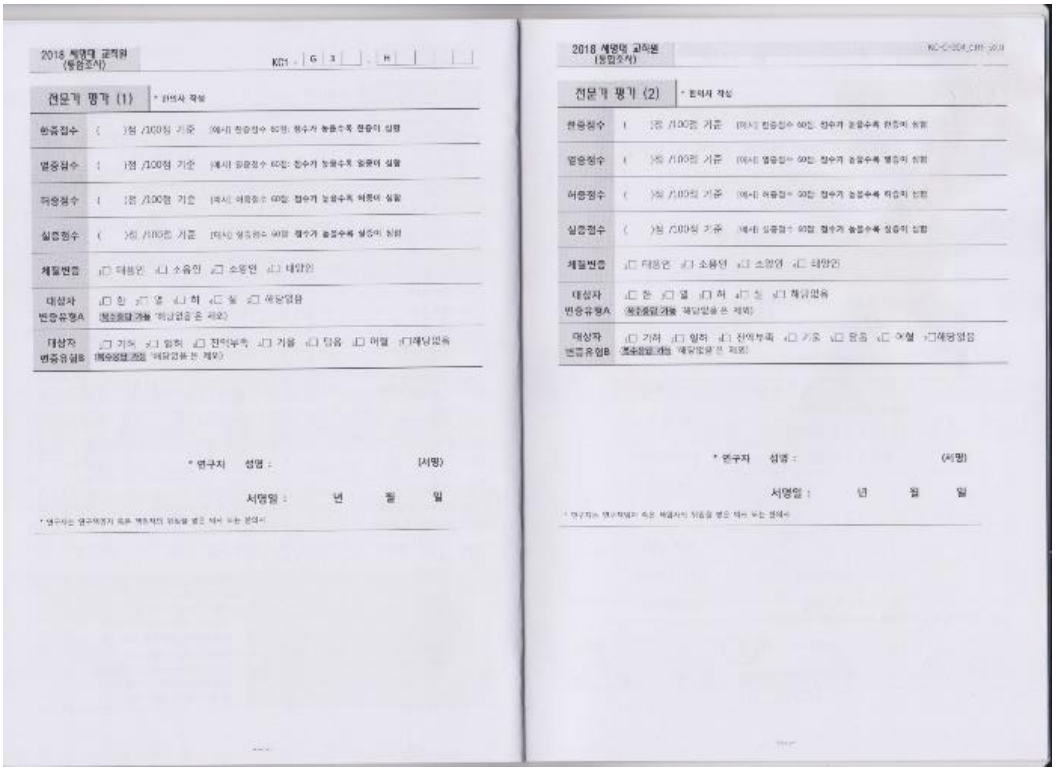

Figure 5.4. The Assessment Sheets for Two KM Doctors

Questionnaire as an Epistemological Locus for Quantification Involving New Agencies

A questionnaire has its epistemology, which interprets subjects' opinions or behaviours by answering processes as well as containing makers' specific intention and views. It also involves various agencies such as question developers (who have the original knowledge and skills, for example, SCM doctors), analysts (e.g. statisticians), operators (e.g. government institutions, companies, SCM doctors, etc.), and subjects. It is probably more complex than a doctor-patient relationship for example. Each questionnaire in the CRF (Clinical Report Forms) had its own history to be created and adapted to the Mibyeong research, otherwise borrowed from existing questionnaire standards. For example, the questions regarding sleep were borrowed from the Pittsburgh Sleep Quality Index and the one for stress was from the Psychosocial Well-being Index Short Form (PWI-SF). On the contrary, the questionnaires of KM concepts described above were mostly developed in the NRIKM. Although those questionnaires had KM concepts in their titles, some did not use KM concepts in the contents. For instance, the Mibyeong Questionnaire was developed by the Mibyeong research team, which could report abnormal symptoms based on the seven categorizations that are not particularly traditional KM concepts: fatigue, pain, sleep disorders, indigestion, anxiety, anger, and depression. Borrowing from Hsu's (1999:100) argument, questions in the seven categories exactly reflected "the modern pace of life", which postulates a life of a middle-class person in the modern society in the belief that whose life can be biomedically analysed and explained through legitimate modern institutions. The purpose of this Mibyeong questionnaire was to specifically fit it into Korean people supplementing the existing questionnaire tools such as the EuroQol five dimensional (EQ-5D) and the Short-Form 12 Item Health Survey (SF-12) (Lee *et al.,* 2016:46). Another example was the Depletion and Stagnation Questionnaire. The questionnaire was based on the

responses of a survey on perception and pattern differentiation of *mibyeong* among KM doctors, and questions were gathered and reassorted from the related questionnaires by the KM doctors in the Mibyeong research team (Baek, Lee, *et al.*, 2015:12). Traditionally, the concepts of Depletion (*hŏ* 虛) and Constraint (*ul* 鬱) were seldom used as a combined term on classical texts. However, the Mibyeong research team made the concept of Depletion and Constraint (*hŏul*) combining the two. It was newly developed from the KM interpretation of fatigue and stress to Depletion and Stagnation, and fatigue and stress were regarded as main factors of subhealth.[171]

Arguably, the questionnaire for the constitution diagnosis (officially called the Korea Sasang Constitutional Diagnostic Questionnaire or 'KS-15') would be the one which had the longest history of its origins or precursory questionnaires from the SCM world. Before the KS-15, there had been more than seven kinds of questionnaires to diagnose Sasang constitutions (Baek, Jang, *et al.*, 2015). The earliest questionnaire was developed in 1987, by professors of the SCM department at Seoul University College of Korean Medicine. This questionnaire was mainly based on the sentences from *Donguisusebowon*, and clinical characteristics of the constitutions empirically observed by some KM doctors were also reflected (Koh and Song, 1987). This questionnaire had a form of questionnaire but did not yet strictly use statistical methods for verifying reliability and validity. It was the beginning that the classical sentences, which learners are required to study and contemplate, became sentences to be answered by subjects and statistically analysed by researchers. In other words, classical texts and

[171] This can be an example of how the concept of constraint is transformed and articulated to appropriate the modern disorder of 'stress' and thus can be related to Scheid (2013)'s attempt to depict how constraint is associated with emotion-related disorders in East Asian medicines.

practitioners' clinical insights became transformed to chopped pieces for statistical analysis and involved new agencies.

The trend of using sentences from the classical texts for making questions maintained to the development of a questionnaire called the QSCC (Questionnaire for Sasang Constitution Classification), which led to the development of several revisions. In the course of formulating the questions, each of the questionnaires gave statistical weight to certain characteristics of Sasang constitutions such as Nature (*sŏng* 性), Disposition (*jŏng* 情), basic patterns, and pathological patterns. In the meantime, statistical methods became more emphasized. Whereas most questionnaires for the Sasang constitution diagnosis were based on the self-report system, which were to be answered by a subject, questionnaires for SCM practitioners were also developed. It was to quantify and standardise not only subjects' response but also practitioners' diverse ways of diagnosing subjects' constitutions. The questionnaires for practitioners were also based on the classical texts and included questions for the observation of the practitioner and the interview with the patient (Kim, Kim and Lee, in preparation). For example, in the questionnaires for practitioners, doctors had to input their observation in four-point scale and numbers of subjects' physical size (e.g. height, head size, waist size, hip size, etc.).

Meanwhile, the main characteristics of the KS-15 was that it was developed based on data from the Korean Medicine Data Centre (KDC) (Baek *et al.*, 2015:213). The KDC modelled a Korean version of biobank which includes clinical information of (Sasang) 'constitutions.' The KS-15 included 14 questions in total and the subsections consisted of the characteristics and the basic patterns (素證). The basic pattern section was again divided into several factors such as digestion, perspiration, bowel movement, urination, and

preference/aversion to coldness/heat. Concretely, 6 questions were to ask about characteristics and participants were required to tick one of three categories. For example, the first question was "*Sŏnggyŏgi taebŏmhashin'gayo*? *sŏmsehashin'gayo*? (Are you bold or delicate in character?)". Then participants had to select one of 1) *taebŏm* (bold), 2) *chunggan* (medium), and 3) *sŏmse* (delicate). However, the contents of the questions seemed not directly related to the sentences of the classical book, *Donguisusebowon*, since the book used other words or expressions to refer to similar characters such as *chin* (to advance 進), *kŏ* (to raise 擧), *chŏng* (calm 靜), and *ch'ŏ* (to stay 處).

Hence, the way in which the information of Sasang constitutions was processed and transformed was to be included as one kind of health data to the Korean version of biobank. In this process, the classical texts were analysed and sorted out based on statistical methods. Next part will further examine how the Korean Medicine Data Centre is organised and how the concept of constitutions is formed for the database.

The Korean Medicine Data Centre as an Assemblage

The Korean Medicine Data Centre (KDC), that the Mibyeong research centre was pursuing to construct, could be an assemblage of data and social practice which is beyond the binary epistemology dividing tradition and modernity or the Eastern and the Western. Rather, more important is that this assemblage was going towards empowering the governmentality of life to the central authority such as the NRIKM. It is noteworthy that such a biopolitical process was happening in the name of KM terms such as *mibyeong* or *chejil* management, and it was

utilizing the expanding social networks of the KM world.

The KDC was cited as one of the representative achievements from the Mibyeong research centre. It boasted itself as the biggest integrated databank in South Korea which was devoted to Korean medicine. Its collaborating institutions encompassed not only major KM hospitals and local KM clinics in the country, but also WM hospitals and others in foreign countries such as China, Japan, Vietnam, and the US. A brochure made by the Mibyeong research team introduced that the KDC started to be constructed with the project of "the development of the constitutional treatment system" since 2006. In 2009, the second stage of the project was initiated by additionally including WM hospitals in South Korea and Japan in the project, and by developing the eCRF system for the Korea Constitution Multicentre Bank (KCMB), the precursor of the KDC. The third stage of the project started in 2012. This was when the project of "the development of the diagnostic criteria for *mibyeong*" was also initiated by the same research team. The project kept enlarging its collecting data and collaborating institutions even to those in Vietnam and the US until in 2015, when the Mibyeong research centre was officially launched. The KCMB was later renamed the Korean Medicine Data Centre (KDC) and the Mibyeong Research Centre opened the web portal which integrated the KCMB with the clinical information of *mibyeong* (Mibyŏngyŏn'gudan, 2016). It is important to know this history because it shows how the central agency has expanded its network and influence.

The KDC contained clinical information on constitutions, physical measurement information and biological information. Clinical information on constitutions included sociological information, personality surveys, ordinary/pathological pattern surveys, medical history surveys, records of constitutional prescriptions, the constitution diagnosis by SCM

experts, and other surveys. Physical measurement information included body-shape measurement (circumference and breadth), photos of face (frontal and left side views), and voice records (vowels, voice recording of reading sentences). Biological information includes general blood test, genetic information (DNA, Cell line, and serum) (Lee, 2014:28). As for the diagnosis of Sasang constitutions, the KDC followed criteria of a "confirmed case of a constitution" (*ch'ejil-hwakchin-ja* 體質確診者 체질확진자) which was set by SCM experts. The definition of the confirmed constitution was introduced as follows:

> It refers to a person whose Sasang constitution has been clinically identified by an expert in Sasang Constitutional Medicine, and its criteria are as follows:
>
> 1) A person who has been given as at least 60 packs of herbal medicine (prescription for the same constitution) and has visited the SCM practitioner at least four times to be examined the clinical course, has no side effects, and whose chief complaints, pathological and basic patterns have improved by more than a certain standard.
> 2) A person who has taken more than 100 packs of constitutional prescriptions and has visited the SCM practitioner at least four times; no side effects, clearly described their initial chief complaints, pathological and basic patterns; with the SCM practitioner's detailed description of changed aspects of the patient after the administration of the constitutional prescription [Lee, 2014:45].[172]

As seen above, the criteria of confirming Sasang constitutions were set by experts' negotiations. The *experts* here were SCM specialists and experienced KM doctors practicing Sasang medicine who were recognised by the society of SCM.[173] Unfortunately, the

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[172] Explaining the process of constructing the Korea Constitution Multicentre Bank, the research report which introduced the criteria added a supplementary condition for Taeyang persons: "because the number of the cases for Taeyang persons are small, the researchers separately collected cases for those who met the criteria of Taeyang persons" (Lee, 2014:45). This means that Taeyang persons were dealt with differently compared to other constitutions, just as seen in the most famous classical text of Sasang medicine, *Donguisusebowon*.

[173] This means that there were also experienced KM doctors, *masters* in other words, practicing Sasang medicine but not recognised by the society of SCM, which will be dealt with in Chapter 6. Those KM doctors were criticized by Professor Lee in Chapter 3 for being *mixed* and not genuinely Sasang medical. However, as described in

negotiations between experts and the statisticians in the team did not happen during my fieldwork so that I could not record them. However, I could see that the drive for standardisation and scientisation was much stronger than the dissenting voices in the team. Nevertheless, one KM doctor in the team told me that it was very difficult to collect even experts' knowledge such that it formed a unified standard. Furthermore, the 'information' to confirm Sasang constitutions was divided into several indicators such as body shape, voice, or personality characteristics and all were data input in the form of questionnaires. In addition, the 'constitutional information' was mingled with other information and sometimes framed as *mibyeong*. Like this, Sasang constitutions were interpreted in this setting of the research institute. In this setting, the 'knowledge of Sasang constitutions' could be viewed not just as 'traditional', 'classical' or 'Eastern', but as an assemblage of diverse data, practices and repertoires that went beyond any distinctive or hybridised 'epistemology'.

In addition to the data collection performed in the KM hospitals, the Mibyeong project widened its application to middle or high school students. During the fieldwork at the Mibyeong Research Centre, I also joined a business trip for an agreement ceremony with executive members of a local association of KM doctors in a city. The association had been carrying out the 'school doctor' project (*kyoŭi saŏp* 校醫事業) since 2015 which let local KM doctors give health lectures to students at local middle or high schools or provide KM treatments to them. It was based on the law legislated in 1991 which allowed KM doctors to participate in the school doctor project (Kim *et al.*, 2017:161). Therefore, the 'school doctor' project was a collaborative work between the local government, the local educational

Chapter 3, there were also mixed views on Sasang medicine even in the SCM society. The question of authenticity was evidently one of negotiations.

institution and the local association of KM doctors. Whereas the project had been initially inclined to *treat* the students, this agreement was to put more emphasis on *prevention* by using diagnostic tools such as questionnaires developed by the Mibyeong research centre. Specifically, the agreement between the association and the Mibyeong research centre was to transfer a smartphone application made by the centre which students could input their health information and KM doctors could screen students with serious conditions based on the analysis of the health information.

In this way, by entering the network between the local agencies, the centre aimed to spread the concept of *mibyeong* and the product of their research to the public as well as KM doctors. This contrasted with Farquhar and Zhang's (2005) description of the life-cultivation arts, i.e. 'nurturing life' (*yangsheng*) in the East Asian medical tradition. Specifically, Farquhar and Zhang say the "life" that is cultivated in *yangsheng* is not bare life, it is more like Agamben's notion of bios - multiple, ramifying, always particular, always a qualified form of life (ibid.:318). On the contrary, the school doctor project seemed to regard "life" as bare life, as described by Agamben (1998), which can be objectified by the sovereign power from modern institutions. In this sense, participants were regarded as research objects which would be objectified in so far as they would be regulated by the new frame of *mibyeong,* rather than being subjects who actively engaged in daily life routines for their health. It implied a new try to be a regulatory power from the institutions of modern nation-states, which did not exist before. In this process, the Mibyeong Research Centre, while drawing on the authority to *mibyeong* as in classical texts, transformed the quality and locus of power, away from the book and to the body politic, by setting the above, multiple and minute routines in place, which enacted a regulatory power of the body. Ulitmately, the discourse of constitution was also

involved to reinforce the legitimacy of the 'Korean way' of management of life.

The example of the KDC, its related tools such as questionnaires and the transformation of social networks, reminds of the discussion of an alternative modernity[174]. Pordie and Gaudilliere (2014) explain that alternative modernity should not be understood as a process of acculturation and local adaptation to the forms of knowledge, values, and ways of acting that are originating in mostly a European modernity. Instead, it involves much more complex dynamics, in ways that respond to the colonial and postcolonial challenges combined with adaptation and resistance, alignment and alternative, heritage and invention. An alternative modernity rests on a dialectic that constantly redefines and displaces the boundaries between the 'inside' and the 'outside', between what is accepted as modern and what is promoted as tradition (ibid.:4-5). Pordie and Gaudilliere discussed the examples of re-invented Ayurveda which became industrial and pharmaceutical: the invention of new herbal combinations with some roots in the classical texts of Ayurveda; the mass-production and global circulation of these remedies in the form of pills; the emergence of large companies operating nation-or world-wide with the classical tools of scientific marketing, etc (ibid.:6-7).[175] The case of the KDC would be similar to that of Ayurveda described of above, insofar as

[174] Gaonkar (1999:6-13) adeptly reviews the discussions of modernity and alternative modernities. According to him, modernity is best understood as an attitude of questioning the present, not just as "presentness" which is defined and marked by "the new" that is always in a state of disappearance, destined to be overcome and made obsolete through the novelty of the next fashion. In various social, cultural, and geographical contexts, this attitude of modernity can be global and multiple and no longer has a governing centre and master-narratives to accompany it (ibid.:13). In doing so, he argues, "everywhere, at every national/cultural site, modernity is not one but many; modernity is not new, but old and familiar; modernity is incomplete and necessarily so" (ibid.:18).

[175] For reference, also see Hsu's (2009) discussion on various modes of "modernising" traditional Chinese medical drugs (*zhongyao*) and transforming them into so-called Chinese propriety medicines (*zhongchengyao*) in the neoliberal wellness markets.

Sasang medicine became systematized and institutionalised as a form of database; informatical combinations with some knowledge from the classical texts of Sasang medicine; domestic and even international circulation of the information in the form of questionnaires and the eCRFs; the emergence of large agencies (such as the NRIKM, KM hospitals and other institutional agencies). However, as Lei (1999:323) points out that the discovery of a Chinese drug *Changshan* as a new anti-malarial drug was actually a re-networking process of Chinese drugs excluding traditional Chinese doctors and including biomedical doctors, the construction of the KDC should be concerned with changing networks and empowering/forbidding certain agencies in transforming networks. In the case of Sasang medicine in the research institute, the status of SCM specialists/KM doctors became a managerial role which governs the circulation of the knowledge, and this might be posssible because KM doctors played an active role in the research projects at the research institute devoted to scientise Korean medicine.

Inside the Team

From now on, this chapter engages with the logic of practice inside the team. As explained earlier, the researchers of the team were from various academic backgrounds: not only Korean medicine, but also nursing science, public health, statistics, bioinformatics, genomics, and bioengineering. Nonetheless, they communicated and cooperated with each other to accomplish research projects, although some sort of tensions or conflicts were exposed in the process. Hence, this part aims to provide ethnographic examples from several occasions such as group meetings, daily conversations, and informal interviews with individual researchers.

Most of the researchers I worked with during my fieldwork had been involved in the

3-year project titled "*Hanŭihak kiban, han'guginŭi kŏn'gangjŭngjinŭl wihan yebanggwalli saŏp*" (Korean Medicine-based, Preventive Management Project for the Health Promotion of Koreans) carried out from 2014 to 2017, a year before I came to the NRIKIM. The report of this project introduced the main purpose and contents as "to develop classification algorithm and self-management software for Mibyeong based on systematic longitudinal clinical DB", and "to develop or enhance Mibyeong classification (or diagnostic) devices using physiological indices in Eastern and Western medicine physiology" (KIOM, 2017:V). Furthermore, the report announced that the research produced several results: the identification of Mibyeong indices for classification, the development of the self-management software for the smartphone application called "Mibyeong-bogam" (Treasured Mirror of Being Not Yet Ill 未病寶鑑)[176], the establishment of Mibyeong clinical database and its management system, the construction of the Mibyeong Yangsaeng (life-nurturing 養生) database, the construction of a nurse cohort, Mibyeong sub-type clinical research (including sleep restriction trial), a healthy volunteer study, a herb tea interventional study, the development of a portable respiratory gas analyser, and the development of a portable pulse analyser to diagnose the *mibyeong* state (KIOM, 2017:Ⅴ). These diverse projects were viable by researchers with aforementioned kinds of expertise, and the follow-up research of similar topics was going on during my fieldwork.[177] Researchers in

[176] Because of its suffix "bogam (寶鑑)", "Mibyeong-bogam" definitely reminds Korean people of *Donguibogam* (東醫寶鑑), the most famous book of Korean medicine.

[177] For example, researchers were working on the construction of a Korean medicine information bank, the development of diagnostic questionnaires of not only SCM, but also *mibyŏng* or other pathological patterns such as coldness (*han* 寒) and heat (*yŏl* 熱). A group of researchers was working on analysing genetic information of certain cohort group, etc.

the centre therefore formed small groups to pursue each sub-project according to their specialities. In what follows I will explore how they exchange research ideas and formulate research directions by crossing the boundaries of their specialised disciplines.

The Book Club Meeting: Forming a Research Culture

I was curious about how researchers with different academic backgrounds communicated with each other to fulfil their main project. In regular working hours, they usually worked with others who were pursuing the same kind of the sub-projects, that is, who had similar professional training backgrounds. Junior researchers often mingled together during lunch time or coffee breaks, but in these times, they usually talked about their private issues such as raising children or buying apartments as well as their incidental work life.

It was interesting to see a regular meeting where more than 15 researchers out of 20 gathered once a week or every two weeks to discuss chapters of a book for an hour (or one and half hours at most). This regular meeting was called the "book club" (*pukk'ŭllŏp* 북클럽) and was usually held on Monday or Tuesday afternoon (but not only then). The time for the meeting was set considering whether most researchers could attend the event. The atmosphere of the meetings did not exactly match their naming. For each meeting, one to three researchers prepared a presentation which summarised certain chapters of a book. The books to read were usually confirmed by Dr. Ryu, the head of the centre. With recommendations from senior researchers, he had suggested books to the researchers based on his ideas of which would be necessary and appropriate for the centre to proceed in the current or future projects. During my fieldwork, we alternated between the reading of three books. For example, if we read two (or

more) chapters of *Epidemiology* this time, next time was two (or more) chapters of *Genetic Variation and Diseases*, and another next time was a similar number of chapters of *the Sapiens: A Brief History of Humankind*. I heard that in the case of the first book researchers had already read the book last year and were trying to read it again, to familiarise themselves with the major concepts of epidemiology for their projects related to population-based cohort study and clinical trials. By contrast, the second book on genomics was a new attempt to understand the field of genomics and its application to their projects. Researchers with a background of genomics, called *yujŏnch'et'im* (the genomics team), were in charge of the presentations. The third book, which in its translation into Korean was already very popular in the country, was regarded as an educational book which could enhance collective and cultural maturation in the team. Although the expertise of all researchers, including KM doctors[178], was significantly inclined to *science*, some researchers looked enthusiastic to absorb and evaluate the historical knowledge and perspective presented in the book, whereas some others did not look interested in it. In addition to the presentations and Q&As, the time was also used for announcements from the head. Those announcements included not only comments to the presentations, feedbacks or suggestions from researchers, but also stories of his business trip which implied the future direction of the centre. For this reason, although it might be not directly related to researchers' main work, the book club meeting was the time that each researcher could understand other researchers' work and that they related with each other. This will be dealt with

[178] The KM doctors whom I met at the Mibyeong Research centre were very inclined to researching with *scientific* methods. This attitude was very different from what I saw from Professor Lee, as described in Chapter 3, who emphasized classical texts and philosophy of the founder of Sasang medicine. The identity formation of KM doctors varies depending on generation or social settings (see also Hsu, 1999; Mol, 2002). It is an important topic which should be further dealt with in the future.

in detail in the following section.

Creating Interdisciplinarity: "I am an outsider to this field but..."

Except for the researchers of the genomics team, it seemed that most of the researchers in the centre did not have enough background knowledge of genomics. There were few questions from few researchers in the Q&A session after the presentations. Questions were based on their "knowledge from the high school level", or their "(indirect) experience from lab research while attending graduate school". Somebody's remark of "I am an outsider to this field but…" when questioning showed a good example of researchers' being novices in the field of genomics. Dr. Ryu once commented that listening to the presentations was "like listening to a lecture of computer (programming) rather than listening to a biology lecture." Dr. Ryu asked the researchers of the genomics team, who were in charge of presenting on the book of genomics, to make a general presentation for novices. Hence, the presentations of genomics played a role as an opportunity to introduce the project of genomics in the centre and to understand it better. Furthermore, the presentations provided a platform for researchers to find a 'trading zone', which researchers could get some research insights for their own research, as well as making comments to the presenters' research. In this sense, the presentations were neither just a series of lectures on genomics, nor one to become a genomic scientist, but to trade knowledge and ideas from different sides. For example, Dr. Ryu commented on any presentation from the perspective of the principal researcher. He asked about which stage in the process could be done *in* the NRIKM among the whole genome sequencing processes: i.e. collecting data, preparation, and data analysis. Then he told the genomics team researchers that he could try to

get certain *machines* or *computers* which would be necessary accordingly. That is, in this case Dr. Ryu used the time to discuss the focus of the research and how to lead it in a certain way, by communicating with the given researchers. Although it was likely that the final decision would be made by discussing further in exclusive meetings with senior researchers' attendance only, the event seemed important to demonstrate to all of the researchers in the centre on what was going to happen or to be decided. Other questions came mostly from KM doctors, who might be able to collaborate with the genomics team. For example, Dr. Koh, a KM doctor with a speciality in KM internal medicine and relatively junior in the centre, was one of the few questioners during the book club meetings and asked about main concepts of genomics and its possibilities of clinical application: such as "as you – the presenter, a molecular biologist – mentioned about tRNA and ribosome, can we say that tRNA consist of ribosome?", "how does tRNA transform to protein?", or "when we experiment with genes related to obesity, can there be a gene that could perform multi-functions if we use a different marker?" Dr. Ryu also cared about the level of difficulty of the presentations, being afraid that the other researchers would find it difficult to understand. Hence, he said, "today's presentation was already a very complicated one. For those of you who are going to present next time, please refer to today's presentation and lower your standards (for other researchers)." Then from the next time genomic researchers became more cautious about transmitting basic knowledge of genomic research, as well as appealing their expertise to other researchers.

In the cases of other books, the discussions were not exactly lively. Another book on epidemiology, was presented by some of the researchers who were involved in clinical research during my fieldwork. The group for clinical research included all of the four KM doctors in the centre. Two KM doctors, Dr. Bae and Dr. Koh, who were relatively active in the Q&A session

for the presentations on genomics, relatively well aware of the information on epidemiology and did not raise questions for the presentations on epidemiology. Consequently, I could not see any questioning to the presenters of epidemiology. It seemed that researchers took it for granted that there were no questions. On the other hand, the third book, unlike the other two books, was presented by various researchers regardless of specialities. It was picked by Dr. Ryu. At the last session of the presentation of the book, he talked about his intention of its selection, saying "(the reason of reading the book for the book club meeting was to see) our situation more *objectively*". He sometimes introduced some examples from Korean history to show the importance of seeing (historical) facts from different perspectives. For example, he once talked about stated the necessity of comparative views when evaluating controversial historical issues such as discussing the remnants of Japanese colonialism in Korea. He stressed that it would need to be evaluated comparing with other (similar) cases such as the British colonial rule in Africa, or the US's national response to Nazi collaborators after World War II. It sounded that Dr. Ryu wanted the researchers in the centre to have certain perspective when working. It seemed like he wanted the researchers to adapt somewhat non-nationalistic perspective – if not an inter- or trans-national gaze – and he aimed at highlighting that many things and events in the world are interconnected as described in the book. In this case, being *objective* could be read 'connected with the international concerns, discourses, or intelligentsia'. This could be related to take part in tackling global issues escaping from nation-centred minds, as well as probably publishing their research for international audiences - on SCI journals. Unfortunately, during my fieldwork, I could not observe any related questions and comments raised from the researchers or discussions among them. Researchers in the team might be less engaged in Dr. Ryu's inducement than what Dr. Ryu expected. However, researchers still followed Dr. Ryu's guidance of reading certain books without any complaints.

Formulating Future Directions

The time of the book club meeting was also used for announcements, which were usually made by Dr. Ryu. The topics of announcements varied from individual researchers' personal events, specifically sharing experiences of international business trips, to communal issues to cope with such as a team's moving plan. One day, Dr. Ryu once interjected with a comment on his visit to a conference in Australia, called the lifestyle medicine conference. He talked about his experience in the conference: how they organised it, which session was most impressive and worth sharing, how the lifestyle prescription could be made to certain states of patients or diseases, and how conferences on integrative or Complementary and Alternative Medicine (CAM) were advertised in the conference. By doing so, he emphasized that the lifestyle medicine conference had many common approaches which the team aims for and it could be "a fringe of the existing [bio-]medical conferences [in the West], and a place which could lead health-related trends distinguished from existing [bio-]medical communities".

Although the time was for the book club, Dr. Ryu used the time to share his experience on the visit to a conference which might be related to his centre's potential research topics. He found interesting that the lifestyle medicine conference might have some connection with conferences on complementary and alternative medicine (CAM)[179], which he might think it would be related to the Mibyeong research. Although it was very likely that those 'international'

[179] The definition of Complementary and Alternative Medicine (CAM) is slightly different in South Korea, compared to that in Europe and the US. Not only KM doctors, but also biomedical doctors who worked on CAM defined CAM as other medicines except for (Western) biomedicine and Korean medicine. This is meant to admit Korean medicine as a conventional medicine in South Korea along with biomedicine (Lee, 2011:26). Dr. Ryu was also well aware of this difference between Korea and the West. Therefore, when encountering difficult issues of explaining/experimenting SCM *medically*, he expected there might be some interesting research items for SCM researchers to learn from CAM conferences in the West.

or ‘Western’ medical conferences would not deal with the concepts of *mibyeong* or even constitution directly, his reasoning of linking those KM concepts to lifestyle medicine approaches made me think that he had some expectation of getting to interesting research items or insights which might inspire the Mibyeong research. He suggested the researchers to attend conferences of the lifestyle medicine which would be held internationally or even domestically. In doing so, Dr. Ryu introduced a professor who was a biomedical doctor and launched the lifestyle medicine society of Korea. Dr. Ryu told us that the professor told him “that’s ‘MUS (medically unexplained symptoms)’!” [180] when Dr. Ryu started talking about *mibyeong.* Before known to KM doctors, or at least to Dr. Ryu and the team, the concept of the MUS was usually dealt with by biomedical doctors, specifically family doctors. With the advice from the professor introduced the concept, Dr. Ryu linked or appropriated it with symptoms in the category of *mibyeong,* and it was likely to be also re-categorised according to the basic patterns of Sasang constitutions. Likewise, introducing a menu for digital and mobile health on the lifestyle medicine society of Australia website, he said “what they do is just like what we do for the development of our mobile application software, the Mibyeong Bogam”. In this way, Dr. Ryu encouraged the researchers to attend conferences on the lifestyle medicine and to build international research network. In this particular case, researchers carefully listened to Dr. Ryu’s remarks as he had not only the hierarchical authority of setting directions of research, but also the speciality of Korean medicine and Sasang medicine which was believed to have

[180] A website run by the National Health Service in the UK explains the MUS like follows: “many people have persistent physical complaints, such as dizziness or pain, that don’t appear to be symptoms of a medical condition. They are sometimes known as ‘medically unexplained symptoms’ when they last for more than a few weeks, but doctors can’t find a problem with the body that may be the cause. … Medically unexplained symptoms are common, accounting for up to 45% of all GP appointments and half of all new visits to hospital clinics in the UK” (NHS, 2018).

the originality of KM scientizing research.

The epistemological and social network of the MUS guided him to the lifestyle medicine conference in Australia, which he encouraged for researchers to attend to 'globalise' their research on Korean medicine. Telling his experience at the conference, he further explained what in the conference intrigued him as a researcher of *mibyeong* and how certain matters could be related to the *mibyeong* research items. By doing so, he played as a mediator between two different fields and expanded his research concerns to an international level with finding corresponding concepts.

Discussing Difficult Issues: Correlating **chejil** *and Genomics*

The book club meeting was also a location for discussing difficult issues. Because it was the centre that used to study *chejil* (constitutions), one of the major issues was probably how to relate genomics with constitutions for the research project. One day, during a presentation on the genomics book by a researcher, Dr. Ryu interjected and raised an issue of difficulties in the constitution classification when integrating with the genomics research. He first asked why the team turned their research focus from the constitution itself to genomics. He explained that one principal researcher [a molecular biologist] in the team brought up an issue of that "there is nothing to do with constitutions [for future research topics]". However, although they no longer used the term 'constitution' or 'SCM' in their project titles afterwards, to maintain the originality of research, the team had to keep using some level of the SCM perspective and the problem of constitution classification was therefore still followed. To this Dr. Ryu responded by emphasising that, to proceed the genomic research, it requires that "the constitution classifying criteria must be clear, just as the criteria of obesity" (when saying this he was clearly

referring to the BMI, which is however also very controversial). Then he described the current level of the constitution classification process with an example. “When there are two SCM specialists [for constitution diagnosis], what we could expect is currently 65 to 70 percent [of consistency]. Then they would say, ‘it is not bad’.” Researchers laughed when they heard the SCM specialists’ response. Dr. Ryu continued and asked a question to the presenter, “this is how the constitutional value (*ch’ejilgap*) turns out. In this situation, what would you suggest to us on this: such as, ‘oh, because of that, we’ve been doing analysis in this way?’”

His comment shows that they turned their research focus from constitutions to genomics. However, the work of defining the Sasang constitution and its application seemed still important and problematic for the current research. For example, Kim, Jin and Kim (2012) shows the procedure of how the team executed the genomic research on Sasang constitutions. It describes, “a total of 241,998 genetic loci across the whole genome were genotyped for 1,222 subjects of a *defined constitution type*. The genetic loci associated with each constitution type were identified and the functional connectivity of genes within these loci was analysed using statistical text mining” (ibid., 262). Kim, Jin and Kim (2012) also describes the process of the constitution diagnosis, “In order to diagnose Sasang Constitutional (SC) type, subjects were prescribed a constitution-specific herbal medicine including *Panax ginseng, Ephedra herba, and Schisandra chinensis* for treatment of their major physical discomfort. After subjects took the medicine for 30 days or more, improvement of pre-existing symptoms or occurrence of adverse effects were recorded. Constitution types were determined only for subjects showing clear improvements in their chief complaints without any adverse effects” (ibid., 262-3). The authors of the article admit its limitation that “there is still the problem of intervention of subjectivity in the diagnosing process such as evaluation by medical doctors” (ibid., 266).

Therefore, the constitution diagnosis by SCM specialists had to be performed beforehand to set groups of defined constitution type. The problem was that the diagnosis from KM doctors (especially SCM specialists) were sometimes different from each other. The researchers in the team were thus concerned that the results of the genomic research on Sasang constitutions would not be reliable.

After Dr. Ryu's comment and question, the presenter, a senior researcher and a biochemist, replied with an awkward smile implying that she was well aware of the issue, "well, that may be why the results do not come out well". Then Dr. Ryu said, "if you said so in the time period from 2006 to 2009 [when the NRIKM had the project of genomics], researchers might have said 'that's why it doesn't work'. But now we launched again a big project of genomics, and you say, 'it doesn't work because the criteria are not precise'…". Even before Dr. Ryu ended his comment, a principal researcher of the genomics team who were a bioinformatician interrupted the conversation: "So, the criteria is, we [the team of genomics] pick participants' data at the two extremes, and we use the constitutional value [from the constitution diagnosis of the SCM specialists], but also use the probability value as well as words used in the questionnaire for constitution diagnosis which was developed in the centre". "No, don't need to explain in detail", Dr. Ryu interrupted. Then Dr. Ryu added to the senior researcher: "You should have answered that you know the issue well and also have some solutions for it. Your first answer was very bad." All researchers in the room laughed, as Dr. Ryu told it a bit humorously. He seemed well aware of how to deal with researchers without wounding their dignity, when he said what he wanted the researchers to do. The senior researcher answered with a smile, too: "I'll try".

The conversation between Dr. Ryu and other researchers shows how the research focus

was negotiated among the researchers during the book club. As seen above, a senior researcher who had been in the centre for about a year and was a relative newcomer seemed not fully to know how to relate her expertise to a new discipline, Sasang constitutional medicine. Dr. Ryu required her to integrate her research methods with the existent topic, and a more experienced researcher in the team explained the way to relate it. Then the new researcher soon realised how to manage the issue and to adjust her expertise to the research direction of the centre.

Although I could not really hear the term *chejil* in official meetings many times during my fieldwork, it seemed that it probably was still important for the research projects in the centre. In an informal interview with Dr. Ryu, he once explained the extent to which the constitution talk for research projects was important in the past. The following is an excerpt from the informal interview with Dr. Ryu.

> Dr. Ryu said, "We [the researchers of the Mibyeong research centre] had talked about constitutions… until the 2010s or so. I had discussed about constitutions with all the researchers [in the centre] but now is … [Me: it has changed?] Yes. Now we are talking about what do to for the management of chronic diseases, this kind of thing… *The advantage of using 'constitutions' in doing research is, that there is an exact centre point.* We could discuss how to diagnose constitutions, disorders/diseases related to constitutions, lifestyle related to constitutions, and so on. But now... we don't adopt constitutions as a slogan of our research. So, now we don't have a centre point. Until nowadays I have said that our research is targeting *mibyeong*, which is a certain unhealthy state. But now we are turning to the lifestyle management. Then what kind of the lifestyle management? PA (physical activity), sleep, diet … Regarding these, we've come to the field of lifestyle medicine, but *something* [that could play as a centre point] *is not clear* [missing]. … However, if we think about the issues of constitution, then we are going back to the past, as we have been thinking of *going forward*."

Dr. Ryu pointed out that there has been transitions of centre points which formed an identity of his group and projects: from constitution to *mibyeong* to lifestyle medicine. When in the beginning the centre point was the constitution, he confessed, it was relatively simple to maintain the identity or originality of their research, to appeal to funders, researchers in other

departments or institutions, and the general public. It was *mibyeong* that his team went *forward* from the past research projects on constitutions, which enabled the team to maintain their research focus with existing researchers and facilities, and additional incorporation of more academic fields and research funds. The discovery of lifestyle as a research item looked another breakthrough for the centre to prolong the competence and attractiveness of their expertise to the external funding bodies. However, in the meantime, as Dr. Ryu indicated, it looked like there was something missing – he said: "it is not clear". He was looking for a concept which would become the pivot of their research, and which could distinguish their research from others. It was what Dr. Ryu was struggling to find. It seemed not appropriate to bring constitution to the forefront of their research as it belonged to the *past* and they had to go *forward* just as scientific progress. This was one of his dilemmas in the scientific research of Sasang medicine.

5.4. Discussion

This chapter examined how *chejil*, i.e. constitution, was dealt with in a research setting. In detail, focusing on the researchers at the Mibyeong research centre, where I spent 3 months, working with a group of about 20 researchers, who largely were involved in one single mega project on preventive health. I explored how they made a social and science-driven network at the inside and outside of the team. At the outside, I found that researchers in the Mibyeong research centre were making social networks with mainly KM universities, hospitals, and local KM associations. The knowledge circulating in this network was mostly quantified in forms of

questionnaires or numbers, to be analysed by statistics. By doing so, they were aiming to establish a Korean version of biobank which would contain KM clinical data as well as various physiological and clinical indicators of Korean and biomedicine. In this process, the knowledge of Sasang medicine was also quantified and split into various psycho-physio-social indicators.

For gaining insight about the inside of the team, I attended the 'book club' meetings to investigate how researchers from different academic backgrounds communicate each other, how to collectively pursue a research goal, and how the concept of *chejil* was transformed and combined with others. Using the book club meetings during which three different kinds of books were presented, the researchers exchanged their expert knowledge with others from different fields. The head of the centre, Dr. Ryu, also used the time to facilitate discussions between researchers to share seniors' knowhow to analyse KM concepts in quantitative words, to develop team spirit for scientific mind, and to introduce new research agendas to progress from past ideas such as away from *chejil* and *mibyŏng* to genomics or *lifestyle* (생활습관) medicine. In this process, as Dr. Ryu implied, *chejil* had formerly intrinsically contributed to developing interdisciplinarity between researchers from different academic disciplines. Researchers in the centre had to put efforts to reveal undiscovered attributes of *chejil* by using their expertise. However, as seen in the conversations between the researchers, this goal was sometimes challenged by junior researchers who were trained in one field and did not fully know how to integrate KM concepts with their expert knowledge. Furthermore, because of the research durations, the team had to set new goals with appropriating and formulating new concepts and terms such as *mibyŏng* or *lifestyle* medicine. Talking overtly about *chejil* inadvertently had come to mean returning to the past and being retrograde. At the same time, however, the team still needed something like *chejil* which could create a pivotal research

agenda, interdisciplinarity, and originality which could distinguish their research from others. It was the main dilemma I observed in the research setting.

Chapter 6. Practising Sasang Medicine

As we have seen in previous chapters, the ways of knowing Sasang Medicine in the school and in the research institute were governed by values of standardisation and scientisation, although there were confronting actants in both settings. Reasons for and the contribution of such dissonances were not limited to each setting but had an impact across many different settings. Particularly, it appears worthwhile to investigate the practice of Sasang medicine in private clinics because it could illuminate underlying dynamics which give impetus for *idiosyncratic inventions* and *socially accepted innovations* in Sasang medicine. They are widely believed to be from the bottom, whereas the values of standardisation and scientisation are usually granted by the top authorities, which, as we will see, however, this is not necessarily the case . Hence, this chapter is devoted to exploring Sasang medicine in the private-practice sector. The practice of Sasang medicine in private clinics often evaded regulations and regimes applying to more visible structures of health care so that styles of Sasang medicine were likely to depend on the practitioners' charisma and discretion, and sometimes led to innovations in the Sasang medicine field. At the same time, within this heavily privatised field, there nevertheless have been certain rules, norms, or habits which have been maintained through kinship-like pedigrees or interpretive traditions of seminal texts. In this context, based on my fieldwork in various private clinics, this chapter firstly discusses the characteristics of plurality in the private setting, and then discusses three issues: one's striving for authority among various clinical practices, determining whether one's therapeutic method is 'innovative' or 'contaminative', and establishing therapeutic rationalities by assembling various and often somewhat idiosyncratic elements.

6.1. Plurality in the Private Setting of Sasang Medicine

Plurality as a Theoretical Framework for Diverse Medical Practices

This chapter tries to see the diverse practices of Sasang medicine in private clinics through the lens of plurality. In his book, Scheid (2002:27) provides detailed discussions on plurality in Chinese medicine. He admits that plurality prevails in the very fabric of Chinese medicine from perceptions of the body to the social relations embodied in learning, teaching, and practice. According to him, plurality in Chinese medical practice encompasses multi-layered knowledge from the canonical texts of the Han dynasty to present-day research in urban hospitals (ibid.).

Explaining the practice of Chinese medicine, Scheid (2002) indicates that there is no agreement between doctors about which method should be applied to a particular case, nor are there any established mechanisms to bring about convergence (30). For example, he notes that diagnostic technologies in East Asian medicine which are usually summarized as the four methods of diagnosis (*sizhen* 四診) do not have unanimity in practice among doctors. Details of specific diagnostic techniques or the interpretation of diagnostic data, and treatment practices are all equally varied (ibid.:30-31). Scheid contends that the history of Chinese medicine is characterized by polemics between advocates of different schools of learning (thought). Such polemics might concern theoretical issues or the correct interpretation of textual sources as much as diagnostic and treatment techniques appropriate to a given patient (ibid.:31).

As for the aspects of medical practice where plurality could emerge, Scheid (2002:30) asserts that, even at the most basic level, one can distinguish at least three disease models and

treatment strategies in contemporaneous use: (1) the experience-based use of specific treatment technologies; (2) an epistemological pattern nosology leading to specific treatments for defined patterns or, at least, locally limited interventions designed to deal with specific causes and (3) an individually based functional disease model. In other words, the first corresponds to *kyŏnghŏmbang* (experience-based prescriptions 經驗方) which were habitually used by certain physicians or their followers, and the second could be specific doctrines such as replenishing the earth (補土; i.e. replenishing the Spleen and Stomach) or cooling and chilling (寒凉) [an excess of heat]. Lastly, the third would correspond to certain disease models which suit to explain certain groups of symptoms from a certain region and certain time period such as *wenbing* (warm disorder 溫病).[181] All of these aspects have been related to sociocultural and epistemological loci for generating plurality in the history of medicine. This, I contend, applies not only to China, but also to Korea.

Scheid (2002:56) goes further to explain the three constitutional aspects of plurality: heterogeneity, multiplicity, and synthesis. According to him, heterogeneity implies that the Chinese medical tradition, its practitioners, and practices are open to and constituted by influences from a variety of domains and from various periods in time (ibid.:33). Furthermore, he explains that multiplicity is a consequence of heterogeneity. Such multiplicity exists at every level of description, within as well as between medical traditions, and even with respect to individual physicians, who reveal themselves to be far more complex than conventional images

[181] To explore the details of the emergence and development of the *wenbing* tradition in the history of Chinese medicine, see Hanson (2011).

of the subject and medical practice have previously imagined (34). Whereas heterogeneity and multiplicity are primarily descriptive concepts emphasizing the plural constitution of fields of practice, Scheid (2002:59) emphasises that synthesis is an analytical concept employed to capture the constitution of such fields as a process of simultaneous emergence and disappearance. In so doing, he suggests that synthesis or syntheses in Chinese medicine can be qualified by four attributes. (1) Locality: syntheses are by definition local, taking place at a particular place and a particular time. (2) Connectivity: syntheses interconnect with one another into larger and smaller patterns. (3) Agency: syntheses are simultaneously viewed as processes of interactive stabilization between interrelating infrastructures, both human and nonhuman, and processes of inclusion and exclusion. (4) Topography and topology: syntheses take place in reciprocally created fields of practice (ibid.:60).

Through these conceptual process and tools, Scheid (2002:31) suggests understanding considerable diversity between types of doctors and modes of transmission of medical knowledge which is based on the social organizations of medical practice. There have been distinct streams of medicine which emerged as foci of interdisciplinary organization often called as the term *pai* (*p'a* in Korean transliteration 派), such as in *piwei xuepai* 脾胃學派 (the spleen and stomach school) or *Hejian xuepai* 河間學派 (the *Hejian* school). The conventional translation for *pai* is "schools", "factions", "lineages" or "groups" but he proposes to call it "current" (Scheid 2007:12). Synchronically, he defines *pai* or current as "groups of practitioners whose members are related to each other by personal association, actual or fictive kinship ties, retrospective histories, or affiliation on the basis of having read or adopted the texts or case records of a deceased physician, and who share ideas, techniques, geographical

proximity, stylistic similarities, aesthetic preferences, or any combination of these" (ibid.:13). Also, *pai* or current can be diachronically defined as "the real or imagined genealogies that tie the members of a current together frequently cut across the questionable periodizations imposed on their subjects by historians and thereby help to relativize them" (ibid.). Following Scheid's definitions described above, this thesis also prefers to use the term 'current' rather than schools, or factions.

Currents of Learning in Korean Medicine

Similar attempts to identify currents of learning in Korean medicine have been made by some scholars. Following the way of classifying different Confucius schools in Korea, Namil Kim (2004:7) suggested to examine the practice of Korean medicine in different categories. Based on the criteria of a current sharing the same doctrine and similar types of publications, Namil Kim (2004:7) enumerated 15 currents [of learning] (*hakp'a* 學派) in the history of Korean medicine: the Hyangyak current (鄕藥學派), the Donguibogam current (東醫寶鑑學派), the Sasang (constitutional) current (四象體質學派), the current of the *Introduction to Medicine* (醫學入門學派), the current of the Complete Compendium by [Zhang] Jingyue (景岳全書學派), the current of the *Book of Changes* in medicine (醫易學派), the current of compromising Eastern and Western medicines (東西醫學折衷學派), the current of supporting yang (扶陽學派), the current of experience-based medicine (經驗醫學派), the current of Eastern

acupuncture and moxibustion (東醫鍼灸學派), the nurturing life medicine current (養生醫學派), the Korean version of the [*Treatise of*] *Cold Damage Disorders* current (東醫傷寒學派), the emergency medicine current (救急醫學派), the paediatrics current (小兒學派), the surgery current (外科學派). This classification was a preliminary attempt as it was primarily based on the contents of learning and common interpretive traditions as known through important medical books and related physicians in history.

Taewoo Kim (2010, 2013, 2016, 2019) further develops the discussion regarding currents of tradition in Korean medicine. He divides institutions of Korean medicine into two sectors: the first sector includes Korean medicine schools and (non-) university-affiliated Korean medicine hospitals whereas the second sector consists of private Korean medicine clinics owned and run by individual Korean medicine doctors. According to him, the first sector plays a significant role in conferring social authority on Korean medicine by training and licensing KM doctors in parallel with the institutional structures of biomedicine in South Korea, while the second sector is the place where most healthcare services by KM doctors are delivered (Taewoo Kim, 2016:139; c.a. 90%). He pays particular attention to the second sector as he observed that it plays a crucial role in the transmission of knowledge of Korean medicine, which is separate from that of KM colleges and university hospitals of the first sector. He finds that voluntarily formed practitioner associations, called *hak'oe* (literally, 'study associations' 學會 학회)[182] play a significant role in transmission of knowledge and circulation of practices

[182] *hak'oe* can be translated to various terms such as 'study group' or '[academic] society' depending on context.

(ibid.).[183] He analyses that the coexistence of the state and private sectors has established a buffering structure that prevents modernist discourse such as standardisation or scientisation from wielding influence in the second sector where most Korean medical care is delivered. By doing so, he argues that the second sector is a locus where emerging traditional practices have been energized by East Asian medical epistemology and its theoretical elaboration, in other words, a locus of "tradition on the move" (ibid.:140). Yet, as the case of Dr. Yoon will show, in particular, even if he may have pointed to a numerically more important group of physicians dedicated to tradition on the move, modernist epistemes also more or less pervade and shape the private sector.

Paying attention to the role of study associations in the second sector, Taewoo Kim (2019) argues that currents [of learning] (*hakp'a* 學派 학파) still exist in contemporary Korean medicine. He defines currents of tradition in East Asian medicine as "communities which share medical doctrines and practices" which could be identified as medical classics they study, characteristics of their masters, therapeutic styles, or their publications (ibid.:595). In this respect, he identifies various currents such as the *Huangdi Neijing* current, the *Shanghanlun* current, the *Donguibogam* current, the *Introduction to Medicine* current, and also the Sasang medicine current (which doctrine is considered to be condensed in the works of one scholar Yi Chema). He particularly notes that there could be currents in a current such as current's' of *Huangdi Neijing*, or current's' of *Donguibogam* (ibid.:595). For example, he instantiates the three different currents of *Donguibogam*, one emphasises pulse images

[183] For comparison, see also Farquhar (1996) and Hsu (1999: chapters 3 and 4), both of which talk of study groups for Chinese medicine.

described in *Donguibogam*, another does causes of disorders (*pyŏngin* 病因), and the third does facial and bodily shapes (*hyŏngsang* 形象). Accordingly, each emphasizes as separately predominant in each current either pulse taking, or asking, or looking (ibid.:610). He analyses that this plurality is based on how the practitioners read and interpret even a single classical text and how they see diverse aspects of human existence in reality on a certain social and cultural context (ibid.).

To sum up, studies on identifying currents of tradition in Korean medicine make a premise that Korean medicine has several currents as the Confucius tradition does and regard this phenomenon as important to see the development or even "innovation" in the East Asian epistemology as being contrasted to the Western modernity. Whereas aforementioned studies focus on plurality in East Asian medicine, this chapter rather tries to more focus on the divergences within a single tradition, namely within Sasang medicine.

As mentioned earlier, Sasang medicine is a bit unique because the practice or the currents of Sasang medicine appear not only in the second sector, i.e. the private clinics, but also in KM schools and hospitals as a specialised discipline, i.e. the state sector. By contrast, the currents of *Donguibogam* or *Shanghanlun* are not taught as a separate 'clinical' discipline in KM schools[184] and as an independent speciality in KM hospitals. In contrast to previous studies which focused on a transversal view of plurality in the practice of Korean medicine, this chapter aims to provide a longitudinal view of currents of tradition by elucidating the

[184] In many KM schools, *Shanghanlun* was taught in the KM pathology (*hanbang-byŏngnihak* 韓方病理學) class, which is considered as a 'basic' subject. I found that some KM schools provided a *Donguibogam*-reading course as an elective or an extracurricular activity.

different practices of Sasang medicine in private clinics.

Sasang Currents of Learning: Diverse Dimensions

This chapter focuses on the practice of Sasang medicine in private clinics, and a brief outline of their dimensions may be necessary here. According to Taewoo Kim (2016:140), "private" clinics are run and owned by KM doctors. In the current healthcare system in capitalist South Korea, KM doctors in private clinics are inclined to maintain considerable daily patient numbers for financial solvency. The perceived efficacy obtained through patients' satisfaction would appear to be what matters most in choosing ways of clinical practice from the available range of therapeutic repertories, whether these are standardised and scientised or not (ibid.). Meanwhile, in this chapter, "private practice" is still limited to KM doctors whose practices are still authorised and supervised by the government. This chapter does not regard practices in the "popular" or "folk" sectors in Kleinman (1980:50)'s sense as "private practices", because those did not require an official recognition by the government. Furthermore, these private practices also relied on digital communication. During my fieldwork, I found patients' groups which were very active online, which numbers of members reached 20,000.[185][186]

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[185] As of 12 November 2020, the numbers of the members of the most representative internet communities were 27,130, 13,372, and 8,045, respectively (https://cafe.naver.com/tgchimtm; https://cafe.naver.com/paradisesaber; https://cafe.naver.com/ecmnaturopathy). Interestingly, all those three internet communities focused on Eight-Constitution Medicine, a diverged branch of Sasang medicine.

[186] There were key figures who acted as a kind of a 'master', but they were mostly not trained KM doctors. They would regularly write posts on constitutional medicine and sometimes delivered offline lectures about constitution diagnosis or diet. However, this chapter does not explore those sectors, although they are worth working on in the future.

Looking at the history of Sasang medicine from the perspective of currents, one can see that its associations have been transformed, developed, and/or diverged. For example, the first association of Sasang medicine is known as *yultonggye* (the Chestnut village gathering 栗洞契), which was formed after Yi Chema's death by his disciples and followers in his hometown Hamheung in order to inherit his teaching and to publish his writings (Sasang ch'ejil ŭihak'oe, 2010:5). The members of the Society of Sasang Constitutional Medicine (*sasangch'ejirŭihak'oe* 四象體質醫學會), insist that they succeed the first association in a direct the line of descent. The society of SCM is probably the most influential academic society particularly in the institutionalised setting. During my fieldwork, I found that most members of the society were professors, fellows, or residents of the SCM department in KM university hospitals. At the same time, many university professors were either students of Professor Lee at Seoul University or students of his students. The society of SCM was the only academic society officially recognised by the Society of Korean Medicine, which is the most representative academic society of Korean medicine overseeing sub-disciplinary societies. To join a full-membership of the Society of Korean Medicine, one should satisfy several conditions such as holding regular academic conferences, publishing at least one academic journal, etc. Several researchers at the National Research Institute of Korean Medicine who were working on Sasang or constitutional medicine were also active in the society of SCM by participating in conferences, working for the same research projects, and joining as board members of the society.

However, throughout my fieldwork I could also observe that there was another layer in the private setting where scholarly activity was exuberant in different aspects, similar with

what Taewoo Kim (2010, 2019) observed about various currents of tradition in Korean medicine. There was no official list of societies or gatherings of KM doctors for Sasang medicine in the private sector, but I could get information from students in KM schools and gatekeeper KM doctors (I also knew this based on my own experience as a KM doctor). What I want to argue is that societies or gatherings in the private setting were not fully separated from the institutionalised sector but were rather in an interdependent relationship, probably just like a hybrid relationship between Western biomedicine and 'Korean medicine'. This phenomenon will be elaborated hereafter.

6.2. Striving for Authority: A Case of Dr. Won

When I thought of conducting fieldwork on the private practices of Sasang medicine, I firstly encountered the name of Dr. Won (1937-),[187] who was regarded as one of the masters in Sasang medicine. Whereas Professor Lee, another living master in Sasang medicine, was

[187] It would be worth mentioning the appellation of a KM doctor. During the fieldwork, I found that there were some rules among KM doctors to call each other in different sites. In the private sector, KM doctors usually called each other as *wŏnjang-nim* (director [of the clinic] 院長님) as most of them were expected to run their own clinic. This can be compared with other appellations of a KM doctor in other settings. For example, in KM hospitals, they were called *kyosu-nim* (professor 教授님) when students or training doctors called professors, or *sŏnsaeng-nim* (先生님) when called by students or other fellow doctors. Meanwhile, KM doctors in the research setting were called *paksa-nim* (doctor 博士님) when they held a doctorate, or *sŏnsaeng-nim* when they did not have it. The honorific suffix *nim* was added when a junior called a senior, and it was omitted in the opposite case. These rules of calling KM doctors surely reflected their changing social relations in different settings.

mainly active in the official academic society which consisted of university professors and hospital physicians of Sasang medicine, Dr. Won had been running his own clinic for more than 50 years, with giving only some private lessons to a few KM doctors. On 13th April 2018, I paid a first visit to him guided by Professor Jeong who told me of Dr. Won's fame among KM doctors. Dr. Won's clinic was in one of the old downtown areas of Seoul. The clinic was located on the first floor of an old-style 5-storey commercial building, which looked like having been built in the 1970s or 1980s (see Figure 6.1). On the ground floor, a small Korean-style pub and a tripe restaurant were located and there was an internet café on the second floor. Because it was an 'old' building, there was no elevator in the building but only stairs. When I entered the clinic, there was a man in his 60s or 70s at the reception and an old medicine cabinet at the back of him. After I introduced myself and the purpose of visit, he guided me and Professor Jeong to Dr. Won in the consulting room. The consulting room had one table, two beds and several kinds of treatment equipment such as acupuncture. Along with an acupuncture l*oci* chart and a wall calendar, some photos were hung on the walls. Several of them were photos of his children and grandchildren. There were souvenir photos. One was a photo of him with the Minister of the Ministry of Health and Social Affairs in the early 2000s and another was a photo of him with his students which seemed to have been taken in the late 1990s or early 2000s. Professor Jeong and I found two figures in the photo who were also famous for practicing Sasang medicine in the KM world. Dr. Won told us that they had been students of him but at some point they did not come to Dr. Won's study meetings and went their own way.[188] On the other side of the walls, there were frames of his KM license acquired in 1974

[188] Later, I also met these two KM doctors and found they interpreted Sasang medicine different from Dr. Won, as he mentioned. One emphasised the philosophical aspects of Sasang medicine so that he valued the *Manuscript of Study* (mentioned in Table 3.1 of Chapter 3) and the connection with the Four Books and the Three Classics

and a written permission from the local authority for the opening of the clinic. There was a bookshelf with books on Sasang medicine, other KM books, reports on health insurance about KM, and booklets published by the Association of Korean Medicine.

During the interview, Dr. Won, a graduate of Seoul University College of Korean Medicine[189], told me that he did not like his alma mater. It was because professors at the time of his attending the school did not appreciate Sasang medicine. At that time, in the late 1950s and early 1960s, Sasang medicine was not included in the school curriculum. He mentioned that he went to KM school to study Sasang medicine, but soon became disappointed by the academic environment of the school. Since then, he had kept a distance from the official academia of Sasang medicine in the sector of institutional health care. Based on his 20 years of clinical experience and understanding of Sasang medicine, he authored a book manuscript *sasangŭiyak sŏngniimsangnon* (Clinical Treatise on the Nature and Principle of Sasang Medicine and Pharmacy 四象醫藥性理臨床論) in 1983. As time went by, he revised it according to his accumulated experience and finally published it as a book in 1997 (Kim, 1997: Ⅰ-Ⅳ). In his book, he stressed the concept of the Nature and Principle of viscera and bowels, based on the phrase from the classical text "the Nature and Principle of viscera and bowels in

(*Sasŏsamgyŏng* 四書三經) (explained in Footnote 60). Another KM doctor learned not only Sasang medicine but also the teachings of the *Donguibogam* and of Eight-Constitution Medicine. He did so by apprenticing himself with different masters so that he developed his own idea of combining different medical systems.

[189] When he entered the college in the late 1950s, it was originally called *tongyang ŭiyak taehak* (College of Eastern Medicine and Pharmacy 東洋醫藥大學) from 1955 to 1964, and *tongyang ŭigwa taehak* (College of Eastern Medicine 東洋醫科大學) from 1964 to 1965. Later it was merged to Seoul University in 1965.

the people of Sasang (四象人 臟腑性理)".[190] For this reason, he preferred the term *ch'esŏng* (the nature of the body 體性) to *ch'ejil* (the character of the body, or constitution 體質). Moreover, he added new ways of diagnosing constitutions [methods on the thorough examination of constitutions 體質通察法] based on his clinical experience. According to Jung (2013:376), Dr. Won's elaboration on the body and facial shapes for the constitutional diagnosis contributed to the development of discussions on constitutional morphology (*ch'ejil hyŏngsangnon* 體質形象論). As for the use of herbs and prescriptions, he provided the method of addition and subtraction (*kagambŏp* 加減法) of herbs according to certain symptoms. It was very different from what Professor Lee and his followers did for the use of Sasang prescriptions: they were just using original prescriptions (*wŏnbang* 原方 원방). On that point, Dr. Won criticized Professor Lee's way of applying prescriptions, and emphasized that practitioners of Sasang medicine should know how to modify tailored prescriptions according to changing bodily signs and symptoms. After he achieved his own understanding of Sasang medicine, he said, he taught a group of KM doctors who wanted to learn from him.[191]

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[190] This phrase appears in "Treatise on the Origin of Medicine" (*Ŭiwŏllon* 醫源論) of *Donguisusebowon* of 1901.

[191] Interestingly, Dr. Won told me that initial members of the group were KM doctors who were his high school juniors. This shows the importance of regionalism or school relations in the social relations of Korean people, especially in the older generations. He graduated from one of the three most famous high schools of his time and it seemed he was very proud of his school, whereas he did not like his university. It seems to be the reason why he gave lessons only to his high school juniors.

Figure 6.1. A Photo of the Building Where Dr. Won's Clinic Is Located. His clinic was on the first floor (Source: Google Earth).

'Hidden' Lineages of Sasang Medicine

Although there were several other masters of Sasang medicine, what made Dr. Won somewhat special was his genealogical relationship with the founder of Sasang medicine, Yi Chema.

There was a story that he was taught Sasang medicine from an old man named Sŏng Un (成雲). Dr. Won wrote in the preface of his book that teacher Sŏng Un and Dr. Won's father taught him and bequeathed a record of secret prescriptions (*pibangnok* 秘方錄 비방록) (Kim, 1997: ⅰ∨). The term Sŏng Un appears in one of Yi Chema's writings, the *Posthumous Work of Tongmu: the Pogŏnsŏng edition* (保健省 東武遺稿). It says, "although I said by diagnosing *sŏngunbyŏng* (Sŏng Un's disorder 成雲病), all Soeum persons are like this" [對診成雲病而言, 然小陰人皆然] (Yi, 1999a:140).

However, the translation of *sŏngunbyŏng* that Dr. Won gave in this book contrasted sharply with what I heard from Professor Lee. When I visited Professor Lee's clinic before I met Dr. Won, Professor Lee said *sŏngunbyŏng* was the symptom caused by a desire to achieve "a cloudlike dream", which meant an impossible dream. The existing Korean translation of the phrase, which authors were North Korean scholars in the 1960s, was also the same as Professor Lee's explanation. Interestingly, the term Sŏng Un only appeared in that very sentence and nowhere in other writings of Yi Chema. From this, I noticed that there had been some tensions between Dr. Won and Professor Lee, or the institutionalised world of Sasang medicine over how to translate the phrase *sŏngunbyŏng.* Moreover, these were also related to recognising the main line of descent from the founder of Sasang medicine, which would have the most authority in the world of Sasang medicine. If someone translates *sŏngun* as a person's name, then she/he would need to admit that Dr. Won is taught by him so that there would be a direct medical lineage from Yi Chema to Dr. Won. If *sŏngun* is translated as a name of a disorder, then Dr.

Won's claim of being related to the founder would lose its legitimacy and it would also affect the authority of Dr. Won's academic contributions in the field. I was curious about why the Society of SCM, which has more institutional power, did not make an effort to reveal the truth. It did not seem to be interest to them. Rather, it seemed to still remain veiled.

Apart from Dr. Won, there were other KM doctors who were known to have access to the authentic lineage of Sasang medicine. One was Dr. Eom (1914-1988), who was born in Hamheung, the birthplace of Yi Chema. According to Jung (2013:360), he was taught by a student of Yi Chema, Han Tuchŏng (韓斗正; 1880-?) for 10 years. Dr. Eom did clinical practice in Hamheung for a while and then defected to South Korea in 1946. Because he did not attend any legitimate KM school, he had to take the KM qualifying examination to be qualified to take the national KM licensing examination, in order to practice Sasang medicine as a licensed KM practitioner. After he acquired the KM license and started running his clinic in Seoul, he published a book *Tongŭi sasang daejŏn* (*The Complete Compendium of Sasang in Eastern Medicine* 東醫四象大全) in 1977, which translated and annotated Yi Chema's classic *Donguisusebowon* (*Prolonging the Life and Preserving the Origin in Eastern Medicine* 東醫壽世保元) in Korean. This was followed by the enumeration of Sasang prescriptions according to the order of the table of contents in *Donguibogam*, his empirical observations of Sasang people, symptoms, and prescriptions, based on his clinical experience for 40 years (Pak, 1977). In 1984, he published a Korean translation of *Kyŏkch'igo* (*The Manuscript of Study* 格致藁), which contains Yi Chema's interpretations of Confucius thought. Although he had strong legitimacy of Sasang medicine recognised as "being taught by the 'best student' (*sujeja* 首弟

子 수제자) of Yi Chema"(Jung, 2013:362; Eom, 1977: Ⅰ), he did not appear as a front figure of any current of Sasang medicine, except for interacting with few elders, including Dr. Chu.

Unlike Dr. Eom and Dr. Won, Dr. Chu (1909-1992) appeared in the major scene of Korean medicine. He was an active member of the society and at the same time he was also known as having the authentic legitimacy of his Sasang medical practice. It is known that he encountered Sasang medicine in the early 1940s when he was at Hamgyeongbuk-do, which was not very far from Yi Chema's hometown (Lee, 2020). Dr. Chu met Yi Jinyoon (李鎭胤; 1894-?), who was a great-grandchild of Yi Chema, at some point and formed a friendship with him. He then ran a KM apothecary shop (*hanyakpang* 韓藥房 한약방) in Seoul that could be operated without a KM license until 1958 when he passed the national KM licensing examination. After then, he opened a KM clinic (*hanŭiwŏn* 韓醫院 한의원) in the same city (ibid.). Afterwards, he became very active for Sasang medicine in the world of Korean medicine. Dr. Chu served as a chairman of the Society of Oriental Medicine (*taehan hanŭihak'oe* 大韓漢醫學會, later the Society of Korean Medicine) as well as the first president of the Korean Society of Sasang Medicine (*taehan sasangŭihak'oe* 大韓四象醫學會, later the Society of Sasang Constitutional Medicine)(Sasang ch'ejil ŭihak'oe, 2010:18-22). The Society of Oriental Medicine was the most representative academic society of the whole community of licensed KM practitioners. Thus, although his main concern was Sasang medicine, his activities were not only limited to the field of Sasang medicine, but also in the field of Korean medicine in general. One of the differences from Dr. Eom and Dr. Won was

that Dr. Chu taught Sasang medicine in KM schools while running his private clinic in Seoul. Similar to Dr. Eom, however, Dr. Chu also published a translation of *Donguisusebowon* called *sasang ŭihak wŏllon* (*Principles of Sasang Medicine* 四象醫學原論) with a renowned philosopher of Sasang medicine in 1973, for the necessity of an official Korean translation of the seminal book in the name of the Society of Sasang Medicine (Sasang ch'ejil ŭihak'oe, 2010:26-28). Also, in 1991, he published a book titled *sasang jillyo bowon* (*Preserving the Primary for Sasang Practice* 四象診療保元) based on his understanding of the classical texts, and his experience of clinical practice. He was obviously a celebrated writer in the world of Sasang medicine.

As we see from the examples of the three people, all of them had similarities: claiming some extent of scholarly lineage with the founder and publishing books with interpretations or commentaries based on their understanding of Sasang medicine. On the other hand, they went through different paths. For instance, Dr. Won did not appear on the front to the official history of Sasang medicine established by the SCM society, whereas Dr. Eom and Dr. Chu were regarded as elders of Sasang medicine in the historical book of the SCM society. Meanwhile, Dr. Chu was specifically more active in the social relations of Sasang medical practitioners than Dr. Eom. Dr. Chu raised many students in KM schools, but Dr. Eom did not do so, while Dr. Won raised his students in the private sector.

Sasang Medicine as Distinctive within the Mainstream Circle

Dr. Won was apparently out of the mainstream Sasang medicine in the institutionalised KM

world, although he was a graduate of Seoul University College of Korean Medicine[192] and had the appealing claim of having a direct medical line to the founder of Sasang medicine. However, the SCM society did not officially recognise his lineage as genuine.[193]

Dr. Won's understanding and interpretation of Sasang medicine was very obviously different from Professor Lee. First, he tried not to use the term *ch'ejil* (constitution or body-quality 體質). Instead, he used the term *ch'esŏng* (bodily-nature 體性). Just like *ch'ejil*, the term *ch'esŏng* did not appear in Yi Chema's writings. Whenever I inadvertently used the term *ch'ejil* during the interview, he said I should correct my use of the word to *ch'esŏng.* It seemed that his coining of the term *ch'esŏng* was based on a paragraph in *Donguisusebowon*, which he briefly introduced in an interview:

> 1) The *sŏng* (nature) of the Taeyang person is sorrow, which goes far away and is dispersed. The *jŏng* (emotion) of the Taeyang person is anger, which is abrupt and urgent. The far-reaching and dispersed nature of sorrow gathers and increases the energy of the lungs. The abrupt and urgent emotion of their anger strikes at and severs the energy of the liver. This is how the Taeyang Person is born with stronger lungs and a weaker liver (太陽人 哀**性**遠散而怒情促急 哀**性**遠散則 氣注肺而肺益盛 怒情促急則 氣激肝而肝益削 太陽之臟局 所以成形於肺大肝小也).

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[192] During the interview with Professor Lee, he sometimes used the idiomatic terms *hakkyop'a* (the school faction 學校派) and *sŏdangp'a* (the private academy faction 書堂派) when referring to KM doctors in his generation. According to him, the former meant graduates of the only recognised KM school at that time, i.e. Seoul University College of Korean Medicine including its past forms since the independence in 1945; whereas the latter referred to those who did not attend the KM school but became KM doctors by passing the national qualifying examinations. At the initial stage, many of the faculty members of the KM school were *sŏdangp'a*, who did not have official education from legitimate KM institutions. However, as more and more graduates were produced, the faculty was filled with graduates of the school and the existing faculty was gradually pushed out.

[193] As mentioned earlier, although it might not be a direct reason, his claim was related to the issue of how to interpret the term *sŏng-un* (成雲) in the classical text. Professor Lee just took it in stride interpreting it as a name of a disease, whereas followers of Dr. Won regarded it as an important clue to claim himself as authentic descendant.

2) The *sŏng* (nature) of the Soyang person is anger, which is broad and embracing. The *jŏng* (emotion) of the Soyang person is sorrow, which is abrupt and urgent. The broad and embracing nature of anger gathers and increases the energy of the spleen. The abrupt and urgent emotion of their sorrow strikes at and severs the energy of the kidneys. This is how the Soyang person is born with a stronger spleen and a weaker kidney (少陽人 怒**性**宏抱而哀情促急 怒**性**宏抱則 氣注脾而脾益盛 哀情促急則 氣激腎而腎益削 少陽之臟局 所以成形於脾大腎小也).

3) The *sŏng* (nature) of the Taeeum person is joy, which is wide and vast. The *jŏng* (emotion) of the Taeeum person is pleasure, which is abrupt and urgent. The wide and vast nature of joy gathers and increases the energy of the liver. The abrupt and urgent emotion of their pleasure strikes at and severs the energy of the lungs. This is how the Taeeum person is born with a stronger liver and a weaker lung (太陰人 喜**性**廣張而樂情促急 喜**性**廣張則 氣注肝而肝益盛 樂情促急則 氣激肺而肺益削 太陰之臟局 所以成形於肝大肺小也).

4) The *sŏng* (nature) of the Soeum person is pleasure, which is deep and hard. The *jŏng* (emotion) of the Soeum person is joy, which is abrupt and urgent. The deep and hard nature of pleasure gathers and increases the energy of the kidneys. The abrupt and urgent emotion of their joy strikes at and severs the energy of the spleen. This is how the Soeum person is born with stronger kidneys and a weaker spleen. (少陰人 樂**性**深確而喜情促急 樂**性**深確則 氣注腎而腎益盛 喜情促急則 氣激脾而脾益削 少陰之臟局 所以成形於腎大脾小也) (Wagman (tr.) 2016:55-56; Lee, 1997:25, English translation modified by the author myself).

He condensed the above paragraph like this: “the strong function of *sŏng* (nature) for Sorrow-Anger-Joy-Pleasure (哀怒喜樂) and the weak function of *jŏng* (emotion) made the big-small relations (大小關係) between *zangfu* organs, and this process caused the differentiation of *ch'esŏng* (body-nature 體性)” (cf. Shin, 2000:1). It seemed that he put stress on the word *sŏng* (nature) rather than *jŏng* (emotion) as the common denominator which

determined the four types, and this word became related to the word *ch'e* (body or 'bodying'[194] 體) to assign individuality. There was another concept which he particularly emphasised: *sŏngni* (nature and principle 性理). The term *sŏngni* was from a phrase in "*sasangin changbusŏngni* ('the Nature and Principle of viscera and bowels in the people of Sasang' 四象人臟腑性理)" of *Donguisusebowon*.[195] In summary, his insistence to speak of *ch'esŏng* rather than *ch'ejil* had overall impact on emphasizing the affective natures of each Sasang constitution: Sorrow, Anger, Joy, and Pleasure.

Moreover, in terms of what kind of classical texts learners should be aware to understand Sasang medicine, he did not regard *Kyŏkch'igo* (*The Manuscript of Study* 格致藁) as an essential text for it, while Professor Lee emphasized some parts of the text to understand Yi Chema's thought, and to practice Sasang medicine better. He assured that "it [*the Manuscript of Study*] is just about [Yi Chema's] philosophy, not about clinical practice. [So, people don't really need to read the book to practice Sasang medicine]." Rather, he emphasized that people

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[194] I borrowed this translation from Zhang (2007:155). In her personal communication with Roger Ames (1997), he suggested that Chinese tradition is "eventful" rather than "essential," so gerunds are better than nouns for translating Chinese concepts. Following this, Korean Chinese word *ch'e* (體) could also be translated into a gerund form 'bodying'. Thus, the translation of *ch'esŏng* could be 'bodying the nature' or 'nature-bodying'.

[195] The whole sentence is: "It was through immense fortune that after 5-6000 years of medical history, and the knowledge brought to us from doctors of the past, that I was able to decipher *the Nature and Principle of viscera and bowels in the people of Sasang*. I decided to write the current text entitled *Donguisusebowon* 余生於醫藥經驗五 六千載後 因前人之述 偶得四象人臟腑性理 著得一書 名曰壽世保元." (Park, 2002; English translation based on Wagman, 2017:97).

need to almost "memorise" (*oewŏya* 외워야) *Donguisusebowon* to be good at Sasang medicine, asking me how many times I had read the book. He said that one should read *Donguisusebowon* at least 30 times to memorize every sentence in the book, but he found no one had ever read even five times. Apart from *Donguisusebowon*, Dr. Won did not stress other writings of Yi Chema. This was unlike Professor Lee. The one exception was a writing called as the *Tongmu's Songs of the Qualities of Herbs* (*tongmu*(*yugo*) *yaksŏngga* 東武(遺稿) 藥性歌), which explained qualities and efficacies of herbs according to each constitution and were a part of the *Posthumous Work of Tongmu: the Pogŏnsŏng edition* (保健省 東武遺稿).[196] He told me that he consulted them when adding and subtracting herbs.

In addition to his different uses of terms and classical texts which distinguished his understanding of Sasang medicine from others, Dr. Won also drew a line against the existing Korean medicine. For instance, he was critical to contemporary KM doctors only talking about *pyŏng* (diseases 病) rather than *changbu sŏngni* (the Nature and Principle of viscera and bowels 臟腑性理). By doing so, he said "Sasang is explaining how the four viscera (i.e., Lungs, Spleen, Liver, and Kidneys) become dysfunctional by intermingling with [the affective dispositions] *ae-no-hŭi-rak* (Sorrow-Anger-Joy-Pleasure 哀怒喜樂) and [the qi qualities] *on-yŏl-lyang-han* (Warmth-Heat-Coolness-Coldness 溫熱凉寒)." Based on this thought, he criticized KM practitioners or groups for emphasizing diagnosis and treatment "rooted in

[196] For details of the *Posthumous Work of Tongmu,* see Table 3.1 in Chapter 3.

[differentiating] patterns" (*chŭngbon* 證本 증본), not considering those "rooted in [differentiating] a person's basic characteristics" (*inbon* 人本 인본). This was his making of distinction from the existing currents of Korean medicine.[197]

In terms of the clinical style of Sasang medicine, Dr. Won showed a critical attitude to the KM doctors in the society of SCM in that they only give prescriptions conforming to in which Sasang category patients belong to. When I asked him to elaborate, he explained that they were using *wŏnbang* (original prescriptions 原方), not adding or subtracting herbs according to patients' changing symptoms. I realised that there was a big difference between Dr. Won and Professor Lee, in terms of whether to use original prescriptions or modified prescriptions. In the interview with Professor Lee, he said if a patient's constitution is confirmed, the doctor can use prescriptions from the relevant part of *Donguisusebowon* of 1901, in their original forms. Professor Lee also said if the constitution is right, even if the target symptoms to be treated are different, there would be no major side effect. It seemed that Professor Lee more emphasized the exact/dogmatic classification of constitutions and the authority of the classical text, whereas Dr. Won was more inclined to a clinician's virtuosity to add or subtract drugs based on the observation of changing symptoms even if a constitution is confirmed.

[197] According to E. Hsu (personal communication, 12th March 2021), this reminds very much of Zhang's personal transmission of knowledge (Hsu, 1999:88-105) - the same words, but with just a slightly different slant to their interpretation, make distinction through subtle differences from the (implicitly vulgar) mainstream understandings.

Dr. Won also criticised the society of Sasang Constitutional Medicine for "using too many biomedical concepts" to explain Sasang medicine. He stressed, "KM doctors are too servile [to Western biomedicine because they are too dependent on it when treating patients]". During the interview, as an example of not being subordinated to biomedicine, he spoke of different kinds of caffeine. He instantiated that caffeine of coffee and that of black tea could be different, in terms of its action and effect. Likewise, he explained that there could be some people who cannot sleep after drinking coffee but can sleep after drinking black tea, whereas there could also be others who cannot sleep with black tea and can do with having coffee. This implied that qualities of drugs (*yaksŏng* 藥性) which stands on the basis of the theory of qi and taste (*kimi* 氣味) can override the purified chemical substances such as Caffeine.[198] This inference was also connected to another that some people react to a same substance differently from others, i.e. the idea of having different *ch'ejil.*

I once asked him about how he differentiated constitutions. As he described in his book in detail, he somewhat emphasized the appearance of people, especially the shape of people's skulls and faces. For example, he explained about the shapes of the face, the forehead, the eyes, the nose, the lip, the lower jaw, etc. All of them did not appear in *Donguisusebowon*, so it could be said that they were observed and systematised by Dr. Won. However, he emphasized that the final decision for constitution differentiation should be made by administering Sasang decoctions and observing the responses. He said he developed his own medicines to try out the responses of the patients, to find out which constitution they belonged to.

[198] There is a nice example of this in Tibetan medicine, too. See Schwabl and Van Der Valk (2019) on a semiotic process of Tibetan medical formulas challenging the biomedical paradigm of single 'active substances'.

In this way, Dr. Won's practice of Sasang medicine was somewhat different from Professor Lee's practice in terms of how to interpret classical texts, which types of classical texts should be valued, to what extent biomedical knowledge could be explained by that of Sasang medicine. Dr. Won's case demonstrates an example of a master of Sasang medicine who claimed to have the authentic lineage to the founder but was not included in the institutionalised circle of Sasang medicine.

6.3. Competing for Legitimacy: Innovation or Contamination?

This part explores an issue of 'innovation' or 'contamination'[199][200] in the field of Sasang medicine. For this, I will present an example of *P'al-ch'ejil ŭihak* (Eight-Constitution Medicine 八體質醫學), which was devised by Dr. Seo (1921-). Throughout my fieldwork, I encountered different views on Eight-Constitution Medicine (hereafter ECM). First, some KM doctors regarded ECM as *innovation* (*hyŏkshin*) from Sasang medicine which expanded constitutional theories and therapeutic methods. On the other hand, there were other KM doctors considered that ECM was *contaminated* (*oyŏmdoen*) by the theory of the Five Phases, which Sasang medicine had discarded. Other KM doctors claimed the uniqueness and creativity of ECM for

[199] Hsu (2001:4) indicates that innovation has its defining characteristic 'the new' which has a positive value, but people are often ambivalent towards 'the new'.

[200] Providing cases of auriculotherapy or ear acupuncture in Europe and in China, Hsu (1995:161) introduces among possible processes of syncretization: a 'distortion' of the original therapy, an 'invention' of a new therapy, and a 'development' of the initial invention and of an 'adjustment' to existent medical concepts, and 'adulterations' due to its popularization.

being distinct not only from Sasang medicine but also from other East Asian medical traditions and having its theoretical roots in Christianity not Confucianism. I deal with these different views of KM doctors based on anthropological fieldwork and archival research.

Three Routes to Approach Eight-Constitution Medicine

ECM was somewhat 'mystical'(*shinbihan* 신비한) compared to other KM subdisciplines or other currents of the KM tradition. It was partly because ECM was not included in the official KM curriculum as Sasang medicine was, and the founder – Dr. Seo – seldom appeared in front of the public as well as fellow KM doctors despite the popularity of ECM. Evidently, some dramatic treatment cases played a crucial role to engrave its existence to the public. One famous example was the case of a biomedical professor. He was professor of Anatomy at one of the most famous biomedical schools in South Korea but was treated by Dr. Seo in 1970 for his chronic stomach disorder (Lee, 2019:117). After he recovered, the professor studied ECM privately under Dr. Seo as an incumbent professor at the medical school, which was very exceptional. Then he wrote a popular book on ECM and played a role as a proselytiser of ECM appearing in mass media (Ch'ae, 1993). Another example was a case of a renowned public philosopher. Frequently appearing in mass media, he became popular among the Korean public due to his theatrical lecturing style and polymathic aspect with producing many publications on Asian philosophies for the public. He also received attention from the public due to his unique educational background. He obtained a doctorate in Oriental studies at Harvard University after studying in Seoul, Tokyo, and Taiwan, prior to taking a tenured position in philosophy at one of the prestigious universities in the country. After he resigned from the

professorship for certain internal conflicts, he entered a KM school to study Korean medicine and to become a KM doctor. He claimed that his interest in Korean medicine started after his incurable arthritis was treated by Dr. Seo in 1966 when he was in his late teens. After he recovered with the ECM treatment, he was fascinated by it and decided to study Asian philosophies first to explore the worldview and values of ECM (Joo, 2007:18-19). In addition to the founder's reluctance to expose himself to the outside world, these two stories intensified the curiosity of ECM from the public and some fellow KM doctors.

I first encountered ECM through a KM student in her final year at Hanguk University during my fieldwork in the institutionalised setting. She was very enthusiastic in learning "constitutional medicine", which for her, meant not only Sasang medicine but also ECM. For this reason, she was very actively participating in private workshops or study associations of constitutional medicine outside the KM school. Once I expressed my interests in ECM as one of various types of constitutional medicine in South Korea, she invited me to an online group chat room on KakaoTalk.[201] The chat room was managed by Dr. Seo's disciple named Dr. Yang. Dr. Yang worked as *pu-wŏnjang* (副院長 부원장)[202] in Dr. Seo's clinic after his graduation from Hanguk University and was then running his clinic in Toronto, Canada. He was the official organiser of ECM learning groups of KM doctors and KM students. Most of the members in

[201] KakaoTalk is a free mobile instant messaging application for smartphones with free text and free call features, launched in 2010. Since then, it has been arguably the most popular messaging application in South Korea.

[202] The literal English translation of *pu-wŏnjang* is "vice director". However, as described earlier, in most cases *wŏnjang* (director 院長) in the KM world usually means an honorific language for those who run their own private clinic. In this sense, *pu-wŏnjang* generally denotes a KM doctor who is [temporally] work in a private KM clinic, along with *wŏnjang*. There are two main reasons why KM doctors want to work as *pu-wŏnjang.* One is not to be burdened by opening and running a private clinic and to get a fixed salary, another is to get training from an experienced KM doctor who is the owner of the clinic. In Dr. Yang's case, working as *pu-wŏnjang* in Dr. Seo's clinic means Dr. Yang worked as apprentice as well as a paid KM doctor because Dr. Seo was a renowned figure.

the chat room seemed KM doctors but sometimes I could find people from related fields such as an acupuncturist who had opened a practice in the US or a student studying nutrition science in the US, although most of them were KM doctors or students at various KM schools in Korea. I had a short online chat with him staying in Toronto. He said he was trying to establish a good education system of ECM for better learning, by applying various methods used in other fields. Those methods included online lectures, clinical training sessions for ECM acupuncture and pulse diagnosis. I could not attend the offline meetings because they conflicted with other fieldwork schedules but attended his online lectures on the history and introduction to ECM. Furthermore, the ECM learning group provided me with a collection of materials written by or related to Dr. Seo. It covered all materials written by him such as research articles, contributions to magazines or newspapers, prefaces to ECM books written by others, as well as his interview reports and dissertations advised by him.

Secondly, with Professor Jeong's introduction, I also met and interviewed another KM doctor as a second informant of ECM, Dr. Kang, a graduate of Seoul University. He was known as practicing ECM in his clinic at the time of my fieldwork. He was a physician of ECM in terms of practicing, teaching and disseminating it. An interesting fact about Dr. Kang was that he was never directly taught by the founder of ECM. It was almost 10 years after his graduation of a KM school when he entered the ECM world with the recommendation of a senior of his university. He studied ECM with *kangŭirok* (recorded lecture transcripts 講義錄 강의록) or video recordings of ECM by senior KM doctors who individually studied ECM and organised academic communities for studying ECM with his colleagues. Thereafter, he gave many lectures about ECM to fellow KM doctors and published several books on ECM and regularly contributed to a KM newspaper for KM doctors. However, in an interview with me, he

confessed that he was once warned by Dr. Seo about teaching ECM to KM doctors because he did not have an official student-teacher relationship with Dr. Seo, which might let people misrecognise him as having the main line of descent from Dr. Seo. Dr. Kang was also critical to Dr. Seo and his group being 'dogmatic', although he still admired Dr. Seo's achievements and extraordinariness.

Thirdly, during my fieldwork at Hanguk University, Professor Han informed me of a KM doctor, Dr. Jin, who was a graduate of Hanguk University and did research on the relationship between Sasang medicine and ECM. Whereas the aforementioned two KM doctors, Dr. Yang and Dr. Kang were active outside the KM schools, Dr. Jin held a doctoral degree in Sasang medicine. Supervised by Professor Mok, his doctoral thesis explored the relationship between the two constitutional medicines. On the other hand, he did not do a residency training of Sasang medicine at a KM hospital. Rather, he was running his own clinic in Seoul. ECM was not included in the official curriculum at the KM school but he apparently accessed the information about ECM from a clinical guidebook for staff and students in the school (N. Kim, 2019). Like Dr. Kang, Dr. Jin did not have a direct lineage to Dr. Seo, the founder of Eight-Constitution Medicine. Rather, it seemed that he was closer to the field of Sasang medicine. This was particularly so compared to Dr. Kang, who devoted himself to study ECM without the recognition from the founder. Unlike Dr. Yang, who was one of the disciples of Dr. Seo and asserted ECM was distinct from Sasang medicine, Dr. Jin took the position that ECM was influenced by Sasang medicine at least in the initial stages of its development. In this way, he published books related to Sasang medicine rather than on ECM, after writing a doctoral thesis on the comparison between the two.

Dr. Seo was no longer running his clinic because he was too old. I could not interview

him due to his health condition. Therefore, my approach to ECM took the above three different routes. Those three KM doctors went through different pathways to ECM: apprenticeship, self-study, and the doctoral-level training. These different socialities sometimes involved different materials for ECM learning according to their specific situations or needs. For instance, Dr. Yang eagerly referred to the latest biomedical knowledge and educational/scientific research techniques to firmly establish an independent scholarly system of ECM; Dr. Kang worked hard on revealing the principles of ECM, which he thought of being not clearly mentioned by the founder, by illuminating its origin and history; Dr. Jin wrote comparative research articles in the journal of SCM and thereafter published books related to Sasang medicine, rather than ECM. Thanks to these three ways to approach ECM, I could estimate this heterogenous character of ECM.

Narrating the Esoteric: Stories that Make Dr. Seo a Legendary Figure

As mentioned before, Dr. Seo was a distinctive figure compared to other masters of Sasang medicine. First, he was regarded as a legendary figure with his life story and dramatic treatment cases of renowned people. Second, it was controversial if someone asks whether ECM was derived from Sasang medicine or not, and to what extent these two were related. Unlike other masters of Sasang medicine, although some of them also had their own unique episodes (mainly related to Yi Chema), Dr. Seo was known with myth-like stories which were about the discovery or origination of Eight-Constitution medicine.

According to press interviews with Dr. Seo (J. Kim, 2011)[203], he was born in 1921. His interest in constitutional differences started when he got a gold tooth, because he felt pain in the tooth just on that day. The pain finally went away after getting rid of his gold tooth. From this, he deduced that his constitution was not matched with materials made of gold (ibid.: 493). Another famous episode was about his encounter with acupuncture. He originally wanted to go to the US and study counselling. While preparing to study abroad, he developed an eye disease. He went to a medical doctor to receive treatment, but eventually lost sight of one of his eyes. The condition even worsened after he got acupuncture treatment from a KM doctor whom he knew. After he realised that acupuncture could improve the condition but could also even worsen it, he borrowed acupuncture needles from the KM doctor and applied them to himself. After trying acupuncture here and there, he accidentally pricked a point on his ankle and the next day his eye healed. Because he did not have any medical knowledge at that time, he asked his colleague - the KM doctor - about the acupoint he had used. The KM doctor said the point was not related to treating eye diseases and, in fact, barely used. Following that event, Dr. Seo gave up the idea to study abroad and started studying this conundrum of how needling a certain acupoint works for a certain disorder [of a certain man]. Several years later, as a result of his self-study, he could finally make a conclusion that human beings could be differentiated into eight constitutions and each constitution had different treatments for disorders. When he started to build up his reputation by his acupuncture method, a KM doctor visited him and advised him to take a KM qualifying examination to get a KM license. Therefore he passed the

[203] As of 2020, Dr. Seo has had press interviews three times in his nearly 100 years of life. It was worth noting that he was known as seldom showing his face to the public compared to the fame of him and ECM. In every interview, secrecy was emphasised: e.g. “this interview is the first official interview with Dr. Seo.” or “Dr. Seo did not officially train his disciples. So the authentic ECM methods kept in secrecy.” It was a special character of ECM compared to other currents of Sasang medicine.

examination after only one month of preparation. It was in 1962, when he was 42. The third turning point of his life was the first presentation on ECM at the International Congress of Acupuncture in Tokyo in October 1965, which Dr. Seo attended as the representative of the Association of Korean Medicine. Dr. Seo claimed that his presentation created a sensation in the world of medicine, followed by the US state of California's granting him a formal license to treat patients, being asked for lectures at Seoul University College of Korean Medicine, and being awarded an honorary doctorate in philosophy (Kim, 2011:493-4). In this manner, he confidentially revealed his specificity.

Innovations

During my fieldwork, I encountered various kinds of literature on Sasang medicine. Those could be classified into the following way: classical texts and their translations or commentaries; textbooks; handbooks or guidebooks; research articles; clinical books (based on certain doctor's experience and interpretation on classical texts); and recorded lecture transcripts (*kangŭirok*). Interestingly, the types of literature I encountered were different according to each setting and situation. For example, textbooks, handbooks or guidebooks and research articles were usually referred in the university or research settings, whereas clinical books or recorded lecture transcripts were mainly circulated in the private setting.[204] While the aforementioned masters of Sasang medicine left at least one clinical book, Dr. Seo did not write a book. Instead,

[204] However, it should be also noted that the "private" mode is not just limited to the spatial aspect. For instance, the training doctor of Sasang medicine in the hospital told me that she read a clinical book in her spare time as she believed it helped her clinical practice.

his major works were published in the form of research articles. It was known that there were two major articles written in English which described the main theoretical aspects of ECM. Dr. Seo himself called those articles as the first paper (*ilch'a palp'yomun* 一次發表文, published in 1965) and the second paper (*ich'a palp'yomun* 二次發表文, pubished in 1973) (Kuon, 1974:587). The first paper was the one presented at the International Congress of Acupuncture in Tokyo in October 1965, and in the following year it was published in the Journal of International Congress of Acupuncture & Moxibustion by the Japanese Acupuncture & Moxibustion Society, titled "A Study of Constitution-Acupuncture".[205] The second paper was published in the Korean Central Journal of Medicine, titled "Studies on Constitution-Acupuncture Therapy" in 1973.

According to Jung (2012:19), the first paper explained the theoretical foundations of the constitutional acupuncture. Concretely, the first paper presented the theoretical framework in *Donguisusebowon* as "splanchnic interrelation theory" (*naejang sanggwallon* 內臟相關論) (Kuon, 1965:152). It came from an interpretation of Yi Chema's distinct *zangfu* inter-relationship such as Lungs and Liver (肺-肝), and Spleen and Kidneys (脾-腎).[206] In terms of

[205] Jung (2012:15) analyses that Dr. Seo valued the year of presentation rather than that of publication, as he referred to the year of 1965 as the "Year of the International Announcement of the Eight-Constitution Theory".

[206] In terms of Lee Je-ma's conception of *zangfu* relationship, Jung (2012:25) explicates that Lee Je-ma recognised the couplings between Lungs and Liver, and Spleen and Kidneys as the pivot of life phenomena, as described in sentences from *Donguisusebowon*, "The inhalation and exhalation of the Lungs and Liver serve as a door allowing qi and bodily fluids in and out of the body" (肝肺者, 呼吸氣液之門戶也), "The Kidney and spleen's excretion and absorption act as a warehouse that stores and distributes liquid and food throughout the body" (腎脾者, 出納水穀之府庫也). (Wagman (tr), 2016:57). Thus, it can be said that Lee Je-ma perceived qi and bodily fluids (氣液), which are related to respiratory metabolism, and liquid and food (水穀), which are related to digestion, as the most essential life substances. Jung (2012:25) points out that this conception is derived

expressions of *dae* (大) and *so* (小) from phrases such as *p'yedae-ganso* (肺大肝小) or *pidae-shinso* (脾大腎小) in *Donguisusebowon*, the first paper considered them as functional strength and weakness (Jung, 2012:26). Especially, the first paper elaborated, "when the strong part [organ] becomes stronger, the weak one weaker; when the weak one becomes weaker, the strong one stronger" (Kuon, 1965:153), which would form a basic theoretical framework of the splanchnic interrelation theory. Based on two disorder models of each Sasang constitution described in *Donguisusebowon*, Dr. Seo designated the first and the second morbidities of each Sasang constitution by distinguishing morbidities from *zang* and those from *fu*, which had the "eight-disease origins" (ibid.:155). The first paper did not directly mention the eight 'constitutions' but the eight "morbidities" (*pyŏngjŭng* 病證) in , which certainly became the initial framework of the eight constitutions. The eight morbidities were defined according to the arrangement of *zangfu* function differences (see Figure 6.2). Simply put, the eight disorders (two to each Sasang constitution) depicted in *Donguisusebowon* corresponded to each morbidity.[207]

from the adaptation and re-establishment of the thought that qi and taste (氣味) is the basis of life phenomena.

[207] For reference, Lee (2019:61) made a comparison table in terms of the changes of disorder names which have similar entities as follows (cf. also see Jung (2012:51)).

Sasang person 四象人	**Name described in the Treatise on Pathological Patterns (in *Donguisusebowon* of 1901) 病證論**	**Eight Morbidities (the first paper) 八病證**	**Eight constitutions (the second paper) 8體質**
Taeyang person 太陽人	Lumbar Vertebrae Disorder Induced by Exopathogen 外感腰脊病	The first morbidity (Large intestine repletion) 1病證 (大腸實)	Hespera 金陰體質
	Small Intestine Disorder Induced by Endopathogen 內觸小腸病	The second morbidity (Liver depletion) 2病證 (肝虛)	Hespero 金陽體質

Furthermore, the first paper related the traditional channel system to the splanchnic interrelations (Kuon, 1965:156). Specifically, the "five important points" - i.e. the five transport points (*osuhyŏl* in Korean or *wushuxue* in Chinese transliterations 五腧穴) system[208] - were emphasized to regulate the relations among the internal organs (ibid.). Notably, inspired by the

Soyang person 少陽人	Spleen Cold-based Exterior Cold Disorder 脾受寒表寒病	The second morbidity (Kidney depletion) 2病證 (腎虛)	Saturno 土陽體質
	Stomach Heat-based Interior Heat Disorder 胃受熱裏熱病	The first morbidity (Stomach repletion) 1病證 (胃實)	Saturna 土陰體質
Taeeum person 太陰人	Oesophagus Cold-based Exterior Cold Disorder 胃完受寒表寒病	The second morbidity (Large intestine depletion) 2病證 (大腸虛)	Jupita 木陰體質
	Liver Heat-based Interior Heat Disorder 肝受熱裏熱病	The first morbidity (Liver repletion) 1病證 (肝實)	Jupito 木陽體質
Soeum person 少陰人	Kidney Heat-based Exterior Heat Disorder 腎受熱表熱病	The first morbidity (Kidney repletion) 1病證 (腎實)	Mercurio 水陽體質
	Stomach Cold-based Interior Cold Disorder 胃受寒裏寒病	The second morbidity (Stomach depletion) 2病證 (胃虛)	Mercuria 水陰體質

[208] A dictionary of Chinese medicine explains about the five transport points as follows: "Any of a series of five points below the elbows or knees on each of the twelve channels. The five points are the well (*chŏng* in Korean or *jing* in Chinese transliteration 井), brook/spring (*hyŏng* or *rong* 滎), stream (*su* or *shu* 輸), channel/river (*gyŏng* or *jing* 經), and uniting (*hap* or *he* 合) points. … The names well, brook, stream, channel, and uniting reflect the nature of the flow of qi at each of these points. The ancient Chinese likened the flow of qi in the channels to the flow of water from its source in the mountains to its home in the sea. At the well points, which are located at the ends of the digits, the qi is shallow and meek. At the brook points, on the hands and feet, the qi has a gushing quality. At the channel points in the area of the wrist and ankle, the qi is described as being like water pouring downward from a shallow place to a deeper one. At the river points on the forearm and lower leg, the qi has developed into a powerful flow. At the uniting points at the knees and elbows, the qi goes deep into the body to unite with its home organ, just as a river flows into the sea. These names are only intended to describe the nature of the qi at each of the five points; they are not intended to indicate the direction of the flow of qi" (Wiseman and Feng, 1998:207). In addition, each of five transport points on one channel corresponds to one of the Five Phases (*wuxing* 五行). Namely, the well, brook, stream, channel, and uniting points on the yang channels correspond to the wood, fire, earth, metal, and water, respectively; whereas those on the yin channels to the metal, water, wood, fire, and earth. This connection with the Five Phases enables various combinations of acupoints for the treatment of twelve channels and *zangfu* organs, by replenishing or depleting them through managing the five transport points.

five transport points system, Dr. Seo devised the concept of the "transmissive point"[209], which has only the function for sending the *qi* of the self-organ[210] to the other four organs, and the "receiving points"[211], which have only the roles for getting the *qi* for the self-organ from the four other organs (ibid.:157).

In addition, he introduced a new way of pulse diagnosis to determine the eight (morbid or physiological) pulse images of the organs (Kuon, 1965:165). This method of pulse diagnosis took the patient's both hands and touched the three points of the patient's wrist which locations were the same as *cun guan chi* (寸關尺).[212] However, Dr. Seo's method was different in that it aimed at getting the eight comparison-figures by sensing the six parts of both hands at the same time (ibid.:166).[213] Besides providing the diagrams for the pulse images of the eight morbidities, he did not particularly elaborate about the rationale of why particular pulse image

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[209] It is called *songhyŏl* (送穴) in Korean in Dr. Seo's later writings.

[210] Dr. Seo defines the self-organ as the organ to which a transmissive point belongs. This also corresponds to the self-channel (Kuon, 1965:159-60). For example, if a transmissive point is *kyŏnggŏ* (*chingchu* or LU8 經渠), the self-organ is the Lungs and the self-channel is the Lung channel system.

[211] It is called *suhyŏl* (受穴) in Korean in Dr. Seo's later writings.

[212] In terms of the positions of the pulse diagnosis, the first paper explains like this: "the positions of the pulse under the doctor's first finger (that is, the index finger), ... is the very A. radialis beside the part of the palm side highest bone of the patient's processes styloides radialis [radial styloid process]. The doctor's first finger should be as a bridge laid between the upward inclined plane of the part and the line of M. flexor carpi radialis, the tip of the finger being almost touched to the M. palmaris longus of the patient. And after his adjusting the finger feelings, so as to be able to observe the A. radialis under the finger, the doctor should in order lay both his second and third fingers according to the same method. His right fingers should be laid on the patient's left hand; and his left ones, on the latter's right one" (Kuon, 1965:166).

[213] The first paper describes the process of the pulse diagnosis like this: "He [the doctor] should press down both the pulse and muscle of the patient with an equal pressure, using his three fingers. By pressing them down as hard as possible vertically when the patient's muscle is elastic, or by doing so through pulling it toward the patient's radius when it is inelastic, the doctor should try to find out under which finger the pulse remains strongly to the end" (Kuon, 1965:166).

is sensed for a certain morbidity. It was just thought to be related to the *zangfu* interrelations of strength and weakness such as strong Lungs and a weak Liver (*p'yedae-ganso* 肺大肝小). For example, if the doctor sensed a strong pulse on the position of the Lungs and a very week one on the Liver position, it would be regarded as *p'yedae-ganso* and the first morbidity of the Taeyang person or the Hespera (see Figure 6.3).

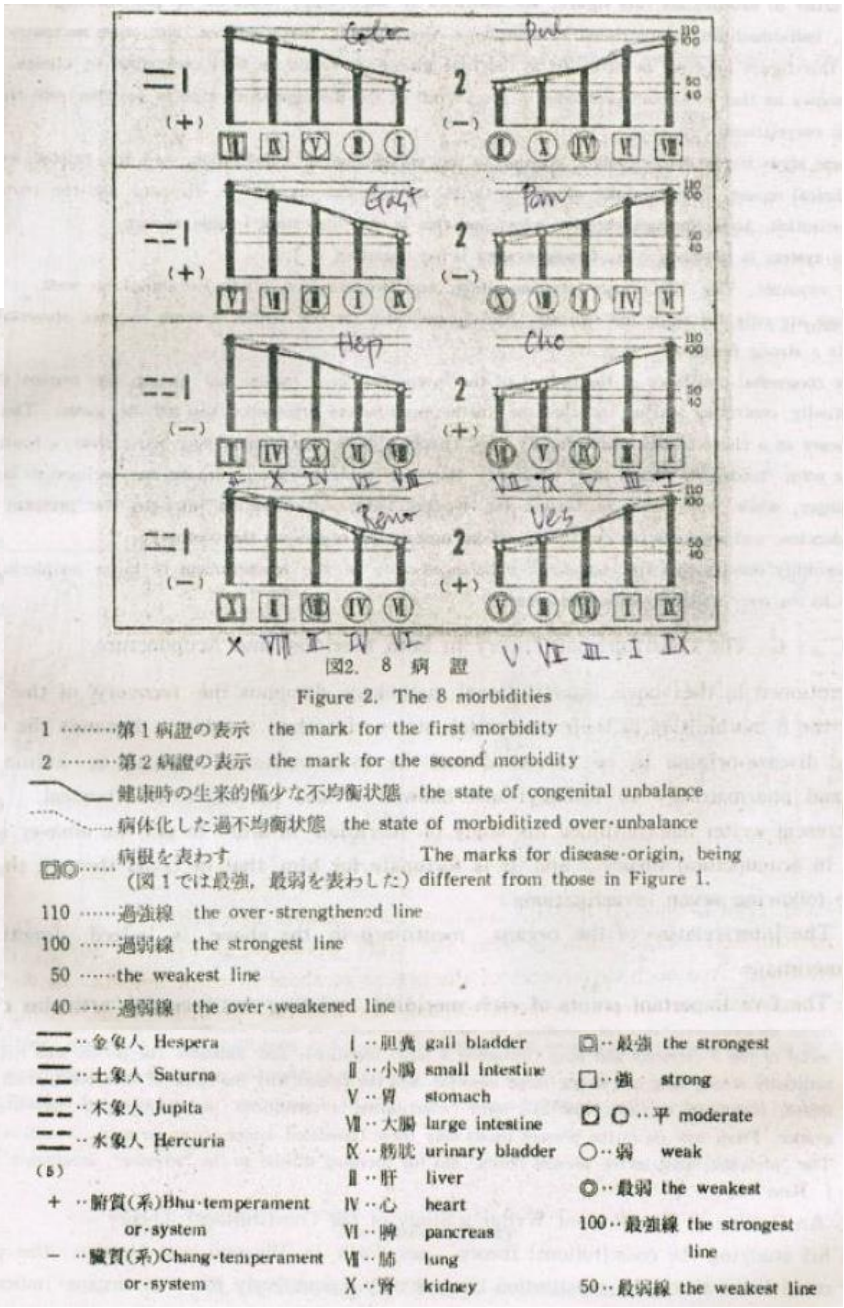


図2. 8 病 證

Figure 2. The 8 morbidities

1 ……第1病證の表示 the mark for the first morbidity

2 ……第2病證の表示 the mark for the second morbidity

健康時の生来的僅少な不均衡状態 the state of congenital unbalance

病体化した過不均衡状態 the state of morbiditized over-unbalance

病根を表わす (図1では最強，最弱を表わした) The marks for disease-origin, being different from those in Figure 1.

110 ……過強線 the over-strengthened line

100 ……過弱線 the strongest line

50 ……the weakest line

40 ……過弱線 the over-weakened line

〓 ··金象人 Hespera
〓 ··土象人 Saturna
〓 ··木象人 Jupita
〓 ··水象人 Hercuria

(5)

\+ ··陽質(系)Bhu-temperament or-system

− ··陰質(系)Chang-temperament or-system

Ⅰ ··胆嚢 gall bladder
Ⅱ ··小腸 small intestine
Ⅴ ··胃 stomach
Ⅶ ··大腸 large intestine
Ⅸ ··膀胱 urinary bladder
Ⅲ ··肝 liver
Ⅳ ··心 heart
Ⅵ ··脾 pancreas
Ⅷ ··肺 lung
Ⅹ ··腎 kidney

◘ ··最強 the strongest
□ ··強 strong
□ ○ ··平 moderate
○ ··弱 weak
◎ ··最弱 the weakest
100 ··最強線 the strongest line
50 ··最弱線 the weakest line

Figure 6.2. Dr. Seo's Visualization of the Comparison of the Functions of *zangfu* (viscera and bowels) in Each Constitution in the First Paper (Kuon, 1965:154-5). He developed his own nomenclature of the four constitutions, *zangfu* organs, etc. As seen in the figure, Sasang constitutions were called different names: a Taeyang person to Hespera (═ 金象人), a Soyang person to Saturna (═ 土象人), a Taeeum person to Jupita (═ 木象人), and a Soeum person to Hercuria (═ 水象人). Two types of disorders of each Sasang constitution in *Donguisusebowon* were called eight morbidities. Specifically, Dr. Seo designated "Bhu-temperament" (臟質) as "+" (positive or *yang*) and "Chang-temperament" (腑質) as "-" (negative or *ŭm*) to classify each constitution's disorders into two morbidities. The names of *zangfu* organs were replaced to Roman numerals and some signs were used to indicate the relative state of strength or weakness.

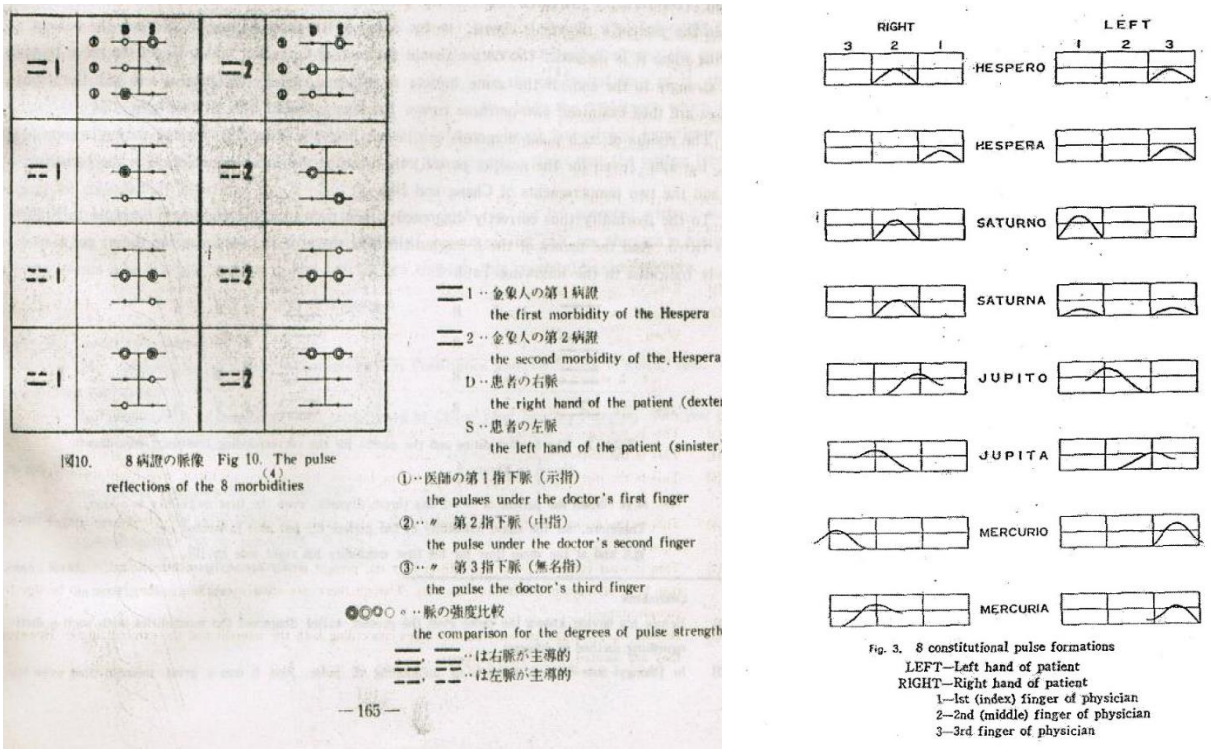


図10. 8病證の脈像 Fig 10. The pulse reflections of the 8 morbidities (4)

Figure 6.3. Dr. Seo's Visualization of the Pulse Images on the Eight Morbidities in the First Paper (left) and the Pulse Images on the eight Constitutions in the Second Paper (right) (Kuon, 1965:165; 1973:301).

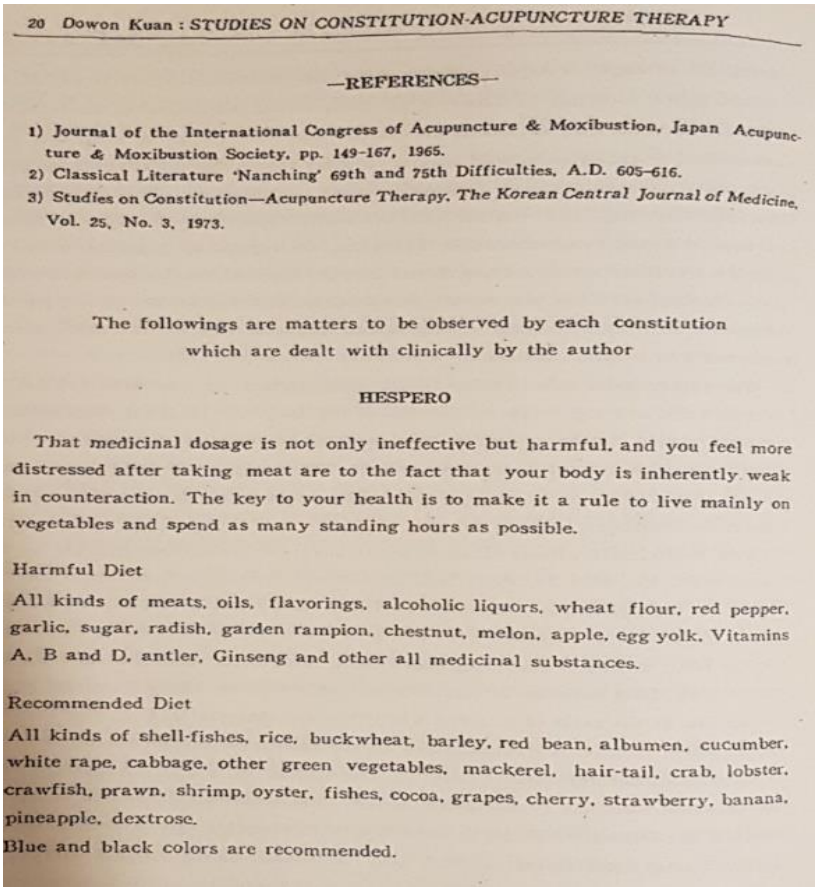
In the second paper published in 1973, Dr. Seo discussed the eight constitutions more directly. First of all, he used the term "eight constitutions" by not using the terms to indicate Sasang constitutions such as Taeyang, Soyang, Taeeum, or Soeum. Instead, he confirmed to

use his own designated terms for each constitution: Hespero (*kŭmyang-ch'ejil* 金陽體質), Hespera (*kŭmŭm-ch'ejil* 金陰體質), Saturno (*t'oyang-ch'ejil* 土陽體質), Saturna (*t'oŭm-ch'ejil* 土陰體質), Jupito (*mokyang-ch'ejil* 木陽體質), Jupita (*mokŭm-ch'ejil* 木陰體質), Mercurio (*suyang-ch'ejil* 水陽體質), and Mercuria (*suŭm-ch'ejil* 水陰體質) (Kuon, 1973:331).[214] The second paper also confirmed the eight distinct pulse "formations" of the inherent eight constitutions (ibid.:330), which was formally described as the eight "reflections" of the morbidities of Sasang constitutions. In addition, the second paper provided six sets of acupuncture formulas for the first time which could be applied to each constitution, namely, Fundamental formulas (*kibonbang* 基本方), Vitalization formulas (*hwallyŏkpang* 活力方), Bactericidal formulas (*salgyunbang* 殺菌方), Paralysis formulas (*mabibang* 麻痺方), Psycho formulas (*chŏngshinbang* 精神方), and Inflammation formulas (*yŏmjŭngbang* 炎症方) (ibid.:334-9). Simply put, the fundamental formulas represented the basic treatment to be necessarily preceded in all treatment of each constitution. The paper added that auxiliary formulas – i.e. the rest five sets of formulas - might be applied additionally according to the nature of disorders. Interestingly, all indications of the five sets of formulas were biomedical diseases such as "neuralgia", "all bacterially caused diseases", "abnormality of autonomic

[214] The naming of the eight constitutions was continuously revised afterwards. Nowadays, they are called Pulmotonia (金陽體質), Colonotonia (金陰體質), Pancreotonia (土陽體質), Gasrotonia (土陰體質), Hepatonia (木陽體質), Cholecystonia (木陰體質), Renotonia (水陽體質), and Vesicotonia (水陰體質) (Jung, 2012:23). For the details of the changes in eight-constitution names, see Jung (ibid.).

nerves" or "arthritis and osteomyelitis". There was no specific explanation about such connections as arthritis and osteomyelitis, but it was assumed that Dr. Seo regarded the "organs" in ECM as identical to the biomedical organs, whereas proponents of SCM circles are cautious about directly relating SCM organs to biomedical ones.

Furthermore, a revised version of the second paper included life and dietary guidelines to each constitution (Kuon, 1974:602-6). Jung (2012:83) analyses that Dr. Seo legitimised the constitutional diet by arguing that animals are classified by species such as carnivores, herbivores, and omnivores but that only humans are classified into various constitutions in the homogenous species. Also, Dr. Seo contended that the customized constitutional diet for each



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The followings are matters to be observed by each constitution which are dealt with clinically by the author

HESPERO

That medicinal dosage is not only ineffective but harmful, and you feel more distressed after taking meat are to the fact that your body is inherently weak in counteraction. The key to your health is to make it a rule to live mainly on vegetables and spend as many standing hours as possible.

Harmful Diet

All kinds of meats, oils, flavorings, alcoholic liquors, wheat flour, red pepper, garlic, sugar, radish, garden rampion, chestnut, melon, apple, egg yolk, Vitamins A, B and D, antler, Ginseng and other all medicinal substances.

Recommended Diet

All kinds of shell-fishes, rice, buckwheat, barley, red bean, albumen, cucumber, white rape, cabbage, other green vegetables, mackerel, hair-tail, crab, lobster, crawfish, prawn, shrimp, oyster, fishes, cocoa, grapes, cherry, strawberry, banana, pineapple, dextrose.

Blue and black colors are recommended.

Figure 6.4. An Example of the Section for Dietary and Life Guidelines in Dr. Seo's Second Paper of 1974[215]

[215] For reference, the papers which Dr. Seo published in English are as follows.

constitution is a combination of foods which supplement the weakened organ of a certain constitution avoiding foods which further reinforcing the already strong organ. This logic was based on his thought that food does not affect the entire *zangfu* organs but rather only one organ (ibid.83-4). Dr. Seo thought it could also be applied to other domains such as exercise, occupations, or various lifestyle habits, just as the Five Phases could be applied to myriad domains (see. Figure 6.4).

In summary, Dr. Seo made six new inventive thoughts. First, he understood the main theoretical framework in *Donguisusebowon* as a *zangfu* interrelation theory. It was distinctive in that he did not put stress on philosophical or virtuous aspects appeared in the classical text, which many other masters of Sasang medicine scrutinized. Second, he related the traditional channel system to this understanding of *zangfu* interrelations, particularly adapting the five transport points system. This attempt of connection was possible based on the premise that [functions and statuses of] *zangfu* organs in Sasang medicine are not different from [those of] *zangfu* organs in the traditional understanding of East Asian medicine. Third, he considered two disorder groups in one Sasang constitution category of each constitutional character, by proposing eight constitutions instead of four. In doing so, fourth, he devised basic and applied acupuncture formulas customized to each of the eight constitutions. It was almost

Alias	Title	Year	Journal Name
The First Paper	A Study of Constitution-Acupuncture	1965	Journal of the International Congress of Acupuncture & Moxibustion
The Second Paper	Studies on Constitution-Acupuncture Therapy	1973	The Korean Central Journal of Medicine
The Second Paper (revised version)	Studies on Constitution-Acupuncture Therapy	1974	*Myŏngdae nonmunjip* (Myongji University Journal)

It should be noted that there was an unpublished article by Dr. Seo written in 1962, which contains the initial ideas of ECM. Lee (2019:71-80) provides detailed explanation on this unpublished article.

unprecedented because no one ever thought of specialised acupuncture methods for each constitution by that time. Most practitioners of Sasang medicine largely focused on herbal prescriptions as highlighted by Yi Chema. Fifth, Dr. Seo further developed customised diet and lifestyle guidelines for each constitution. Although some guidelines were mentioned in the classical texts of Sasang medicine such as *the Posthumous Work of Tongmu: the Pogŏnsŏng edition* (保健省 東武遺稿), Dr. Seo did not just reclassify them but also added new items even including Western drugs such as vitamin or glucose. Sixth, perhaps the most important thing is that Dr. Seo presented the above ideas in a new stylistic form of 'journal articles', not as a clinical book of 'experience' or a translation or commentary of the classical texts of Sasang medicine. Although he referred to Sasang medicine at the initial stage, he finally drew a boundary against Sasang medicine and claimed that ECM is a completely new medicine. This attitude might correspond to the frequently cited definition of innovation as 'the doing of new things or the doing of things that are already being done in a new way' (Hsu, 2001:4; originally from Schumpeter (1947:151)). Furthermore, such Dr. Seo's attitude was quite contrasted to the way other Sasang masters' advocated the old (or the classical texts), just as Sima Qian created the model for the dynastic histories of the following two thousand years but also indirectly alluded to Confucius' words 'I transmit and do not create' (Hsu, 2001:5; originally from Durrant (1995:11)). In this way, Dr. Seo's ECM was unprecedented and innovative in the history of Sasang medicine.

Last but not least, there is one thing which needs to be further explored. As we have seen, the first paper in 1965 did not try to break away from Sasang medicine, whereas the second paper makes clear that ECM is distinctive from Sasang medicine. Jung (2012:24) explains that the first paper intended to devise the acupuncture of Sasang medicine, and the

second paper was of the establishment of the eight-constitution acupuncture. Then how was the change possible between the publications of the two papers? And what happened between 1965 and 1973? The next session will explore these questions. However, it will not trace the whole history of ECM or the systems of ECM in general[216] but more pay attention to how ECM became distinctive from Sasang medicine and how ECM could be diverged from Sasang medicine, by examining a dispute on a KM journal in the late 1960s.

The Dispute

As well as presenting at the International Congress of Acupuncture in Tokyo in October 1965, Dr. Seo wrote its condensed versions for the official journal of the Society of Korean Medicine, the *Bulletin of Korean Medicine* (*taehan hanŭihakh'oebo* 大韓漢醫學會報), which was the predecessor of the *Journal of Korean Medicine* (*taehan hanŭihakh'oeji* 大韓韓醫學會誌) in May 1965 and in January 1966. The former was to report the outline of the presentation to the association members in Korean language before the conference, and the latter was to provide a concise version of the final presentation to the members in both English and Korean after the conference. Dr. Chu, a master of Sasang medicine and the then chairman of the Society of Korean Medicine wrote a critique on Dr. Seo's constitution-acupuncture theory in the same bulletin in January 1966. Dr. Chu raised a problem that the idea of the "splanchnic interrelation theory" seemed not to be based on Sasang medicine. Furthermore, he criticized that Dr. Seo

[216] For the detailed process of the ECM practice, see Taewoo Kim (2010:155-162).

did not take account of the 'intrinsic' *zangfu* relations in Sasang medicine, i.e. the corresponding relations of Lung-Oesophagus (*p'ye-wiwan* 肺-胃脘), Spleen-Stomach (*pi-wi* 脾-胃), Liver-Small Intestine (*kan-sojang* 肝-小腸), and Kidney-Bladder (*shin-panggwang* 腎-膀胱). By doing so, Dr. Chu reprehended that Dr. Seo was just following the existing *zangfu* theory, taking the exterior-interior relations (*p'yorigwan'gye* 表裏關係) of Lung-Large Intestine (*p'ye-taejang* 肺-大腸), Spleen-Stomach (*pi-wi* 脾-胃), Liver-Gall Bladder (*kan-tam* 肝-膽), Heart-Small Intestine (*shim-sojang* 心-小腸), and Kidney-Bladder (*shin-panggwang* 腎-膀胱) for granted (Hong, 1966:158).

Dr. Chu also commented on Dr. Seo's "diagnostic method of constitutional pulses" (*ch'ejil maekchin* 體質脈診), which did not appear in Yi Chema's writings. He considered that Dr. Seo's new way of pulse diagnosis would lead to the same conclusions with the existing method of pulse diagnosis because he extrapolated that Dr. Seo's pulse diagnosis related not just pulse images to the constitutions but also could relate patterns of disorders with the same pulse images, which would be regarded as not entirely innovative. For this reason, Dr. Chu even argued that the way of pulse diagnosis used in the Five Phase acupuncture could be better than Dr. Seo's idea of pulse diagnosis because he thought that the constitutional diagnosis and the pattern differentiation could become mixed up if Dr. Seo's method was applied (ibid.:159).

In the next issue of the same bulletin in February 1966, Dr. Seo disputed the criticism with a fierce tone, using the title "the truth ignored" (*muksaltanghan chilli* 默殺당한 眞理)

for his counterargument article (Kuon, 1966:37). He insisted on his position that the properties of the Five Phases (五行) of *zangfu* remained unchanged even in Yi Chema's *zangfu* theory. In other words, Dr. Seo, Yi Chema still admitted the knowledge of the traditional *zangfu* theory which function is explained by the Five Phases theory, but just discussed the differences of strength or weakness of organs according to the four constitutions (ibid.). He criticized Dr. Chu's argument, insisting that Dr. Chu's account of the *zangfu* theory in Sasang medicine as the exterior-interior relations of Lung-Oesophagus, Spleen-Stomach, Liver-Small Intestine, and Kidney-Bladder is a misunderstanding. Dr. Seo explained that these couplings of *zangfu* organs did not reflect the *zangfu* relations based on the Five Phase theory. He argued that each of the Five Phases attributes for an organ, such as the Fire attributes for Small Intestine (小腸-火) or the Metal attribute for Large Intestine (大腸-金) were unchangeable designations and those were expressions of the intrinsic physiology in Korean, Chinese and other East Asian medicines. In other words, he insisted that the physiological functions of Small Intestine in Chinese, Korean medicines, and Sasang medicine, and even Western biomedicine have common ground, although they were expressed in different words or concepts. To Dr. Seo, the attribute of the Fire was merely used in East Asian medicines to denote the function of Heart and Small Intestine. Moreover, he believed that Yi Chema insisted not on the changes of the intrinsic *zangfu* relations but on the various arrangements of the strength and weakness of the *zangfu* functions according to the Sasang constitutions.

In other words, to Dr. Seo, the reason why Yi Chema omitted the explanation of the established *zangfu* theory in *Donguisusebowon* was that he just took the theory for granted. Dr. Seo contended that the constitutional theory in *Donguisusebowon* reorganised the

understandings of human physiology, pathology, and treatments in a new way, but it was not about a cataclysmic change of the basic principles such as the Five Phases or the *zangfu* exterior-interior theory. According to Dr. Seo, "Yi Chema just established a framework of a new medicine, but did not complete it" (Kuon, 1966:209). To put it another way, the main controversial issue between Dr. Seo and Dr. Chu was whether to admit the Five Phases theory into Sasang medicine. The fact was that Yi Chema did not mention the Five Phases in his writings, but Dr. Seo and Dr. Chu did not agree with each other whether Yi Chema took for granted the Five Phase theory or rejected it.

Dr. Chu did not officially reply to Dr. Seo's counterargument because any article by him on this dispute was no longer published. It seemed that those two renowned people in the world of Sasang medicine drifted apart afterwards. At the time of the dispute, Dr. Seo was a lecturer of Sasang medicine at Seoul University College of Korean Medicine after serving as a vice-president of the Association for Sasang Medicine (*sasang ŭihak'oe* 四象醫學會) in the late 1950s, which was the precursor of the Society of SCM, while Dr. Chu was the then chairman of the Society of Korean medicine (elected on 20th April 1965). Just as Sasang medicine, their devout Christian faith was also an important factor to bring them closer at the initial stage (Lee, 2019:54). However, Dr. Seo was not included in the list of the board members when Dr. Chu became the first president of the Korean Society of Sasang Medicine (*taehan sasangŭihak'oe* 大韓四象醫學會) in 1970 (The Society of Sasang Constitutional Medicine, 2010:22), which encompassed most core members of the circle of Sasang medicine as its board members and aimed to be recognised as an official sub-society of the Society of Korean Medicine. Instead, as we already have seen, Dr. Seo published his second paper in the *Korean*

Central Journal of Medicine in 1973, which mostly contained biomedical articles. After Dr. Seo published the second article, he began to make wide use of the "eight constitutions" or the "eight-constitution medicine". This looked like heresy from the viewpoint of the mainstream circle of Sasang medicine practitioners who only worked with four constitutions. Since then, ECM has never been taught in the KM schools. Vice versa, the ECM group also argued that their medicine had a completely different theory and framework from Sasang medicine.

As demonstrated above, ECM had two aspects depending on which side people look at it. On the one hand, ECM was an 'innovation' because it brought a novel acupuncture method customized to different constitutions, which the world of Sasang medicine did not see before. Along the way to develop such method, Dr. Seo made various inventive thoughts putting physiological and pathological theories, diagnostic methods, and caring methods of health. On the other hand, people at the 'mainstream' side of Sasang medicine countered Dr. Seo's claim evaluating that it was mixing the traditional *zangfu* theory which explains the relationship of *zangfu* organs based on the Five Phases theory. It could be seen as 'contammination' in their view. Unlike the case of Dr. Won's Sasang medicine presented in the previous section, the [official] dispute – which was very rare to see on the frontstage of the history of Sasang medicine - was possible because Dr. Seo was also once in the mainstream circle of Sasang medicine taking positions at the society of Sasang medicine as well as the university. Since the time of the dispute, the SCM society and Dr. Seo's group have been completely separated. One was active on the institutionalised sector and the other in the private sector. Whereas ECM has lost its legitimacy in Sasang medicine, it has attempted to have a status as an independent discipline, just as Sasang medicine tried to be from the existed Korean medicine. This is a good example of a discourse on *chejil* being derived from the same origin but diverged into different paths.

6.4. Diverse Practices for Clinical Practicableness

This part deals with two cases of KM doctors practicing 'Sasang medicine' in the private sector. Each of them concentrated on different parts of Yi Chema's writings and developed them with innovative ideas of hybridity. In this part, I argue that those cases are the results of pursuing clinical practicableness by kneading[217] the knowledge of Sasang medicine. During the interviews with the KM doctors, I observed that their clinical practice had two sides in common: one consisted of seeking Yi Chema's authentic intention by studying and analysing his writings; another was appropriating external medical knowledge to Sasang medicine for their clinical practice. Unlike the cases of Drs Won, Chu, Eom, or Seo, the KM doctors in the following cases were from a later generation so that they were not very much adhered to the legitimacy issue. Therefore, the hybridization in their practice could be read as efforts to adjust the classical knowledge of Sasang medicine to 'effective' clinical practice. Particularly, this part focuses on how the diverse translations on constitutions (*chejil*) are possible by exploring different perspectives on constitution diagnosis. This investigation is fulfilled by in-depth interviews and archival research on the KM doctors' writings and relevant sources.

'Measurable' Sasang Types: Dr. Yoon and the Body Structure and Shape in Sasang

Dr. Yoon was one of the well-known figures in the field of Sasang medicine in South Korea.

[217] I borrowed this term from cooking, which meaning is "to mix and work up into a homogenous plastic [malleable] mass, by successively drawing out, folding over, and pressing or squeezing together" (OED Online, 2020). The dough in kneading, I would argue, could be classical texts of Sasang medicine.

He was most known for inventing a body measuring method for Sasang constitutional diagnosis. Originally educated at Seoul National University[218], he later decided to succeed his family business of running a KM clinic so that he entered Seoul University of Korean Medicine in 1970 to become a KM doctor. Dr. Yoon's father (1921-1995) was a renowned KM doctor who was an autodidact of KM who had passed the national KM qualification exam. His father was an active member of the Hwayo Society of Oriental Medicine (*hwayo hanŭihak'oe* 火曜漢醫學會), which brought together many elders of the KM world, including Dr. Chu and Professor Lee, every Tuesday evening for academic seminars. (Namil Kim, 2003). Its legacy had come down to the Society of the Body Structure and Shape in Sasang (*ch'ehyŏng sasanghak'oe* 體形四象學會), which was led by Dr. Yoon (Namil Kim, 2011:446).

When I interviewed Dr. Yoon, he told me that he also attended the regular meetings of the Hwayo Society following his father and could see many KM doctors discussing KM theories and practice, especially Sasang medicine. Dr. Yoon's father devised a diagnostic method for examining the body structure and shape, which Dr. Yoon refined into the Body Trunk Measuring Method (*Ch'egan ch'ŭkchŏng-bŏp* 體幹測定法) (ibid.). Dr. Yoon published on its usefulness in his doctoral thesis at Seoul University in 2001, under the guidance of Professor Lee. This meant that this method was more or less recognised by the Society of SCM although he did not take the residents' training of Sasang medicine. Furthermore, it might be the reason why his method was circulating in institutional settings, that is, in the clinical

[218] For his brief profile, see the website of his clinic (http://www.xn--sp5ba12bhzv89b.com); retrieved on 18 December 2020).

training of Sasang medicine at Hanguk University and in the scientific project for the development of the Sasang diagnostic tool at the National Research Institute of Korean Medicine (NRIKM). It might be also possible because he aimed at a measurable standard of "objectivity, reproducibility, and convenience"[219] of the Sasang constitution diagnosis.

Dr. Yoon explained to me that his idea of measuring the body parts for diagnosis derived from two paragraphs from *Donguisusebowon* of 1901. One was from the *Treatise on* zangfu (臟腑論) as follows:

> The area of the lungs corresponds to the region below the neck and above the back. The area of the oesophagus corresponds to the region below the jaw and above the chest. Hence, the region above the back and the chest is the upper-*jiao*.
> The area of the spleen corresponds to the mid-back area. The area of the stomach corresponds to the diaphragm area. Hence, the region between the mid-back area and the diaphragm is the upper-middle-*jiao*.
> The area of the liver corresponds to the waist. The area of the small intestine corresponds to the navel level. Hence, the region between the waist and the navel is the lower-middle-*jiao*.
> The area of the kidneys corresponds to the area below the lumbar. The area of the large intestine corresponds to the region below the navel-abdomen area. Hence, the region below the lumbar and the navel is the lower-*jiao* (Choi, 2009:55; with modificatons).

> 肺部位在頸下背上 胃脘部位在頷下胸上 故背上胸上以上謂之上焦.
> 脾部位在膂 胃部位在膈 故膂膈之間謂之中上焦.
> 肝部位在腰 小腸部位在臍 故腰臍之間謂之中下焦.
> 腎部位在腰脊下 大腸部位在臍腹下 故脊下臍下以下 謂之下焦.

Dr. Yoon argued that the above paragraph illustrated the four different compartments of the body torso which could be developed outwardly according to the relationships of strength and weakness in *zangfu* organs of each Sasang constitution. For example, if the *zangfu* relation

[219] See the website of his society (http://www.chehyung.com/shop/main/html.php?htmid=service/menu2_3.htm); retrieved on 18 December 2020.

of a Taeyang person was to have “a large lung and a small liver” (肺大肝小), as described in *Donguisusebowon*, Dr. Yoon’s unique logic was that the outward compartment of the lungs of the Taeyang person should be *physically* (or *seemingly*) larger than that of the liver, and their *physical* descriptions were specified in the paragraph. In other words, he interpreted *dae* (large 大) and *so* (small 小) in the phrase as the physical size of specific areas of the body. Moreover, Dr. Yoon emphasized sensible interpretations of the classical texts as these still had abstract points. For instance, the phrases of “the neck/upper back region” (頷下背上) and the region “below the jaw and above the chest” (頷下胸上) needed to be more clarified to measure the corresponding body parts. Dr. Yoon pointed out that it could be problematic if the word 頷 is to be translated as “a protuberant brow”, which was the literal meaning. Instead, he argued that it should be translated as *taech'u-hyŏl* (大椎穴; GV14), which anatomical location was just below the spinous process of the 7th cervical vertebrae, considering the height of the jaw from the symmetrical phrase “below the jaw and above the chest” (頷下胸上). As for the term “below the jaw” (頷下), he suggested that it should be the point of *ch'ŏndol-hyŏl* (天突穴; CV22) because it is the point where the jaw could be reached when the chin is pulled downward to the torso. Likewise, he established concrete points of the body corresponding to the descriptions based on the anatomical knowledge and devised five lines on the torso which represent spatialized functions of certain organs in Sasang medicine.

In addition, another paragraph from *the Treatise on the Pattern Differentiations of People with Sasang* (*sasangin pyŏnjŭngnon* 四象人辨證論) in the same book was emphasized to demonstrate the spatial relations of *zangfu* functions in Sasang medicine:

The Taeyang person has a developed nape for the rising posture and a slender waist for the standing posture. The Soyang person has a developed chest for the self-embracing posture and small hips for the sitting posture. The Taeeum person has a thick waist for the standing posture and a weak nape for the rising posture. The Soeum person has a developed hips for the sitting posture and a weak chest for the self-embracing posture (Choi, 2009:239; with modifications).

太陽人 體形氣像 腦頴之起勢[220] 盛壯而 腰圍之立勢 孤弱

少陽人 體形氣像 胸襟之包勢 盛壯而 膀胱之坐勢 孤弱

太陰人 體形氣像 腰圍之立勢 盛壯而 腦頴之起勢 孤弱

少陰人 體形氣像 膀胱之坐勢 盛壯而 胸襟之包勢 孤弱

Dr. Yoon appropriated the above paragraph to support his idea of comparing those five lines for the constitution diagnosis. Adding his clinical experience and biomedical knowledge, he provided the four types of the torso according to Sasang constitutional characteristics (see Figure 6.7). Hence, a practitioner should read physical tendencies of patients' torsos for the constitution diagnosis taking the measurements of length of the five lines.

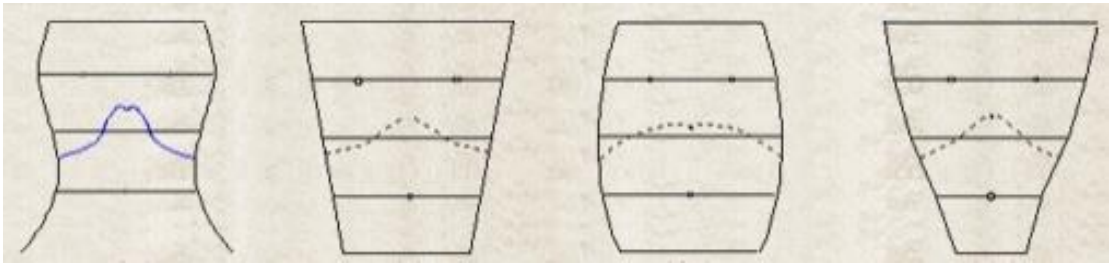

Figure 6.5. The Diagrams of Sasang Constitutions with the Five Lines (from the left; the So-eum person, the So-yang person, the Tae-eum person, and the Taeyang person).[221] The five lines which Dr. Yoon devised are like the following: The first line is the lineal distance between the coracoid processes of the left and right side of the body; the second line is the straight distance between the lines at the red-white flesh borders (*chŏkpaekyukche* 赤白肉際) of both armpit regions; the third

[220] Hsu (2018:93) follows Jullien (1995:85) in explaining *shi* (*se* in Korean pronunciation, 勢) as 'a propensity' that "emanates from its constitution". She imputes it into "aesthetic implications, which evoke awareness of the invisible of cosmic potentialities and of the depth and power of human emotion" (ibid.). However, in Dr. Yoon's case, he paid more attention to the quantification of the body regions by measuring the length between anatomical points which would represent the *se* of each region.

[221] http://www.chehyung.com/shop/board/view.php?id=discern&no=8; retrieved on 27 February 2021.

> line is the straight distance which encompasses the extension of the line between *puryong-hyŏl* (不容穴; ST19) on the left and right to the red-white flesh borders of hypochondrium; the fourth line is the straight distance which connects the navel and *ch'ŏnch'u-hyŏl* (天樞穴; ST25) on the left and right and reaches to the red-white flesh borders of hypochondrium; the fifth line is the straight distance which connects the external sides of anterior-superior iliac spine (ASIS). The bent in each diagram indicates the coastal angle.[222]

Hence, Dr. Yoon focused on the term *ch'ehyŏng* (the body structure and shape 體形) and delved into this concept, by examining particular paragraphs and sentences in the classical texts and creatively interpreting them based on his clinical experience, specifically borrowing biomedical knowledge. Notably, as explained earlier, his method for the constitution diagnosis was adopted not only by his followers in private clinics but also by the SCM society and thus in the clinical training for Sasang medicine in KM schools. Although its beginnings were to improve "clinical accuracy and effectiveness" in the clinic of private KM practitioners, the incorporation into the institutional setting appears to have been made possible because of his pursuit of "objectivity, reproducibility, and convenience", which met the demands of the institutionalised sector such as "standardisation" and "scientisation'. Finally, last but not least he benefited from having studied for his doctorate under Professor Lee at the SCM department.

'Analytic Psychological' Sasang Types: Dr. Shim and the Sasang Mind Study

Dr. Shim was a well-known KM doctor for devising the Sasang Mind Study (*sasang shimhak*

[222] For more details, see the website of Dr. Yoon's society (http://www.chehyung.com/shop/main/html.php?htmid=service/menu2_4.htm; retrieved on 27 February 2021).

四象心學) or "Oriental Psychoanalysis Therapy".[223] As indicated in the title, it was known that the Sasang Mind Study paid attention to the mind-aspect of Sasang medicine and tried to integrate it with analytical psychology initiated by a Swiss psychiatrist Carl Gustav Jung (1875-1961). I met and interviewed Dr. Shim with Professor Jeong, who was my gatekeeper and Dr. Shim's schoolmate, although it had been almost 20 years since they had met. On 27th April 2018, Professor Jeong and I visited Dr. Shim's private clinic located in an upper/upper-middle class neighbourhoods of West Seoul, holding the interview mostly in a nearby restaurant while having dinner.

Dr. Shim attended Seoul University College of Korean Medicine in the early 1980s. He told me that the time he got interested in Sasang medicine was when he entered graduate school at his alma mater in the late 1980s. However, his major at the graduate school was "psychiatry" (*chŏngshin-gwa* 精神科)[224] rather than Sasang medicine. He explained that in the late 1980s and early 1990s "every professor made remarks on Sasang medicine while he was attending lectures of psychiatry", alluding that studying Sasang medicine was a trend at that time. However, he thought the professors' comments on Sasang medicine were inconsistent – because their understandings were based on different currents of Sasang medicine - and soon became dissatisfied with it. Hence, he decided to study Sasang medicine by himself to prove "it is false". He firstly bought books from all currents of Sasang medicine which were available

[223] "The Oriental Psychoanalysis Therapy" is the English translation of *sasang shimhak* used by Dr. Shim in his article, but in my thesis I prefer to use the literal translation "Sasang Mind Study" to reveal the underlying meaning of the Korean term *sasang shimhak*.

[224] During the interview, Dr. Shim often used the term, *chŏngshin-gwa*. In this context, it is an idiomatic form for 'neuropsychiatry of Korean medicine' (*hanbang-shin'gyŏng-jŏngshin-gwa* 韓方神經精神科), which is one of the eight official specialities in Korean medicine.

at that time. He said most of the books added arbitrary interpretations, so he decided to study not only Sasang medicine but also Yi Chema's intellectual trajectory. That is, he started to read the Four Books (四書).[225] He inferred that Yi Chema might also have studied them to take the national civil service examinations in the Chosŏn dynasty. As his study progressed, he realised that several terms in the *Supplementary Annotations to the Classic of the Heart*[*-Mind*] (*shimgyŏng buju* 心經附註)[226] and the *Reflections on Things at Hand* (*kŭnsarok* 近思錄)[227] were overlapped with ones in *Donguisusebowon*. It was based on a thought that most Confucian scholars of the Chosŏn dynasty used to read those books.[228] After he gained an understanding of Sasang medicine, which he considered his own, he and his graduate colleagues in the department of KM neuropsychiatry did a joint study with KM doctors in the department of Sasang Constitutional Medicine at the same university. By doing so, he figured out how Sasang

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[225] The Four books are classical texts for Confucianism, which consist of the *Great Learning* (*taehak* 大學), the *Doctrine of the Mean* (*Chungyong* 中庸), the *Analects* (*Nonŏ* 論語), and the *Mencius* (*Maengja* 孟子).

[226] Its original script, the Heart Classic (心經), is written by Chen Dexiu (陳德秀; 1178-1235), a major Neo-Confucian scholar and official in the late Song dynasty. It is a collection of passages from the Confucian classics as well as Song Neo-Confucian writings. It is based on Chen's emphasis that the rectification of the heart[-mind] is the foundation of self-cultivation (Taylor and Choy, 2005:53). Later, a Confucian scholar Cheng Minzheng (程敏政; 1178-1235) of the Ming dynasty added supplementary annotations.

[227] The *Reflections on Things at Hand* (published in circa 1175) is an anthology of Neo-Confucianism compilated by Zhu Xi (朱熹; 1130-1200). There is an English translation of this book. See Zhu, Lü and Chan (1967).

[228] Yi Hwang (李滉; 1502-1571; pen name: Toegye 退溪), one of the most prominent Korean Confucian scholars of the Chosŏn dynasty, was known as a faithful scholar of Zhu Xi's philosophy. In his study of Zu Xi's works, he attached much importance to the *Supplementary Annotations to the Classic of the Heart* (心經附註). Unlike scholars of Zhu Xi who did not highly regard or even criticized the book, Toegye rejected such criticism and maintained that the book was as essential as the *Four Books* (四書) and *Reflections on Things at Hand* (近思錄) (Hyoungchan, 2018:34). According to Hyoungchan Kim (ibid.), Toegye encouraged young scholars to read this text and it probably made a great influence in Korean Confucianism

medicine was studied in the SCM department, and he later kept his distance from their approach. Since then, he and several KM doctors following him formed a study group for the Sasang mind study (四象心學研究會) and had been having regular meetings.[229]

During the interview, Dr. Shim told us that he was "fortunate" because he found there was a common feature between Yi Chema and C. G. Jung in that both philosophies modelled the theories from the *Book of Changes* (*chuyŏk* 周易). As his initial interest was in psychiatry, he also studied analytical psychology by reading Korean books written by a psychiatrist who trained in the Jung Institute of Zurich. In doing so, he claimed that there were similarities in the theoretical frameworks between Sasang medicine and analytical psychology. For example, in his article which explained the principles of the Sasang Mind Study[230], Dr. Shim appropriated Jung's model of four cognitive functions such as intuition (*chikkwan* 直觀), feeling (*kamjŏng* 感情), sensation (*kamgak* 感覺), and thinking (*sago* 思考). He then made Sasang constitution types correspond to these functions in Jung's framework. He published these findings in three research articles. One preliminary article was published in 1993 in the *Journal of SCM* and the other two major articles were published in 1997 in the *Journal of*

[229] The way they had a meeting was very unique and interesting. Dr. Shim told me that those who want to join the group should do kendo (劍道) with the group members. He explained that practicing kendo is a good way to study their unconsciousness because brandishing a wooden sword by an opponent could be an instinctive threat. Moreover, Dr. Shim said the assessment of the whole training of the Sasang mind study is done by interpreting their dreams in the psychoanalytic way. However, I could not have opportunities to conduct participant observation in these events. Therefore, I did not deal with these aspects in this thesis, while his explanation on practicing kendo and interpreting members' dreams sounded worth studying in the future.

[230] In the article, he originally named the medicine he devised as *tongŭi shimhak* (the Mind Study of Eastern Medicine 東醫心學) but later he changed it with *sasang shimhak* (the Mind Study of Sasang 四象心學).

Oriental Neuropsychiatry, the official journal of the society of KM neuropsychiatry.

Concretely, Dr. Shim firstly matched the four cognitive functions to the four virtues in Sasang medicine. For instance, he interpreted intuition as benevolence (*in* 仁) regarding benevolence as "a state of mind which puts much more weight on the future rather than the past, and strives to prepare for the things to come". Following the logic of Sasang medicine, he explained *in* (benevolence) was also connected to the nature of sorrow (*aesŏng* 哀性)[231] in that benevolence was about *striving* to prepare the future for caring (T. S. Kim, 1997:6). Sorrow was regarded as the nature of a Taeyang person. The other cognitive functions – i.e. feeling, sensation, and thinking – were also matched with the other virtues: righteousness (*ŭi* 義), propriety (*ye* 禮), and wisdom (*ji* 智), respectively. In the process of connection, Dr. Shim added his unique interpretations, engaging and integrating various frameworks from analytical psychology and Sasang medicine (see Tables 6.1 and 6.2).

Furthermore, Dr. Shim matched Sasang *zangfu* organs with the four cognitive types. For example, he explicated oesophagus (胃脘) as the organ which *decides* whether to eat and swallow or not. Its instantaneous decision on *new things* tell that it has an inclination identical to that of *intuition.* (ibid.:15) (see Table 6.3). Finally, in this logic, the Taeyang type was assigned to the intuition type, which was extroversive and pro-spiritual; the Soyang type was

[231] The nature of sorrow (哀性) and the feeling of sorrow (哀情) are different in Sasang medicine. Dr. Shim explained that the nature of sorrow was striving to make provision for the future, whereas the feeling of sorrow was a state of mind of resigning, submitting to fate, and being grief-stricken when it gets tired from striving too hard (T. S. Kim, 1997:9).

the feeling type, which was extroverted and pro-physical; the Taeeum type was the sensation type, which was introverted and pro-physical; and the Soeum type was the thinking type, which was introverted and pro-spiritual (ibid.:13). He also explicated other major terms in Sasang medicine borrowing the theoretical framework of Jung's analytical psychology (see Table 6.3).

Table 6.1. Dr. Shim's Categorization of Agents in Analytical Psychology and Sasang Medicine[232]

Cognitive function	**Inclination**	**Mind/Body**	**Axis of time and space**	**Virtue**	**Nature**	**Sasang person**
Intuition	Intuitive understanding	Extrovert mind	Axis of time	Benevolence	Sorrow	Taeyang person
Feeling	Speculative verification	Extrovert body	Axis of space	Righteousness	Anger	Soyang Person
Sensation	Sensational experience	Introvert body	Axis of time	Propriety	Joy	Taeeum person
Thinking	Emotional alignment	Introvert mind	Axis of space	Wisdom	Enjoyment [Pleasure]	Soeum person

Table 6.2. Dr. Shim's Interpretation of the Four Virtues to Connect with the Four Natures (T. S. Kim 1997:9-11)

Virtue	**Dr. Shim's interpretations**	**Nature**
Benevolence	Looking from the axis of time, benevolence is a state of mind which gives much more weight on the future rather than the past, and so strives to prepare for the things to come. It is a state of mind which makes decision sincerely in every occasion. And with enough experience it understands beforehand – by capturing certain indications of the matter – the situation of the matter yet to come. But when it gets tired from striving too hard to make provision, it resigns itself – submit to fate – and be grief stricken.	Sorrow
Righteousness	Looking from the axis of space, righteousness is a state of mind which directs toward a justice that most people agree – It is a state of mind which is eager to rouse a consensus of contemporary opinion. But when idea precedes action, it gets impatient and – eventually – angry.	Anger
Propriety	Looking from the axis of time, propriety is a state of mind which bear the things of the past firmly in its memory and put it into practice appropriately. It has a tendency to follow the evolution of latest events until it gets familiar to the matter. When something against its expectations happens, it accepts the matter anyway. But to protect itself from having to accept the unexpected matter, it smiles (or laughs).	Joy
Wisdom	Looking from the axis of space, wisdom is a state of mind which has a tendency to discover what is reasonable by putting its own thoughts – rather than other's thoughts – in order. It focuses on what interests itself and takes pleasure from it without any concern of others' opinions. But when enjoyment [the pleasure] has gone too far, it experiences difficulty to withdraw from taking pleasure in a certain matter.	Enjoyment [Pleasure]

[232] Tables 6.1, 6.2, and 6.3 are made based on the contents in Dr. Shim's article (T. S. Kim 1997).

Table 6.3. Dr. Shim's Interpretations on the Functions of Digestive Organs Regarding the Cognitive Functions (T. S. Kim 1997:15)

Digestive organs	**Dr. Shim's interpretations**	**Cognitive function**
Oesophagus	It decides whether to eat and swallow or not. Its instantaneous decision on new things tell us that it has an inclination identical to that of 'intuition'.	Intuition
Stomach	It is to digest food or to vomit. Food is assimilated and converted into organic tissue by the stomach, with the support of the digestive enzymes in the duodenums. Its function has an inclination identical to that of 'feeling'. – in alignment with the mood.	Feeling
Small intestine	It absorbs the digested foodstuff selectively and actively. Its function has an inclination identical to that of 'thinking'. – reference and logical arrangement based on data.	Sensation
Large intestine	It absorbs water passively – by an osmotic action – from the residue of foodstuff. Its function has an inclination identical to that of the 'sensation'. – reception of experiences.	Thinking

Like some other masters of Sasang medicine in the private sector, Dr. Shim was critical to the approaches made in institutionalised Sasang medicine. Based on his study, he criticized the SCM society for not paying attention to Yi Chema's study as the study of a virtuous scholar (*sŏnbi*) in the Chosŏn period, which could be regarded as the 'scholarly' or 'Confucianist' (*yu* 儒) aspect of the study of scholarly physicians (*yuŭi* 儒醫). In other words, he was critical that the SCM society was emphasizing Yi Chema's writings only, not the books which Korean virtuous scholars or Confucianists usually would read in the past such as the *Heart Cannon with Commentaries* and the *Reflections on Things at Hand.* He dismissed the authority of Yi Chema's *Manuscript for Study* as just an anthology no different from what any virtuous scholar usually wrote in the past. During the interview, likewise, Dr. Shim did not mention the posthumous works of Yi Chema or other writings.

Furthermore, He seemed to think a practitioner's involvement was inevitable for the constitution diagnosis process just as psychoanalysis, even though standardised questionnaires were used. And he criticized the questionnaires for the constitution diagnosis

made by the SCM society in that the questionnaire did not engage a practitioner's guide and interpretation throughout the constitution process just as the Myers-Brigs Type Indicator (MBTI) or the Minnesota Multiphasic Personality Inventory (MMPI) did.

In addition, Dr. Shim was also critical to the Eight-Constitution Medicine, because of their mistranslation of classical phrases. In particular, he criticized that ECM just translated the terms *dae* (大) and *so* (小) as "strong" and "weak" respectively. He pointed out that this translation in ECM came out of the intention of relating the *zangfu* relations with the five-phase theory. For instance, the phrase *p'yedaeganso* (肺大肝小) from *Donguisusebowon* was translated as "strong lungs and weak liver (in function)" in ECM so that its basic treatment method was supposed to depleting the lungs and supplementing the liver. However, Dr. Shim explained that *dae* and *so* should be translated as *ŏrŭnsŭrŏpta* (mature 어른스럽다) and *ŏrida* (immature 어리다). He said that this idea came from Jung's concepts of "superior" and "inferior". He thereupon gave an imagined example of an encounter between Confucius and a professional wrestler. Although the pro-wrestler would be *stronger* than Confucius in physicality, when they took a trip, the pro-wrestler would learn a lot from Confucius. Moreover, if there had been a child and a dog in a same room, although the dog might be *stronger* than the child, the child would control the dog in the end. In this way, Dr. Shim argued that *dae* was ability of conscious control as a gentleman (*kunja* 君子) guides an

ordinary man (*soin* 小人), rather than just being strong in physicality.[233]

In this way, Dr. Shim established his own practice style of Sasang medicine based on his experience of psychiatry, analytical psychology and his extensive reading of classical texts which virtuous scholars in the past would study. This was possible because his study of Sasang medicine started from his interests in psychiatry and analytical psychology. He could approach Sasang medicine from a different perspective compared to other Sasang masters. By doing so, he created a new current of tradition which would make the understandings of Sasang medicine more plentiful.

6.5. Discussion

This chapter investigated diverse or sometimes contesting practices of Sasang medicine in the private-practice sector. Various actants of Sasang medicine – i.e. KM doctors practicing Sasang medicine, classical texts, therapeutic modalities and instruments, and government's regulatory guidelines played in this sector. Notably, there were certain groups of practitioners whose members are related to each other by personal association, actual or fictive kinship ties, retrospective histories to the founder of Sasang medicine and a master, interpretive similarities of the classical texts, and who share ideas, techniques, geographical proximity, aesthetic preferences, or any combination of these. This chapter, following Scheid (2007), named these

[233] During my fieldwork, I could see there were also other interpretations of *dae* and *so* in Sasang medicine, although those were outside the scope of this thesis. For example, Taewoo Kim (2017:83) indicates that his teacher of Sasang medicine, another master of Sasang medicine in the private-practice sector whom this thesis did not deal with, explained *dae* and *so* correspond to Movement (*tong* 動) and Stillness (*chŏng* 靜), respectively. For its detailed description, see Taewoo Kim (2017:83-4).

groups ‘currents’ and explored diverse currents of Sasang medicine in the private-practice sector, based on in-depth interviews with masters of those currents.

This chapter looked at the diverse practices of Sasang medicine in three different ways: these are practices 1) striving for authority, 2) competing for legitimacy, and 3) pursuing clinical practicableness. As a renowned master of Sasang medicine among KM doctors, Dr. Won was presumed to have the authentic academic lineage to the founder Yi Chema and presented his own inventive ideas which were believed to better stand out the founder’s intention, but his view was not officially accepted in the institutional sector – i.e. the school education and hospital practice of Sasang medicine. Meanwhile, Dr. Seo was initially active in the mainstream circle of Sasang medicine but after his innovative ideas on acupuncture methods on each Sasang constitution, he had to meet with strenuous opposition. He finally walked his own way and became a master of a current called Eight-Constitution Medicine, which group insists that it is no longer relevant to Sasang medicine. On the other hand, practices of Dr. Yoon and Dr. Shim showed rather freer interpretations and adaptations of Sasang medicine and its classical texts. Each of the masters focused on specific parts of classical texts and developed their own diagnostic and therapeutic methods by interpreting those texts with their unique intellectual backgrounds and experiences.

Hence, it was observed that there were such multi-layered complexities in diverse styles of Sasang medicine of the private-practice sector. Accordingly, discussions of *ch’ejil* in this setting became not only epistemological, but also located in such sophisticated social dynamics.

Conclusion

My research addressed the following overarching question: what does the notion of *ch'ejil* (constitution) do in Sasang medicine? In other words, my research investigated how 'constitution' is understood and transformed in the three settings of South Korea, namely (1) the standardised education of Sasang medicine; (2) the scientisation project of Sasang medicine; and (3) the clinical practice of Sasang medicine by virtuous practitioners. Specifically, the settings for ethnographic fieldwork were: the Hanguk University College of Korean Medicine in Ilsan, the Mibyeong (sub-health) research centre at the National Research Institute of Korean Medicine in Daejeon, and the private-practice sector in Seoul and other urban areas of South Korea.

This thesis firstly examined the relation between 'Sasang medicine' and 'Korean medicine', which in the current dual medical system of South Korea are officially opposed to 'Western-style (bio-)medicine'. In the institutionalised sector, Sasang medicine is presented as one independent subject in the KM curriculum and is included in the system of KM specialities as one speciality along with other seven. That is, Sasang medicine is considered to be specialised within the institutionalised KM system. However, at the same time, Sasang medicine is also widely known to the Korean public, and its relation to Korean medicine in the public sphere is accordingly viewed in very diverse ways, and sometimes not as a sub-specialty of KM but as a new or improved form of KM. The term *ch'ejil*, in particular, is pervasive in everyday conversations. Examining these phenomena, this thesis poses the question: how did Sasang medicine become 'successful' in the KM world and the Korean public sphere? Specifically, how did a medical theory and practice from the (geographical/epistemological)

periphery in the Korean peninsula become ‘ Sasang medicine’, which is recognised as a relatively recent medical tradition that became involved in the mainstream of the KM world of South Korea?

As examined in previous chapters, contemporary Sasang medicine practitioners trace its origin to a scholar-physician called Yi Chema (1837-1900). His project of practising a medicine which had a theory that he considered to faithfully reflect Confucian values, and especially Mencius’ philosophy expressed in a numerology of four. His project was also in line with the Korean Confucian debates of his time and dealt with ‘the Principle’(*i*) and qi, and human nature (*shimsŏng*). Under this ideological influence of the late 19th century, he combined with his clinical experience and medical knowledge by his creative interpretations of Confucius’ texts and classical medical texts.

In the early 20th century, Sasang medicine was of interest to the Korean public and intellectuals for another reason. That is, Korean intellectuals referred to Sasang medicine based on their nationalistic motive. They regarded Sasang medicine not as a medicine invented by one individual scholar-physician but as a national pride that could withstand and oppose Western (bio-)medicine as well as Chinese medicine. In this process of the new labelling, the term *ch’ejil* emerged as a modifier of Sasang medicine to raise its awareness among the Korean public. The use of *ch’ejil* for Sasang medicine gave Sasang medicine attributes of being scientific and progressive, and it made Sasang medical knowledge malleable to suit any relevant knowledge systems and discourses.

Hence, I argue that since the early 20th century, the term *ch’ejil* has played an essential role in raising the legitimacy of Sasang medicine, and its ‘(social) efficacy’. In other words, the use of *ch’ejil* gave Sasang medicine the image of being ‘state of the art’ or ‘scientific’, and it also provided Sasang medicine with a slack epistemological space to be combined with other

disciplines such as the ABO blood-type theory, genomics, or personalised medicine. Most importantly, this process of empowering Sasang medicine accompanied transformations of practices in different social settings. To demonstrate those transformations of Sasang medical practices, this thesis articulates three propositions. First, the combination of the notion of *ch'ejil* and Sasang medicine contributed to making Sasang medicine distinctive from other sub-disciplines of Korean medicine and establish itself in the institutionalised education setting. Second, it enabled researchers to proceed with scientific research projects in the research institute by crossing epistemological borders of disciplines. Third, it influenced the processes of innovating KM practices in the private-practice sector. These are the main concerns dealt with in the ethnography of this thesis. The ethnography presented here does not just try to prove the propositions but also tried to depict tensions and conflicts inherent in past and present transformations.

Authoritative Interpretations of Classical Texts of Sasang Medicine

It can be said that tensions and conflicts usually arise in fields of power. So, who has the power in the world of Sasang medicine? In other words, who has most authority for deciding on the contents of Sasang medicine in the official KM curriculum and clinical practice in institutionalised settings? I found that Professor Lee was the symbolic figure who represented the authoritative form of Sasang medicine in institutionalised settings. He had been continuously engaged in the institutionalising project of Sasang medicine before the establishment of the SCM (Sasang Constitutional Medicine) department (*sasang-ch'ejil*(-*ŭihak*)-*kwa*) in KM hospitals and was also involved in professionalising and scientizing movements of Sasang medicine in research institutes of Korean medicine.

During the in-depth interviews with Professor Lee, which lasted several months, I found the following. First, Professor Lee emphasised the classical texts of Sasang medicine overall, which were mainly written by Yi Chema, the founder of Sasang medicine, but selectively highlighted individual books or specific phrases from the classical texts. His way of dealing with individual books and phrases to approach the 'spirit' of Sasang medicine was like combining numbers to open a combination lock. I later found that there could be different ways of selecting and interpreting classical texts and phrases of Sasang medicine. However, only Professor Lee's way was authorised in institutional learning by being reflected in textbooks and junior SCM professors' understanding of Sasang medicine.

On the contrary, Professor Lee's way of handling Sasang classical texts was not the only factor for Sasang medicine's institutionalisation. His biomedical background – which was much less known than his emphasis on the classical texts – undoubtedly contributed to his involvement in establishing Sasang medicine within the KM hospital system. Unlike many other KM doctors at his time, Professor Lee had the opportunity to get biomedical training and to acquire a special license for biomedical practice. Although his training was short-term and his work limited to one single rural district, this biomedically recognised status as *hanji*-ŭisa ({bio-}medical doctor for a limited district 限地醫師) opened doors for him within the biomedical establishment. This biomedical experience enabled him, different from other KM doctors, to join as a staff member in the newly-built KM hospital, which adopted a newly set up and integrated 'Korean-Western cooperative medical treatment'. He was very proud of his hospital for having a CT scanning machine for the first time in the country. It is likely, I argue, that his biomedical background, aided by state of the art technology, must have attracted many patients who consequently multiplied his practice's (social) efficacy, and thereby paradoxically made the SCM department firmly settle into the hospital system, alongside his deep knowledge

and masterful practice of Sasang medicine. It is important to remember that such paradoxical factors co-existed in the institutionalised setting, that ironically rationalise Sasang medicine's legitimacy of existence, with tensions described widely among scholars interested in the 'modernisation' of contemporary East Asian medicines.

Authoritative Interpretations Practiced in the Standardised Education

My interest moved from figuring out the authoritative form of Sasang medicine to examining how it was practiced in various social relations and institutions. Hanguk University College of Korean Medicine (HUKM) was the place I investigated its practices at University-level education. The HUKM was standing on a multi-layered social platform. Namely, the HUKM was built initially in Gyeongju, the capital of the ancient kingdom of Shilla (57 BC – 936 AD) but more recently it included a modern-style new school building and hospital in the affluent new town, Ilsan. The hospital's construction in Ilsan, which happened ahead of that of the school building, was unquestionably to attract upper/upper-middle class Korean people in that area. Hence, in terms of its initiation, the HUKM was rooted in traditional values such as those of the ancient kingdom's Buddhism, but the logic of its extension seemed to represent Korea's modern capitalistic desire for expansion – i.e. from the tradition to the modern, the rural to the urban, and the poor to the rich.

The structure of Sasang medical knowledge also followed a similar path. Sasang medicine was included as a 'clinical subject' in the subject-oriented curriculum, and its knowledge was contained in the standardised and systematised textbook. Also, it was taught to students according to standardised guidelines based on a juridical organisation approved by the government. What was distinctive for Sasang medicine was that Sasang medicine was arguably

the only ‘clinical’ subject that acknowledges the contents of the most seminal book written by its founder Yi Chema in their entirety. Despite the textbook of the systematised knowledge of Sasang medicine, knowledge of classical texts and phrases was still stressed, and students were sometimes required to memorise them. However, the types and number of classical texts referred to in university education were significantly fewer than those mentioned by Professor Lee during my interviews with him. This tendency was seen to be reinforced when looking into the clinical handbook used in clinical training, which used more diagrams and photos than the textbook. The authority of the classical texts of Sasang medicine was contrasted to the standardised devices and techniques in the hospital practice.

In this educational setting, various kinds of generational differences among the KM doctors were worth investigating. Professor Mok’s case showed how Professor Lee’s authoritative interpretations of Sasang medical texts could be transmitted to other academic institutions through academic lineage. Meanwhile, Professor Han provided an example of how the younger generation of Sasang medicine professors acts and makes relationships with other social players such as a research institute or even the mass media. Dr. Park’s work revealed a division of labour in hospital teaching and junior doctors’ aspiration to be specialists or masterful Sasang medicine practitioners themselves. The transformative impact of the student body was also a fascinating point to investigate. Students were not submissive actors in the education of Sasang medicine. They chose what to learn or not, or sometimes even resisted Professor Han’s guidance. In particular, student Hwang showed little respect for the importance of *chejil* in designing a formula for treatment. He thereby impersonated almost the same attitude which I saw among ordinary KM doctors in the private-practice sector who claimed to use Sasang medicine but, according to Professor Han’s teaching, did not entirely do so. Those KM doctors were neither ‘SCM specialists’ (*sasangch'ejilgwa chŏnmunŭi*) nor members of

Professor Lee's academic lineage. They just chose Sasang medical practice when appropriate, and otherwise used other methods. Hwang's role play in class reflected this practice, and Professor Han was furious at it because it was not based on disciplined Sasang medicine – which refers to a particular way of interpreting the classical texts. Hwang also did not heed the hybrid modern loose concept of *ch'ejil*, although its mixed character was not explicitly mentioned in class. The canon of the education of Sasang medicine was not only informed by classical texts, but also drew on many recent hybridised knowledges and routines, like the centrality of *ch'ejil*.

'Modern' Dilemmas in the Research of Sasang Medicine

Working at the National Research Institute of Korean Medicine (NRIKM) raised another issue of knowledge production/transformation in Sasang medicine: scientisation. The scientisation of traditional medicine has been related to how it could make networks with other modern institutions and scientific disciplines. In this sense, the NRIKM was located at the centre of the scientisation of Sasang medicine (as well as Korean medicine) by being aligned with other government-funded institutions for scientific research and national progress. The making of the Korean Medicine Data Centre (KDC) by the Mibyeong Research Centre researchers at the NRIKM demonstrated how the researchers established an expanding assemblage of various kinds of information in the name of 'Korean medicine'. Along with biomedical information such as vital signs, blood test results, or heart rate variability data, the information on *ch'ejil* was also included in the KDC. Notably, the questionnaires with systematised questions were used to quantify the information of *ch'ejil* and other KM factors. In doing so, the clinical encounter between the doctor and the patient was replaced with the practice of

filling in the questionnaires, and the KM doctors practised like a manager or decision-maker of the newly constructed medical bureaucracy. I regard the making of the KDC is a project of establishing a new regulatory power. The information on *ch'ejil* became quantified (or fragmented) and took up a part of a KM assemblage that could be seen as an attempt to build up alternative modernity.

The book club meetings at the Mibyeong Research Centre were a somewhat casual but certainly dynamic scene to look into the scientific Sasang medicine research's interdisciplinarity. Although the ostensible reason for the meeting was to learn new trends of their research, I also observed how researchers from different academic backgrounds communicated with each other and formulated future research directions. During the meetings of a 'book club' I attended, researchers talked about the books' contents and exchanged opinions about problematic issues in their research. In particular, researchers from the (natural) sciences such as biochemistry or statistics found difficulties when relating their disciplines to the research on Sasang medicine, or *ch'ejil*. The team leader Dr. Ryu, the SCM specialist, had to continuously develop new ideas to satisfy the scientific world as well as the world Sasang medicine. To do this, he introduced new agendas which could be seen as 'progressive' forms of *ch'ejil* research, such as 'Mibyeong research' or 'lifestyle medicine'. By doing so, the characteristics of *ch'ejil* became constantly reinterpreted in the emerging global fields of Complementary and Alternative Medicine, which are also subject to (inter-)national demands of modernisation. In this way, the projects from the NRIKM were vigorously pursuing an alternative path to modernity.

Contesting Interpretations of Classical Texts in the Private-Practice Sector

While the dynamics of modernity powerfully drove the educational and scientific research settings in the names of standardisation and scientisation, the private-practice sector was the arena of competition among diverse currents of tradition in Sasang medicine. Diverse styles and lineages of Sasang medicine appeared in this sector, and, depending on how relevant it is to the founder Yi Chema, their ways of interpreting his texts and concepts, constitutional diagnostic methods or treatment methods differed. Those diverse styles and lineages of Sasang medical practice did not just exist separately but also mutually influenced or competed with one another.

Dr. Won's case demonstrates an example of a master of Sasang medicine who was presumed to have the authentic academic lineage to the founder but was not accepted by the institutionalised sector of Sasang medicine. Compared to Professor Lee, Dr. Won emphasised different kinds of classical texts of Sasang medicine and developed a specific constitution diagnostic method of looking at a patient's physiognomy. Unlike Professor Lee, Dr. Won readily added or subtracted drugs from the original prescriptions in the classical texts. In particular, he devised his own concept of *ch'esŏng* (body-nature) by thinking that it would better reflect the founder's intentions than the nowadays highly hybridised notion of *ch'ejil*. Although he privately taught many KM doctors, he was hardly influential outside the private-practice sector of Sasang medicine. Whereas the term *ch'ejil* was widely used in almost every corner of Korean society, and often appealed for Sasang medicine's legitimacy, Dr. Won's core term *ch'esŏng* was not very much appropriated outside of his circle.

Dr. Seo's case was a bit special because it showed a big clash between different understandings of Sasang medicine. While Dr. Won had been pushed out of the mainstream

circle of Sasang medicine early on, Dr. Seo was initially included in the leading society of Sasang medicine. What distinguished him from other KM doctors of Sasang medicine most was that he recognised the Chinese medical Five Phases theory and considered it to be reflected in Sasang medicine, although Yi Chema's texts do not actually make reference to it. Dr. Seo was confronted by massive opposition from practitioners of Sasang medicine who firmly believed Yi Chema devised the theory of Sasang (Four Images) and the framework of the Four Elements (*sawŏn-gujo* 四元構造) by way of replacing the theory of Five Phases. After a historic debate in the representative journal of Korean medicine, Dr. Seo was forced to go down to a separate path. As a result of his own study, he claimed that he was the founder of Eight-Constitution Medicine and that it is not relevant to Sasang medicine. At the initial stages of his creative thinking and inventiveness, Dr. Seo might have thought that he made innovations in Sasang medicine, but other KM doctors considered them to represent a contamination of Sasang medicine by the theory of Five Phases. Hence, he eventually founded another current of tradition. This is an excellent example of how contesting interpretations of classical texts in the same circle of intellectuals eventually lead to the formation of separate disciplines.

Dr. Yoon and Dr. Shim's cases show another contrasting example of interpreting classical texts of Sasang medicine, namely in regard of the body and the mind. Dr. Yoon mainly focused on several passages in the classical texts enumerating the body parts of each *ch'ejil*. Then he inferred exact locations on the body parts based on anatomical knowledge. He figured out that Sasang *ch'ejil* could be identified by measuring the length of different body parts and comparing the ratios between them. Although he was a practitioner of Sasang medicine in the private-practice sector, his method could be adapted to standardised forms of education and to scientific research on Sasang medicine. This was, presumably, because he was a student of

Professor Lee and his purpose of objectifying the constitution diagnosis matched that of the others in the institutionalised sector.

On the other hand, Dr. Shim concentrated on reminding his colleagues of the academic climate in the founder's times: Yi Chema was a Confucian scholar before practising medicine. Dr. Shim thereby found Confucian books which were not medical but widely read by Confucian scholars and studied them to understand the intellectual context in which Yi Chema's thought was located. Dr. Shim was primarily interested in KM neuropsychiatry, and hence he found striking similarities between C. G Jung's four cognitive functions and the Sasang *ch'ejil*. So, he tried to interpret *ch'ejil* based on Jung's theory of analytic psychology. These two examples illustrate to what extent the conception of *ch'ejil* could be broadened. Dr. Yoon and Dr. Shim did not feel the need to maintain Sasang medicine's authenticity strictly. Rather, they just pursued what they were interested in and tried to integrate external knowledge with Sasang medicine. Importantly, their explorations were more personal and less constrained than Dr. Ryu's at the NRIKM, who tried to integrate Sasang medicine with other kinds of scientific knowledge in order to attract governmental funding.

Parallels and Comparisons

The investigation in the three medical fields of Sasang medicine can be in parallel with previous studies on the different kinds of objectivity (Daston and Galison, 2007) and different styles of knowing *shen* (spirit) in Chinese medicine (Hsu, 2000). As shown in the tables below, Daston and Galison (2006) explains a history of objectivity since the mid-nineteenth-century Western sciences, demonstrating how the concept of objectivity differs from truth-to nature, mechanical representation, and trained judgment. Hsu's (2000) elaboration on styles of knowing *shen* in

different social settings of Chinese medicine has more similarities with my research. Borrowing the categories from Galison and Daston (2007), Hsu (2000)'s investigation on a healer, a senior doctor, and a TCM doctor has different epistemic virtues such as secret knowing, personal knowing, and standardised knowing. The images of the social relations in the different social settings are charismatic, patriarchal, and bureaucratic, respectively. Accordingly, the logic of practice differs: secret knowing is responsive to others to confirm the effectiveness; personal knowing emphasises personal experience; standardised knowing uses independently researched and self-confidentially produced knowledge to reconfirm given standards. The way of being also differs among the three: secret knowing relates to clientele, personal knowing to followers, and standardised knowing to fellow doctors and superiors.

One may come across that my research is somewhat similar to Hsu's (2000) typology since my research also dealt with similar practices of knowing such as standardised knowing and personal knowing. However, I labelled them differently as 'disciplinary knowing' and 'practical knowing' to pay more attention to the habitus of social actors in each setting, i.e. what they pursue as taste, what kind of social order is assigned (or negotiated), how they interact with each other, and how they make a logic of practice in each medical field. In this sense, the example of interdisciplinary knowing in the research institute can be meaningful in that it elucidates the cooperative image of Sasang medicine to 'modernly' advance with other scientific disciplines as well as its dilemma of being modern. By doing so, comparing to Hsu's (2000) categorisation, my research aims for making a different set of social harmonics in viewing the modes of existence of Sasang medicine.

Galison and Daston 2007:371

Epistemic virtue	**Truth-to-nature**	**Mechanical objectivity**	**Trained judgment**
Persona	Sage	Worker	Expert
Image	Reasoned	Mechanical	Interpreted
Practice	Selection, synthesis	Automated transfer	Pattern recognition
Ontology	universals	particulars	families

Hsu 2000 (put together by the author myself)

Epistemic virtue	**Secret knowing**	**Personal knowing**	**Standardised knowing**
Persona	Healer	Senior doctor	TCM doctor/medical expert
Image	Charismatic	Patriarchal	Bureaucratic
Practice	Responsive to others to confirm the effectiveness	Knowing based on personal experience	Using independently researched and self-confidentially produced knowledge to reconfirm given standards
Ontology	Relationship with clientele	Relationship with followers	Relationship with fellow doctors and superiors

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Epistemic virtue	**Disciplinary knowing**	**Interdisciplinary knowing**	**Practical knowing**
Persona	University professor and students	Researcher	Clinician
Image	Authoritative	Cooperative	Liberal
Practice	Drawing boundaries of knowing to raise authority	Crossing boundaries to 'advance' knowing	Using authoritative interpretation of classical texts based on personal experience
Ontology	Relationship with juniors such as residents and students	Relationship with fellow researchers	Relationship with followers

Diverse and Dynamic Ecologies of Medicine

What this thesis intends to emphasise is that there is diversity in the practice of Sasang medicine and such diversity is interwoven with various social actors' habitus. The three settings of my research and the various social backgrounds of my interlocuters reflect those aspects. Importantly, the diverse practices of Sasang medicine, and also the *ch'ejil*, even in different settings, are mostly interconnected with each other. They often mutually influence each other, sometimes co-evolve, and then form a social efficacy of health and healing. The diverse and dynamic ecologies of Sasang medicine should be taken account of from such an anthropological perspective before judging them from the vantage point of the biomedical gaze which tends to posit only one singular path to health and healing. By doing so, as Alter *et al.* (2021:302) points out, one will be confronted not just with epistemological problems of meaning but with ontologial questions critically concerning the nature of the body, the self, efficacy, and health.

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Glossary of Korean Terms

Korean transliterations	English	Korean or Chinese characters
ae	Sorrow	哀
ae-no-hŭi-rak	Sorrow-Anger-Joy-Pleasure	哀怒喜樂
aejŏng	the feeling of sorrow	哀情
aesŏng	the nature of sorrow	哀性
allerŭgi ch'ejil	constitutionally susceptible to allergic disorders	allergy-體質
anmyŏn ch'ŭkchŏng	the facial measurement	顔面測定
at'op'i ch'ejil	constitutionally susceptible to atopic disorders	atopy-體質
boto	replenishing the earth (i.e., replenishing the Spleen and Stomach)	補土
ch'e	body or ‘bodying’	體
ch'egan ch'ŭkchŏng-bŏp	the body trunk measuring method	體幹測定法
ch'ehyŏng	the body structure and shape	體形
ch'ehyŏng ch'ŭkchŏng	the body-shape measurement	體形測定
ch'ehyŏng sasanghak'oe	the Society of the Body Structure and Shape in Sasang	體形四象學會
ch'ehyŏng gisang	somatic morphology and physical comportment	體形氣像
ch'ejil	constitution, or the character of the body or body-quality	體質
ch'ejil bunsŏk	the constitution analysis	體質分析
ch'ejil byŏngjŭng	pathological patterns of constitutions	體質病證
ch'ejil chŏngbo ŭnhaeng	the constitution information bank	體質情報銀行
ch'ejil gaesŏn	constitution reform	체질개선
ch'ejil -gap	the constitutional value	체질값
ch'ejil hyŏngsangnon	discussions on constitutional morphology	體質形象論
ch'ejil maekchin	diagnostic method of constitutional pulses	體質脈診
ch'ejil t'ongch'albŏp	methods on the thorough examination of constitutions	體質通察法
ch'ejil yŏn'gu	the research of (Sasang) constitutions, or constitution research	體質硏究 체질연구
ch'ejil chindan	constitution diagnosis	體質診斷
ch'ejil hwakchin-ja	confirmed case of a constitution	體質確診者 체질확진자
ch'ejil ŭihak	medicine of different constitutions	體質醫學
ch'esŏng	the nature of the body or body-nature	體性
ch'igwa ŭisa gyuch'ik	the Regulations for Dentists	齒科醫師規則
ch'ilchŏng	the seven emotions	七情
ch'im	sunken	沈

Korean transliterations	English	Korean or Chinese characters
ch'ŏ	to stay	處
ch'ojin-sogyŏn	opinion on the first medical examination	初診所見
ch'on-gwan-ch'ŏk	names of contacting points of the wrist for pulse diagnosis	寸關尺
ch'ŏn'gi	heavenly affairs	天機
ch'ŏnch'u-hyŏl	ST25	天樞穴
ch'ŏndol-hyŏl	CV22	天突穴
ch'ŏnt'aegŭk	the Heavenly Supreme Ultimate	天太極
ch'uha baesang	the neck/upper back region	隹頁下背上
cha	femineity	雌
chaenŭng	talent	材能
chagi	being desperate	自棄
changbu sŏngni	the Nature and Principle of viscera and bowels	臟腑性理
chayul shin'gyŏnggye	autonomic nerve system	自律神經系 자율신경계
chayulsŏng	autonomy	自律性 자율성
chejungwŏn	House of Saving the People	濟衆院
chi	wisdom	智
chibang	the earth’s squareness	地方
chidamyŏŭi	Will, Courage, Concern, and Intention	志膽慮意
chikkwan	intuition	直觀
chillyo gwamok	a list of KM subjects which a specific KM doctor claims to treat	診療科目 진료과목
chillyo girokpu	the Medical Record Form	診療記錄簿
chin	to advance	進
chindan mit ch'iryo kyehoek	diagnosis and treatment planning	진단 및 치료계획
chipchŭng	picking up [meaningful and useful] patterns	執證
chipchŭng	picking up patterns	執證
chŏkpaek yukche	the red-white flesh borders	赤白肉際
Choksamni	ST-36	足三里
chŏlgi	twenty-four solar terms	節氣
chŏng	well	井
chŏng	to remain; calm; stillness	靜
chŏng	emotion	情
chŏng	movement	動
chŏngshin	spirit	精神 정신
chŏngshin-gwa	psychiatry	精神科
chŏngshinbang	Psycho formulas	精神方
chŏnmun gwamok	specialised subjects	專門科目 전문과목

Korean transliterations	English	Korean or Chinese characters
chŏnt'ongjŏgin	traditional	전통적인
chuna	Pushing and Pulling	推拿
chŭng	pattern	證
chŭngbon	rooted in [differentiating] patterns	證本 증본
chŭngch'i ŭihak	pattern-treatment medicine	證治醫學 증치의학
chŭnghu	symptoms	證候
chŭngnye-girokchi	the Case Report Form	證例記錄紙
chungp'ung	stroke	中風 중풍
chungp'ung-huyujŭng	sequelae of stroke	中風後遺症 중풍후유증
hae	comprehend	解
haekshim	core	核心
haengse	handling the world	行世
hak'oe	study associations	學會 학회
hakkyop'a	the school faction	學校派
hakp'a	currents [of learning]	學派 학파
hallyang	cooling and chilling	寒凉
hamha hyungsang	below the jaw and above the chest	頷下胸上
han	coldness	寒
hanbang	[the way of] Korean medicine	韓方 한방
hanbang byŏngwŏn	Korean medicine hospital; KM hospital	韓方病院 한방병원
hanbang-byŏngnihak	KM pathology	韓方病理學
hanbang-jonghapkŏmsashil	the KM comprehensive examination room	韓方綜合檢査室
hanbang-shin'gyŏng-jŏngshin-gwa	neuropsychiatry of Korean medicine	韓方神經精神科
hangmunsabyŏn	Learning, Inquiring, Thinking and Discerning	學問思辨
hangshim	Constant Mindset	恒心
hanji-ŭisa	(bio-)medical doctor for a limited district	限地醫師
hanji-ŭisa myŏnhŏ	a special license for Western-style medical practice in a limited area	限地醫師免許 한지의사면허
hanjŭng	cold patterns	寒證
hanmun	classical Chinese	漢文 한문
hanŭi	Oriental medicine	漢醫 한의
hanŭi	Korean medicine	韓醫 한의
hanŭigwa-taehak	KM school	韓醫科大學
Hanŭihak kiban, han'guginŭi kŏn'gangjŭngjinŭl wihan yebanggwalli saŏp”	Korean Medicine-based, Preventive Management Project for the Health Promotion of Koreans	한의학 기반, 한국인의 건강증진을 위한 예방관리 사업
hanŭihak palchŏn yŏn'gujiwŏnsaŏp	the research support project for the development of Korean medicine	韓醫學發展研究支援事業
hanŭisa	doctor of Korean medicine	韓醫師 한의사

Korean transliterations	English	Korean or Chinese characters
hanŭisa	Korean medicine doctor or oriental medicine doctor	漢醫師, later revised as 韓醫師 in 1986; 한의사
hanŭiwŏn	KM clinic	韓醫院 한의원
hanyakchongsang	herbalist	韓藥種商 한약종상
hanyakpang	KM apothecary shop	韓藥房 한약방
hanyaksa	pharmacists of Korean medicine	韓藥師 한약사
hanyangbang hyŏpchin	Korean-Western cooperative medical treatment	韓洋方協診 한양방협진
hanyŏl	coldness and heat	寒熱
hap	uniting	合
Hapkok	LI-4	合谷
Hejian xuepai	the Hejian school	河間學派
hŏ	depletion	虛
hodoksŏ	being fond of reading books	好讀書
hogŏl	hero	豪傑
hosaek	to have strong sexual desires	好色
hŏul	depletion and constraint	虛鬱
hŏyak ch'ejil	constitutionally weak and nonenergetic	虛弱體質
hŭi	joy	喜
hwallyŏkpang	Vitalization formulas	活力方
hwayo hanŭihak'oe	the Hwayo Society of Oriental Medicine	火曜漢醫學會
hyangyak hakp'a	the Hyangyak current	鄕藥學派
hyŏkshin	innovation	혁신
hyŏn	wiry	弦
hyŏng	brook/spring	滎
hyŏngsang	facial and bodily shapes	形象
hyunggyŏk-yŏlchŭng	heat pattern in the chest-diaphragm	胸膈熱證
i	the Principle	理
ich'a palp'yomun	the second paper (pubished in 1973)	二次發表文
igiilwonron	the monism of the Principle and the Vital Force	理氣一元論
igiiwonron	the dualism of the Principle and the Vital Force	理氣二元論
ikta	to read	읽다
ilbanŭi	general practitioner	一般醫 일반의
ilch'a palp'yomun	the first paper (published in 1965)	一次發表文
illyuhak	anthropology	人類學 인류학
illyun	human relations	人倫
imsang	clinical practice	臨床

Korean transliterations	English	Korean or Chinese characters
imsangjŏgin	clinical	임상적인
imshich'amjŭng	grasp the patterns [of disorders] with facing the season/time	臨時參證
in	benevolence	仁
inbon	rooted in [differentiating] a person's basic characteristics	人本 인본
inmul	people	人物
inmun-taehak	college of humanities	人文大學
Insa	human affairs	人事
inŭiyeji	Benevolence, Justice, Courtesy and Wisdom	仁義禮智
ipch'un	the beginning of spring	立春
ipkimyŏng	establishing one's fate	立其命
jangri	the principle of the viscera	臟理
jŏng (= chŏng)	emotion	情
kaekwansŏng	objectivity	客觀性 객관성
kagambŏp	the method of addition and subtraction	加減法
kamgak	sensation	感覺
kamjŏng	feeling	感情
kan-sojang	Liver-Small Intestine	肝-小腸
kan-tam	Liver-Gall Bladder	肝-膽
kangnyŏng	health and peace	康寧
kangŭirok	recorded lecture transcripts	講義錄 강의록
kanul	liver constraint	肝鬱
kanul-gich'e	liver constraint and qi stagnation	肝鬱氣滯
kanyak	to simplify and minimize their lives	簡約
kasan	reserving family properties	家産
kiaek	bodily fluids	氣液
kiaek-chi-gi	the qi of Qi-fluid	氣液之氣
kibonbang	Fundamental formulas	基本方
kich'e-hyŏrŏ	Qi stagnation and blood stasis	氣滯血瘀
kijon-ŭihak	conventional medicine	旣存醫學 기존의학
kimi	qi and taste	氣味
ko	bitterness	苦
kŏ	to raise or to lift	擧
kohoha	the Ancient Formula Current	古方派
kojongmyŏng	peaceful death	考終命
kŏmdo	kendo	劍道
kongbu ch'ejil	prone to study	공부체질

Korean transliterations	English	Korean or Chinese characters
konggwa-taehak	college of engineering	工科大學
kongŭi	public health physician	公醫
kugŭbŭihakp'a	the emergency medicine current	救急醫學派
kulbangsushin	Bending, Releasing, Receiving and Stretching	屈放收伸
kunja	gentleman	君子
kwahag-ipkuk kisul-charip	rely on science to establish the state, rely on technology to establish autonomy	科學立國 技術自立
kwanbo	the official gazette	官報
kyŏng	channel/river	經
kyŏngakchŏnsŏ hakp'a	the current of the Complete Compendium by [Zhang] Jingyue	景岳全書學派
kyŏnggŏ	LU8	經渠
kyŏnghŏm	experience	經驗 경험
kyŏnghŏmbang	experience-based prescriptions	經驗方
kyŏnghŏmŭihakp'a	the current of experience-based medicine	經驗醫學派
kyŏngje ch'ejil	economic constitution	경제체질
kyŏngjung	slight or serious importance	輕重
kyosa	to impress others by clothing themselves in expensive materials	嬌奢
kyosu-nim	professor	敎授님
kyoŭi saŏp	school doctor project	校醫事業
kyoyuk	education	敎育
mabibang	Paralysis formulas	麻痺方
maek-chin	pulse diagnosis	脈診
maekpu	floating pulse	脈浮
mibyeong	not yet ill	未病
Mibyeong-bogam	Treasured Mirror of Being Not Yet Ill	未病寶鑑
mibyŏng yŏn'gudan	the Mibyeong Research Centre	未病硏究團
mishimsul	beautifying the heart’s intention	美心術
moŏnshich'ŏng	Appearance, Word, Vision and Hearing	貌言視聽
mul	Thing	物
mulsadan	the four principles of the thing	物四端
myŏngmaek-shilsu	the Real Number of the Life Pulse	命脈實數
naejaejŏk	intrinsic	內在的
naejaejŏk chayulsŏng	intrinsic autonomy	內在的 自律性 내재적 자율성
naejaejŏk chayulsŏngŭi kŭktaehwa	the maximization of the intrinsic autonomy	내재적 자율성의 극대화
naejaejŏk saengmyŏng hyŏnsang	the inherent life phenomenon	內在的 生命現象 내재적 생명현상
naejang sanggwallon	splanchnic interrelation theory	內臟相關論

Korean transliterations	English	Korean or Chinese characters
naeoe-wansok	Loosening and Tightening in the Internal and External body parts	內外緩束
naesu	guarding	內受
no	Anger	怒
noech'u-ji-gise	rising momentum of the crest	腦隹頁之起勢
obok	the Five Blessings	五福
oegwahakp'a	the surgery current	外科學派
oesŭng	conquering	外勝
oewŏya	necessary to memorise	외워야
ohaeng	the Five Phases	五行
ŏhyŏl	stagnant blood	瘀血
ojang yukbu	five viscera [zang] and six bowels [fu]	五臟六腑
on-yŏl-lyang-han	Warmth-Heat-Coolness-Coldness	溫熱凉寒
onko-ch'angsin	Creating the new by revising the old	溫故創新
onko-chishin	Learning the new by revising the old	溫故知新
ŏrida	immature	어리다
ŏrŭnsŭrŏpta	mature	어른스럽다
osuhyŏl	the five transport points	五腧穴
oyŏmdoen	contaminated	오염된
p'a (or pai in Chinese transliteration)	current	派
p'aet'ŏn	patterns	패턴
p'al-ch'ejil ŭihak	the Eight-Constitution Medicine (ECM)	八體質醫學 팔체질의학
p'algwae	the eight trigrams	八卦
p'ibiel-kirokchi	the PBL (Problem-Based Learning) Report Form	PBL 記錄紙
p'umsu-ŭihak	medicine of inherited traits	稟受醫學
p'ye-taejang	Lung-Large Intestine	肺-大腸
p'ye-wiwan	Lung-Oesophagus	肺-胃脘
p'yebiganshin	Lung-Spleen-Liver-Kidney	肺脾肝腎
p'yedae-ganso	a large lung and a small liver	肺大肝小
p'yorigwan'gye	the exterior-interior relations	表裏關係
p’alhyo	becoming effective	發效
paekpogigyŏmsu	Enjoying one hundred blessings together with longevity	百福而兼壽
paeuda	be learned; to learn	배우다
paksa-nim	doctor	博士님
pal-chejil uihak	eight-constitution medicine	八體質醫學 팔체질의학
pi-wi	Spleen-Stomach	脾-胃
piwei xuepai	the spleen and stomach school	脾胃學派

Korean transliterations	English	Korean or Chinese characters
pokchin	abdominal diagnosis	腹診
pon'gwa	main/medical course	本科
pon'gwasaeng	students in the medical course	本科生
pŏpko-ch'angshin	creating the new with following the old	法古創新
powŏn	Preserving the Origin	保元
pu	wealth	富
pu-wŏnjang	vice director	副院長
pugwibinch'ŏn	Wealth, Nobility, Impoverishment and Humbleness	富貴貧賤
pukk'ŭllŏp	book club	북클럽
puryong-hyŏl	ST19	不容穴
puyang hakp'a	the current of supporting yang	扶陽學派
pyŏng	disease; disorder	病
pyŏngbŏp	the art of war	兵法
pyŏngbyŏn	pathological changes	病變
pyŏngin	causes of disorders	病因
pyŏngjŭng	pathological patterns, or morbidities	病證
pyŏngjŭng	bodily disorders	病症
pyŏngjŭng-ronch'i	pattern differentiation and treatment determination	辨證論治 변증론치
pyŏnjŭng	pattern differentiation	辨證
qizhuang	[physical or observed] shape	其狀
rak	Pleasure	樂
ryang	coolness	凉
sa	Affair	事
sa-shim-shin-mul	Affair-Heart-Body-Thing	事心身物
saam ch'imbŏp	Sa-am acupuncture	舍菴鍼法
sadan	the Four Extremities	四端
saenghwalsŭpkwan	lifestyle	생활습관
sago	thinking	思考
sahoe-ŭihak	medicine of different socialities	社會醫學
sajang sabu	four viscera [zang] and four bowels [fu]	四臟四腑
sajin	the four methods of diagnosis	四診
salgyunbang	Bactericidal formulas	殺菌方
samul	affairs and things	事物
samul-t'ang	Four Substances Decoction	四物湯
Samŭmgyo	SP-6	三陰交
san	sourness	酸

Korean transliterations	English	Korean or Chinese characters
sangha-sŭnggang	Ascending and Descending in the Upper and Lower body parts	上下升降
sasadan	the four principles of the affair	事四端
sasang	the Four Images	四象
Sasang ch'ejil ŭihak	Sasang Constitutional Medicine	四象體質醫學
sasang shimhak	the Sasang Mind Study	四象心學
sasang shimhak yŏnguhoe	the study group for the Sasang mind study	四象心學研究會
sasang ŭihagŭi haesŏl	Explanations for Sasang Medicine	四象醫學의 解說
sasang ŭihak	Sasang medicine	四象醫學
sasang ŭihak'oe	the Association for Sasang Medicine	四象醫學會
sasang-ch'ejil(-ŭihak)-kwa	SCM (Sasang Constitutional Medicine) department	사상체질의학과
Sasang-ch'obon'gwŏn	the First Draft of Sasang	四象草本卷
sasangch'ejil hakp'a	the Sasang (constitutional) current	四象體質學派
sasangch'ejil ŭihak'oe	the Society of Sasang Constitutional Medicine	四象體質醫學會
sasangch'ejilgwa chŏnmunŭi	SCM specialists	사상체질과 전문의
sasangin changbusŏngni	the Nature and Principle of viscera and bowels in the people of Sasang	四象人 臟腑性理
sasangin changbusŏngni	the Natures and Principles of viscera and bowels of the four types of people	四象人臟腑性理
sashimshinmul	affairs, heart, body, and thing	事心身物
sawŏn-gujo	the framework of the Four Elements	四元構造
se	propensity	勢
shiho-gyeji-t'ang	Bupleuri Radix and Cinnamomi Ramulus Decoction	柴胡桂枝湯
shim	Heart	心
shim-sojang	Heart-Small Intestine	心-小腸
Shimjŏk-kwanch'al	Observation of the Heart	心的觀察
shimsadan	the four principles of the heart	心四端
shimshin	the heart and the body	心身
shimshin-ŭihak	medicine of heart and physique	心身醫學
shimsŏng	human nature	心性
shimsul	intention	心術
shimt'aegŭk	the Supreme Ultimate of the Heart	心太極
shin	Body	身
shin yuhak	Neo-Confucianism	新儒學
shin-panggwang	Kidney-Bladder	腎-膀胱
Shin'ganhoe	The New Trunk Association	新幹會
shinbihan	mystical	신비한
shinch'ukpon	Donguisusebowon of 1901	辛丑本

Korean transliterations	English	Korean or Chinese characters
shindoshi	new/planned city	新都市 신도시
Shinmun	HT-7	神門
shinsadan	the four principles of the body	身四端
shirhak	Practical Learning	實學
so	small	小
soahakp'a	the paediatrics current	小兒學派
sŏdangp'a	the private academy faction	書堂派
Sohae	HT-3	少海
soin	ordinary man	小人
sojang-hwa	the Fire attributes for Small Intestine	小腸-火
sojŭng	basic patterns	素證
sojŭng-sŏlmunji	the Basic Pattern Questionnaire	素證說問紙
sŏkkŏjap	a state of being sundry, or jumbled practice	섞어잡
sŏl-chin	tongue diagnosis	舌診
Sŏn	Zen	禪
sŏnbi	a virtuous scholar	선비
sŏng	Nature	性
songhyŏl	transmissive points	送穴
sŏngin	sage	聖人
sŏngjŏng	nature and emotion	性情
sŏngni	nature and principle	性理
sŏngŭm	voice	聲音
sŏngunbyŏng	Sŏng Un's disorder or disorder of having cloudlike (absurd) dreams	成雲病
sŏnsaeng-nim	teacher or master (lit. an honourific language for a person who is born earlier than the speaker)	先生님
sŏŏl	illegitimate son	庶孼
soŭmin	Soeum person	少陰人
sŏurhanŭigwadaehak	Seoul College of Korean Medicine	서울漢醫科大學
soyangin	Soyang person	少陽人
su	longevity	壽
su	stream	輸
sugishin	cultivating one's body	修其身
sugok	liquid and food; Water-food	水穀
sugok-chi-gi	the qi of Water-food	水穀之氣
suhyŏl	receiving points	受穴
sujeja	the best student	首弟子 수제자

Korean transliterations	English	Korean or Chinese characters
sujok-naengjŭng	syndrome of feeling cold in hands and feet	手足冷症
sŭk'aet	SCAT (Sasang Constitution Analysis Tool)	스캣
sunyŏk	forward and reverse shifts	順逆
T'aebaek	SP-3	太白
T'aech'ung	LV-3	太衝
t'aegŭk	the Supreme Ultimate	太極
t'aegŭk ch'imbŏp	the T'aegŭk acupuncture	太極鍼法 태극침법
T'aegye	KI-3	太溪
t'aehwang	yellow coat of the tongue	苔黃
t'aeŭmin	Taeeum person	太陰人
t'aeyangin	Taeyang person	太陽人
T'aeyŏn	LU-9	太淵
t'ongch'i	national governance	通治
t'ongjŭng-buwi	painful area	痛證部位
t'uhyŏn	being jealous of people’s wisdom	妬賢
t'uil-chi-shim	the tendency of isolate themselves from others	偸逸之心
tae	large	大
taebyŏn-sŏnt'ong	good bowel movement	大便善通
Taech'u-hyŏl	GV14	大椎穴
taehan hanŭihak'oe	the Society of Oriental Medicine, later the Society of Korean Medicine	大韓漢醫學會
taehan sasangŭihak'oe	the Korean Society of Sasang Medicine	大韓四象醫學會
taejang-kŭm	the Metal attribute for Large Intestine	大腸-金
taeso gwan'gye	the big-small relationships	大小關係
taeyangin	Taeyang person	太陽人
tam	Phlegm	痰
tan'gwa-taehak	college	單科大學
the bianzheng lunzhi	pattern differentiation and treatment determination	辨證論治
tok'ak'	self-learning	獨學 독학
tong	movement	動
tongjeŭihakkyo	the Tongje Medical College	同濟醫學校
tongsŏ ŭihang yŏn'guhoe	The Association for Research Eastern and Western Medicine	東西醫學研究會
tongsŏŭihakchŏlch'ung hakp'a	the current of compromising Eastern and Western medicines	東西醫學折衷學派
tongŭi	Eastern medicine	東醫 동의
tongŭi sanghan hakp'a	the Korean version of the [Treatise of] Cold Damage Disorders current	東醫傷寒學派
tongŭi shimhak	the Mind Study of Eastern Medicine	東醫心學

Korean transliterations	English	Korean or Chinese characters
tongŭibogam hakp'a	the Donguibogam current	東醫寶鑑學派
tongŭich'imguhakp'a	the current of Eastern acupuncture and moxibustion	東醫鍼灸學派
tongyang taehakkwan	the Tongyang Academy	東洋大學館
tongyang ŭigwa taehak	College of Eastern Medicine	東洋醫科大學
tongyang ŭiyak	Eastern Medicine	東洋醫藥
tongyang ŭiyak taehak	College of Eastern Medicine and Pharmacy	東洋醫藥大學
ŭi	righteousness	義
ŭian	medical case histories	醫案
ŭigwa-taehak	college of medicine; (bio-)medical school	醫科大學
ŭigwan-jŏngje	Wearing clothing neat and tidy	衣冠整齊
ŭihagimmun hakp'a	the current of the Introduction to Medicine	醫學入門學派
ŭijaŭiya	a doctor should be attentive [to the situation and symptoms of the patient]	醫者意也
ŭiryo iwŏnhwa ch'egye	the dual medical system	醫療二元化體系
ŭiryo-illyuhak	medical anthropology	醫療人類學 의료인류학
ŭisa	medical doctor	醫士 의사
ŭisa	medical doctor	醫師 의사
ŭisa gyuch'ik	the Regulations for Medical Doctors	醫師規則
ŭisa gyuch’ik	the Decree of the Medical Doctor	醫士規則
ŭisaeng	student of medicine	醫生 의생
ŭisaeng gyuch'ik	the Regulations for Students of Medicine	醫生規則
ŭiyŏk hakp'a	the current of the Book of Changes in medicine	醫易學派
ul	Constraint	鬱
ŭmyang	yinyang	陰陽
ung	masculinity	雄
wan-kŭp	lesser or greater urgency	緩急
wang	gazing	望
wanshil-mubyŏng	overall health and lack of illness	完實無病
wenbing	warm disorder	溫病
wenbing xuepai	the Warm disorder current of learning	溫病學派
wiwan	oesophagus	胃脘
wŏlli	principle	原理 원리
wŏn'gi	the original qi	元氣
wŏnbang	original prescriptions	原方 원방
wŏnin	the Origin of Human Beings	原人
wŏnjang	director	院長

Korean transliterations	English	Korean or Chinese characters
wŏnjang-nim	director [of the clinic] (an honourific language)	院長님
wŏnjŏn	classics	原典 원전
wŏnmun	classical texts	原文
wŏnshi yuhak	Original Confucianism	原始儒學
woori	collective self	우리
wutairen	the Five Appearances among People	五態人
yajiankang	subhealth	亚健康
yajiankangxue	Subhealthology	亚健康學
yak	(herbal) medicine	藥
yak-ch'im	pharmacoacupucture	藥鍼
yakpang	formulas	藥方
yaksŏng	qualities of drugs	藥性
yan	verify	驗
yang bing	yang disorder	陽病
yang-ok-chip	Western-style house	양옥집
yangban	the traditional ruling class or gentry during the Chosŏn Dynasty	兩班
yanggyŏk-sanhwa-t'ang	Diaphragm-Cooling Fire-Dissipating Decoction	凉膈散火湯
yanghanbang hyŏpchin	Western-Korean Cooperative Treatment (WKCT), or the cooperative treatment between WM and KM	洋韓方協診
yangin	yang person	陽人
yangjin-hanch'i	diagnosing with Western medicine and treating with Korean medicine	洋診韓治 양진한치
yangsaeng	Nurturing the Life, or life-nurturing	養生
yangsaengbŏp	regimen	養生法
yangsaengŭihakp'a	the nurturing life medicine current	養生醫學派
yangŭi	the two opposing principles	兩儀
ye	propriety	禮
yegwa	preparatory/pre-med course	豫科
yegwasaeng	students in the pre-med course	豫科生
yin bing	yin disorder	陰病
yŏkto	the way of changes	易道
yŏl	heat	熱
yŏlchŭng	heat patterns	熱證
yŏmjŭngbang	Inflammation formulas	炎症方
yŏn'gu	research	研究
yŏnae ch'ejil	prone to be good at dating	연애체질
yongmo-sagi	Appearance and Manner of Speech	容貌詞氣

Korean transliterations	English	Korean or Chinese characters
yowi-ji-ipse	standing momentum of the waist	腰圍之立勢
yowijiipse-sŏngjang	a well-developed waist	腰圍之立勢盛壯
yuhodŏk	love of virtue	攸好德
yujŏnch'et'im	the genomics team	유전체팀
yukkyŏng pyŏngjŭng	the pathological patterns according to the Six Warps	六經病證
yukshipsagwae	the sixty-four hexagrams	六十四卦
yultonggye	the Chestnut village gathering	栗洞契
yuŭi	scholarly physicians	儒醫
zangfu	viscera and bowels	臟腑
zangxiang	state of the internal organs	臟象

Korean book titles and chapter headings

Korean (or Chinese) Transliterations	English	Korean/Chinese characters
Ch'ongnonjŏk wŏllip'yŏn	chapter for the general fundamentals of Sasang medicine	總論的原理篇
Changburon	Treatise on zangfu	臟腑論
Changsŏgak tongmuyugo	Posthumous Work of Tongmu: The Changsŏgak edition	藏書閣 東武遺稿
Chejung shinp'yŏn	New Compilation for Helping the Multitude	濟衆新編
Chihaengron	Treatise of Knowing and Action	知行論
Choŭihak	Korean Minority Medicine in China	朝醫學
Chungyong	Doctrine of the Mean	中庸
Chuyŏk	Book of Changes	周易
Donguisusebowon	Prolonging the Life and Preserving the Origin in Eastern Medicine	東醫壽世保元
Donguisusebowon Kabobon	Prolonging the Life and Preserving the Origin in Eastern Medicine: The Kabo edition	東醫壽世保元 甲午本
Donguisusebowon Sasangch'obon'gwŏn	Prolonging the Life and Preserving the Origin in Eastern Medicine: The First Draft of Sasang	東醫壽世保元 四象草本卷)
Donguisusebowon Shinch'ukpon	Prolonging the Life and Preserving the Origin in Eastern Medicine: The Shinch'uk edition	東醫壽世保元 辛丑本
Gujin yiguan	Mirror of Ancient and Modern Medicine	古今醫鑑
Gyowu hoeji	Magazine of the College Alumni Association	校友會誌
Hanbang ŭiyakkye	World of East Asian Medicine	漢方醫學界
Huangdi neijing	Yellow Emperor’s Inner Cannon	黃帝內經
Huorenshu	Book of Saving People	活人書
Jingui yaolue	Essential Prescriptions from the Golden Cabinet	金匱要略
Komunjinbo	True Treasures of the Old Writings	古文眞寶
Kŭnsarok	Reflections on Things at Hand	近思錄

Korean (or Chinese) Transliterations	English	Korean/Chinese characters
Kyojap'yŏngsaengjam	Aphorisms for Instructing Children for Their Whole Lives	敎子平生箴
Kyŏkch'igo	Manuscript of Study	格致藁
Lingshu	Divine Pivot	靈樞
Maengja	Mencius	孟子
Muksaltanghan chilli	“The truth ignored”	默殺당한 眞理
Myŏngsŏllok	Record for Illuminating the Good	明善錄
Nonŏ	Analects	論語
Obongnon	Treatise of the Five Blessings	五福論
Ŏnhaengon	Treatise of Words and Deeds	言行論
Ot'aeillon	Treatise on the Five Forms of People	五態人論
Pibangnok	record of secret prescriptions	秘方錄 비방록
Pogŏnsŏng Tongmuyugo	Posthumous Work of Tongmu: The Pogŏnsŏng edition	保健省 東武遺稿
Sasang ch'obon'gwŏn	First Draft of Sasang	四象草本卷
Sasang gujoron	Sasang Structural Theory	四象構造論
Sasang jillyo bowon	Preserving the Primary for Sasang Practice	四象診療保元
Sasang ŭihak wŏllon	Principles of Sasang Medicine	四象醫學原論
Sasangin pyŏnjŭngnon	Treatise on the Pattern Differentiations of People with Sasang	四象人辨證論
Sasangŭiyak sŏngniimsangnon	Clinical Treatise on the Nature and Principle of Sasang Medicine and Pharmacy	四象醫藥性理臨床論
Sasŏ	Four Books	四書
Sasŏ samgyŏng	Four Books and Three Classics	四書三經
Shanghanlun	Treatise on Cold Damage	傷寒論
Shigyŏng	Book of Odes	詩經
Shimgyŏng	Heart Classic	心經
Shimgyŏng buju	Supplementary Annotations to the Classic of the Heart[-Mind]	心經附註
Shindonga	New East Asia	新東亞
Shin'gich'ŏnhŏm	Experiential Practice of the Body Organism	身機踐驗
Sŏgyŏng	Book of Documents	書經
Suwen	Basic Questions	素問
Taehak	Great Learning	大學
Taehan hanŭihakh’oebo	Bulletin of Korean Medicine	大韓漢醫學會報
Taehan hanŭihakh’oeji	Journal of Korean Medicine	大韓韓醫學會誌
Tongmu(yugo) yaksŏngga	Tongmu’s Songs of the Qualities of Herbs	東武(遺稿) 藥性歌
Tongsŏ ŭihak yŏn'guhoe wŏlbo	Monthly Magazine of the Association for Researching Eastern and Western Medicine	東西醫學研究會月報
Tongŭi bogam	Treasured Mirror of Eastern Medicine	東醫寶鑑
Tongŭi sasang daejŏn	Complete Compendium of Sasang in Eastern Medicine	東醫四象大全

Korean (or Chinese) Transliterations	English	Korean/Chinese characters
Ŭibang yuch'wi	Assembled Categories of Medical Prescriptions	醫方類聚
Ŭihagironp'yŏn	chapter for the medical theory	醫學理論篇
Ŭiwŏllon	Treatise on the Origin of Medicine	醫源論
Yixue rumen	Introduction to Medicine	醫學入門
Yŏkkyŏng	Book of Changes	易經
Yuryak	Summary of Confucianism	儒略

Korean personal names

Korean/Chinese Transliterations	Chinese characters	Years of birth and death
Chen Dexiu	陳德秀	1178-1235
Cheng Minzheng	程敏政	1178-1235
Choi Han-ki	崔漢綺	1803-1877
Chŏng Yakyong	丁若鏞	1762-1836
Han Sŏkchi	韓錫地	1709-1791
Han Tuchŏng	韓斗正	1880-?
Hŏ Chun	許浚	1539-1615
Pak Chiwŏn	朴趾源	1737-1805
Sŏng Un	成雲	?-?
To Ŭnkyu	都殷珪	? -1940
Yi Byŏnghaeng	李炳幸	1906-1974
Yi Chema	李濟馬	1837-1900
Yi Hwang (pen name: Toegye)	李滉 (退溪)	1502-1571
Yi Ik	李瀷	1681-1763
Yi Jinyoon	李鎭胤	1894-?
Yi Kyu-kyung	李圭景	1788-?
Yi Ŭlho	李乙浩	1910-1998
Zhu Xi	朱熹	1130-1200