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Commercialization of Medicine in the Late 19th and Early 20th Century in Korea*

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Abstract

From the 17th century onwards, Joseon society began to see medical practitioners who were not ashamed of searching for profits. These practitioners acted as agents and led Korea towards commercialization. However, Western missionaries and the colonial government slowed the pace of commercialization. Both of them performed medical treatment free of charge as a means to settle in Korea as quickly as possible. Their action consequently prevented Koreans from growing into active consumers. Nevertheless, they were not powerful enough to block the commercialization of medicine. Western missionaries and the colonial government began to retreat from their policy of charity. Furthermore, Korean doctors who had studied Western medicine tried to distance themselves from this benevolent art. They began to blame Korean patients who stuck to old medical ethics and set their sights on the inevitable pursuit of profit. Because of this desire, Korean patients would have no choice but to change, which was the primary reason the status of Korean patients changed from subjects to consumers.

Keywords: benevolent art, commercialization, Western medicine, medical missionary, charity hospital, colonial government

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Introduction

Horace N. Allen, the first Western missionary and Western medical doctor in Korea, found that Korean patients, after being treated, did not pay their bills. He said, "The Koreans seem to go on the principle of no cure no pay. Payment, moreover, seems seldom to be in money." Only after successfully curing illnesses did he receive eggs, meat, pigs, chickens, pheasant, and all manner of eatables. After forcing patients to pay a very small amount of money, he confessed, "This did not seem to be a wise policy." Patients considered payment a favor to the doctors, rather than an expression of their gratitude (Allen 1908, 205).

The patients' attitude did not merely originate because circulation of money in the late Joseon Dynasty was nonexistent, but that traditionally, Koreans were not accustomed to paying a doctor's bill. It was not out of the ordinary for them to be provided medicine for free. As a consequence, Korean patients had a tendency to regard themselves as recipients rather than consumers. However, from the 17th century, clear evidence of commercialization can be seen (Kim 1998; Shin 2006). The introduction of Western medicine, which seemed lucrative, might have increased the speed of commercialization in the medical business. However, more time was needed for Korean patients to take a more active approach to medicine.

This study aims to reveal the process of the commercialization of medicine in modern Korea by following a transition in the concept of patients. A couple of turning points seem to have change the direction of the concept of patient. Those points were the opening of doors to Western powers and the growth of Western-style doctors who had different views on profit seeking. As both the scene and performer had changed, Korean people should have changed their approach to medicine. However, the way to a commercialized society was not a straight road. Sometimes the performer had to decelerate and sometimes, figuratively, road conditions were not so favorable.

By uncovering the influences of each of these turning points in the minds of Koreans, the policy of foreign medical doctors, and the stance of newly certified Korean doctors, this study will show how socio-economic

conditions fostered changes in the medical field. To achieve this goal, this paper will first investigate how and why new medical practitioners adopted almost the same attitude Confucian scholars held toward patients and then find out when and how doctors turned in a reverse direction toward traditional medical ethics. As a result, this study will disclose how passive subjects in Korea became active consumers in the defining of patients.

Continuity in the Traditional Way of Treating Patients

Confucianism and a Benevolent Art

Korea had a long tradition of medical ethics based on Confucian ethics, which emphasized benevolence and charity and were referred to as *insul* 仁術, or the benevolent art. Originally, the king was the primary charity provider, and he was responsible for nursing his subjects like children. Benevolence was the primary theme in medieval Korean medicine (Lee 2012, 260). However, the benevolent art became the primary duty of doctors, that is, providing free treatment to patients. King Sejo, the seventh king of the Joseon Dynasty, stressed that preserving morality should be the top priority for doctors (Shin 2000, 171).

Confucianism, which dominated Koreans' ideas of life in the Joseon Dynasty, played a major role in establishing the benevolent art an ethical doctor should follow. Hospitals were to be given names that were in line with the Confucian ethics. For example, Hyeminseo 惠民署, one of three main medical institutions in Joseon, means "a house of bestowing favors on people." As a consequence, Korean doctors valued these very ethics. According to *Dongui bogam* 東醫寶鑑, the most well-known Korean traditional medicine book published in 1603, medical practitioners showed great affection toward people. Thus, Confucianism strengthened its ideological basis in the Joseon society beginning with the quality of medical care and a high standard of ethical care. Confucian morality became more important than any other consideration, for instance, than good technical skills or a long family tradition (Shin 2000, 171–172).

However, these practitioners were not standard doctors but Confucian doctors. They were generally *yangban*, or ruling class, who made great contributions toward charitable treatment. Therefore, a Confucian doctor was more of a scholar than a practitioner, an individual who thoroughly investigated undeveloped areas and either provided new medical theories to professional doctors or offered treatment to patients without charge. By protecting the health of the people in the town they resided, they were able to preserve the community they ruled. It is no wonder, then, that *yangban* provided medical care without charge.

A medical *gye* 契, a traditional private fund, in Gangneung, Gangwon-do province, might be an example of providing medicine to community members. This gye was established in 1603 to stably provide members of the gye, mainly the ruling class in a town, with medicine. Officially the beneficiary was limited to members only, but practically, the gye functioned as a public clinic for residents in a town (Lee 2009, 108–109). As a consequence of this long tradition of the benevolent art, Korean patients were not even in the habit of saying, "Thank you," much less paying the bill, even though they had received prescriptions as well as long consultations (Jo, 182).

Though the benevolent art was a widespread medical ethic in premodern Korea, professional practitioners seeking profit did exist. In the first decade of the 17th century, the Joseon government abolished the policy of acquiring goods for government use through tax and adopted a new policy to purchase goods through government-designated merchants (Eckert, 158). As the tax could be paid in coin, it resulted in the circulation of currency and fostered the accumulation of capital. This change shifted Korea toward a commercial society. As the number of markets and merchants increased, commercialism became a new and attractive ideology in Korean society.

The circulation of medicine was one example symbolizing this new trend. Medical markets were created in some major cities like Daegu, the third largest city in South Korea, where medical herbs that were either cultivated or imported were exchanged. Merchants who dealt with medicine increased in number. It became easier for Koreans to purchase medicine as long as the individual could afford it. Before this time, medicine was

regarded as a specialty item—a present to be given at special events, like farewell parties. Granting special medical gifts to vassals was one of the king's main ceremonies that took place at the end of the year (Shin 2006, 344–391).

The dynamic on medical arrangements continued. According to a diary written by Yu Man-ju, a nobleman living in Seoul in the 18th century, he was able to visit pharmacies and buy medicine without many difficulties. When his son became seriously ill, he consulted more than six doctors in the same month. After receiving a doctor's prescription, he had the prescription filled at a pharmacy without delay. Furthermore, Confucian scholars began to take a positive attitude toward legally making a profit through the opening of drug stores; instead, they blamed government officials for illegal moneymaking schemes through the acceptance of bribes.

Nonetheless, retailing medicine was still regarded as losing dignity and only prescribing was recommended as a job for Confucian scholars. However, as the system of social status in Joseon society was in turmoil, some *yangbans*, ruined *yangbans* in particular, to earn a living, could not but sell medicine by using their traditional knowledge of oriental medicine (S. Kim 2009, 60–66). As medicine was enjoyed more widely than ever, overdosing on medicine became an occasional social issue. According to Yu Man-ju, "Practitioners routinely prescribe over ten kinds of medicine, the effect of which could be questioned." He suggested that medicine comprised of less than three herbs would be more efficacious as well as cheaper (Kim 1998, 137).

Accordingly, in the 18th century, Korea saw a surge of new classes that were not ashamed of seeking profit. They would grow into agents leading Korea toward a newly commercialized society. Therefore, as the number of doctors and pharmacists seeking profits increased, Korean patients who wanted proper treatment would have to pay bills. Koreans now had to prepare themselves to be consumers rather than recipients of Confucian charity.

Western Medicine and a Benevolent Art

The opening of ports to Western countries in 1876 might account for the accelerated speed of the commercialization of medicine in Korea. On the one hand, the port opening led Korea to face aggressive Japanese and Western powers, yet, on the other hand, it increased opportunities for the ruling class to pursue commercial profits. Korean *yangban* officials, rice merchants and *yangban* landlords had more chances to increase their wealth by exporting rice (Kim 2005, 33–34).

Similarly, the Japanese also had opportunities to extend their wealth. In particular, Japanese drug merchants made rounds along the provinces in Korea and sold medicine such as *hotan* 寶丹 and *senkintan* 千金丹, which were manufactured in Japan. The popularity of such drugs was so high, "Korean patients, whenever coming across a Japanese merchant, would go to him and ask for the medicine." Some drug merchants would compound medicines in front of the patient even though they were not licensed to be pharmacists in Japan.[1] A Western doctor claimed that the Koreans, like the Chinese, were a nation of medicine consumers, and drug stores were numerous (Woods 1984, 119). What impressed him must have been newly arrived Japanese drug sellers or practitioners as well as the drug stores that were already prosperous in the late Joseon Dynasty.

However, in Seoul, Koreans could receive almost the same treatment they received before 1876 because the first Western hospital, Jejungwon 濟衆院, was established to provide free treatment to Koreans. Jejungwon was founded by Allen with the financial help of the Korean government, in particular, the considerable support of King Gojong. Acquainted with a social environment antagonistic towards Christianity, Allen thought that getting the support of the royal family, especially the king, would be favorable to his mission. After healing the queen's nephew from a near fatal injury, Allen was provided with an opportunity to establish a new Western-style hospital. He took advantage of the opportunity provided to him by the royal family

1. "Koshikan oyobi ryojikan hokoku" 公使館及領事館報告 (Report of Japanese Legations and Consulates in Korea), *Gwanbo* (The Japanese Official Gazette), September 20, 1898.

(Park 2002, 42–50). Furthermore, the situation was beneficial for Allen because "the King was earnest in desiring a modern hospital and it had to be fitted up" (Allen 1885, 75).

Accordingly, Allen submitted a proposal for the establishment of a Western hospital to the Korean government in which he explicitly mentioned that the hospital would exhibit the king's love for his people. He suggested, "Should this be granted, the institution should be called 'His [C]orean Majesty's Hospital,' and it would certainly be gratifying to His Majesty to see his people cared for properly in their distress, while it would undoubtedly still further endear the people to their monarch and elevate them in many ways."[2] According to Allen, to show the king's deep concern for his subjects' health, the hospital should be a charitable one with "the medicine and services being free to all who cannot pay" (Allen 1885, 75). The king felt that he needed additional support from the people under a new socio-political environment created by opening Korea's gates to Western countries. Thus, providing medical benevolence and having the Korean people know the king's affection for them would be an effective way to strengthen his position.

Just after the opening of Jejungwon, the Korean government ordered local governments to let the populace know about its good intention to relieve people's suffering from diseases that could not be cured through consumption of traditional medicine. The announcement said that an American doctor had great skill, particularly in surgery. Hence, people might be cured miraculously with just one visit. The government would provide free service: "Visit this hospital and receive treatment without doubt!"[3]

In fact, this new hospital was not unfamiliar to Koreans. Even though the treatment performed in the new Western compound was different in every respect, the method of management was almost identical, which was clear to the founder of Jejungwon as well, for Allen believed that he had

2. "Proposal for Founding a Hospital for the Government of His Majesty, the King of Korea in Seoul," *Documents on United States Legation in Korea*, Kyujanggak no. 18046-1.
3. *Tongni gyoseop tongsang samuamun ilgi* 統理交涉通商事務衙門日記 (Report of Ministry of Diplomacy and Commerce), Kyujanggak no. 17836.

re-established an institution similar to those that had been in existence for hundreds of years (Allen and Heron 1886, 3).

Consequently, results seemed to meet the king's expectations. The hospital was very popular not only for treatment but also for novelty. To dissuade curious sightseers, "a charge of 100 cash was made for all medicine taken away from the premises." After one year, Allen said, "The people seemed very much in favor of the new hospital and responded in numbers to His Majesty's proclamations" (Allen and Heron 1886, 3–4). Considering that due to their incapability in successfully treating patients, previous medical institutions that represented the king's love for the people were abolished in 1882, the effect of founding a new hospital was even more significant for King Gojong.

Furthermore, missionary hospitals founded in the early period of evangelization shared the characteristics of Jejungwon. Another example would be a Methodist missionary hospital founded in the same year as Jejungwon. Though this hospital was called "American doctor's dispensary" in English, Koreans knew it by a different name, Sibyeongwon 施病院, which means, "a merciful hospital." At Sibyeongwon, poor Koreans in particular were able to receive medicine at low prices, or even free of charge (Lee 2003, 54–57).

At least in 1880s, establishing missionary hospitals seemed to be a collaborative effort between missionary societies and the royal family. The first Western hospital for women established by a female Methodist missionary was another example of the royal family's earnestness in showing their generosity. It was the queen that named the hospital Bogu Yeogwan 保救女館, which means "salvation for all women hospital." Whether or not the king directly contributed, by showing that the founding of hospitals was related to him, he was able to announce his affection for the people. Missionaries also had enough reason to cooperate with the royal family. Although receiving an infidel government's support, including even the naming of a hospital, might seem rather contradictory to the objectives of missionaries (Allen 1885, 74), if they wanted to settle in Korea as quickly as possible, few other choices were available.

However, as Koreans learned they could visit Western hospitals, for

instance missionary hospitals, the same way they visited Confucian doctors, they took the same attitude toward Western doctors of not wanting to pay the doctor's bill. They might not have been able to afford medicine, given that "the Korean patients who [came] . . . are, in the majority, of the lowest and poorest class." That missionary doctors gave the medicine for free to all the poorest was no wonder. In fact, however, Korean patients seemed to have no intention to pay. Even though the price of medicine was cheap, especially compared to traditional medicines, "they seem often very much surprised to find there is any charge" (Institute of the History of Christianity in Korea 1993, 12, 20).

Along with Western missionaries, another *patriarch* who wanted to *nurse* his children arrived on the scene. That patriarch was the Japanese. A benevolent art was once again emphasized by Western medicine, this time in the form of colonialism. Japanese hospitals founded in major ports by the Japanese government from the late 19th century adopted the same policy as Western missionary doctors. For instance, in order to gain the favor of Koreans, who since the late 16th century invasion by Japan of the Korean peninsula, had continuously held bad feelings towards Japan, a Japanese hospital in Wonsan, Hamgyeongnam-do province, treated more Koreans than Japanese, for whom the hospital was originally designated (Park 2005, 60–61). The Japanese policy called for financial victimization. Since Korean patients were not accustomed to paying medical bills, the Japanese who wanted to open hospitals in Korea would have to sacrifice profit. A Japanese doctor who worked for a Dojiniin 同仁醫院 (Dojin Hospital), which was established to support the rule of the Residency-General, complained that only two or three Korean patients expressed their gratitude out of 150–160 who were treated. Clearly, producing a profit by running a hospital in Korea seemed very unlikely.[4]

In one such indication, in 1909, one year before the official colonization of Korea, the Japanese Residency-General, established Jahye Uiwons 慈惠醫院, also known as "charity hospital," in three major cities. This number

4. Giichi Kobayashi 小林義一, "Chuncheon Tongsin" (A Report from Chuncheon), *Dojin* 同仁 40 (1909): 15.

increased to 46 by the end of Japan's colonial rule. Considering that after the March First Independence Movement, the biggest nationalist movement in the colonial period, the colonial government added funds for increasing the number of charity hospitals, appeasing Korean people with medical treatment was a major priority (Park 2005, 252). As the name for these hospitals suggests, they were not profit-oriented. For example, in 1909, the total hospital bills amounted to just three percent of total operational expenses because the Korean government, already under the control of the Japanese Residency-General, financially supported the hospitals within a limit of 45,000 won.[5] Furthermore, the regulations on charity hospitals stated that these institutions were to provide "medical treatment to the poor." Thus, Koreans were able to receive treatment without charge though Japanese residents were required to bring special documents authorized by pre-certified offices, such as administrative offices or police stations.[6]

Even though the main bodies, Western medical missionaries and the colonial government, were different, the intention of performing free treatment was the same: to win the people's loyalty. In the colonial period, it was the Japanese Emperor, or at least the governor-general toward whom the Korean people would have to express their loyalty. Replacing the Korean king, the Japanese Emperor regarded himself as the parent of Koreans and thus took his turn to care for his subjects and give them basic medical coverage. Bestowing a private purse on the Korean people and establishing charity hospitals would be an indisputable expression of his love for Koreans. In return, Koreans would have to be devoted sons and respectful toward the benevolent father, which was why Korean patients treated in charity hospitals had to submit a letter of appreciation to the Japanese Emperor (Shin 1997, 362).

Even though some Koreans were suspicious of the political intentions behind the establishment of charity hospitals,[7] Korean people treated in charity hospitals had less resentment toward colonial rule as a consequence

5. "Jahyewon yesan" (Budget of Jahye Hospital), *Hwangseong sinmun*, September 3, 1909.
6. "Jahyewon gaegeong gyojeong naeyong" (Revised Regulation of Jahye hospital), *Maeil sinbo* (Daily News), April 1, 1911.
7. "Jeollanam-do Yeosu," *Dojin* 47 (1910): 23.

of this merciful policy (Shidehara 1919, 79). Consequently, two medical powers, missionaries and colonial hospitals, prevented Koreans from becoming active consumers rather than passive recipients.

The New Way of Treating Patients as Customers

Retreat from Charity Policy

Even though they continued to provide free treatment, missionary doctors did not think they would be able to continue in this style of management long-term. A missionary doctor anticipated, "In a few years I think we can charge nearer the real value of the drugs, and perhaps soon" (Institute of the History of Christianity in Korea 1993, 278). As Allen pointed out, some medicines like quinine were an exception to the free treatment policy: "Except in cases where quinine was desired for persons," he did not provide even small amounts (Allen and Heron 1886, 4).

Unsurprisingly, the ratio of free treatment at Severance Hospital, the successor of Jejungwon, confirmed that the anticipation of medical missionaries was right. In 1901, total expenses were US$ 2478.06, among which US$ 330.22 came from patients (Avison 1901, 20–21), meaning about 87 percent of the patients received free treatment. In the 1920s, the situation changed. Of the hospital cases, 27.3 percent were free, and in the outpatient department, 38.6 percent were free in 1923–1924.[8] The ratio of free treatment dropped about 50–60 percent during those 20 years. By the early 1930s, not much had changed. Out of 18,332 outpatient cases, 6,486 or 35.5 percent were free.[9] Compared to the free treatment ratio of governmental hospitals, which remained at 13–14 percent in the late 1920s to the early 1930s (Park 2009, 167), the ratio of Severance Hospital was higher. Severance Hospital, however, was losing its reputation as a charitable hospital.

Similar to the benevolent art performed by missionary doctors, the

8. Severance Union Medical College (1924, 4).
9. Severance Union Medical College (1933, 29).

colonial government did not continue its charitable treatment for long. The free-of-charge policy was vulnerable to economic conditions. In 1916, charity hospitals started to collect fees from general patients, giving free treatment only to the poor. They pointed out that if free treatment had been provided without limits, people would have only relied on government assistance, and they would not try to support themselves. Additionally, another reason was given for the reduction in free treatment, an increase in managing expenses: "Due to the expansion of administrative work, expense accounts have significantly increased."[10]

In addition to the reduction in free treatment owed to economic causes, in 1925, the policy of running charity hospitals changed because the colonial government decided to cut subsidies. In 1923, the Japanese government in Japan proper adopted a retrenchment policy fueled by the damage of the Kanto earthquake. Following the policy of Japan proper, the colonial government could not but help retrenching its finances. The colonial government therefore started to shift its financial burden to provincial governments; consequently, the management of charity hospitals shifted to the provincial government. Thus, the name of the charity hospital was changed into Dorip Uiwon 道立醫院, or "provincial hospital" (Park 2005, 264–267). This change was directly reflected in the decrease in the ratio of charity patients. Before the 1920s, about 60–80 percent of patients were charity patients, but the situation changed in the 1920s. In 1928 only 14.3 percent of patients treated in provincial hospital were charity ones. The ratio then dropped to 3.6 percent in 1940 (Park 2009, 166). It would be appropriate to say that the colonial government no longer felt it necessary to appease the Korean people with free treatment.

As for Korean doctors, in particular private practice physicians, they criticized the profit-oriented policy of the provincial hospital. From that time on, the speed of commercialization in the medical field seemed to have accelerated. As far as common sense was concerned, the provincial hospital should have treated the poor or lower class; however, it sought a

10. Japanese Government-General of Korea, 1922, *Joseon wisaeng sajeong yoram* 朝鮮衛生事情要覽 (A Handbook on the Sanitary Condition in Korea), 10.

profit. Concurrently, the colonial government began to evaluate the hospitals from a commercial point of view, and each department in the hospital competed to gain the most profit. Provincial hospitals were becoming more profit-oriented than private clinics, which was "one of the main problems in developing a sanitation policy" (Hanseong Uisahoe 1933, 56–57).

Pursuit of Profit as Doctor's Right

As Western medicine showed superiority in special areas, such as surgery, it became apparent that Western medicine had the potential to make money. Advertisements spread by a traditional drug manufacturer on which names of the first graduates of Severance Medical School in Korea were printed not only showed that Western medicine comprehensively gained credibility among Koreans after the turn of the century but also that Western medicine became attractive to profit seeking drug manufactures. According to the advertisements, the graduates conducted an experiment on the medicine produced by the drug manufacturer. The graduates are even described as having been given a doctor's degree[11] even though Korea did not have any organized degree system at that time. Thus, it was not uncommon around 1900 for drug manufactures to utilize Western medicine or hire Western-style doctors as part-time or full-time practitioners (Lee 2010, 356–363). Western medicine was becoming a golden goose in the Korean medical field and drug manufacturers seemed to the first to sense the changes.

As Western medicine was becoming popular, a movement to protect its growing status was launched by Korean doctors who studied Western medicine. The Medical Research Association (醫事硏究會), established in 1908, manifested that its first priority was to urge the government to enact a law on medical doctors. It worried that if there were no law, allegedly incompetent practitioners might undermine the rising status of Western-style doctors. If its demands were to become a law, the law would have been able to accelerate profit seeking, because one of main goals of the law was to

11. *Gwanggo,* 1909. Seoul:Jahye yakbang.

protect official doctors with private practices from illegal practitioners.[12]

In fact, the Korean government enacted in 1900 the Rule on Medical Doctors (醫士規則) that enabled them to claim their exclusive rights to medical treatment as long as they were authorized by the government. Yet, the law ostensibly acknowledged Oriental-style doctors only. The demand made by the association was asking for official recognition of Western medicine and showed that doctors' attitudes toward medical profit had strengthened. The result of this movement would be that Koreans could no longer rely on the practice of the benevolent art from Western-style doctors. Nevertheless, Western-style doctors voluntarily tried to regulate their medical practices, such as establishing a regulation on treatment fees. The regulation was not a strict rule they had to obey, but a general recommendation they could follow because a lack of compromise on fees could prevent doctors from performing charitable treatment (Hanseong Uisahoe 1933, 44). Korean doctors did, however, make a regulation that would control unbounded profit seeking. Some doctors even asserted that treatment fees were not compensation but a token of gratitude from patients.[13] It was true as well that some Korean doctors provided free treatment and some founded together a charity hospital (Park 2007, 182). In addition, compared to Taiwanese doctors, the economic environment for Korean doctors was not favorable. Korean doctors, "due to the undeveloped economy of Korea," faced difficulty in being commercially successful.[14]

Nevertheless, Korean doctors tried to escape from the moral fetter, that is, the benevolent art. Competition between doctors in Korea was becoming fierce as the number of doctors increased. In 1913, when the colonial government proclaimed a law on medical doctors, the number of Western-style medical doctors was only 641. However, the number exceeded 2,000 in 1933 and exceeded 3,000 in 1940. Thus, before 30 years had passed, the number went up almost five-fold. Making things worse, "most medical

12. "Uihoe cheongwon" (Petition of Medical Association), *Hwangseong sinmun*, April 21, 1909.

13. Lee (1935, 172).

14. Shiga Kiyosi 志賀潔, "Sirop gyoyuk-e himsseora" (Make an Effort in Industrial Education), *Dongmyeong* (Eastern Light), January 1, 1923.

doctors had set up practices in cities" (Japanese Government-General of Korea 1935, 108), where they had to be more competitive. It would be unlikely, therefore, for medical doctors to be philanthropic to patients.

In contrast to this emphasis on profitability, in 1929, a doctor in a private practice would admit without hesitation that providing free treatment to the poor in the name of the benevolent art was what doctors were for. However, though they might be able to afford the doctor's bill, people forced doctors to provide free care, taking advantage of the term, "benevolent art."[15] Another doctor complained that patients would not appreciate a doctor's work no matter how much the doctor devoted himself to treat patients nor however extensively the doctor sacrificed his resources and time. In such cases, the benevolent art was merely undue pressure.[16]

Furthermore, in a roundtable discussion that dealt with medical topics, one doctor joked that doctors should try to imbue the following thinking in a patient's mind: "Unless you pay the bill, the medicine will not work." Thus, medical treatment was newly prescribed as a contract between doctor and patient although a fixed contract form did not exist. Hence, if the patient was considered as breaching the contract, it was reasonable for the doctor to boycott treatment (Hanseong Uisahoe 1933, 55). No matter how heartily patients begged for treatment, doctors, it was claimed, could refuse to give treatment as long as patients refused to pay. To Western-style doctors, the benevolent art was becoming an obstacle in commercializing medicine. They clearly did not want to keep the traditional ethics of medical practitioners anymore.

However, it was not easy for Korean people to embrace the notion of a medical consumer. Western missionary hospitals kept providing free treatment to Korean patients even though the portions of free treatment had been decreasing, as was still the case with the charity hospitals of the colonial government. After the policy change of the 1920s, the Japanese imperial family continued providing a private purse. This fund was appropriated for giving free treatment, distributing first aid boxes, and assisting in-patient

15. Sin (1929, 58).
16. Yu (1935, 96).

fees, implying that the deep attachment of Korean people to benevolence had partly continued in the colonial period.

Most of all, Confucian ethics were deeply rooted in Korea. For instance, the Korean president of a medical school, one of the earliest medical school graduates in the United States of America, emphasized the importance of the benevolent art by saying that being rich was no guarantee of genuine happiness.[17] He still viewed Western medicine as a rising profession in modern Korea from the standpoint of traditional ruling Confucian ethics and asserted that the success of a doctor did not rest on how much money he made but on how faithfully he performed the benevolent art. Accordingly, he pointed toward a graduate of his college as being a righteous doctor who charged only 20 percent of the general bill.[18] Thus, he seemed to hope his graduates would raise their status to the level of *yangban*, who were responsible for their community. However, he merely expressed his hope at a graduation ceremony or in a magazine theoretically instead of practically expending effort to establish a new ethics in Western medicine. Considering that he built and ran an orphanage, he seemed to focus more on individual awakening than social reform. As a result, some graduates promised to be doctors who would always be on the patients' side.[19] The fact that this promise was published in an article in a popular magazine, which was generally interested in the exceptional, explicitly demonstrates that they were out of the ordinary. Instead, the benevolent art was just becoming an old ethic to no longer follow or protect.

As a result, by degrees, Koreans began to consider doctors as selfish merchants rather than loving gentlemen. When Korean people thought that they received unfair medical expenses, they called the doctors thieves.[20] In the 1930s, a doctor confessed that Koreans truly did not believe in doctors any more, mainly because of two issues: making unreasonable profits and the refusal to treat moneyless patients. According to him, some Koreans even considered a doctor a low-class worker who harnessed the medical

17. O (1941, 204).
18. O (1937, 41–42).
19. Yang (1933, 102).
20. Kim (1932, 84).

profession to make money.[21]

In traditional Korea, this criticism might have been hurled at some profit-seeking drug manufacturers. However, in the colonial period, the target of attack was not restricted to those who were considered "greedy" drug dealers. It was aimed at doctors in general. At long last, Korean doctors were criticized for the violation of Korean traditions, and Koreans had arrived at a place where they perceived doctors from a different angle.

While traditional medical ethics surely began to lose power to regulate medical personnel, new professional ethics were not yet established. The state could have been a referee to control medical treatment. Unlike the Japanese government proper, however, the colonial government could not deeply intervene in the medical field. The medical insurance system was probably a means for a state to reestablish the relationship between medical doctors and patients. Hence, in 1927 Japan saw the establishment of medical insurance, which mainly covered factory workers and in 1938 included residents in rural areas. Some papers in colonial Korea anticipated this system would start around 1939, but they were wrong (Park 2009, 178). Colonial government could not afford medical insurance system. Instead it had increased the number of medical practitioners. However, compared to the number of doctors in Japan proper, the number in Korea was still low. The medical supply did not satisfy the needs of the Korean people.

Without growth in the economy or the establishment of a social welfare system, being a consumer would be a long process. Until the time when most Koreans managed to pay doctors' bill, or a welfare system like medical insurance was founded, they would pay an agonizing visit to a charity ward mainly operated by government hospitals, no matter how long it took them to walk.[22] Only in 1977 was the medical insurance system created in Korea, though it solely benefited laborers working in a large factory. As the number of beneficiaries covered by insurance increased, the doors of hospitals obviously opened wider so that Koreans started to view themselves as consumers who could afford a doctor's bill.

21. Yu (1935, 92–97).
22. Kim (1939, 299).

Conclusion

There is little doubt that, from the 17th century onwards, Joseon society began to see medical personnel who tried to escape from the Confucian ideology of shunning profit seeking. In particular, drug manufacturers or practitioners who were working in the pharmaceutical business were in the vanguard of this trend.

However, to become a commercial society, they had a long way to go. There were several obstacles as well. Western missionaries were the first to hold up the pace of commercialization. Even though they performed different methods of treatment, in order to take root in heathen ground, they, at least in the beginning, provided Koreans with free or low priced Western medicine. As a consequence of their charity, Koreans considered Western medicine similar to traditional medicine that was provided by lenient kings or noblemen.

The second impediment to commercialization was the colonial government. To appease resentment felt toward Japanese colonial rule, the colonial government, like Western missionaries, furnished Koreans with free or low priced medical treatment through charity hospitals. The medical policy of the colonial government led Koreans, at least in early days, to view Western medicine as a kind of benevolent art.

However, these obstacles were not significant enough to block the way to commercialization of medicine in Korea. Due to the retrenchment policy of the Japanese government in Japan proper and the stabilization of the colonial regime, the colonial government discontinued its charity policy in the mid-1920s. In the same period of time, Korean doctors strove to free themselves from traditional restraints. They began to criticize Korean patients who adhered to older medical ethics and carried out an effort to instigate the pursuit of profit. Although the benevolent art had deep roots in Korea, it was not tough enough to resist the strength of commercialized medicine.

Accordingly, Koreans had to adapt themselves to the new environment. Beneficiaries of unbounded affection from either the king or Confucian doctors in the pre-modern period and medical missionaries and the

colonial government in the early modern period, Koreans were again doomed to reestablish their positions as patients, that is, consumers of Western medicine. This perspective was, however, from the view of medical doctors. From the standpoint of patients, Koreans still wanted patriarchal care. They could not afford treatment fees and, even if they could, seeing a doctor was a rough job, as the number of practitioners was not enough to meet medical needs, yet they had to accept the change. It was a way of going from recipient to consumer even though they were not ready to accept this transition.

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