ABSTRACT

This paper deals with East Asian medicine in South Korea, a topic quite under-studied in social science in comparison to traditional medicine in other East Asian countries. It was only in the late 1990s that Korean medicine started to gain the attention of social scientists, sparked by controversies surrounding the pharmacy debates. Korean researchers based at Korean and Western academic institutions began work on the topic mainly in the form of doctoral dissertations, most dealing with the professionalization process of Korean medicine along with some descriptions of its theories and practices. This paper aims to supplement these contributions by offering an insight that prior research failed to supply, namely a detailed description of the dual healthcare system called Yiwŏnhwa, an unusual institutional aspect of South Korean healthcare governance under which the state recognizes two legitimate, mainstream medicines: Western and Eastern. Proper understanding of this fundamental premise of the South Korean healthcare structure will not only enrich understanding of the issues regarding East Asian medicine in Korea but also inform decision-making in various healthcare fields, including health policy research, health economics, and clinical research.

INTRODUCTION

In contrast to social science research on traditional medicine in other East Asian countries,¹ East Asian medicine

The above image, kindly provided by Jaseng Hospital of Korean Medicine, shows the Head of the Hospital, Dr. Joon-shik Shin, treating a patient admitted to an emergency department of the hospital for a severe acute spinal incident. Drs. James Young and Janine Gauthier at Rush University Medical Center in Chicago observe.

in South Korea has long been more a subject for historians than social scientists, despite Charles Leslie’s indication of the need to study it in the 1970s. Even in Korea there are few systematic studies on it predating the 1990s. Elements of traditional medicine were featured, for example, in works on shamanism and local illness categories, and in some anthropologically informed studies focusing on healthcare-seeking behavior in rural regions. However, these studies cover Korean medicine only briefly; the English-language literature is similarly sparse, with Kim and Sich, who report “Naeng” as a case of “folk illness” specific to Korean culture, seeming to be the only work mentioning Korean medicine as important to understanding local healthcare practices.

Social scientists turned their attention to Korean medicine only in the 1990s, when the seemingly straightforward intergroup conflict between Korean medical doctors and pharmacists over the dispensing rights of herbal medicines dragged on for four years, drawing everyone in the country into the debates. Intrigued by the sudden emergence of traditional medicine as a major social and political topic, doctoral dissertations, both in the West and Korea, began to focus on the issue, most dealing with the professionalization process of Korean medicine. Cho adds to the body of literature with a distinctively user-oriented focus. Still no English-language monograph dealing with a social scientific analysis of Korean medicine exists.

This paper attempts to supplement the prior scholarship by providing insights from the provider’s perspective, with a focus on the country’s dual healthcare system, under which the state recognizes two legitimate, mainstream healthcare systems, namely Western and Eastern, and two types of medical doctor, MD and KMD. As the most important basis for medical practice under the law, this system acts as the fundamental premise upon which all professional activities of concerned healthcare parties, such as MDs, KMDs, dentists, pharmacists, and most importantly, the state apparatuses, operate. Thus without a deep understanding of what this system entails in reality, the full story of Korean medicine cannot be told as researchers intend it to.

The aim of this paper is two-fold. Firstly, I seek to illustrate the role of Korean medicine in the country’s dual healthcare system, from its developments since the Chosŏn dynasty to the process of its professionalization in the modern period, and through to its clinical practice. I hope to give readers an idea of how the integration of Korean medicine into the country’s healthcare structure manifests in various aspects of healthcare practices and relevant sociopolitical issues. To

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Oriental Medicine), (PhD, Keimyung University, 2000); Jongyoung Kim, “Hybrid Modernity: The Scientific Construction of Korean Medicine in a Global Age” (PhD, University of Illinois at Urbana Champaign, 2005); Eunjeong Ma, “Medicine in the Making in Post-colonial Korea (1948-2006)” (PhD, Cornell University, 2008); Taewoo Kim, “Medicine Without the Medical Gaze: Theory, Practice and Phenomenology in Korean Medicine” (PhD, The State University of New York, Buffalo, 2011).


Although there are three types of doctor – MD, KMD, and dentist – MD and dentist are grouped together as “Western” medicine practitioners, and the term “dual healthcare system” is commonly and officially used.

For example, see this quote: “Our medical system adopts a dualized license system ... different from Western countries and Japan... Currently, our medical education institutions are divided into two and the doctor license is dualized, and the clinics are also dualized, and it causes a lot of discomfort on the patients’ parts.” (Jaeshik Kim, Wongil Lee, and Jangsoo Suh, “Ureyimhwawwa Dongsŏshak Yŏng’u” (Debates on Medical License Unitarization and Research on East-West Medicine), The Korean Journal of Medical History 7 (1998): 47-60. Italics added.)
Achieve this, I will delineate in detail the professionalization process of Korean medicine in its encounter with the force of modernity.

Secondly, by elucidating Korean medicine’s rather unusual ascent, I’d like to challenge the common theoretical framework utilized in descriptions of non-biomedical systems within which the categorical distinction between biomedicine and non-biomedical, or CAM, is accepted with a more or less unconscious understanding of these two in such terms as rational and irrational, scientific and unscientific, mainstream and marginal, epistemologically authoritative and alternative, professional and lay, prestigious and vulgar. The Korean case clearly shows that the authority of biomedicine, whether it is effected from its epistemology or from economic success, can somehow be distributed to multiple parties across MDs and KMDs in the state’s deeply integrated healthcare governance, despite the fact that the latter is purported to be practicing traditional medicine. Consequently, we see that in the Korean case Western medicine, in its conventionally perceived form and contents, is being denied the seat of sole purveyor of scientific and healthcare rationality that characterizes the bulk of healthcare governance in technologically developed countries.

**THE HISTORICAL DEVELOPMENT OF EAST ASIAN MEDICINE IN KOREA**

Practices of East Asian medicine in Korea, China, and Japan have slightly different characteristics. Unlike Western medicine, which has standardized techniques and pharmaceutics, it is important to know the historical developments of medical tradition in each country, as with East Asian medicine, history and historical texts are much closer to those who practice it. For example, because of the cessation of diplomatic ties with China, the Wenbinghue tradition, which prospered in the continent during the Qing period and became the major source of prescriptive rational, in did not take root in Korea. Thus just as the development of the Koboha [Gobang’ya] (古方派) faction in the 17th century characterizes the later developments of East Asian medicine in Korea, the publication of the Dongábügamb during Chosón Dynasty is important in understanding the later developments of Korean medicine.

**Chosón Dynasty (朝鮮, 1392-1897) to Port Opening (開港, 1876)**

Hyangyakgugubbang (綱藥救急方) – Hyangyak (綱藥) meaning local medicines in contrast to Tangyak (唐藥) meaning medicine from China – was published in 1236 during the Koryó Dynasty (918-1392) as the first medical book in Korea, and it contained descriptions of about 180 different types of local medicine, thereby giving rise to the Hyangyak tradition on the peninsula. The Chosón Dynasty saw the indigenization process of medicine accelerate. Hangyakgugubbang was upgraded to contain more than 960 formulas in the newly expanded volume of Hyangyakjipsöngbang (綱藥集成方), which was published in 1431 during the reign of King Sejong (世宗, reigned 1418-1450). He also ordered the compilation of the various formulas in accordance with the disease conditions against which the formulas were supposed to be effective, leading to the publication of Ŭbangryuch’ui (賢方類聚) in 1445.

The knowledge gained with the publication of these two projects in the early Chosón Dynasty contributed significantly to the birth of the symbol of Korean medicine in 1679, the Dongábügamb (東醫寶鑑). A book compiled by Hó Jun (許濬, 1539-1615) at the behest of King Sónjo (宣祖, reigned 1567-1608) for distribution to his people after six years of war with Japan, the Dongábügamb offered a faithful and systematic arrangement of contemporary medical achievements in an easy-to-use format complete with descriptions of various folk therapies utilizing locally grown herbs and medicines for those who did not have access to expensive medicines.

In the middle of the 500 year-long Chosón dynasty, the Qing Dynasty replaced the Ming Dynasty in China in 1644. With the interruption of Confucian Chosón’s diplomatic relationship with Qing, a corresponding break in the exchange of medical ideas followed, resulting in a gap in the Korean medical discourse regarding Wenbinghue [Onbyonghak] (溫病學), which developed in southern China in the 17th and 18th centuries. Small-scale introduction of knowledge of Western medicine occurred in the 18th century, mainly through Shirak (實學) scholars such as Ch’ôngyagyong (丁若鏞, 1762-1836) and Ch’ó Hanki (崔漢綺, 1803-1877).

**Port Opening (1876) to the Korean Empire (1897-1910)**

Unable to retain its policy of isolation in the context of rapid imperial expansion, in 1876 Chosón signed an agreement with Japan to open Korean ports to Japanese com-

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13 Four Sector Analysis is one of the major diagnostic principles in TCM (*Ibid.*, 107-8.).
17 Dongwon Shin, Namil Kim, and In-seok Yeo, *Hanguk Ŭpŏng Ingyun Danggubang (The Donggubang Read in One Volume)* (Seoul: Dulnyok, 1999); Ho Kim, *Hŏjuná Danggubangmang’i (A Research on Hub Joon’s Eastern Medical Compendium)* (Seoul: Iljisa, 2000).
mmercial activity. In the field of healthcare, this period can be characterized as a time of piecemeal changes, both in the introduction of Western medicine and in the adaptation to it by traditional physicians. The country’s first Western hospital, Chejungwŏn (濟榮院), and a medical school affiliated with it were in operation, though only briefly. Vaccination measures were propagated by Ji Sŏgyŏng (池錫永, 1855-1935), a traditional scholar-physician who accompanied the country’s learning mission to Japan following the opening of the port, to be implemented quite successfully nationwide by 1900.

The first governmental Western medical school, Uhaggyo (醫學校), was established in 1899, and many teachers were traditional physicians. The court hospital Nebuhŏngwŏn (內部病院), affiliated with this school, was also largely staffed by traditional doctors who had mastered vaccination techniques.

A decree promulgated by King Kojong in 1901 shows the ways in which “medicine” was conceived by the establishment of the day, possibly foreshadowing the development of Korean medicine in the postcolonial era. This first modern decree on the term “doctor (醫士),” translated literally as “medical scholar,” defined the profession as:

Those who, after having mastered medicine, are well versed in transformative orders in nature (天地運氣), diagnostic methods including pulsation (脈侯診察), internal and external bodily landscapes (內外景), and small formulas (大小方), qualities of warm and cold in drugs (藥品溫涼), and methods of supplementing and leaking (針灸補瀉), and therefore, are able to give prescriptions according to the characteristics of the patient’s pathological symptoms (對症投劑).

And the decree continues by providing that those who seek to qualify as doctor:

… shall be required to obtain the license of medical practice through the examination of the Ministry after the acquisition of certificates of graduation from the college of medicine and pharmacy. (The Ministry of Home Affairs, Korean Empire, “Ordinance No. 27,” January 2, 1900.)

Considering the later developments of East Asian medicine in post-independence South Korea, this event, though the decree could not be implemented, holds considerable significance, seeming to have foretold the interesting amalgamation of Western and East Asian medicine – namely East Asian medicine in a Western medical institutional framework. Still, we do not know whether the decree was the result of traditional doctors’ first professionalization effort to actively embrace Western medicine upon the country’s opening to the outside, as was seen in Dr. Ji Sŏgyŏng’s case, or if it was simply the product of the state’s policy to combine old virtues with new ideas (舊本新參).

21 So Young Suh, “Korean Medicine between the Local and the Universal: 1600-1945” (PhD, University of California, Los Angeles, 2006), 113-5.
25 Gyuhwan Shin, Han’ahak wa Sŏyanghakâ Inshikgwa Suyong (The Use of Korean Medicine Among the Public), in Han’ahak Shingminjirâ A’lla: Shongjinjiông Han’ahak Gahdehwa Yong’u (The Korean Medicine Suffering the Colonial Regime: Study on the Modernism in Korean Medicine During the Japanese Colonial Period.,) ed. Institute of History of Medicine (Yonsei) (Seoul: Acanet, 2008), 114.
26 Hunnyoung Cho, Han’ahak Piptangwa Heosul (Criticisms and Explanation on Oriental Medicine) (Seoul: Sonamu, 2009).
27 Unschuld, “The Social Organization and Ecology of Medical
Table 1: The number of Western and Eastern medicine doctors in Korea during the Japanese colonial period

<table>
<thead>
<tr>
<th>Year</th>
<th>WM doctors</th>
<th>EAM doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915</td>
<td>954</td>
<td>5804</td>
</tr>
<tr>
<td>1920</td>
<td>1111</td>
<td>5376</td>
</tr>
<tr>
<td>1930</td>
<td>1972</td>
<td>4594</td>
</tr>
<tr>
<td>1940</td>
<td>3660</td>
<td>3604</td>
</tr>
</tbody>
</table>

Post-Independence South Korea (1945-2010s)

In the wake of Japan’s 1945 withdrawal from Korea, the peninsula was divided into two zones of control: the communist North and the capitalist South. In the American-supported South, a free market-based healthcare system was instituted in which government intervention was minimized, leaving healthcare to practitioners of various kinds. Small-scale efforts at medical professionalization were demonstrated, on the parts of doctors practicing Western medicine, by the adoption of an educational system based on the American model, as well as by the attempts, on the parts of traditional doctors, to regain the status of mainstream medical practitioners, leaving healthcare to practitioners of various kinds.

In 1951, the National Assembly based in the wartime capital of Pusan drafted the country’s first healthcare law, Kungminyŏpsŏp (國民醫療法), with the main debates occurring primarily over the legal status of traditional doctors. Intense discussions in deciding whether to give the traditional doctors the title of “medical doctor” (醫師) and their practice the name of “clinic” (醫院) reflected lingering sensitivities to the degrading of titles during Japanese colonization. After several postponements, the majority finally voted in favor of East Asian medicine practitioners and passed the law, setting the fundamental framework of the country’s unique dual healthcare system, which accorded traditional physicians the status of “medical doctor” with the same recognition as Western medical practitioners and dentists.

EAM doctors quickly established a four-year college called Sŏulhanŏngwadehak (서울漢醫科大學) in 1953; 10 years later, the four-year college expanded into the six-year Tongyangŏngwadehak (東洋醫科大學). The legal revision that allowed this extension meant not only the solidification of the country’s dual healthcare system, as doctors of East Asian medicine now had the same educational qualifications as Western medicine doctors, but also the reinforcement of their monopoly over the market, as the revision made it virtually impossible for other non-regular practitioners of traditional medicine, such as acupuncturists, to achieve professionalization.

The economic development of the country in the 1970s saw a rise in the popularity of treatments in Korean medicine clinics, already highly regarded in the 1960s, the trend particularly visible in the growing demand for Chŏpyak (貼薬), For example, the entry achievements of Kyunghee University Department of Oriental Medicine in the 1970s already put the college at the same level as other Western medical schools in the capital. In the 1980s, two more Oriental medical colleges were established in the universities of Wongwang and Donguk.

The year 1987 was a significant moment in healthcare as the country began its journey toward national healthcare insurance with universal coverage. This is also the point that marks the state’s direct control over the free market-based healthcare sector by way of reimbursement payments. Importantly for Korean medicine, with the expansion of the national health insurance the state included key Korean medicine treatment modalities, such as herbal extracts and acupuncture, within its reimbursement scheme. Healthcare practitioners were now required to line up in the state’s three-step healthcare delivery system (namely primary, secondary and tertiary clinics and hospitals) and in the insurance system, which doctors had to join on a compulsory basis. The government also changed the official designation of East Asian medicine from “Oriental medicine” (漢醫學) to “Korean medicine” (韓醫學) in that year.

On March 1, 1993, after decades of military rule, a civilian president was to be inaugurated. What happened, however, on the eve of the inauguration of President Kim Young Sam (in office 1993-1997), sparked the country’s largest ever non-democratization-related conflict. The outgoing Minister of Health and Social Affairs, who was later accused by KMDs of corruption, deleted a sentence in the Pharmaceutical Act in a putative attempt to streamline domestic regulations to fit with international standards, following in the spirit of

33 J. Park, “Traditional Medicine in Korea and America” (PhD, Brown University, 1994).
35 Ma, “Medicine in the Making,” 54.
38 This school was acquired by Kyunghee University two years later.
the new governmental motto of “internationalization of the nation.”

The deleted sentence was “Pharmacists should keep a medicine cabinet other than the traditional one and keep it clean” (Article 11, Clause 1, Paragraph 7 in the Enforcement Decree of the Pharmaceutical Act), and it, KMDs argued, had practically prohibited pharmacists from handling Korean medicines, while pharmacists argued that it simply meant pharmacists should keep their medicine cabinet as hygienic as possible, unrelated to their rights to handle the medicine. Many pharmacists began to install traditional medicine cabinets immediately after its deletion; consequently, KMDs protested against pharmacists and the government which, they believed, favored pharmacists, and as the pharmacists reacted the dispute escalated to a colossal scale, with the conflict now also involving the concerned parents of the students who were boycotting classes. The Ministry of Education was thus brought into the picture as students in the KM colleges and in a considerable number of pharmacy colleges faced suspension. At the end of the dispute, which continued until 1996 and put the issue of Korean medicine at the center of national concern, four ministers of health and four vice health ministers were sacked, and the state was left deeply embarrassed, finally forced to hand over mediation rights to a civil rights group.

The pharmacists eventually won the conflict, and they were able to deal in herbal medicines, though with a limited range of 100 formulas. However, the Korean medicine communities attempted instead to gain the state’s institutional support, the number of Korean medicine colleges now having grown to 11. As was promised, the state established the Korean Institute of Oriental Medicine in 1994, and a bureau dealing exclusively with matters of Korean medicine within the Ministry of Health and Welfare in 1997.

Male KMDs were also allowed to finish their mandatory military services as public health medical officers, the quota for Korean medicine physicians in the military expanded, and the country’s only national hospital, Kungnipryowŏn (國立醫療院), established the Department of Korean Medicine. This state support increased the profile of the colleges of Korean medicine, already destinations for the nation’s high achieving students, even more than before, to the extent that in the early 2000s entry difficulty for Kyunghee University’s Department of Korean Medicine was equal to, if not greater than, that of the Department of Medicine of Seoul National University, the country’s all-time top-ranked school since the establishment of the nation. In the late 1990s and early 2000s, the nation’s 11 schools of Korean medicine, in terms of the achievements of students who enter the schools, have maintained, on average, higher positions than most Western medical schools in Korea.

The 2000s can be characterized by active state intervention in matters of Korean medicine, starting with the introduction of specialist qualification in 2000 in eight subfields: internal medicine, gynecology, pediatrics, neuropsychiatry, acupuncture, ophthalmology-ENT-dermatology, rehabilitative medicine, and Sasang constitutional medicine. In 2003, the National Assembly passed the Korean Medicine Promotion Law, which specified the duty of the state and the provincial governments to draft Korean medicine promotional policies every five years. In 2010, for example, the central government alone spent 52.1 billion Korean won (US$48.5 million) in Korean medicine-related R&D, comprising 5.23 percent of state spending in healthcare technology R&D, with increases at a yearly rate of 16.5 percent since 2006. In 2008, the first national Korean medicine medical school in the form of the American-style graduate school system was established at Pusan National University. The year 2010 saw another revision to the healthcare law that allowed MDs, KMDs, and dentists to employ each other in hospital-level facilities. As of now, the state plans to establish the country’s first national hospital of Korean medicine when the old National Medical Center is relocated in a few years’ time.

THE TWO-TIERED MEDICAL LICENSE SYSTEM

(KIWÔNHWA SYSTEM)

Korea’s healthcare can be described as a dual medical system. Korean medicine has the same legal, institutional, economic, and social recognition as Western medicine, creating a unique situation where two types of legitimate medical doctor (MD and KMD) function in the country’s healthcare sector. In all legal regulations, KMDs are subject to the same legal duties and rights as are MDs and dentists. How-

found at http://blog.daum.net/gogi2222/2. The tendency of students to opt for Korean medicine schools over Western medicine schools upon acceptance to both was particularly strong in this period.

Lee, Dongshiajìntiănghūghāi Hyŏndehua, 113-4.

Ma, “Medicine in the Making,” 143.

Ibid., 160-2.


Ibid., 265.

The assortment of Pechi’p’yo from the late 1990s to 2010s can be
Table 2: A comparison of legal rights and status among doctors in Korea

<table>
<thead>
<tr>
<th></th>
<th>MD</th>
<th>DDS</th>
<th>KMD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td>Mix of 6- and 4-year (41 schools)</td>
<td>Mix of 6- and 4-year (15 schools)</td>
<td>Mix of 6- and 4-year (12 schools)</td>
</tr>
<tr>
<td><strong>Specialist Training</strong></td>
<td>Since the 1990s</td>
<td>In place (not adversarial at the clinical level)</td>
<td>In place (not adversarial at the clinical level)</td>
</tr>
<tr>
<td><strong>Certificate</strong></td>
<td>Medical, birth, death</td>
<td>Medical, death</td>
<td>Medical, birth, death</td>
</tr>
<tr>
<td><strong>Hospital</strong></td>
<td>Hospital, clinic, long-term care hospital</td>
<td>Dental clinic, dental hospital</td>
<td>KM clinic, KM hospital, long-term care hospital</td>
</tr>
<tr>
<td><strong>Alternative Military Service</strong></td>
<td>Military physician, public health</td>
<td>Military physician, public health</td>
<td>Military physician, public health (after 1 year of clinical training)</td>
</tr>
<tr>
<td><strong>Employment in the Public Sector</strong></td>
<td>Professional license holder (as a Medical Officer in WHO or in KOICA)</td>
<td>Professional license holder (as a Medical Officer in WHO or in KOICA)</td>
<td>Professional license holder (as a Medical Officer in WHO or in KOICA)</td>
</tr>
<tr>
<td><strong>Practice</strong></td>
<td>Cross-employable among each other (at the hospital level)</td>
<td>Cross-employable among each other (at the hospital level)</td>
<td>Cross-employable among each other (at the hospital level)</td>
</tr>
<tr>
<td><strong>Number of Physicians</strong> (2012)</td>
<td>104,397</td>
<td>26,098</td>
<td>19,912</td>
</tr>
<tr>
<td><strong>NHI (2010)</strong></td>
<td>Hospitals (41.2%); Clinic (22%)</td>
<td>3%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

ever, in practice the Yiyŏnhwa system strictly separates two official healthcare systems, with MDs practicing “(Western) medicine” and KMDs practicing “Korean medicine,” despite the fact that there is no definition whatsoever regarding what constitutes “medicine” and “Korean medicine” in the law itself. Korean Medicine is thus best defined as “what KMDs are practicing.” Accordingly, despite the fundamental premise of the bipartite license system, legal proceedings show that the firm legal line demarcating these two practices has become increasingly difficult to draw, as stated in a legal statement issued by the court:

Though in our country where Western and Korean medicine are completely legally separated, with the development of technology in diagnosis and treatment methods, and with the increasing narrowing of the gap between two medicines, it is very difficult to distinguish the area of expertise between MDs and KMDs. ... (Court ruling on the case of a neurologist using acupuncture as a part of nerve stimulation therapy. 31002-2707, 85.3.19. Italics added and translation by the author.)

A definition of Korean Medicine, however, was attempted with the installation of the Korean Medicine Promotion Law, in which Korean Medicine was defined as “medical practice and medicinal affairs based upon Hanŭhak that has been handed down to us from our ancestors.” Its new revision, effected in 2012, added “and scientifically developed KM medical practice and medicinal affairs” after “medical practice and medicinal affairs” in the above sentence. However, in the Medical Law itself, there is still no definition of what constitutes “medicine” or “Korean medicine.”

Two types of medical schools exist in the country: there are 41 western medicine schools and 12 Korean medicine schools. The Korean medicine curriculum has the distinctive contents of East Asian medicine, though couched in the framework of medical education. These medical schools generally top annual SAT charts in terms of entry difficulty. And according to national statistics, these doctors have similar income levels. In terms of the portion of healthcare resources taken up, KMDs and dentists occupy a small part, around four percent of annual governmental health insurance reimbursements, partly because the non-insurance-covered treatment modalities that contribute to the finances of KM clinics such as Chŏpyak (貼創) are not reimbursed by the government. Dentists also resort to non-NHI-covered treatments such as dental implants as a major part of their income. Subsequently, there have been assertions by civil rights groups that both Chŏpyak and popular dental treatments should be covered in national health insurance as they constitute a major portion of the public’s out-of-pocket expenses in healthcare spending.

The Korean state continues to have difficulties in accommodating this two-tiered healthcare system, as there are no comparable cases for consultation in other technologically developed countries. Most government officials whom I met while working on various governmental projects mentioned the difficulties they face in coping with this distinctive Yiyŏnhwa system, strongly expressing their wish to make the outcome of Korean medicine policy products to be as comparable as possible, in style and content, to what they call “Ŭggwa,” (醫科) meaning Western medicine. Recently, to the relief of the officials at the Department of Statistics and other related governmental Ministries, an advance in this direction was made as the Korean medicine community finally agreed to use the newly updated, ICD-10-based KCD (Korean Classification of Disease), discarding their independent KCD-OM disease classification system.

The governmental bureau that deals exclusively with matters of Korean medicine in the Ministry of Health and Welfare (MOHW) has two subdivisions: the bureau of Korea Medicine and Pharmacy Policy and that of the Korean Medicine and Pharmacy Industry. Though the Ministry of Education is responsible for the regulation of the nationwide

59 A definition of Korean Medicine, however, was attempted with the installation of the Korean Medicine Promotion Law, in which Korean Medicine was defined as “medical practice and medicinal affairs based upon Hanŭhak that has been handed down to us from our ancestors.” Its new revision, effected in 2012, added “and scientifically developed KM medical practice and medicinal affairs” after “medical practice and medicinal affairs” in the above sentence. However, in the Medical Law itself, there is still no definition of what constitutes “medicine” or “Korean medicine.”

58 Park, Hanbanggyowwa Uryŏbop, 84.


60 In an attempt to meet this public need, the government issued a plan to reimburse Chŏpyak in October 2012, and unexpectedly, the KMDs are divided over whether or not they should accept the government’s proposal. See “Chi’ryoyong Ch’ŏpyak Pohŏm Gubŏhwonako Haisadul Nehong” ( Internal Conflicts Escalated Among KMDs over the NHI Coverage of Therapeutic Chŏpyak), Money Today, November 6, 2012.

61 Since the February 2012 I have been involved in various governmental health policy projects and had a chance to work with governmental officials, notably from the Ministry of Health and Welfare and Korea Health Insurance Review and Assessment Service (HIRA).
medical schools, the opening of the national Korean medicine medical school at Pusan National University (PNU) based on the governmental platform of Korean medicine initiatives such as standardization (or scientization), globalization, and industrialization of Korean medicine seems to be facilitating the exchange of opinions between the staff at Korean medicine bureaus at MOHW and those at PNU. The Korea Institute of Oriental Medicine (KIOM) conducts basic science research, and a significant portion of the government’s annual funding goes to this institute. The 21st Dongubogam Project is one of the main research projects that KIOM is pursuing today as it aims to create a 21st-century version of Dongubogam, incorporating all the scientific advances and textual scholarship that the institute has produced since its inception.

For the establishment of Pusan National University School of Korean Medicine, the government spent 50 billion Korean won (US$47 million) in building a cutting-edge medical school where the student-staff ratio is close to 5:1, with a state-of-the-art lab and library, and other facilities such as the Problem-Based Learning quarter and large venues dedicated to practical clinical training and tests (OSCE and CPX). The on-site clinical research center affiliated with the school’s hospital of Korean medicine is one of the biggest clinical research centers in the country where all major clinical research activities can be performed.

We have seen so far the way in which Korean medicine is fully integrated into the country’s healthcare system under the Yiwoinhuw system, despite the fact that the nature of that system and the decades-old antagonism between its two parts prevents the integration in practice, which is an important aspect to be explored but beyond the scope of this paper. In the following sections, I will present a brief sketch of the practices of Korean medicine with which to examine the integrated institutional features of Korean medicine hitherto described.

Figure 1: The author (in the middle) is moderating a debate class in the module “Korean Medicine and Contemporary Society” among second-year Korean medicine students at PNU. (Photo provided by the author.)

The practice of Korean medicine should be seen against an institutional backdrop where Korean medicine doctors’ practices are subject to detailed government and legal regulation. This is the point that prior scholarship on Korean medicine has failed to elucidate, lacking clarification of this fundamental context. Most KM doctors open their clinics individually or in groups of two or three. Many clinics tend to specialize in fields such as pediatrics, gynecology, dermatology, or ENT, while some specialize even further in specific conditions. Many of them are networked, meaning the central office provides support for customer care at individual clinics despite the fact that local doctors have control over treatment. Opening or working in long-term care hospitals is another trend in the fields. Most KMDs working in hospitals have free access to various diagnostic and treatment equipment, while locally based physicians are also able to ask nearby radiologists to conduct various tests for them.

Given access to comprehensive rights in the system, the doctors utilize a multitude of treatment modalities which can be largely divided into two groups: treatments based upon classical theories of East Asian Medicine and those based upon biomedicine.

62 The head of the Korea Medicine Bureau at the Ministry of Health and Welfare, and the representative from PNU School of Korean Medicine, for example, sit together on the state-level committee established for the exchange of information on East Asian medicine between China and South Korea.

63 The Korea Institute of Oriental Medicine is under the Ministry of Education and Science.

64 One rationale behind the establishment of PNU School of Korean Medicine was to facilitate cooperation between these two groups of doctors, according to the speech delivered on April 25th, 2012 at PNU by lawmaker Kim Yongik, the former presidential adviser for healthcare and social welfare who coordinated the establishment of the school.

65 Eunjeong Ma, for example, dealt with the legal dispute over the use of computed tomography (CT) staged between MDs and KMDs (Ma, “Medicine in the Making”), and those disputes have been continuous concern for those in and out of the medical circle (See Jongchan Lee, Hanguk Ŭryo Denonjeng (Debates on Healthcare in Korea) (Seoul: Sonamu, 2000)). For meaningful dialogues to occur, however, many methodological huddles need to be cleared, and one of the implicit aim of this paper is to provide an impetus in that direction.

66 As Korean medicine is mainstream medicine in the country’s healthcare, CAM practices are considered to be therapies that are not part of Korean medicine, as can be seen in the following quote: “As the only country in the world where the medical practice is divided into two, this situation causes problems... In the situation where orthodox medicine is dualized, CAM practices are also expanding their territories.” KH Byun, “Noingông’ang Jüngiínűl Wihan T’onghabihákku Yökhalgwa Piryosŏng” (The Need and Role for ‘Integrative Medicine’ for Gerontological Care), 2009.
East Asian Medicine-Based Treatments

For treatments using medicines in granule, pill, or decoction form, the most frequently utilized style of clinical reasoning is that of the Donggabogam, which is a standard form of practice where various East Asian medical theories such as Yinyang and the Five Phases (陰陽五行), Theories of Meridian (經絡理論), Zhang Xiang [Jangsan] (藏象), Eight Rubrics diagnosis (八難診斷), and Kimiron (氣味論) are applied according to the disease conditions at hand.67 Another form derived from this and used by many doctors is Hyŏngsanghak (形象醫學), where the choice of formulas is based upon the four key elements (精氣神血), which the Donggabogam describes as the fundamental attributes of life. The excess and deficiency in each of these four attributes correspond to the pathophysiology of each person.68

Another defining feature of Korean medicine is Sasang Constitutional Medicine (四象醫學, SCM). According to Sasang practitioners, human constitutions are divided into four types. When the doctor approaches the patients’ conditions, he or she should first begin with an identification of the patients’ innate constitution [Chiin] (知人) and then proceed to identify the symptomatic patterns [Chijúng] (知時). The consultation is wrapped up with the appropriate prescriptions [Yongyak] (用藥).69

Shanghanlun [Sanghanlon] (傷寒論)-based practices also have considerable influences in the practice of Korean medicine. The stream can be divided into two groups, the first being the classical stream which acknowledges the six meridian-based interpretation (六經辨証) of the classical text and the other being the Japanese style Kobangp’a (古方派), famous practitioners of which including 18th-century Japanese scholar Yoshimasadódo (吉益潤道, 1702-1773), who discarded all classical theories to establish a theory of pharmacutes based purely on clinical experience.70 Wembingh’oe [Onbyŏnghak] (溫病學) formulas are also used by those who work on conditions such as atopic dermatitis and psoriasis, in which heat is considered to be the main pathological factor. Raising Yang therapy [Buyangbŏ] (扶陽法) is another stream of Korean medicine practice that has a distinctive group of supporters.71

With respect to acupuncture and moxibustion (鍼灸), the majority of physicians apply the classical style of needling that adheres to the Theory of Twelve Meridians (十二經絡理論). Various classical techniques such as Yŏngsubosa (迎收補瀉), Yŏmjonbosa (捻轉補瀉), Mujabŏp (鍼刺法), Gojábŏp (巨刺法), and Ashihyŏlbŏp (阿是穴法) are utilized.72 This classical acupuncture technique is called Ch’ech’im (體針). This classical acupuncture is also based upon the concept of Zhang Xiang [Jangsan], which holds that troubles with internal organs manifest themselves on corresponding surfaces of the body. As for moxibustion, the indirect method of moxibustion [Kyŏngu] (隔灸), in which moxa is burned on an elevated porous plate placed over specific acupoints, is much more commonly used than is direct moxibustion [Jiggu] (直灸), applied directly on the skin. Cupping techniques [Puhang] (附紅) of the dry (乾) and wet (濕) type, the latter involving slight bloodletting, are also routinely utilized for conditions affecting the musculo-skeletal structures.

An acupuncture technique popular among most Korean doctors is Sa Am Ch’imbŏp (含岩針法), in which only five acupuncture points on the forearm and lower leg are utilized for treatments. Eight constitutional acupuncture [Pa’lche’jilch’im] (八體質針) is also commonly used among doctors, and it divides the Sasang constitution into two more subtypes using hot and cold or Yin and Yang attributes. The first needling in this technique is implemented in order to identify the constitution, with proper needle insertions then taking place on the points that have been set for the conditions of each of the eight constitutional types.73 One acupuncture therapy [Ilch’im] (一針療法) was formerly very popular among practitioners. In this practice, extreme care is given in diagnosing the patient’s pathological conditions to find the single most important needling point.74 A newly emerging acupuncture technique is Beggak Ch’imbŏp (百針針法), in which the right meridians and points are chosen based upon the successive order the circulating qi follows along the tracts of the twelve meridians.75 Acupuncture techniques that are widely used in China and Japan such as Tongsich’imbŏp (董氏針法) and Sawada ch’imbŏp (澤田流針法) are also actively applied in practice by some physicians.

Biomedicine-Based Treatments

Ch’unayobŏp (推拿療法), which manipulates mainly the spinal column, is also a popular therapy among KM physicians. The Korean Medicine Chuna Society is now building an active alliance with osteopathic colleges in the US.76 Mesŏn

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67 These are the basic theories of East Asian medicine. See Farquhar, Knowing Practice: The Clinical Encounter of Chinese Medicine, chapter 4.
68 See Hyŏngsang Society's homepage (http://www.hyungsang.or.kr) for details.
70 Tehanbokch’ihakhoe (大韓腹治醫學會) is the academic society which follows this style of Shanghanlun-based practice. See http://www.bokchi.com for more information.
71 Somunhakhoe (素問學會) is the center for exchange of information by physicians who rely on this method of clinical reasoning. See http://www.somun.or.kr for more information.
72 These are all techniques that are used to extract bad qi (邪氣) and replenish good qi (正氣), and to maximize the therapeutic efficacy of acupuncture stimulation.
74 Kim’s Iŏch’im Hakhoe was once the venue for exchanging information on this technique.
75 See Taewoo Kim, Medicine Without the Medical Gaze: Theory, Practice and Phenomenology in Korean Medicine” (PhD, State University of New York at Buffalo, 2011), 137-70 for details.
76 The society is set to start its professional training program at the College of Osteopathic Medicine at Michigan State University next year, according to the executive directors at the Korean
treatment（埋線療法）, in which thin autolytic filament-like materials are inserted under the skin, is another emerging therapy, and it is mainly used for aesthetics and pain relief. Smile-in-Face acupuncture [Anmyōmisochi’m]（顔面微笑針）is a therapy applied for clients who have aesthetic concerns. Extensive anatomical knowledge is required to correctly apply these techniques as they are aimed to affect muscular structures underneath the skin. Various techniques of peeling medications are also used for dermatological treatments.

IMPLICATIONS OF THE INTEGRATED STATUS OF EAST ASIAN MEDICINE IN SOUTH KOREA’S HEALTHCARE

Comparing Traditional Medicine in Other Countries

The degree of the public’s trust and the social and cultural capital accorded to Korean medicine is quite unusual in comparison to the status of traditional medicine, and complementary and alternative medicine (CAM) in other countries. In China, for example, despite the active promotion of traditional Chinese medicine (TCM), young aspiring high-school graduates do not seem to choose TCM colleges as their destinations, partly because the career prospects of TCM practitioners are not so bright. With the Meiji Reform Japan adopted Western medicine as its only legitimate medicine, and practitioners of East Asian medicine have since not been recognized as official medical doctors; instead, East Asian medical practices are shared by a small group of Kampō physicians, acupuncturists, and allied health professionals educated in junior college-level institutions. The Taiwanese state aspires to enhance the profile of Chinese medicine by establishing more colleges of Chinese medicine, but the preference of the public and students for Western medicine remains an obstacle. According to Charles Leslie, in India the efforts of Ayurvedic physicians to gain status ended in failure in 1970s, bringing Ayurvedic practitioners to para-professional status. Osteopathic physicians in the US may be the only non-biomedical profession successful in achieving status comparable to that of Korean medical doctors. Further study is necessary to critically compare these two professions and their relationships with their respective biomedical communities (see Table 3).

The successful ascent of Korean medicine cannot simply be attributed to its economic success, as public recognition of a “trustworthy” physician involves not only economic considerations but also a mainstream healthcare consciousness—a sense in which ordinary people are comfortable relying on medical professionals in matters of health that go beyond the legal provisions accorded to them. Nor did the situation come about simply through cultural affinity. The successful professionalization efforts of physicians of Korean medicine in the six decades of post-independence Korea might offer another explanation. But this explanation does not explain why the same strategy did not work for other professions in Korea or elsewhere. Indeed, in-depth analysis is necessary to fully explain the success of Korean medicine.

Integrative Medicine and Controversy: The Impact of the Global on the Local

As we have seen, the South Korean healthcare system in its modern, institutionalized, and mainly biomedical-based

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77 See http://rank2010.netbig.com for college rankings for Chinese high school graduates. In 2005, for example, Beijing TCM College, one of the country’s most revered TCM institution, ranked below 100th place. Subject-based rankings, however, which are how the Korean college rankings are constructed, might put those colleges well under the 500th position.

78 Hsu, The Transmission of Chinese Medicine, 147.


82 See Norman Gevitz, The DOs: Osteopathic Medicine in America (Baltimore, London: The Johns Hopkins University Press, 2004) for details regarding the professionalization of osteopathic medicine in the US.

83 See Na, “Why Just Korea?,” 49.

84 For example, Korean medicine cannot be said to be culturally closer to Koreans than Ayurveda is to Indians.

85 In that vein, Cho refers in “The Quest for Professional Status” to KMDs’ apt use of what he calls “legalist strategy,” in which legal justifications were frequently used to solidify KMDs’ monopoly over the Korean medicine market.
form exists within a heterogeneous dispersal of Western and Korean medicine practitioners. In the context of this unique mixture of medical rationality in Korean healthcare, the globalization of healthcare in Western countries has had interesting impact.

One case in point is the advent of integrative medicine in the West. It is generally defined as a new paradigm of medicine characterized by patient-centered care and a team approach in which diverse complementary and alternative medicine therapies are actively employed.86 This trend has also arrived in Korea, as evidenced by the establishment of several medical societies advocating for this integrative approach.87

The issue in the Korean healthcare system is the existence of two types of medical doctor. The state’s many healthcare policies had hitherto been geared to facilitate cooperation between these two types of doctors in the name of “cooperative treatment” [Hyŏpjjin] (協診), not the patient-centered amalgamation of practices that this integrative approach to healthcare yearns to achieve. Subtle differences in the Korean context exist with epistemological and political connotations in the use of the notions of “cooperation” and “integration” as the former recognizes the worth and thus endorses the status quo of the current Yiwŏnhwa system, while the latter devalues the bipartite state of the healthcare systems and supports instead their unification or the discarding of the one.

A remark by a longtime head of a Western and Korean medicine cooperative hospital did not fail to notice the subtlety in their names. One consists mainly of MDs, another a mixture of MDs and KMDs, and another mainly of KMDs.

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87 There are three medical societies that have “integrative medicine” in their names. One consists mainly of MDs, another a mixture of MDs and KMDs, and another mainly of KMDs.
tleties implied in the use of those words. When asked about the approaches of “integrative medicine” in a workshop that was held for the facilitation of cooperative medical care, he responded,

1 was talking in terms of the cooperative care utilizing both doctors, but if you talk about “integrative medicine” it’s a completely different matter (hence my statements should be entirely re-evaluated in different terms or my statements do not help in the discussion).88

The controversy surrounding the “Natural Novel Drug” [Chŏnyŏnmulshinyak] (天然物新藥)89 shows the complexities of developments in the healthcare field within the context of industrial interests and legal regulations. This new category of drugs is actually Hanyak (韓藥, formerly 漢藥), “East Asian medicine” prescribed in Korean medicine clinics. The only difference between the “Natural Novel Drug” and Hanyak is that the novel drugs have been developed by domestic pharmaceutical companies and have passed some clinical trials. Nevertheless, due to aspects of corporate interests and Korea’s complex legal regulations, the drugs are prescribed only by Western medicine doctors, with reimbursements endorsed by National Health Insurance. Through this process, KMDs have been excluded from the right to prescribe, thus defying the Yiwŏnhwa system stipulating the strict separation and recognition of exclusive licensure in the two medical systems. Furthermore, the development of these drugs had been funded by the government on the basis of the Korean Medicine Promotion Law in an attempt to boost the competitiveness of domestic pharmaceutical companies in global markets.

The KMDs are now staging protests against the governmental agencies that allowed these developments to occur, asking the Ministry of Health and Welfare to prevent Western medical doctors from prescribing these drugs. We can thus see in this case how global economic forces, namely competition in the global pharmaceutical market, have come to have an unexpected impact at the local level, namely the Yiwŏnhwa-based healthcare system.

CONCLUSION

The main contribution of this paper has been to give the reader a window into the dual nature of the Korean healthcare system. We have extensively looked at the ways in which traditional medicine has developed from the Chosŏn

88 Myungcheol Ryu, “East-West Copperative Model in Kyunghee University East-West New Medicine Hospital” (presented at the PNU Western and Korean medicine Cooperative Treatment Symposium, Pusan National University, March 18, 2012).

Dynasty to contemporary Korea. It is also apparent that Korean medicine had a strong legal foothold in the establishment of the country’s first medical law in 1951, where it was given legitimate status as mainstream medicine alongside biomedicine. Nevertheless, we further note that developments in the colonial era and prior periods have had substantial impact on later developments. If, for example, Korean medicine had not had a relatively secure presence during the colonial era due to such factors as the lack of medical staff, the enormous autonomy given to the Chosǒn Government-General, and the breakout of the Sino-Japanese war in the 1930s, which led to an urgent need for medicine on the war front, the fervor and enthusiasm shown on the floor of the National Assembly in drafting the country’s first medical law that ultimately ushered in a system of dual healthcare would not have come about.

Thus, this paper has discussed in detail the historiography of developments in medicine to review the Korean situation as thoroughly as possible, not just synchronically but also diachronically, in order to understand the factors that might have contributed to the interesting healthcare system we find in contemporary South Korea. This multi-dimensional understanding, along with knowledge of the elements of contemporary healthcare politics, is essential for understanding South Korean healthcare, whether in the social scientific context of analyzing professional conflict, legal disputes, disease classification schemes, and national health insurance, or in the clinical context of researching Korean medicine.91

“License unitarization” [Ŭryûrwŏnhwa] (醫療一元化) is seen as a quick method for addressing the complicated healthcare issues in Korea today. Despite the favorable opinions harbored by nearly every stakeholder concerned, including Western and Korean medicine physicians, pharmacists, the public, and the state, strong animosity among those in the field prevents its implementation.92 Indeed, in years to come, it will be a matter of great academic interest to observe how the actors in Korean healthcare reach a compromise.


91 Many CAM-related clinical research papers written by Korean authors, mainly by MDs, frequently fail to depict the South Korean healthcare correctly as many of them, either intentionally or unintentionally, omit this Yiwŏnhwa healthcare framework.

92 This antagonism between Western and Korean medicine physicians is no longer a surprise for the public. The typical strategy of MDs (Ŭsa) in downgrading KMD (Hanûisa), mainly through internet exchanges, is to refer to them as “Hanbangsa,” removing off the ultimate “medical doctor” designation, while KMDs call Western medicine practitioners “Yangbangsa,” employing the same strategy, or “Yangbaekjŏng,” meaning Western butchers. Both MDs and KMDs call pharmacists (Yakssa) “Yakssage,” meaning drug wrappers, implying that they should simply wrap medicines and not execute clinical judgments.