

# **Adapting to a ‘Biomedical World’**

The Relationship between Doctors of Korean Medicine (KM) and Biomedical Doctors  
in the Process of ‘Western- Korean Cooperative Medical Treatment’ (WKCT)  
in Hospital Settings

by In Hyo Park

Dissertation

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First Supervisor: Prof. Dr. Dr. Thomas Gerlinger

Second Supervisor: Prof. Dr. Lutz Leisering

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*To Prof. Dr. Gunnar Stollberg*  
*(1 October 1945 Berlin – 25 March 2014 Berlin)*

# Acknowledgement

The main idea of this thesis traces back to the time when I recognized differences of attitudes between biomedical doctors and KM doctors towards physical therapists in a “co-operative” hospital in Busan, South Korea, while taking part in a practical training as an apprentice therapist during the study in the department of physical therapy 9 years ago. Since the late Prof. Dr. Gunnar Stollberg – my ex-doctoral supervisor – expressed interest in my experience and the existence of two different kinds of medical doctors in South Korea, their relationship in actual clinical settings has been the main theme for my doctoral research, followed by fieldwork in Busan in 2011 and 2012. However, I never realized that it would take such a long time to finish the thesis by the year of 2017. Meanwhile, I have struggled with writing in order that the findings of this study would not remain as a historical report about the past, but still as a current report describing the actual relationship between KM and biomedical doctors.

In acknowledging a variety of help and support I received for this thesis, first, I would like to express my deepest thanks to my first doctoral supervisor Prof. Dr. Dr. Thomas Gerlinger and the second supervisor Prof. Dr. Leisering, both of whom continuously encouraged me with optimism and confidence with patience, as well as providing theoretical and methodological insights with me to finish the thesis. I also would like to thank my wife Sook-kyoung, my daughter Jeong-yun, my parents and my parents in law, and my sister Sae-young and brother in law Kyeong-han, as well as my friends Andrés who gave me enormous inspiration for the thesis, Kyeong-won and Seok-ah who gave me energy to go on writing, Jae-jin and Shin-yeong who kindly allowed me to finish the final draft in their home during my last stay in Bielefeld. I have also been indebted to Mr. Richard Forsythe for his thorough proofreading.

As of finishing this thesis, I feel that I have started to undertake the track of connecting the disciplines of sociology and anthropology with the fields of medical health science, dealing with the relations between medical professionals, and merging the cultural aspects of health and illness with qualitative research methods. I herewith resolve to devote myself to academic pursuits by recognizing that this thesis is not the end, but the beginning of the road.

*This thesis is respectfully dedicated to the memory of the late Prof. Dr. Gunnar Stollberg, who made me reify my uncertain ideas and encouraged me to keep on conducting the thesis to the day of his passing.*

# Summary

## **Background and Purpose of the Study**

With the re-emerging importance of traditional medicine (TM) and the growing interest in complementary and alternative medicine (CAM) since the late-twentieth century, their relations with modern biomedicine have been widely discussed within the concept of medical pluralism. As a case study, this work examines the current South Korean medical system in which traditional medical practitioners are acknowledged by the state as Korean medicine (KM) doctors, holding an equal legal status with biomedical doctors. It aims to analyze the relationship between KM and biomedical doctors in clinical practices in which they are mutually involved with their patient management under the name of ‘Western-Korean Cooperative Treatment’ (WKCT). Concerning the main research questions, this study first seeks to find the crucial mediating factors that enable two different styles of doctors to work together despite their different viewpoints on health and illness. Moreover, it also tries to examine their power relations in the process of the WKCT in clinical practices.

## **Conceptual Framework – Biomedical Dominance in Situations of Medical Pluralism**

The concept of ‘medical pluralism’ as “the co-existence in a society of differing medical traditions, grounded in different principles or based on different world-views” (Cant, 2004: 184) was raised to describe and analyze various forms of the relationship between modern biomedicine and TM/CAM in the discipline of medical anthropology (e.g. Leslie, 1976, 1977, 1980; Dunn, 1976), medical sociology (e.g. Baer, 1995; Cant and Sharma, 1999) and medical history (e.g. Ernst, 2002; Jütte, 2013). Under the concept of medical pluralism, various studies have explored the relationship between biomedicine/biomedical doctors and traditional indigenous forms of medicine/medical practitioners in each society, with the range of conflict, coexistence and cooperation. Among them, critical medical anthropologists (e.g. Baer, Singer & Susser, 2003; Singer, 2004; Baer, 2011) have a particular interest in the issues of biomedical dominance over traditional indigenous medicine in situations of medical pluralism, arguing that the unequal status of biomedicine and traditional forms of medicine within a certain medical system reflects the unequal situations in a wider society to which the medical system belongs, while they usually indicate biomedical doctors’ superior legal status over traditional healers or their patients’ higher socio-economic status compared with those

patients of traditional healers as evidence of biomedical dominance. This study examines the South Korean case of KM and biomedical doctors' working relationships in clinical settings where two different kinds of medical doctors are jointly involved in the process of diagnosis and treatment for identical patients, while comparing it with the previous research regarding the debates on biomedical dominance over other forms of medical traditions within the notion of medical pluralism. In this study, I focus on whether there is any kind of situation that can be classified as biomedical dominance despite their equal legal status as medical doctors and – if so – how such a dominant situation is exerted in the process of the WKCT in the clinical practices.

## **Research Method**

In order to examine the actual process of the WKCT in clinical settings and analyze the relationship between KM and biomedical doctors in this process as an empirical inductive study, I conducted qualitative interviews with 24 interviewees (twelve KM doctors, two students in a KM school, six biomedical doctors and four hospital administrators) in four different styles of WKCT hospitals (a medium-scale KM-oriented hospital, a large-scale KM-oriented hospital, a medium-scale biomedicine-oriented hospital and a large-scale biomedicine-oriented hospital) in the city of Busan in 2011 and 2012. During the interviews, I mainly focused on the concrete process of the WKCT in clinical settings, the working relationship with their counterparts and external factors having an effect on the process of the WKCT. This was followed by the coding process, inspired by the Grounded Theory approach.

## **Historical Background and Current Features of the South Korean Medical System**

Characterized as a dualized professional medical system of KM and biomedicine, the South Korean medical system can be understood within the historical context of the inflow of 'Western' biomedicine and its settling down process as an orthodox medicine on the one hand and the modernization process of traditional medicine in response to the prevalence of biomedicine on the other, from the 'Open Port Period' (1876-1910) over the Japanese colonial period (1910-1945) to the post-colonial period (1945-). During this modern era, biomedicine has occupied a prominent position as the mainstream medicine predominating over traditional medicine. Meanwhile, traditional medicine has experienced competition, conflict, subordination and re-acknowledgment from the state, as well as coexistence and cooperation in the face of the relationship with Western biomedicine. As a result, a peculiar

dualized medical system has been developed since the beginning of the post-colonial period with the establishment of the Medical Service Act (MSA) in 1951, acknowledging both biomedical doctors and KM doctors as medical doctors with an equal legal status while strictly separating their medical jurisdictions. Under this circumstance, the biomedical sector enjoys its position as the mainstream medicine – in terms of its size and leverage – in the current South Korean medical system, whereas the KM sector is also in range with the biomedical sector as an important part of the professional medical sector. The strict separatism of the MSA into the KM and biomedical sectors has resulted in the need for their cooperative medical actions in clinical settings, shaping clinical practices as the concept of ‘Western-Korean Cooperative Medical Treatment’ (WKCT) despite the constant conflicts between KM and biomedical doctors over their medical territory.

### **Findings of the Fieldwork**

Based upon interviews with physicians and hospital administrators in four WKCT hospitals, the following research findings were discovered concerning the actual process of the WKCT and the relationship between KM and biomedical doctors.

#### **- Actual meaning of the WKCT in clinical Settings**

Contrary to general expectation originating from the term ‘cooperative treatment’, the WKCT in clinical settings observed in all four hospitals is a process in which physicians send their patients shortly to their counterpart for additional diagnoses or therapies through the request of referral/consultation and receive the results of such medical actions. In this sense, the WKCT can be classified as a kind of ‘parallel treatment’ rather than ‘cooperative treatment’ in terms of its actual meaning.

#### **- Process of the WKCT**

KM doctors’ WKCT requests to biomedical doctors are usually conducted for 1) biomedical inspection to confirm their patients’ diagnosis, 2) acute patient care and intense pain control and 3) uptake of biomedical technicians such as physiotherapists, the great majority of which are considered by the KM doctors as an essential part for their patient management. By contrast, biomedical doctors’ WKCT requests to KM doctors – which are considerably less frequent than the cases of KM doctors’ WKCT requests to biomedical doctors – are usually conducted for 1) relief of symptoms and pain control for non-fatal yet intractable chronic diseases, such as facial nerve palsy and chronic musculoskeletal

diseases, 2) additional treatments for irreversible diseases with sequela in the chronic phase, such as after-effects of stroke and 3) management for incurable or end-state diseases such as terminal cancers, most of which are considered by the biomedical doctors as unessential 'add-on' therapies. In sum, it was widely observed in all four hospitals that KM doctors tend to be more dependent on WKCT requests to biomedical doctors for biomedical diagnoses and therapies than biomedical doctors.

#### **- Frequency of contact and the ways of communication between KM and biomedical doctors in the process of the WKCT**

In most cases, KM and biomedical doctors have contact with each other when they make requests for the WKCT and receive the results of medical actions from their counterpart, which means that they do not actively intervene in their counterpart's medical actions while entrusting such actions into the hands of their counterpart. Concerning the means of contact, it was predominantly observed that they tend to make contact more indirectly through nurses, training doctors or their patients rather than engaging in direct contact. In this regard, their contact and communication in the process of the WKCT are very limited overall. Regarding the means of their communication, biomedical information is exclusively exchanged in the process of the WKCT in the situations where most of the biomedical doctors do not have any concrete knowledge on KM therapies while KM doctors have learned both biomedical and traditional medical knowledge since their school days. In this situation, KM doctors' biomedical knowledge has a crucial role to communicate with KM and biomedical doctors in this process.

#### **- External factors related to the process of the WKCT**

##### **1) Patients**

The majority of patients hospitalized in WKCT hospitals expect additional therapies from their attending doctors' counterpart through the process of the WKCT, particularly for certain diseases such as stroke, facial nerve palsy and orthopaedic pains, while often mentioning their preference for KM therapies in the cases of such diseases. However, the patients more frequently tend to show more trust in biomedical explanations on their diseases with the results of biomedical diagnostic inspection than KM explanations and diagnoses, which has an effect on KM doctors' stronger dependency on their counterpart's biomedical actions.



## **2) Hospital administrators**

Regardless of the different hospital settings, it was widely observed that the WKCT is considered by hospital administrators as an important means of P.R. for their hospitals. Meanwhile, they also devoted effort to supporting the WKCT process with diverse strategies, such as providing incentives to physicians who make additional requests for the WKCT, hosting joint conferences for KM and biomedical doctors and arranging private meetings between KM and biomedical doctors. However, their efforts to promote the WKCT have clear limitations under clinical circumstances in which physicians who are actually in charge of patient management have the ultimate authority in making clinical decisions for their patients. In this situation, hospital administrators often complain about the difficulties in persuading biomedical doctors – the majority of whom are more reluctant to take part in the WKCT than KM doctors – to be more interested in KM therapies and more actively involved with the WKCT and KM therapies.

## **3) Legal regulations, government policy and National Health Insurance (NHI) policy**

As a by-product of the dualized South Korean medical system that strictly separates the areas of KM and biomedical sector, the WKCT has been encouraged by the South Korean government as the first step towards integrating the divided professional medical system since the 2000s. In this regard, the South Korean government's policy for promoting the WKCT has a particularly positive effect on the process of the WKCT in a national hospital ('D' hospital) through supporting cooperative research work between KM and biomedical doctors with financial support. However, NHI policy on the reimbursement of the costs of the WKCT treatments has rather a negative effect on the frequency of WKCT requests, given that it does not fully cover the expenses of medical actions separately conducted by the biomedical and KM sectors in the process of the WKCT, while considering the WKCT as a kind of over-treatment. From this policy, KM doctors tend to encounter more disadvantages than biomedical doctors in a situation where KM therapies are widely considered more optional or less essential than biomedical therapies by patients and biomedical doctors. Moreover, a policy of National Health Insurance Service with newly integrated disease codes of biomedicine and KM recommended by WHO – most of which are integrated into biomedical terminology – reinforces KM doctors' reliance on biomedical diagnoses.

## **Analysis of the Research**

### **- The core element connecting KM and biomedical doctors in the process of the KWCT: KM doctors' biomedical knowledge**

In a situation where biomedical doctors do not have any concrete KM knowledge – aside from their general indifference to it – KM doctors' biomedical knowledge based upon their learning experience at KM schools and clinical experience in WKCT hospitals play a central role in connecting KM and biomedical doctors in the process of the WKCT. In this process, the KM doctors are steadily situated to recall, utilize and develop their biomedical knowledge to communicate not only with the biomedical doctors but also with their patients, most of whom prefer biomedical explanations to KM. In this regard, the majority of KM doctors whom I interviewed displayed confidence in their biomedical knowledge. During the interviews, it was also observed that they frequently use biomedical terms and colloquial hospital expressions describing various medical tasks, originally used by biomedical doctors in biomedical hospitals. However, their necessity to utilize biomedical knowledge in WKCT hospitals makes them more dependent on biomedical doctors' medical actions, which has a negative effect on their power relations with biomedical doctors, who have exclusive authority to prescribe biomedical diagnostic inspections and treatments. As a result, the superiority of biomedicine and biomedical doctors over KM and KM doctors is reinforced in the process of the WKCT in clinical practices.

### **- Biomedical dominance over KM in clinical settings of WKCT hospitals**

To summarize the findings of the fieldwork in WKCT hospitals in South Korea, asymmetric situations around KM and biomedical doctors appear across the entire range of the process of the WKCT in terms of frequency of WKCT requests, the dependency on their counterpart's medical actions and general interest in their counterpart's medical knowledge, together with the biomedicine-friendly hospital settings originating from patients' general preference for biomedical explanations and medical insurance policy. Meanwhile, KM doctors are constantly situated to adapt themselves to such a biomedicine-friendly circumstance of WKCT hospitals. In this asymmetric situation, unequal power relations between biomedicine/biomedical doctors and KM/KM doctors come into view in the process of the WKCT, which is not explicitly visible in the South Korean medical system when they work in separate spaces.

## **Contributions and Limitations of the Study, with Future Research Perspectives**

This study has examined how biomedical dominance manifests itself over KM in the clinical process of the WKCT within hospital settings, while focusing on the actual daily process of the physicians' patient management. This contrasts the majority of previous research on biomedical dominance, which has predominantly devoted attention to medical suppliers' different legal status or medical consumers' different socio-economic status. However, several aspects of research limitations and consequent future research perspectives remain, outlined as follows. First, given that this study has exclusively focused on the working relationship between KM and biomedical doctors in WKCT hospitals – a kind of exceptional place where they are mutually involved with patient management while a great majority of them still work in separate places under the influence of the dualized medical system regulated by the MSA – the findings of this study should not be generalized as representing a common situation encompassing the entirety of the South Korean medical system. In order to understand more general situations concerning the relationship between the biomedical sector and the traditional sector in South Korea, it is necessary to examine the situations in clinic-level institutions in future research, as well as examining the multi-layered relationship among KM and biomedical doctors with folk medical healers. Second, this study limited its interviewees to physicians – apart from small numbers of hospital administrators – to focus on the relationship between KM and biomedical doctors. However, considering the research findings that patients and government policy with NHI policy significantly factor into the physicians' decisions in the process of the WKCT, it will be worthwhile focusing on the role of patients as well as the state including policy-related personnel as main subjects of the future research. Third, as this study mainly focuses on the relations 'between' KM and biomedical doctors, insufficient attention has been devoted to the difference 'within' each of the groups, e.g. possible differences in terms of physicians' medical specialties, their work places, gender and age. Future research should also consider such internal differences within the groups of KM and biomedical doctors to examine their power relations more delicately. Finally, this study has discovered the importance of biomedical knowledge as the core element of connecting KM and biomedical doctors in the process of the WKCT, as well as the key element having a crucial influence on their power relations in the clinical practices. In this regard, it will be useful to adopt theoretical perspectives on power-knowledge relations – such as the Foucauldian approach – in future research.

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# Abbreviation

ABR: Absolute Bed Rest  
AKOM: Association of Korean Medicine  
CAM: Complementary and Alternative Medicine  
CMA: Critical Medical Anthropology  
CSAT: College Scholastic Ability Test  
CT: Computed Tomography  
CVA: Cerebrovascular Accident (Stroke)  
EMR: Electronic Medical Record  
ENT: Ear, Nose, and Throat  
EWSC: East-West Stroke Center  
FACT-F: Functional Assessment of Cancer Therapy - Fatigue  
FACT-L: Functional Assessment of Cancer Therapy - Lung  
ICD: International Classification of Diseases  
IMS: Intramuscular Stimulation Therapy  
KCD: Korean Standard Classification of Diseases  
KM: Korean Medicine  
KMA: Korean Medical Association  
KOSIS: Korean Statistical Information Service  
MRI: Magnetic Resonance Imaging  
MSA: Medical Service Act of the Republic of Korea  
NHI: National Health Insurance  
NHIS: National Health Insurance Service<sup>1</sup>  
SLR: Straight-leg-raising Test  
SOAP: Subjective, Objective, Assessment, Plan  
TCM: Traditional Chinese Medicine  
TKM: Traditional Korean Medicine  
TM: Traditional Medicine  
WKCT: Western- Korean Cooperative Medical Treatment

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<sup>1</sup> English inscription of this organization was officially changed from ‘National Health Insurance Corporation’ (NHIC) on 1 January 2013 (Bo-ram Lee, 2012).

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## Notes

Concerning the romanization of Korean words, I followed “Romanization of Korean” by the National Institute of Korean Language,<sup>2</sup> with some exceptions in the cases of Korean authors’ names as shown in their articles. They are written in italic type in the main body of the thesis. If considered necessary, Chinese letters will be denoted after them to avoid ambiguity concerning the meaning.

In case the authors that I infer from the body are Korean, I will include their full name because it is difficult to distinguish only by their last name.

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<sup>2</sup> From: “Romanization of Korean,” National Institute of Korean Language, retrieved 26 May 2016 from [http://www.korean.go.kr/front\\_eng/roman/roman\\_01.do](http://www.korean.go.kr/front_eng/roman/roman_01.do).

## Part I. Introduction

The last few decades have witnessed the re-emerging importance of traditional medicine (TM)<sup>3</sup> and complementary and alternative medicine (CAM)<sup>4</sup> in current medical systems worldwide, with the acknowledgement of the positive role of TM for public health care in developing countries on the one hand, as well as the growing interest in CAM in the Western world on the other hand. Their relationship with modern medicine comes in various forms, from conflict over coexistence and cooperation to integration, depending on differing historical, socio-cultural and economic situations in each area. Such phenomena have been discussed within the notion of ‘medical pluralism’ in various disciplines, first in the discipline of medical anthropology (e.g. Leslie, 1976, 1977, 1980; Dunn, 1976) and followed by medical sociology (e.g. Baer, 1995; Cant & Sharma, 1999) and medical history (e.g. Ernst, 2002; Jütte, 2013). As an example of such phenomena, this study examines the relationship between biomedical doctors and doctors of ‘Korean medicine’ (KM) – a modernized and professionalized form of traditional medicine in the Republic of Korea (South Korea) – in the process of patient management in clinical practices in hospital organizations where both biomedical and KM doctors work together for their patients under the name of ‘Western-Korean Cooperative Treatment (WKCT).’

Compared to the majority of Western countries, one of the most distinctive aspects of the South Korean medical system is that KM doctors – in charge of the traditional sector of professional healthcare – have an equal legal and social status as biomedical doctors, with both being licensed medical doctors. On the other hand, compared with other East-Asian countries such as Japan, China and Taiwan, the areas of KM and biomedical doctors’ medical control authorities are more strictly divided (Gang-jae Yoon, 2013). Accordingly, as a process of cooperative medical actions of KM and biomedical doctors for their patient management in hospital settings, the WKCT is a unique phenomenon under such a medical environment,

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<sup>3</sup> TM is defined by World Health Organization (WHO) as “the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness” (WHO, 2000: 1).

<sup>4</sup> According to the definitions of CAM by WHO, it generally refers to “a broad set of health care practices that are not part of that country’s own tradition and are not integrated into the dominant health care system” (ibid.).

with the legal equality of KM and biomedical doctors and the strict segmentation of their medical authorities. From this perspective, this study aims to analyze the process of the WKCT in clinical practices in WKCT hospitals. Therefore, it seeks to explore KM and biomedical doctors' relationship with each other in the process of exchanging their patients, as well as their ways of communication and external factors affecting their relationship in this process, with the aim of examining the situation of medical pluralism in current South Korean medical system. In this study, I strive to ascertain the crucial factors that enable two different styles of doctors to work together despite their different viewpoints concerning health and illness. I also try to ascertain how these factors influence the power relationship between them. In this respect, the debate on biomedical dominance in situations of medical pluralism is considered as the main theoretical concept for the research. The South Korean medical system seems to be less hierarchical between the biomedical and traditional medical sectors than anywhere else in the world, due to the equal legal status between biomedical doctors and KM doctors authorized by the South Korean Medical Service Act (MSA).<sup>5</sup> Notwithstanding this circumstance, I try to examine whether there is any hierarchical aspect or dominance over the other sector between them and – if so – how these aspects are embodied in the clinical settings during the process of diagnoses and treatments in their work places. In order to ascertain the answer to the research questions, I collected data through fieldwork, visiting four different WKCT hospitals in the city of Busan in 2011 and 2012, conducting semi-structured qualitative interviews with KM and biomedical doctors as well as hospital administrators. In the following section, I will first introduce the definitions of key terms such as biomedicine, biomedical doctor, KM, KM doctor and the WKCT, as well as a WKCT hospital. Subsequently, I will present the main research questions within the scope of this study. Finally, I will briefly summarize the outline of the chapters of the dissertation.

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<sup>5</sup> Medical Service Act of the Republic of Korea, Enacted on 20 Mar. 1962 (Act No. 1035), Revised on 23 Jul. 2010 (Act No. 10387).

## 1. Definitions of Key Terms

Before mentioning the definitions of key terms in this study, let us take a look at Article 2 of the MSA of Republic of Korea<sup>6</sup> – officially translated to English by the Korea Legislation Research Institute<sup>7</sup> – to understand the scope of this study.

### *Article 2 (Medical Persons)*

*(1) The term "medical person" as used in this Act refers to a **medical doctor**, a dentist, **an oriental medical doctor**, a midwife or a nurse who holds a license granted by the Minister of Health and Welfare.*

*(2) By type, a medical person has the mission to seek the improvement of public health and contribute to help citizens enjoy healthy lives by performing his/her mission specified in the following subparagraphs, respectively:*

- 1. A medical doctor's mission is to administer **medical treatment** and to provide guidance for health;*
- 2. A dentist's mission is to administer dental treatment and provide guidance for oral hygiene;*
- 3. An oriental medical doctor's mission is to administer **oriental medical treatment** and provide guidance for health based on **oriental medicine**;*
- 4. A midwife's mission is to assist childbirth, to take care of pregnant women, women at childbirth, women in puerperium and newborn babies and to provide guidance for their health;*
- 5. A nurse's mission is to nurse injured or sick people, or postnatal women, to assist in medical treatment and to conduct health activities as prescribed by Presidential Decree.*

Among the ‘medical persons’ mentioned above in Paragraph 1, this study deals with the relationship between “a medical doctor” (*Uisa*) and “an oriental medical doctor” (*Han-uisa*),

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<sup>6</sup> From: “Medical Service Act,” Statutes of Republic of Korea, retrieved 26 May 2016 from [http://elaw.klri.re.kr/kor\\_service/lawView.do?hseq=21627&lang=ENG](http://elaw.klri.re.kr/kor_service/lawView.do?hseq=21627&lang=ENG).

<sup>7</sup> It is “a government-funded national policy research institute established in July 1990 to systematically collect and manage legal information and conduct professional research on legislation.” From: “Greetings,” Korea Legislation Research Institute, retrieved 26 May 2016 from <http://www.klri.re.kr/eng/category/greetings.do>.

which are modified to translate into a ‘biomedical doctor’ and a ‘Korean medical (KM) doctor’ in this study. Likewise, “medical treatment” (*Uiryō*), “oriental medical treatment” (*Hanbang Uiryō*), “medicine” (*Uihak*)<sup>8</sup> and “oriental medicine” (*Han-uhak*) will be translated to ‘biomedical treatment,’ ‘Korean medical (KM) treatment,’ ‘biomedicine’ and ‘Korean Medicine’ (KM) in this study to clarify the difference between two groups corresponding to the purpose of this study, the reasons for which will be explained in each section of this chapter. In this regard, key terms such as biomedicine/biomedical doctor, KM/KM doctor and WKCT/WKCT hospital will be introduced before detailing the research questions and providing an outline of the dissertation. In the following sections, I will first introduce a dictionary definition of each term, together with legal definitions based upon the MSA, the fundamental law of medical affairs in South Korea. Subsequently, analogous terms of these key terms will also be examined in each section. In this part, I will explain the reason why I chose certain terminology, considering the medical situation in South Korea and the main focus of the research. Such terms have transformed in various ways according to the change in time or the different viewpoints of each group. The diversity of terminology reflects the characteristics of each era and the main concern or interest of each group, often resulting in conflicts between the groups over the official establishment of each term. As a further remark regarding this section, I herewith pre-indicate that in the cases of biomedicine and KM I will consider both terms mainly as the exclusive practice areas of KM and biomedical doctors rather than the forms of different knowledge systems, to ensure a focus on the relationship between the two medical groups as the main interest of this study.

### **1.1 Biomedicine (*Uihak*), Biomedical Doctor (*Uisa*)**

The term ‘biomedicine’ is generally understood as “clinical medicine based on the principles of the natural sciences, such as biology and biochemistry.”<sup>9</sup> It is often used synonymously with the terms ‘modern,’ ‘Western,’ ‘mainstream,’ ‘conventional,’ ‘orthodox,’ ‘allopathic’ and ‘evidence-based’ medicine, which are selectively employed depending on the context. It is also called “school medicine” in many European countries (Cant & Sharma, 1999: 9),

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<sup>8</sup>As a matter of fact, there is no such expression of ‘medicine’ in Article 2 above. However, deduced from the terms of the traditional sector – namely oriental medical doctor, oriental medical treatment and oriental medicine – we can infer that the area of a (bio-) medical doctor’s authority will be translated as ‘medicine.’

<sup>9</sup> From: “Biomedicine,” Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health (2003), 7th Edition, retrieved 26 May 2016 from <http://medical-dictionary.thefreedictionary.com/biomedicine>.

including Germany (*Schulmedizin*), given that it is taught at university level.<sup>10</sup> The term ‘modern medicine’ is used to provide a contrast with traditional forms of medicine, while the term ‘Western medicine’ is often used to make clear the locality of the medical system in comparison with non-European indigenous medicine. ‘Mainstream medicine’ and ‘conventional medicine’ – defined as “medicine as practiced by holders of medical doctor’s degree”<sup>11</sup> – both often imply its dominating status as professionalized medicine over other forms of medicine. Together with the term ‘orthodox medicine,’ they are frequently used as the opposing concepts of CAM. Further terms related to such concepts in opposition to CAM include ‘allopathic medicine’ and ‘evidence-based medicine.’ ‘Allopathic medicine’ means “the system of medical practice which treats disease by the use of remedies which produce effects different from those produced by the disease under treatment,”<sup>12</sup> which is often argued by CAM therapists – particularly homeopaths – to criticize the concepts of biomedical practices because they believe that it is far from a fundamental cure of disease, but merely the relief of symptoms.<sup>13</sup> By contrast, ‘evidence-based medicine’ – defined as “the application of the best-available (i.e., most reliable) evidence gained from the scientific method to guide clinical decision-making”<sup>14</sup> – proceeds along the lines of the term biomedicine in that it emphasizes natural scientific evidence. However, this term is often employed by biomedical doctors and scientists to criticize CAM, whereby they indicate the lack of objective remedial evidence in most CAM therapies.

Such an area of medical practice is generally termed simply as ‘medicine’ (*Uihak*) in South Korea, as shown in Article 2 of the MSA with the terms ‘medical treatment’ and ‘medical doctor.’ When it is juxtaposed with KM, it is often called ‘Western medicine’ (*Yang-uihak* or

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<sup>10</sup> “*Medizin, die an den Hochschulen gelehrt wird und allgemein anerkannt ist*” (medicine, which is taught in universities and generally accepted to the public). From: “Schulmedizin,” Duden Online (German-German dictionary), retrieved 26 May 2016 from <http://www.duden.de/suchen/dudenonline/Schulmedizin>.

<sup>11</sup> From: “Definition of Conventional Medicine,” Medicinenet.com, retrieved 26 May 2016 from <http://www.medicinenet.com/script/main/art.asp?articlekey=33527>.

“Definition of Mainstream Medicine,” Medicinenet.com, retrieved 26 May 2016 from <http://www.medicinenet.com/script/main/art.asp?articlekey=33619>.

<sup>12</sup> From: “Definition of Allopathy,” MedicineNet.com, retrieved 26 May 2016 from <http://www.medicinenet.com/script/main/art.asp?articlekey=10981>.

<sup>13</sup> From: “Allopathy Vs Homeopathy, Discuss,” Civil Service India, retrieved 26 May 2016 from <http://www.civilserviceindia.com/subject/Essay/allopathy-vs-homeopathy3.html>.

<sup>14</sup> From: “Evidence-Based Medicine,” Segen’s Medical Dictionary (2012), retrieved 26 May 2016 from <http://medical-dictionary.thefreedictionary.com/evidence-based+medicine>.

*Yangbang*) or ‘modern medicine’ (*Hyeondae Uihak*). During the interviews with physicians in the fieldwork, it was observed that most KM doctors tended to call it ‘Western medicine,’ specifying its origin and locality in contrast to KM, originating in Korea. On the other hand, they seem to prefer this term to ‘modern medicine’ or ‘medicine,’ to indicate that biomedicine is only a part of the South Korean medical system along with KM, and that KM is also a modernized form of traditional medical principles. By contrast, the majority of biomedical doctors who I interviewed tended to call it ‘modern medicine’ or merely ‘medicine,’ placing great stress on its modernity and its superior position as a mainstream medicine, not only in current South Korea but also in global medical systems worldwide, as well as often showing antipathy against the term ‘Western medicine’ and against being called ‘Western medical doctors.’ However, in this study, I will adopt the term ‘biomedicine’ as a counterpart of KM, because the term ‘medicine’ may be misunderstood as the entirety of the medical area encompassing KM, while ‘Western’ or ‘modern medicine’ are not value-neutral terms under the circumstances whereby biomedical doctors emphasize the universality of biomedicine and KM doctors argue that KM is a modernized form of traditional medicine. Instead, I consider that the term ‘biomedicine’ best describes its main characteristics of being natural science-based medicine, reflecting its most distinctive feature in comparison with KM. Likewise, those in charge of the biomedical area will be termed as ‘biomedical doctors (*Uisa*).’ In fact, their area of authority mostly overlaps with that of medical doctors in Western countries. However, a significant difference is that it is not allowed for biomedical doctors in South Korea to practice traditional medical treatments such as acupuncture, moxibustion and herbal medication, which belong to the exclusive area of KM.

## **1.2 Korean Medicine (KM, *Han-uhak*), KM Doctor (*Han-uisa*)**

There are several different definitions of Korean medicine (KM) found in Korean dictionaries and encyclopedias. Let us take a look at some examples below.

*An Ethnomedicine ('Minjok' Uihak)<sup>15</sup> that has been created and developed in the*

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<sup>15</sup> The term ‘*Minjok*’ is generally translated to ‘nation’ or ‘national.’ However, corresponding to the explanation above, *Minjok Uihak* (medicine) matches better with the term ‘ethnomedicine’ in English, which is more widely used to describe such phenomena, referring to “the study of traditional medical practice which is concerned with the cultural interpretation of health, diseases and illness and also addresses the healthcare-seeking process and healing practices” (Williams, 2006: 215).



*process of long history of Korea aiming for the treatment of disease and promotion of health, utilizing herbal medication, acupuncture, moxibustion, cupping and manual therapies. It has been developed under the distinctive Korean circumstance including the natural environment, physical constitutions and cultural aspects (The Compilation Committee of Unabridged Dictionary of Korean Medicine, Unabridged Dictionary of Korean Medicine, 2010).*

*A traditional medicine that was introduced from China and has been developed independently in Korea (the National Institute of the Korean Language, Korean Standard Unabridged Dictionary, 2000).*

*Medical practices that have been developed in Korea since the ancient period. It is also often called oriental medicine, in response to Western medicine, in that it shares medical traditions based upon an East-Asian philosophy within ‘the Chinese character cultural sphere’<sup>16</sup> including China, Japan and Korea. It aims to promote health through vitalizing internal energy within the human body while observing vital phenomena in dynamic and holistic ways. As KM considers the human body as a microcosm, the main principles of KM are based upon Eum-Yang (Yin-Yang)<sup>17</sup> and O-haeng (Five Elements)<sup>18</sup> theory (Doosan Encyclopedia).<sup>19</sup>*

Taken together with the definitions above, KM is a form of indigenous traditional medicine

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<sup>16</sup> It refers to “a regional area in which cultural communication is possible through using Chinese characters, such as China, Taiwan, Japan, and Korea. In a broad view, Vietnam and Singapore are also included.” From: “*Hanja Munwhagwon*” (Chinese Character Cultural Sphere), Naver Encyclopedia for Students (*Haksaeng Baek-gwa*), retrieved 26 May 2016 from <http://terms.naver.com/entry.nhn?docId=1523306&cid=47320&categoryId=47320>.

<sup>17</sup> 陰, 陽. “In Chinese philosophy and religion, two principles, one negative, dark, and feminine (*yin*) and one positive, bright, and masculine (*yang*), from whose interaction all things are produced and all things are dissolved... A balance of yin and yang is essential to Health. A deficiency of either principle can manifest as Disease.” From: “Yin Yang,” Medical Dictionary Online, retrieved 26 May 2016 from <http://www.online-medical-dictionary.org/definitions-y/yin-yang.html>.

<sup>18</sup> 五行. “The basic constituents of nature according to the traditional Chinese construct—fire, earth, metal, water and wood. These elements are not static, but have dynamic qualities that undergo cyclical transformations from one to another: wood creates fire, which creates earth, which creates metal, which creates water, which creates wood, etc. Health is achieved if the life energy flows in an uninterrupted manner.” From: “Five Elements,” Segen's Medical Dictionary, 2011. Farlex, Inc., retrieved 26 May 2016 from <http://medical-dictionary.thefreedictionary.com/five+elements>.

<sup>19</sup> From: “Korean Medicine” (*Han-uihak*), ‘Doosan Encyclopedia,’ retrieved 26 May 2016 from [https://www.doopedia.co.kr/doopedia/master/master.do?\\_method=view&MAS\\_IDX=101013000839424](https://www.doopedia.co.kr/doopedia/master/master.do?_method=view&MAS_IDX=101013000839424).

that 1) has been constantly changed and developed from the past to the present, 2) according to Korean cultural and historical circumstances, 3) while exchanging and sharing medical traditions with other East-Asian countries such as China and Japan. Regarding the character of indigeneity developed within the context of Korean history, it can be said that KM belongs to a category of traditional indigenous medicine, although we should also consider that KM emphasizes its constant change and development from the ancient period until the present. On the other hand, considering its holistic views on health and illness – as briefly mentioned in the definition by Doosan Encyclopedia – KM shares the characteristics in its contents with those of CAM, which has different viewpoints on health and illness, standing in contrast to biomedicine. However, similar to the situations in neighboring countries such as China, Taiwan, and North Korea, KM and KM doctors are placed within the professional medical area together with the biomedical sector, as a result of the professionalization and institutionalization in the post-colonial era from the middle of the 20<sup>th</sup> century. In this sense, KM also has a character of conventional medicine in that it is conducted by those who have a KM doctor's license, who are equally respected as biomedical doctors and dentists by the MSA. KM doctors – marked as 'oriental medical doctor' in the MSA – poses exclusive authority for the usage of KM therapies against biomedical doctors and non-professional folk healers, while they are not allowed to apply or prescribe any medical actions single-handedly that belong to biomedical domains, such as ordering X-rays and CT/MRI scans for diagnoses and applying any biomedical therapies including the prescription of biomedical medication.<sup>20</sup>

Concerning the similarity with traditional Chinese medicine (TCM) and TCM doctors in China and Taiwan, KM has an affinity with TCM concerning several key aspects. First, KM and TCM share the main principles of therapy such as Yin-Yang and the Five Elements theory, as well as the contents of the therapies – such as herbal medication, acupuncture, moxibustion, cupping and manual therapies – although KM doctors and scholars argue that their interpretation and practical application are different. Second, both of them aim at

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<sup>20</sup> Despite the division of the medical practice areas between KM and biomedical doctors specified in Article 2 of the MSA (“1. A medical doctor's mission is to administer medical treatment and to provide guidance for health; 3. An oriental medical doctor's mission is to administer oriental medical treatment and provide guidance for health based on oriental medicine”), there have been constant disputes between KM and biomedical doctors concerning the concrete boundaries of biomedical and KM treatments until now, resulting in severe conflicts between KM and biomedical doctors. Further details on this issue will be introduced later in Chapter IV. 2.3 ‘Conflicts between KM and biomedicine over their medical territory.’

modernizing traditional ways of medical treatment through the academization and professionalization process. Finally, as a result of such processes, both TCM and KM doctors officially have an equal status as biomedical doctors, with both being medical doctors approved by the governments. Nevertheless, there are also several significant differences between them. For instance, types of medicinal herbs and their usage are different from each other, which are deeply influenced by natural environments such as climate, geographical features and vegetational conditions. Moreover, concrete principles of therapies vary in each country, as the contents of East Asian philosophies such as Confucianism and Taoism have been developed in different ways in each place. Finally, regarding the access to biomedical diagnoses and treatments, KM doctors have more difficulty in utilizing biomedical treatments than TCM doctors in China, who are allowed to order biomedical inspection and treatments alone without biomedical doctors' help (Gang-jae Yoon, 2013). Accordingly, the area of biomedicine and KM is more separated than in China.

Concerning the changes of Korean terminology referring to KM, it used to be called 'oriental' medicine (*Han-uihak*, 漢醫學),<sup>21</sup> before the official change of the term into Korean medicine came with the revision of the MSA in 1986,<sup>22</sup> corresponding with KM doctors' efforts to clarify its originality as indigenous Korean medicine developed in Korea (Lee, Park & Yu, 2008). In line with this, the Association of Korean Medicine (AKOM) – the central organization of South Korean KM doctors<sup>23</sup> – adopted 'Korean medicine' as the official English term referring to '*Han-uihak*' in 2012, replacing the term 'Korean oriental medicine,' which was previously used by the AKOM (Jin-young Park, 2012). This was despite official opposition from the Korean Medical Association (KMA) – the central organization of biomedical doctors in South Korea<sup>24</sup> – fearing that it could be misunderstood as '(bio-)

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<sup>21</sup> Phonetically, it sounds the same as KM in Korean '*Han-uihak*.' However, it is based upon a different Chinese character '*Han*' (漢), which means 'Han' dynasty of ancient China, also often referring to East Asian cultural area, whereas the Chinese character '*Han*' (韓) in the term KM (*Han-uihak*) means 'Korean.'

<sup>22</sup> Despite the change of the term in 1986, the official English transcription in the MSA remains as 'oriental medicine' in the MSA to date, as shown on page 3.

<sup>23</sup> "Started with the name of 'Union of Korean Medicine Doctors' in 1898," it was "authorized as a medical association with national organizations of Korean Medicine doctors by the government in 1952." From: "Introduction of AKOM," Homepage of the AKOM (*Daehan Han-uisa Hyeophwe*), retrieved 26 May 2016 from <http://www.akom.org/eng/Introduction.php>.

<sup>24</sup> It is a corporation of South Korean biomedical doctors, and a member of the World Medical Association since 1949. From: Homepage of Korean Medical Association (*Daehan Uisa Hyeophwe*), retrieved 26 May 2016 from <http://www.kma.org/>.

medicine in Korea.’<sup>25</sup> By comparison, WHO uses the term traditional Korean medicine (TKM), corresponding to the term TCM, while the South Korean Ministry of Health and Welfare also follows this term when they translate KM into English (ibid.). In the case of academic articles written in English, TKM has been more commonly used to refer to ‘*Han-uhak*.’ However, the term KM has recently been increasingly used in academic articles. In this study, I will adopt the terms ‘KM’ and ‘KM doctor’ as the counterparts of biomedicine and biomedical doctor, given that it is the closest English term that literally reflects the Korean term ‘*Han*’ (Korean) – ‘*Uihak*’ (medicine) as it is, as well as being the official English term determined by the AKOM, although it is not still officially used by the South Korean government and WHO. On the other hand, compared with other English terms such as ‘oriental’ medicine and ‘traditional’ Korean medicine, I also consider that the term KM better describes the notions that KM is essentially an indigenous medicine developed in Korea and that it has been constantly changed and developed until present to achieve professionalized medicine.

### **1.3 Western-Korean Cooperative Medical Treatment (*Yang-Hanbang Hyeopjin*, WKCT), WKCT Hospital<sup>26</sup>**

In a situation where there has been no exact legal definition of ‘Western-Korean Cooperative Treatment’ (WKCT) to date, it is generally known to the public in South Korea as “a medical treatment system where KM and biomedical doctors inspect and diagnose together and decide the most effective treatment for patients” (Dong-huei Lee, 1994: 5). In other words, the WKCT is a diagnosis and treatment process for patients in which both KM and biomedical doctors are jointly involved with diagnoses or treatments for certain patients in the same or neighboring hospitals. Such hospitals are usually called ‘WKCT hospitals.’ As ‘WKCT hospital’ is not an official term based upon legal regulations such as the MSA, there has been no complete statistical enumeration survey on the total number of the WKCT hospitals nationwide to date.<sup>27</sup> For this reason, there is no exact information concerning the rate of the

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<sup>25</sup> Against this change of the English term by the AKOM, the KMA filed a law suit to ban this new English term in 2012. The request of the KMA was dismissed by the court's decision in a civil process in June 2015 (Jun-ho Bang, 2015).

<sup>26</sup> Further details on the history, current features and typology of the WKCT and WKCT hospitals will be introduced in Chapter IV. 3 ‘Western- Korean medical cooperative treatment.’

<sup>27</sup> According to a written answer of ‘Korean Statistical Information Service’ (KOSIS) to my question concerning the total number of the WKCT hospitals left in online Q & A site of KOSIS, there has been no

WKCT hospitals among all hospital organizations in South Korea. However, considering that the WKCT is commonly observed in most KM hospitals and convalescent hospitals,<sup>28</sup> we could estimate that approximately one-third of hospital level organizations in South Korea can be categorized as WKCT hospitals.<sup>29</sup> Concerning the ratio of KM doctors involved with the WKCT process, at least approximately 15 percent of KM doctors – all of whom work in hospital-level medical institutions – are estimated to work with biomedical doctors for the WKCT. This is inferred from the fact that there is at least more than one biomedical doctor at each hospital level medical institution, including KM hospitals.<sup>30</sup> However, considering that KM doctors working at KM medical clinics can also take part in the WKCT with neighboring biomedical hospitals, about which there are no statistical data, the actual ratio can be higher than above-mentioned figure.

As the terms ‘WKCT’ and ‘WKCT hospitals’ are not officially stipulated based upon any legal regulations but are rather expressions to describe such activities or hospitals for hospital public relations or academic use, there are various terms in Korean referring to them. From

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statistical information investigated by KOSIS to date. From: “Q & A: The Rate of WKCR Hospitals Nationwide” (*Uisawa Han-uisaga Dongsi-e Geunmuhaneeun Uiryogigwan-ui Biyul*), 26 Aug. 2015, Korean Statistical Information Service, retrieved 26 May 2016 from [https://kosis.kr/serviceInfo/serviceInfo\\_06Detail.jsp?pageNo=1&p\\_id=9087&q\\_search\\_type=&q\\_search\\_key=&q\\_search\\_text=](https://kosis.kr/serviceInfo/serviceInfo_06Detail.jsp?pageNo=1&p_id=9087&q_search_type=&q_search_key=&q_search_text=).

<sup>28</sup> A convalescent hospital (*Yo-yang Byeongwon*) is defined in the MSA as “a special hospital for the aged, including mental institution ... and medical rehabilitations facilities” (Clause 3 (d) of Article 3 of Medical Service Act). It is also often translated in English to ‘long-term care hospital’ (e.g. Hyeong-sik Ahn et al. 2014). Both KM and biomedical doctors are allowed to establish a convalescent hospital in accordance with the MSA (Clause 2 of Article 33 of the MSA).

<sup>29</sup> According to the Ministry of Health and Welfare Statistical Yearbook 2012 (2012a: 168 175), there were 178 KM hospitals (564,572 beds) and 975 convalescent hospitals (135,294 beds) out of 3,064 hospital-level medical institutions and general hospitals in 2011. Concerning the rate of WKCT hospitals among KM hospitals, according to the Korea Institute of Oriental Medicine (2009: 86), 94.7 percent of KM hospitals answered that the WKCT is conducted in their hospitals in 2009, whereas Ji-seon Ryu et al. (2009: 31) report that 82 percent of KM hospitals nationwide were involved with the WKCT in 2008. In the case of convalescent hospitals, it was reported in a survey research of Research Institute for Healthcare Policy (Hyeong-sik Ahn et al. 2014: 32) – based upon data gathered in 2013 – that convalescent hospitals surveyed have 151 beds on average, while there are 0.9 KM doctors and 2.1 biomedical doctors per 100 beds on average. Considering this data, we can estimate that there is more than one KM and biomedical doctor in each convalescent hospital. Thus, grounded upon such data above, we could estimate that at least approximately one-third of hospital organizations nationwide (a quarter of total hospital beds) can be categorized in WKCT hospitals, even without considering the rate of the WKCT hospitals within the categories of biomedical hospitals and clinic level hospital institutions which collaborate with other hospital institutions of their counterpart.

<sup>30</sup> This estimation is grounded on the fact that 2,359 KM doctors (14.8% out of 15935 incumbent KM doctors) work at hospital level medical institutions as of 2011 (Ministry of Health and Welfare, 2012a: 152, 154).

an empirical perspective, ‘Western-Korean cooperative medical treatment’ (*Yang<sup>31</sup>-han<sup>32</sup>bang Hyeopjin*) is most widely used in the majority of cases in mass media and academic articles. However, quite a few KM doctors and scholars tend to prefer the term ‘*Han-yangbang Hyeopjin*’ (Korean- Western cooperative medical treatment) to WKCT, as is often observed in academic articles written by them (e.g. Jong-hwan Kim et al. 2004; Dong-hyun Kim et al. 2010; Kyeong-yeon Han et al. 2013). By contrast, the term ‘*Ui-hanbang Hyeopjin*’ (Medicine- Korean cooperative medical treatment) is occasionally observed, mostly in journalistic articles (e.g. Ki-won Kim, 2009; Ui-gyu Seo, 2012), which reflect biomedical doctors’ critical viewpoints about such concepts of cooperative treatment with KM doctors, while criticizing the terms ‘Western medicine’ (*yang-uihak*) and instead trying to retain the terms ‘medicine’ (*Uihak*) and ‘medical doctor’ (*Uisa*) as officially marked in the MSA.

Concerning the English transcriptions referring to this cooperative treatment, as mostly observed in academic articles, ‘Oriental- Western cooperative medical treatment’ had been dominantly used until the early-2000s, as KM used to be translated into ‘oriental medicine’ in English during this era (e.g. Su-hyeon Jeong et al. 2003; Bong-hyun Kim & Hae-jeong Nam, 2011). More recently since the 2000s, ‘Western- Korean’ or ‘Korean- Western (medical cooperative) treatment’ (e.g. Jong-deuk Kim et al. 2007; Hyun-jin Kim, 2013) have also been widely used in academic articles. Besides these terms, ‘integrative medicine therapy’ (e.g. Seung-chan Park et al. 2011) or ‘combined treatment’ (e.g. Jung-hun Lim & Sung-min Lim, 2012) are also observed rather than ‘cooperative treatment.’ However, in this study, I will adopt the term WKCT as a de facto representative term that intactly translates ‘*Yang-hanbang Hyeopjin*’ among such various terms above. I also considered adopting the term ‘biomedicine- Korean cooperative medical treatment’ (BKCT), as I adopted the terms biomedicine/biomedical doctors and KM/KM doctors for this study. However, considering that I have not discovered any article that translates this term into ‘BKCT’ in English, I will use the term WKCT in this study because it is most widely used in both mass media and academic articles.

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<sup>31</sup> ‘*Yang*’ in Korean stands for a Chinese character 洋, referring to ‘Western’ in this context.

<sup>32</sup> As mentioned in footnote 19 (pp. 9), ‘*Han*’ in Korean stands for a Chinese character 韓, referring to ‘Korean’ in this context.

## 2. Research Questions

This study aims to examine the concrete process of the WKCT in clinical practices in hospital settings in South Korea and analyze the relationship between KM and biomedical doctors in this process within the frame of medical pluralism. More concrete research questions are as follows:

- 1) In the process of clinical practices for patient management,
  - What does the WKCT actually mean?
  - How can we describe the process of the WKCT from beginning to end?
  - In which situation and upon what score do the physicians, both KM- and biomedical, make requests to their counterpart for the WKCT?
  
- 2) Concerning the ways of contact and communication between KM and biomedical doctors in the process of the WKCT,
  - How do KM and biomedical doctors, who conduct diagnoses and treatments based on different principles of health and illness, communicate with each other in the process of the WKCT?
  - How often and in which parts of the process do the KM and biomedical doctors contact with each other for their patient management?
  - What is the main media for their communication? What enables them to understand and connect with each other?
  
- 3) Concerning the external factors that could influence the process of the WKCT,
  - How and to what extent do patients, hospital administrators, and the state's medical policies influence the physicians' decisions?
  - How do the size and ownership structure (public or private) of hospitals have an effect on the process of the WKCT in clinical practices?
  
- 4) Concerning the relationship between KM and biomedical doctors in the process of the WKCT,
  - How much are they interested in their counterparts' therapies and medical principles or

WKCT process?

- How do they evaluate their counterparts' medical knowledge (e.g. biomedical doctors' evaluation of KM doctors' medical knowledge)? How do they evaluate their own knowledge on their counterparts' medical principles (e.g. KM doctors' self-evaluation of their biomedical knowledge)?
- Who is more dependent on the WKCT or their counterparts' medical action?
- Who is more influenced by external factors, such as patients, hospital administrators, and the state's medical policies?

To summarize, in the situation in current South Korean medical system where both KM and biomedical doctors are recognized by the state with an equal legal status as medical doctors and their medical jurisdictions are strictly divided, this study aims to answer the question of how their power relations function when they work together for their patients in hospital settings in the clinical process of the WKCT. Through this question and its answer, I will examine the distinctive South Korean medical situation whereby traditional medical practices have achieved a high position, with an equal legal status as the biomedical sector compared with any other medical system worldwide, having a specific significance in the debates on medical pluralism.



### **3. Outline of the Dissertation**

Part I ‘Introduction’ started by examining the key terms of this study, namely biomedicine/biomedical doctors, KM/KM doctors and WKCT/WKCT hospitals. In this part, I considered both their lexical semantics and practical usage in the South Korean medical situation. Subsequently, I presented the main research questions of this study. In this chapter, I will summarize the outline of the dissertation from Part II to VI as follows.

Part II ‘Literature review of key concepts and previous research’ introduces the key concept of this study – namely ‘medical pluralism’ – as well as debates concerning biomedical dominance over indigenous traditional medicine in situations of medical pluralism, followed by previous research work within the discipline of social science related to the process of the WKCT. Chapter II.1 first introduces the concept of medical pluralism developed within the discipline of medical anthropology, medical sociology and medical history. After examining various typologies of medical systems worldwide regarding the forms of relations between biomedicine and CAM/indigenous traditional medicine, I will examine the debates concerning the relationship between them. In this part, I will particularly explore critical medical anthropologists’ arguments (e.g. Baer, Singer & Susser, 2003; Singer, 2004; Baer, 2011) on biomedical dominance/hegemony over traditional indigenous medicine. Chapter II.2 introduces several research studies related to the process of the WKCT in South Korea within the discipline of social science conducted with qualitative research methods, including Kye-hyun Kim (2004), and Myeong-se Sohn and Won-chul Lee’s (2010) qualitative survey research on the current features of the WKCT and Jongyoung Kim’s (2005) ethnographic research on the hybrid characteristics of KM and its relationship with natural science and biomedicine. In connection with the previous research on medical pluralism and the WKCT, Chapter II.3 illustrates the scope and significance of this study. In this chapter, I will clarify the scope of the research, setting limits to the relationship between KM and biomedical doctors who are mutually involved in patient management in WKCT hospitals to concentrate on their working relationship in clinical practices. Concerning the significance of this study, I will emphasize the peculiar feature of South Korean medical system whereby the legal domains of biomedicine and traditional medicine are more clear and the dominant position of the biomedical sector is less explicit than any other countries, given that the traditional

indigenous medical sector has legally achieved equal status with the biomedical sector through its professionalization process and the legal acknowledgment of the state with the clear-cut medical domains between the biomedical and traditional indigenous sectors.

Part III ‘Research methods’ introduces the general process of this study and the main research method, together with a brief introduction to fieldwork locations, namely four WKCT hospitals in the city of Busan. In Chapter III.1, I will introduce the personal history of the research process based upon inductive empirical research with qualitative interviews under the subtitle “developing through trial and error” (Silverman: 2005: 307). In this part, I will explain the origins of the research interest from my own personal experience, the reason behind qualitative interviews as the chosen research method, the process of case selection, changes in the main topic and the relevant conceptual framework after the pilot research, the process of fieldwork in four hospitals and the process analysis. In Chapter III.2, the fieldwork location will be introduced with the characteristics of four hospital settings in the city of Busan as well as the demographic profiles of interviewees in each hospital, followed by explaining the process of data collection and analysis through qualitative interviews inspired by the grounded theory approach (Glaser & Strauss, 1967; Corbin & Strauss, 1990; Charmaz, 2006, et al.).

Part IV ‘Medical pluralism in South Korea and Western-Korean Cooperative Medical Treatment’ (WKCT) deals with the historical background and the current features of the South Korean medical system, devoting particular attention to the establishment of the dual medical system of biomedicine and KM in the professional medical sector. Chapter IV.1 ‘History of medicine and medical professions in Korea’ starts by briefly summarizing the characteristics and developments of the traditional Korean medicine and medical system until the late 19<sup>th</sup> century as a unique indigenous medicine developed under natural and cultural circumstances in Korean peninsula and as a part of East Asian medical system sharing traditional Chinese medical principles with neighboring countries. Subsequently, the process of ‘Western’ biomedicine’s inflow and its achieving dominant position over traditional Korean medicine from the period of ‘opening port’ to the Western imperial powers (1876 – 1910) and the Japanese colonial period (1910 – 1945) will be explored. In this part, the changes of traditional medicine and its way of survival under the dominance of biomedicine

will also be examined. Finally, the post-colonial process (1945- ) of establishing the South Korean dual medical system will be described with the professionalization of traditional medicine and traditional practitioners' achievement of equal legal status with biomedical doctors as KM doctors.

Chapter IV.2 deals with the current South Korean medical system, characterized as a dual professional medical system with biomedicine and KM, whereby the numbers of physicians, hospital organizations, medical schools and graduates were detailed. Subsequently, the legal aspects concerning the medical jurisdictions of biomedicine and KM regulated by the MSA will be examined. In this part, I will argue that there is a kind of contradictory situation whereby the territory of the KM and biomedical doctors' medical actions are declared to be strictly divided by the MSA, whereas there is a lacking legally clear division on certain concrete medical actions in terms of whether they belong to the KM or biomedical sector. Such an ironic situation gives rise to a need for collaborative work for patient management between KM and biomedical doctors in clinical practices, as well as constant conflicts over their medical boundaries. In this regard, the last part of Chapter IV.2 deals with the conflicts between KM and biomedical doctors over their medical territory, such as biomedical doctors' application of 'intramuscular stimulation therapy' (IMS), KM doctors' application of 'pharmacopuncture' and KM doctors' arguments against biomedical doctors' exclusive application of modern diagnostic equipment. Finally, as a stepping stone to the Part V 'Case study' – analyzing the findings of fieldwork in WKCT hospitals – Chapter IV.3 introduces definitions, the historical development, legal regulations and current features of the WKCT.

Part V 'Case study: the implementation of a medical pluralism in hospital settings in South Korea' analyzes the clinical situations of the WKCT and the relationship between KM and biomedical doctors in the process of the WKCT based upon the fieldwork results obtained in 2011 and 2012 in four WKCT hospitals in Busan. First, Chapter V.1 provides an overview and details of the organizational features of four hospitals, including the history, size (number of physicians and hospital beds), spatial characteristics and style (biomedicine- or KM-oriented) of each hospital. As the longest and the most important chapter in this study, describing the process of the WKCT and the relationship between KM and biomedical doctors in this process, Chapter V.2 first examines the actual meaning of the WKCT based

upon its process in the clinical practices in each hospital. In this chapter, I will clarify that the ‘cooperative’ treatment of KM and biomedical doctors does not mean that they actively discuss and mutually decide upon certain types of collaborative medical treatments; rather, it is a kind of referral/consultation process in which they send their patients to their counterparts for additional diagnoses or treatments, thus confirming the notions introduced in Chapter IV.3.1, ‘Definition of the WKCT and its actual meaning in clinical settings.’ Chapter V.2.2 ‘Process of the WKCT’ describes the clinical process of the WKCT in each hospital, illustrating the concrete process of the WKCT observed in four hospitals and dividing the cases into KM doctors’ WKCT requests to biomedical doctors and biomedical doctors’ requests to KM doctors. In this part, I will devote particular attention to the KM and biomedical doctors’ differing request frequencies, the reasons behind such requests and dependence on the WKCT process and their counterparts’ medical actions. Chapter V.2.3 examines the frequencies and ways of contact and communication between KM and biomedical doctors in the process of the WKCT. In this chapter, I will particularly focus on the importance of biomedical terms and KM doctors’ biomedical knowledge, which mediates the KM and biomedical doctors in the process of the WKCT. Subsequently, Chapter V.2.4 examines external factors that influence the process of the WKCT and the physicians’ decisions in this process, discovered in the interviews with the physicians and hospital administrators. First, I will explore the role of patients who receive the diagnostic inspections or treatments through the WKCT process, paying attention to their influence on the physicians’ decisions and the power relationship between KM and biomedical doctors. Second, the role of hospital administrators will be examined, whereby I illustrate their various efforts towards promoting the WKCT in each hospital, together with their limited influence on the physicians who are actually involved with the WKCT process. Finally, I will examine the state policy to promote the WKCT and the National Health Insurance (NHI) policy related to the WKCT, considering how and the extent to which the South Korean government’s promotion policy for the WKCT influences the actual clinical process of the WKCT, together with the influence of the NHI policy on the WKCT process.

Chapter V.3 analyzes the findings of the fieldwork described in Chapter V.2 regarding the debates concerning biomedical dominance over traditional indigenous medicine in medical pluralism. Chapter V.3.1 summarizes the findings of the fieldwork, paying attention to the

asymmetrical relations between KM and biomedical doctors in the process of the WKCT commonly observed in all four hospital settings. Subsequently, Chapter V.3.2 examines KM doctors' biomedical knowledge in response to the research question of what connects the KM and biomedical doctors working with different medical principles in the process of the WKCT. In this part, I will review the KM doctors' learning experience of biomedical knowledge in KM schools and WKCT hospitals as well as the reinforcement process of such knowledge within the clinical settings of the WKCT hospitals, followed by examining the influence of KM doctors' biomedical knowledge on the power relationship between KM and biomedical doctors. Finally, in Chapter V.3.3, I will reconstitute the South Korean situation in WKCT hospitals regarding the debates concerning the biomedical dominance in situations of medical pluralism. In this chapter, the various asymmetric situations in the relationship between KM and biomedical doctors will be interpreted with the connection of the concept of biomedical dominance. On the other hand, KM doctors' daily situations in WKCT hospitals will be reviewed as a process of adapting to biomedicine-friendly hospital settings, connecting with the argument of the "hospital as the primary locus of biomedicine" raised by Baer et al (2003: 344).

As the closing part of this study, Part VI clarifies the research limitations regarding the research methods and scope, as well as suggesting future research plans to overcome such limitations. In this part, I will first indicate the limitations of this study resulting from the research design of the inductive empirical research project in a limited area of the research topics and spatial settings based upon qualitative interview method. Nevertheless, I will cite the rationale behind the decision for such a research method and scope to reify the actual clinical situations in the process of the WKCT. Finally, I will suggest future research plans to remedy such limitations of the research, as well as considering ever-changing situations in South Korea regarding the relationship between KM and biomedical doctors and the legal regulations connected with the process of the WKCT.



## **Part II. Literature Review of Key Concepts, and Previous Research**

*Consequently, medical pluralism as a term suggested that a cosmopolitan, Western, modern, scientific biomedicine did not have the monopoly over health care, as had been taken for granted in medical circles, but that it was competing with a plurality of professionalized traditional medical systems (Hsu, 2008: 317).*

Before examining the relationship between KM and biomedical doctors in the process of the WKCT, this part reviews literature on the key concept of this study – medical pluralism – paying particular attention to the debates on biomedical dominance over traditional medicine in situations of medical pluralism, followed by introducing previous research on the WKCT within the disciplines of social science. In the first chapter of this part, I will introduce the concept of medical pluralism, together with its history and the development of the debates within the disciplines of medical anthropology, sociology and history. Subsequently, I will examine further details concerning the critical medical anthropology perspective, which particularly pays attention to the power relationship between biomedicine and indigenous medicine. In this part, I will review how the aspects of hierarchical relations between such medical sectors – more accurately, the phenomenon of biomedical dominance – has been discussed within the debates concerning medical pluralism. In the second part, I will introduce academic research on the WKCT in South Korea in the disciplines of social science. In connection with the previous research on medical pluralism and the WKCT in South Korea to date, the scope and the significance of this study will be introduced in the last part.

# **1. The Concepts of Medical Pluralism and the Debates on Biomedical Dominance over Traditional Medicine in Situations of Medical Pluralism**

## **1.1 Definition and Development of the Concept ‘Medical Pluralism’**

Medical pluralism is defined in “Key Concepts in Medical Sociology” (Gabe & Monahan, 2004) as “the co-existence in a society of differing medical traditions, grounded in different principles or based on different world-views” (Cant, 2004: 183). As the term ‘pluralism’ literally means “a theory or system that recognizes more than one ultimate principle,”<sup>33</sup> medical pluralism refers to a general phenomenon in which various medical principles co-exist in a certain place and time, rather than a singular universal medical principle. The concept of ‘pluralism’ originates in political phenomena and the disciplines of political philosophy (Cant, *ibid.* 183; Stollberg, 2013: 142), emphasizing “the existence of a range of social interests and interest groups” in contrast to “the monistic social theories of the nineteenth century” (Cant, *ibid.* 183). Stollberg (*ibid.*) indicates that pluralism is “an active engagement with diversity or plurality” requiring “some mutual knowledge of the differences.” Based upon this, he proceeds to connect pluralism to a medical phenomenon that refers to “an order of medical actors and conceptions acknowledging other actors and conceptions to be members of the medical system within a (national) society” (*ibid.* 142). Although such a phenomenon of medical pluralism has been omnipresent worldwide, it is comparatively recently in the late-20<sup>th</sup> century that the concept of pluralism was adopted to describe medical situations in academic fields, firstly by medical anthropologists (Cant, 2004: 184; Hsu, 2008: 317; Baer, 2011: 405) who observed the active role of indigenous traditional medicine for health care in Latin America, Asia and Africa despite the existence of modern biomedicine imported from the West. As Hsu (*ibid.* 316) indicates that “where the medical profession strove for a monopoly of health care, medical anthropologists pointed out the existence of pluralism,” the concept of medical pluralism played an important role for anthropologists as a tool to analyze medical phenomena from cultural perspectives.

Amongst such medical anthropologists who examined cultural aspects of medical phenomena in regional areas, Charles Leslie warrants mention as a pathfinder who “coined the term”

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<sup>33</sup> “Pluralism” (1.4), Oxford Online Dictionaries, retrieved 26 May 2016 from <http://www.oxforddictionaries.com/definition/english/pluralism>.



(Hsu, *ibid.* 317) ‘medical pluralism,’ which describes such phenomenon of coexistence of biomedicine and traditional indigenous medicine while mentioning that “medical systems are pluralistic structures of different kinds of practitioners and institutional norms” (Leslie, 1976: 9). At the foundation of this notion, he regarded the cultural approach as being important in describing medical systems, which conceives “the medical system to be composed of deliberate actions, by members of a society, to maintain or enhance health and to cure illness,” emphasizing “categories of thought and traditions within the culture” (*ibid.* 10-11). In line with his research projects of cultural studies on regional medical systems – with particular interests in Asian medical systems with “Great (Medical) Traditions”<sup>34</sup> such as India, Arabic countries and China – he argued that traditional medicine still has an important role in each place in terms of both medical and cultural contexts, despite the inflow and development of biomedicine from the West (1976). He also actively took the lead in various symposia and conferences as a convener and editor concerning the issues of medical pluralism since the 1970s (Baer, 2011: 406), while emphasizing the comparative research on medical systems worldwide within the disciplines of medical anthropology and interdisciplinary cooperative research amongst anthropology, sociology, history, geography and medical ethics (*ibid.*). On the other hand, as a WHO consultant on traditional medicine,<sup>35</sup> he also indicated the importance of studying medical pluralism in that “fundamental comparative research on the pluralistic structures of medical systems would be an instrument of planning and also a technique for training personnel to design such programs in a realistic manner” (Leslie, 1980: 194); namely, such studies can conduce the health promotion in developing countries through utilizing indigenous traditional medicine.<sup>36</sup>

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<sup>34</sup> Leslie labeled medical traditions in China, India and Mediterranean Arabic countries as “great tradition” medicine, which “maintained their individual characters although they were in contact with each other” and “share general features of social organization and theory that allow us to describe a generic great tradition medicine which can be contrasted with cosmopolitan medicine” (1976: 2). According to his explanation, the term ‘great tradition’ is derived from Robert Redfield’s work on the anthropological study of civilization, “Peasant Society and Culture” (1956). In this study, Redfield argued that “the development of civilization was characterized by the differentiation of Great from little traditions” (Leslie, *ibid.* 2); “the great tradition is cultivated in schools or temples” while “the little tradition works itself out and keeps itself going in the lives of the unlettered in their village communities” (Redfield, *ibid.* 70).

<sup>35</sup> From: “In Memoriam: Charles Leslie,” University of Delaware, retrieved 26 May 2016 from <http://www.udel.edu/udaily/2010/aug/leslie082809.html>.

<sup>36</sup> In this connection, it is worth considering the WHO policy of primary health care, which emphasized the role of traditional practitioners at local levels, standing out in the Alma Ata Declaration in 1978, appearing at around the same time as the emergence of the concept of ‘medical pluralism’ (WHO, 1978: 5).

In line with Charles Leslie's anthropological approach to the medical systems in cultural aspects with the concept of medical pluralism, it is also worthwhile addressing Arthur Kleinman's work (1980) on a model of the medical sector within a single medical system, explaining "how multiple healing systems coexist in a society" (Oberhelman, 2013: 2). In his work on the Chinese (Taiwanese) medical system following a long period of fieldwork in Taiwan, Kleinman categorized three different yet overlapping sectors within a local cultural system of health care, encompassing the aspects of both patients and healers – the popular sector, professional sector and folk sector – all of which constitute the internal structure of health care systems (Kleinman, *ibid.* 49-60). The popular sector – the largest of the three sectors – is "the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care activities initiated" (*ibid.* 50), referring to the area of the general public receiving and evaluating medical treatments as patients and their families through social networks within communities. The other sectors mainly describe the area of medical suppliers, with the professional sector referring to "the organized healing professions" including "modern scientific medicine and professionalized indigenous medical systems" (*ibid.* 53), and the folk sector comprising "non-professional, non-bureaucratic" (*ibid.* 59) medical healers whose medical techniques are more dominantly related to the popular sector than the professional sector. Through categorizing such areas and examining the overlapping between the sectors, Kleinman analyzed the medical systems in a certain cultural area with a more stereoscopic view. As Oberhelman (*ibid.*) evaluates, despite some weakness in his approach, which risks overlooking the dominant status of a certain sector – practically the professional sector – while mainly focusing on categorizing heterogeneous sub-sectors within a medical system, his work should be highly appreciated given that it lively illustrates the existence of medical pluralism while showing "how competing and coexistent medical traditions operate in a culture" (*ibid.* 5), based upon concrete field research at the level of clinical medical practices.

In compliance with such academic interests concerning the concept of medical pluralism, there has been various medical anthropological research on regional medical systems based upon ethnographic fieldwork predominantly in non-European regions, such as India (e.g. Leslie, 1977), Japan (e.g. Lock, 1984), Mexico (e.g. Finkler, 1982) and Papua New Guinea (e.g. Frankel & Lewis, 1989) since the 1970s, describing how biomedicine and traditional

indigenous medical forms co-exist within each cultural boundary. Such anthropological work predominantly focused on the fact that indigenous traditional forms of medicine that seemed to disappear or be substituted by biomedicine still play an active role within each place. Meanwhile, medical sociologists who adopted the notion of medical pluralism in their work have been more interested in the phenomenon of the emergence of CAM in Western countries. Among them, Cant and Sharma (1999) conducted empirical research on such phenomenon of CAM's re-emergence and its relationship with biomedicine in the UK in the late-20th century through examining the relationship between "users" (patients or customers of medical services), "alternative practitioners," "biomedicine" and "the state" as "the players" involved in the field of medical activity (ibid. 14-20). They argued that the emergence of the notion of CAM is not a fully new phenomenon but rather it has always existed, stating that "there has always been the possibility of choice between different kinds of practitioner ... and there have always been multiple ways of understanding health and sickness" (ibid. 1). As an example of medical pluralism in British history, they indicated the existence of competition between biomedicine and other forms of medical practices in the 19<sup>th</sup> century. For this reason, they called the medical phenomenon in the late-20<sup>th</sup> century the "re-emergence" of medical pluralism (ibid. 1). However, they also suggest that we can call the situation in the late-20th century a "new medical pluralism" given that biomedicine has a dominant position over CAM through its professionalization and legitimate authority recognized by the "state" and the "users"; meanwhile, various practices of CAM are structured in subordinative positions to biomedicine in the British medical system, whereas such a dominant position of biomedicine was not yet explicitly observed in the 19th century. In other words, they emphasize that while alternative therapies are acceptable in current British health care system, their positions are subordinated to biomedicine. In this context, they recall McLennan's explanation (McLennan, 1995) on pluralism to underpin the existence of the concept 'dominance' within the notion of pluralism itself, quoting that "the force of any brand of pluralism depends on its ability to characterize and problematize some prevailing monistic orthodoxy" (ibid. 98). In this connection, they go on to argue that "we shall treat it (pluralism) as one of a pair of concepts; pluralism implies the possibility of some kind of 'monism' and vice versa" (Cant & Sharma, ibid. 3). In sum, while the majority of medical anthropologists focused on the existence of traditional and indigenous medical forms with modern biomedicine and how they function in

a certain medical system,<sup>37</sup> Cant and Sharma argued for greater interests in the analysis of the dominance of biomedicine in situations of medical pluralism, under the premise that “the concept of medical pluralism cannot be fully comprehended without some appreciation of the concepts of medical dominance and professional self-interest” (Cant, 2004: 186).

Following medical anthropologists’ and sociologists’ interests in the concept of medical pluralism, medical historians have begun to show interests in this concept since the 1990s (Ernst, 2013: 11). Their historical approaches enabled examining the phenomena of medical pluralism with more of a diachronic insight within and between regions: in many cases, in Western Europe in the 19<sup>th</sup> and 20<sup>th</sup> centuries (e.g. Gijswit-Hofstra et al. 1997; Bradley, 2002; Jütte, 2013), as well as research in non-European regions (e.g. Arnold & Sarkar, 2002; Liebeskind, 2002; Scheid, 2009). Concerning the main interests of medical historians concerning the issues of medical pluralism thus far, Ernst (ibid. 22) mentions that they “have begun to recognize the importance of transnational links, circulation of ideas and practices, and the globalization of western as well as indigenous medicines” and “such work focuses on the plurality of approaches and the intrinsically plural nature of healing.” There has also been various research conducted by medical historians calling for more differentiating conceptualization of medical pluralism to capture various relations between orthodox and heterodox medical forms in various regions in the past and present. Among them, Ernst (2002: 4) argues that it is necessary to differentiate between the terms pluralism and plurality: while ‘pluralism’ implies the “desirability of (the situations of) medical pluralism,” actively acknowledging the existence of other forms of medical traditions, ‘plurality’ merely describes a situation where “a variety of medical approaches exist alongside each other” (ibid. 8), regardless of how they acknowledge, compete with or ignore each other. Through this differentiation, she argues that the power relationship between various medical forms – more concretely, the hegemony of biomedicine over other forms of traditional medicine or CAM – can be better observed.

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<sup>37</sup> As a matter of fact, both Leslie and Kleinman also recognized and expressed in their work that biomedicine has a dominant position over traditional indigenous medicine in each medical system in non-Western countries (e.g. Leslie, 1980: 191; Kleinman, 1980: 56). However, their main academic interests concerned the ways in which these different medical forms co-exist at the regional level in medical practices, rather than the analysis on their unequal relationship and the mechanism enabling such a relationship. In this sense, the profound differing point between them resides in their different interests within the situations of medical pluralism.

While agreeing with Ernst's argument above, Stollberg (2013: 149) – a historian and sociologist in one – suggests differentiating between “politically based medical pluralism” and “medically based medical pluralism.” In his explanation employing the medical history of (West) Germany in the 20<sup>th</sup> century, politically-based medical pluralism refers to a situation where the state acknowledges various forms of therapies through legislation or accepts them into the public health insurance system. As an example of politically based medical pluralism, he refers to the establishment of the pharmaceuticals act (*Arzneimittelgesetz*) in West Germany in 1976, which officially acknowledged the usage of traditional herbal medicine, as well as the acceptance of acupuncture covered by public health insurance companies in the 2000s (*ibid.*). By contrast, according to his explanation medically based medical pluralism is “prepared by scientific studies of the efficacy of drugs and medical practices” (*ibid.*). According to my understanding, it describes a situation where the principles of other forms of medicine are understood and accepted within their medical principles. According to him, Germany has not yet fully achieved medically based pluralism, given that traditional herbal medication is suspected concerning scientific proof of remedial effects in terms of the notion of ‘evidence-based medicine,’ whereas the scientific effect of acupuncture therapy is partially acknowledged by biomedical research (*ibid.*). Through clarifying such differences within the notion of medical pluralism, he tries to analyze the situations of medical pluralism with more accurate conceptual instruments in each society in the past and present.

This chapter has introduced the definition of medical pluralism, originating from the notion of pluralism from the discipline of political philosophy, followed by various academic researches within the disciplines of anthropology, sociology and history. The concept of ‘medical pluralism’ was first adopted in the 1970s by medical anthropologists who studied medical systems particularly in non-European cultural areas and argued for the active role of indigenous traditional forms of medicine despite the existence of ‘modern’ biomedicine. They were followed by medical sociologists who were more interested in the situations in Western countries, where the (re-)emergence of CAM was observed in the late-20<sup>th</sup> century. Together with the efforts of medical historians who applied such concepts in the more concrete historical past, the concept of medical pluralism was used in such various disciplines to comprehend medical phenomena in each place with cultural contexts, partly expecting that

their work would contribute to public health promotion adopted by local governments or WHO, while it was also utilized as an instrument to analyze the relationship between various medical forms and therapists, paying attention to their power relations. In the next chapter, I will examine the literature on the issues of biomedical dominance/hegemony over traditional medicine and CAM in the situations of medical pluralism, after introducing various types of medical systems classified within the notion of medical pluralism.

## **1.2 Typologies of Medical Systems**

Regarding the relationship between various medical sub-systems in current medical systems in different cultural areas or countries, several classification systems have been introduced by medical anthropologists and sociologists, as well as international health organizations. Such categorizations mostly describe the various degrees of the relationship between biomedicine and TM or CAM in situations of medical pluralism, representing socio-cultural, historical and political situations in each place. Although typological approaches are at risk of oversimplifying complicated actual realities and looking upon ever-changing situations as being fixed, they provide better insights to analyze internal structures with regard to the situations of medical pluralism in each national medical system. Bearing in mind such risks, in this chapter I will introduce categorizations of medical systems proposed by WHO (2002), Young (1994) and Last (1996).<sup>38</sup>

### **1.2.1 Three Types of Health Care Systems by WHO (2002)**

Trying to encourage the usage of TM/CAM and its integration into national health care systems, as specified in Declaration of Alma-Ata in 1978 (WHO, 1978), WHO introduced three categories of medical system in their report ‘WHO Traditional Medicine Strategy 2002-2005’ (2002), “describing the degree to which TM/CAM is officially acknowledged by the national states and integrated into their health care systems” (ibid. 8). In this connection, WHO proposes three medical systems: 1) an integrative system; 2) inclusive system; and 3) tolerant system.

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<sup>38</sup> National states mentioned below in those typologies as examples belonging to certain categories are classified according to the medical situations in each state when the research was conducted (WHO: 2002, Young: 1994, Last: 1996). Note that they can be different from the current situations in 2016.

### **1) Integrative System**

An integrative system refers to a medical system where “TM/CAM is officially recognized and incorporated into all areas of health care provision” (ibid. 8), which means that “TM/CAM is included in the relevant country’s national drug policy; providers and products are registered and regulated; TM/CAM therapies are available at hospitals and clinics (both public and private); treatment with TM/CAM is reimbursed under health insurance; relevant research is undertaken; and education in TM/CAM is available” (ibid. 8-9). WHO evaluates that only some East-Asian countries such as China, the Democratic People’s Republic of Korea (North Korea), the Republic of Korea (South Korea) and Vietnam belong to this category (ibid. 9).

### **2) Inclusive System**

In an inclusive system, TM/CAM is not as fully integrated into official health care as in the integrative system. In the cases of developing countries such as Equatorial Guinea, Nigeria and Mali, they “have little or no regulation of TM/CAM products,” whereas some developed countries like Canada and the UK “do not offer significant university level education in TM/CAM” (ibid. 9) but try to “ensure the quality and safety of TM/CAM” (ibid.). As examples of countries belonging to this category, WHO lists India, Sri Lanka, Indonesia, Ghana, Nigeria, United Arab Emirates, Japan, Australia, Germany, Norway, the United Kingdom, Canada and the USA (ibid. 10).

### **3) Tolerant System**

A tolerant system refers to a national health care system based exclusively upon biomedicine, with the legal tolerance of some TM/CAM practices (ibid. 9). Utilizing this categorization with the three types of health care system, WHO tries to support and encourage the integration of TM/CAM into the official health system for health promotion in each country.

## **1.2.2 Models of Health Care Pluralism by Young (1994)**

David Young – a medical anthropologist specialized in medical systems in East Asia<sup>39</sup> –

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<sup>39</sup> From: “Professors, Instructors, Adjunct, Emeriti,” Homepage of Anthropology, University of Alberta, retrieved 26 May 2016 from <https://uofa.ualberta.ca/anthropology/people>.

presented his article “the models of health care system” in an international workshop “Traditional Health Systems and Public Policy” in Canada in 1994 (Islam & Wiltshire, 1994). In this presentation, he proposed five “types of relationship between biomedicine and indigenous healing traditions within the same society” (Young, 1994: 62), based upon the criteria regarding their relationship “in terms of structural equality (legal recognition and access to resources)” and their “nature of interaction” (ibid. 62). Accordingly, while WHO mainly focuses on the degree of TM/CAM’s integration into national health care systems in each country, Young additionally considers the degree of interaction and mutual cooperation between different medical forms – particularly between biomedicine and TM/CAM – within each society. With these notions, he introduces five types of health care system: 1) intolerant orthodoxy; 2) tolerant orthodoxy; 3) parallel independent traditions; 4) collaboration and combination; and 5) integration.

### **1) Intolerant Orthodoxy**

In this type, biomedicine is in a monopolistic status, while “using its power base to prevent alternative healing traditions from obtaining legal status” (ibid. 62). As examples, he mentions previous health care situations in Africa when “colonial powers persecuted indigenous healers,” the former Soviet Union and Cuba when they exclusively allowed modern scientific medicine, as well as Western countries such as Canada, which were “intolerant of native healing traditions until recently” (ibid. 62). Despite such a prohibiting policy, he argues that indigenous healing traditions were not eliminated but were simply forced to exist underground. In this sense, he supports this type of medical situations called “unofficial medical pluralism” (ibid. 63).

### **2) Tolerant Orthodoxy**

Tolerant orthodoxy – practically the same as the concept of “tolerant system” by WHO (2002) – refers to a situation where “there is a single orthodox healing traditions, but many of its practitioners are tolerant of alternative traditions” to “provide culturally appropriate health care, while understanding the beliefs and behaviors of minority patients” (ibid. 63). He mentions several concrete situations in Canada as examples of tolerant orthodoxy. Amongst such examples, he illustrates a situation examined by Gregory (1988) where nurses who are involved with primary health care projects for Indian ethnic groups need to “be aware of and



understand traditional Indian health beliefs and practices if a holistic nursing approach is to be sustained” (Gregory, *ibid.* 39). Accordingly, although alternative forms of medicine are not officially acknowledged by the state, practitioners in clinical settings accept utilizing such forms of medicine in their practices for their patient management. However, despite its tolerance, biomedicine “retains its position of structural superiority” (Young, *ibid.* 63) as the only official medical form acknowledged by the state. In this sense, tolerant orthodoxy also belongs to the category of unofficial pluralism.

### **3) Parallel Independent Traditions**

While the first two types of health care system describe situations where only a single form of medicine – namely biomedicine – is officially authorized by the state, types 3, 4 and 5 demonstrate that two or more forms of medical traditions are legally recognized,<sup>40</sup> with the degrees of their interaction being differentiated. Among them, the type “parallel independent traditions” shows the least cooperation in terms of integration between different medical traditions, whereby “there is little active collaboration among practitioners of the different traditions” (*ibid.* 63). He argues that this type is commonly observed in many African societies, where “traditional and biomedical clinics exist side by side” with “little cooperation between the personnel of traditional and biomedical clinics” (*ibid.* 63-64). In this type of health care pluralism, their relations are generally characterized by “indifference” (*ibid.* 64), not actively agreeing with each other’s medical principles. In this sense, Young labels this type of medical pluralism as “a passive type of official healthcare medicine,” which is similar to the notion of “politically based medical pluralism” by Stollberg (2013: 149), as introduced in Chapter II.1.1 (pp. 27). Apart from that, Young argues that official medical pluralism does not automatically imply “structural equality” (*ibid.* 64). Particularly in the case of type 3, Young argues that it is very commonly observed that biomedicine has a superior position over other forms of traditional medicine.

### **4) Collaboration and Combination**

Type 4 illustrates situations where more active collaboration is observed between different plural medical traditions, generating “a combination of therapeutic techniques, or else the

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<sup>40</sup> In his usage of the term ‘tradition,’ not only traditional medicine but also biomedicine belongs to medical ‘tradition’ (Young, *ibid.*).

beliefs, practices and medicines of two or more traditions are combined by a single individual” (ibid. 64). As the most common type of collaboration, he mentions “referring patients to each other” (ibid. 64). As an even higher level of collaboration, he shows examples in a Beijing hospital in China where the “interdisciplinary” team comprises biomedical personnel and traditional Chinese medicine practitioners with Mongolian or Tibetan medicine healers (ibid. 64). In this interdisciplinary team, he observed that a patient with gangrene<sup>41</sup> of the toes associated with diabetes was first sent to the biomedical sector for biomedical medications. As his symptom was not alleviated, he was subsequently sent to the sector of traditional Chinese medicine, where the TCM doctors successfully cured the injured toes on each foot (ibid. 64). He evaluates such collaborative work as “pragmatic” in that “it does not require agreement among the practitioners concerning the cause of the problems or even the best solution,” while “simply agreeing to try a treatment which has a high probability of success” (ibid. 64-65). In this type of medical pluralism, Young emphasizes the active role of government while intervening between different medical traditions for a balance of power, or encouraging indigenous medical practitioners to adopt biomedical techniques to improve their therapeutic effects (ibid. 65). In sum, type 4 ‘collaboration and combination’ is a more active type of health care pluralism than type 3 ‘parallel independent traditions,’ albeit “without the cooperation, or even knowledge, of the practitioners involved” (ibid. 66).

## **5) Integration**

Type 5 is the highest level of official health care pluralism regarding the degree of interaction between different medical traditions, aiming “to synthesize the theory and practice” of them “into a more comprehensive system” (ibid. 66). This type of health care pluralism corresponds with Stollberg’s notion of “medically based medical pluralism” (2013: 149). As an example, Young illustrates the efforts of Chinese researchers who “have tried to develop a theory which would be broad enough to explain the flow of *Qi* through the meridians, as understood in traditional Chinese medicine” (ibid. 66), although such efforts have not been fully successful and acknowledged by biomedical doctors. However, he does not consider the results of such efforts necessarily desirable because “it would lead to a new orthodoxy and to

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<sup>41</sup> Gangrene refers to “the decay or death of an organ or tissue caused by a lack of blood supply. It is a complication resulting from infectious or inflammatory processes, injury, or degenerative changes associated with chronic diseases, such as diabetes mellitus.” From: “Gangrene,” Gale Encyclopedia of Medicine (2008), retrieved May 26 2016 from <http://medical-dictionary.thefreedictionary.com/gangrene>.

the abuse of power which can result in any system dominated by a single healing tradition” (ibid. 66).

Despite acknowledging that such a typology would bring misunderstanding of actual medical reality as it is based upon logical boundaries, Young argues that it could inspire health policy-makers to solve medical problems and improve health policies in their states, through understanding “1) the extent to which biomedicine and indigenous healing traditions should be provided with structural equality, and 2) the different options available in terms of potential interaction among healing traditions” (ibid. 67).

### **1.2.3 “Plural Medical Systems in Terms of the Officially Accepted Range of Medical Subculture”<sup>42</sup> by Last (1996)**

Murray Last (1996) – an anthropologist specialized in African medical culture and history<sup>43</sup> – argues that despite the existence of biomedicine being widely recognized as the universal cosmopolitan medicine at present, there are various different appearances of medical circumstances in each national state, subject to national cultural variations, including socio-political contexts. In this regard, he introduced three types of national medical cultures<sup>44</sup> reflecting “the nature of a state’s medical culture” and “the organizational possibilities for indigenous practitioners” (ibid. 380), based upon his premises regarding the professional recognition of medical practices by the national states: first, “professions of medicine function primarily within a national medical culture” (ibid. 376); second, “these national medical cultures are partly the product of a nation’s ruling political philosophy and partly the product of the ways people express their health needs and find solutions to them” (ibid.); and third, “professionalization is one solution to the dilemma of practitioners of traditional medicine in the face of unequal competition from other systems of medicine” (ibid.). To put his categorization more plainly, quoting Singer and Baer’s remark, “societies vary considerably in the degree to which they tolerate medical pluralism” (2007: 147). Following

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<sup>42</sup> From: Singer and Baer, 2007:147.

<sup>43</sup> From: “Murray Last,” Homepage of UCL (University College London) Anthropology, retrieved 26 May 2016 from [https://www.ucl.ac.uk/anthropology/people/honorary/m\\_last](https://www.ucl.ac.uk/anthropology/people/honorary/m_last).

<sup>44</sup> He uses the concept “a national medical culture” to express “the national arena in which competition between medical systems takes place, with professionalism as one factor in that competition” (ibid. 376).

such criteria, Last (ibid. 380-387) presents three types of national medical cultures, namely 1) exclusive systems, 2) tolerant systems, and 3) integrative systems, with several detailed models as concrete examples of each category.

### **1) Exclusive Systems: Medical Monopolies**

In the cases of exclusive systems, the national states “recognize and tolerate only one medical subculture, namely biomedicine” (Singer & Baer, 2007: 147). In this category, Last presents three concrete models: The Marxist, French and American model. In the **Marxist model** – a monopoly of the state observed in the former Soviet Union and Eastern European countries until the 1980s – biomedical practitioners were employed in public clinics or by the state as civil servants. Meanwhile, traditional or alternative healing practices were banned while they were considered as “reinforcing the class divide, by helping to prevent people having a proper scientific understanding of their condition and pandering instead to superstition” (Last, ibid. 381). The **French model** is observed in France, former French colonies in Africa and parts of Latin America. In this model, the state “recognizes only biomedical practitioners and defines alternative medical systems as illegal” (Singer & Baer, ibid. 147), while employing biomedical doctors in official medical organizations as civil servants, similar to the Marxist model. However, the practitioners in this model can also establish private clinics, unlike Marxist model. The **American model** also belongs to the category of exclusive systems given that biomedicine clearly stands in a superior position, as acknowledged by the state. However, compared to the first two models – in which the state plays a decisive role in regulating the whole part of each medical system within each country – the American model allows relatively more spaces in the private sectors based upon the principles of a free medical market. In line with this, as an important difference of the American system compared with the Marxist and French models, Last (ibid. 382) indicates “the lack of standardization due to privately run institutions in all aspects of medicine.”

### **2) Tolerant Systems: Medical Markets**

In contrast with exclusive systems, tolerant systems embrace a “laissez-faire policy toward alternative medical systems” (Singer & Baer, ibid. 148). In the **British model** – including Australia and New Zealand – which reflects the traditions of common law, various alternative medical practices are allowed to offer medical services as long as the regulations do not

particularly restrict certain specific medical actions. Medical regulations merely define who can be officially labeled as a ‘medical doctor’ in charge of the biomedical sector or decide which medical treatments are included in the financial coverage of the National Health Service, most of which had been medical treatments conducted by biomedical doctors until recently. In this situation, patients can freely choose various medical products between biomedicine and other forms of alternative medicine such as osteopathy, chiropractic and naturopathy. This kind of medical system is also observed in developing countries, the majority of which are former colonies of Britain. In the **German model** – observed only in Germany – licensed biomedical doctors can freely apply various forms of medicine under the German tradition of *Schulmedizin* (‘school medicine’) and *Naturheilkunde* (‘naturopathy’). Meanwhile, a *Heilpraktiker* (‘non-medical’ or ‘alternative practitioner’) may apply various kinds of alternative healing techniques after they pass an exam “to show that they know the state law regulating medical practice” (Last, *ibid.* 385). In this situation, these alternative practitioners are allowed to conduct various alternative healing techniques.

### **3) Integrated Systems: Asian Pluralism**

Integrated systems refer to medical systems where non-biomedical traditions – mostly developed in their own cultural areas – are actively used with the public, with biomedical ‘Western’ medicine. Most of the countries that belong to this category are Third World countries. However, Last (*ibid.* 385) assorted a Indian and Chinese model as an independent sub-category of this type of system based upon their strong professionalization degree of indigenous medical traditions, compared to other countries in this category. In this background, he suggests two models in this category: Indian and Chinese models, and the Third World model. In the **Indian and Chinese models**, various indigenous traditional forms of healings with long traditions with a huge volume of written medical texts passed down from the past achieved high levels of acknowledgment by the state, taking rank with ‘Western’ medicine. India – a former British colony – achieved the professionalization of indigenous medical traditions with their own professional associations under the tolerance of the British common-law system. Furthermore, in China, traditional Chinese medicine is officially acknowledged by the state as being equivalent to biomedicine.<sup>45</sup> In differentiating between

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<sup>45</sup>Although Last did not mention in his work (1996), medical systems in North and South Korea, and Vietnam belong to this model in that traditional forms of medicine are officially acknowledged by the states equally with

the Indian and Chinese models, he pays attention to the role of the states: whereas the Indian model – influenced by the British model – allows traditional alternative practitioners to have autonomy to regulate themselves, the Chinese model tends to strictly govern medical services in a public sphere through the state policy in the same manner as former socialist states in Eastern Europe. However, unlike such European socialist regimes, China integrated its medical tradition into the official medical system with biomedicine, while modifying traditional medicine into TCM in 1949 with the establishment of the Mao regime (Hsu, 1999; Scheid, 2002). In the **Third World model** – observed in many developing countries – although various forms of indigenous alternative medical traditions have not experienced professionalization as seen in Indian and Chinese models, they are widely applied to patients in communities – especially in rural areas and for lower classes – while smaller numbers of biomedical practitioners predominantly work in urban areas for the upper classes.

In summary, Last shows through his typology that diverse shapes of medical pluralism exist based upon different historical, cultural backgrounds and political situations, especially paying attention to the role of the state, which regulates the official forms of medicine; however, in most cases biomedicine is in a superior position over other forms of medical practices. In the sense that Last categorizes various medical systems based upon the degree of the acknowledgment of traditional- or alternative medicine by the states, his typology is similar to that of WHO (2002). However, his categorization emphasizing the role of the state in deciding the relationship between the superior position of biomedicine and other forms of medicine is often linked to critical medical anthropologists' perspectives (e.g. Baer, 2011; Singer & Baer, 2007) who are interested in the power relationship between medical sub-systems and biomedical dominance over other forms of medicine, which will be introduced in the next chapter.

This chapter has introduced typologies of national medical cultures by WHO (2002), Young (1994), and Last (1996), describing different medical situations in terms of medical pluralism. WHO's categorization focuses on the degree of TM/CAM's integration towards national health care systems with the official acknowledgment by the national states, with the notion that such an integration will contribute to promoting public health in line with its primary

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biomedicine (WHO, 2002).

health care policy, first established in the Declaration of Alma-Ata in 1978 (WHO, 1978). By comparison, Young categorized in more detail regarding the relationship between biomedicine – as a mainstream medicine in current societies – and other forms of medicine, providing an instrument to understand different medical situations in each society regarding the concept of medical pluralism. As already mentioned, Last’s categorization strongly illustrates differing relations between the state, biomedicine and TM/CAM, providing clues to examine the power relations among them. In the next chapter, I will review the literature on biomedical dominance over traditional medicine in situations of medical pluralism before examining the main focus of this study, namely the relationship between two types of professionalized doctors – namely KM and biomedical doctors – in clinical practices in South Korea.

### **1.3. Biomedical Dominance in Situations of Medical Pluralism**

As briefly mentioned earlier in the arguments of Sharma and Cant (1999) and Ernst (2002), it was implied that in the situations of medical pluralism there exist worldwide phenomena of biomedical dominance over other forms of medicine. They indicate the risk of the concept of ‘medical pluralism,’ which could overlook such phenomena, while merely focusing on tracing the existence of various different medical forms within a single society. In this regard, Cant (2004) demands more sufficient attention to the biomedical dominance, paying attention to the power relationship with TM/CAM when conducting research on medical pluralism within the disciplines of anthropology and sociology of medicine. As the main concern of this study is to examine the relationship between KM and biomedical doctors in the process of their clinical work for patients in hospital settings in South Korea, the power relation between biomedicine and TM/CAM and the debates on biomedical dominance hold crucial importance. Amongst scholars within various disciplines dealing with the situations of medical pluralism, critical medical anthropologists have contributed the most to this issue, centering it as their main academic subject in the issues of medical pluralism and labeling such phenomena as “biomedical dominance” or “biomedical hegemony” (Baer et al. 2003: 329). In this chapter, I will introduce the issues of the power relationship between biomedicine/biomedical practitioners and TM/CAM healers, and more concretely biomedical dominance over TM/CAM in situations of medical pluralism, with critical medical

anthropologists as the central figure of the debates, particularly paying attention to Merrill Singer and Hans Baer's studies (Baer, 1995, 2004, 2011; Baer et al. 2003; Singer & Baer, 2007).

Regarding various types of situations of medical pluralism, let us first take a look at Singer and Baer's argument on 'dominative medical system.'

*Medical systems do not exist in a vacuum but rather reflect the class, racial, ethnic, and gender relations and inequalities of the wider society. In a dominative medical system, several different healing traditions coexist in the same society, but one tends to be more closely aligned with the dominant social groups in that society and to be the dominant healing tradition as well (Singer & Baer, ibid. 121).*

In their explanation, the medical system in each society is characterized by the structure of the very society to which such a medical system belongs. In this situation, different groups based upon various medical principles in a medical system reflect unequal relations between social groups in the society. In this regard, they argue that the medical system is constitutively a dominative system, as long as there are dominative relations between such social groups in society. Based upon this notion, they define medical pluralism as follows.

*State Societies manifest the coexistence of a highly elaborate array of medical traditions at both the conceptual and the practice level, a pattern medical anthropologists call medical pluralism (ibid. 121-122).*

Taken together with Singer and Baer's viewpoints on medical system, medical pluralism is a general phenomenon concerning "the coexistence of a highly elaborate array of medical traditions" (ibid. 122) in a dominative medical system in a state-level society. However, they argue that there are worldwide various ranges of medical pluralism from conflict to cooperation, depending on the socio-cultural settings in each place.

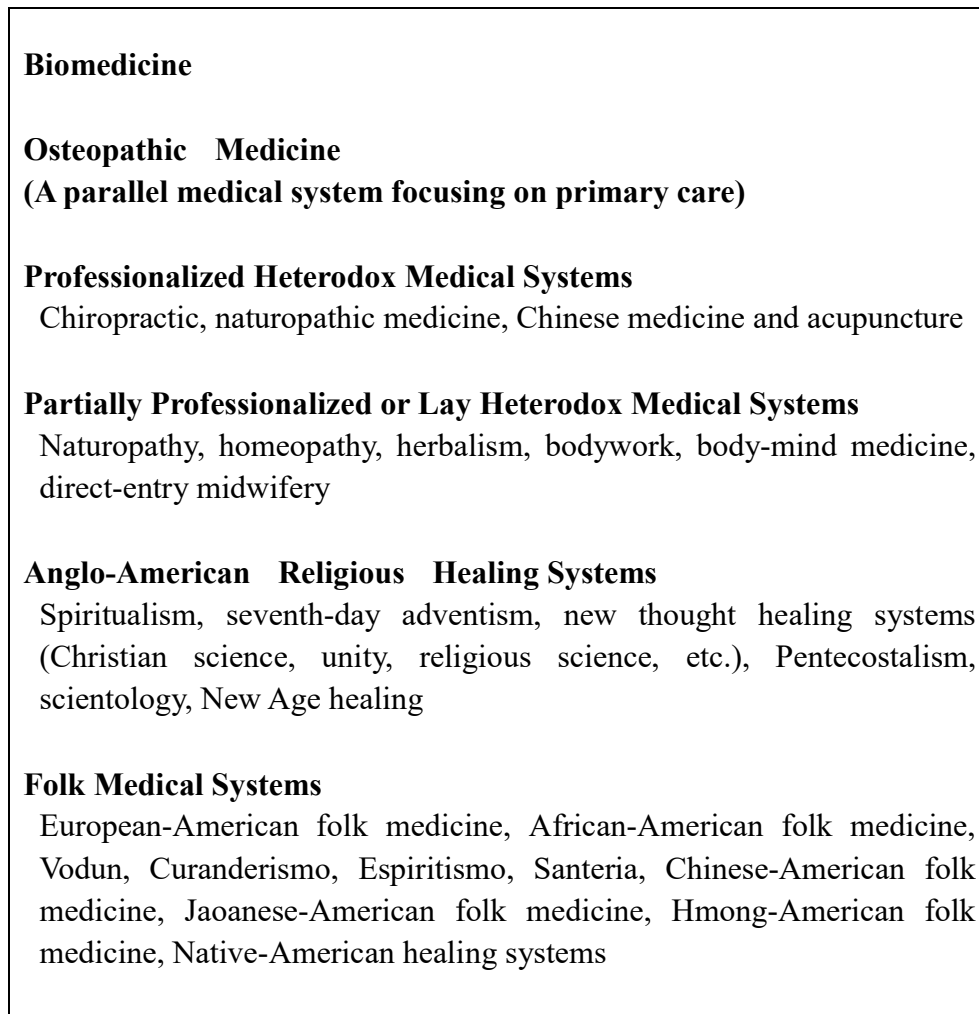
Concerning such diverse appearances of medical pluralism in different cultural areas, they instantiate ethnographic field research on concrete medical situations in developing and



developed countries in their work (Baer et al. 2003; Baer, 2004; Singer & Baer, 2007), such as Bolivia (e.g. Crandon-Malamud, 1991), Haiti (e.g. Brodwin, 1996), Indonesia (e.g. Ferzacca, 2001), Zaire (e.g. Janzen, 1978), Australia (e.g. Willis, 1989; Han & Ballis, 2007) and the United States (Baer, 2001), as examples of biomedical dominance over traditional and alternative forms of medicine. Citing the cases above, they show examples of dominative medical systems worldwide, in situations where: 1) lower class ethnic groups in rural areas face difficult access to biomedical services in terms of geographical distance and medical expenses in developing countries (Janzen, *ibid.*; Cradon-Malamud, *ibid.*; Brodwin, *ibid.*); 2) the usage of medical services in terms of social groups based upon class, gender or ethnicities is connected with certain types of medical traditions (Baer, *ibid.*; Ferzacca, *ibid.*; Willis, *ibid.*; Han & Ballis, *ibid.*); 3) various traditional indigenous forms of medicine are stratified regarding the degree of professionalization and the official acknowledgment by the state under the authority of biomedicine (Baer, 2001; Willis, *ibid.*). Accordingly, such phenomena formulate dominative medical systems with biomedicine as the peak, as shown in modern history in Australia and America (Baer, *ibid.* Willis, *ibid.*), as illustrated below in Figure II.1 ‘the USA Dominative Medical System’ as an example. Concerning this model of US American medical pluralism, Baer (2011) explains this as follows.

*I have developed a model of medical pluralism in the United States that recognizes biomedicine's institutional and economic hegemony and power differences within plural medical systems... This scheme is based on the thesis that the principal practitioners of each medical subsystem tend to be drawn from specific classes, racial and ethnic categories, and genders depending on their status in the larger society (Baer, 2011: 414).*

Figure II.1 The USA Dominative Medical System (Baer, 2011: 415)



In the same vein, Singer and Baer argue that “national medical systems in the modern world should be described as ‘plural’ rather than ‘pluralistic’ in that biomedicine enjoys a dominant status over both heterodox and folk medical systems” (2007: 144), corresponding to Ernst’s argument on ‘plurality’ and ‘pluralism’ (2002) described in Chapter II.1.1 (pp. 26). Accordingly, situations of medical pluralism in reality are not based upon the mutual respect of other forms of medicine with rather equal status, which could often be misunderstood as “pluralism,” connected with the shade of meaning “pluralistic” but based upon an unequal power relationship between biomedicine and other forms of traditional or alternative medicine, generally observed worldwide regardless of various differing concrete medical situations in each society.

As one of the concrete venues in which such biomedical dominance in situations of medical

pluralism is most commonly observed, Baer et al. (2003: 344) pay attention to the hospital as “the primary locus of biomedicine.” After briefly mentioning Foucault’s well known term ‘clinical (medical) gaze’ (1973) through which modern hospitals served as a place in which “the poor, sex workers, vagabonds, and the mentally disturbed were institutionalized and subjected to various medical experiments and surveillance” (Baer, et al. *ibid.* 344), followed by mentioning the American history of hospitals since the beginning of the 20<sup>th</sup> century, they emphasize that “the hospital is an elaborate social system, interlaced with smaller social systems and a wide variety of other occupational subcultures,” bordering on “a bureaucratic assemblage of workshops that deliver a labor-intensive form of medical care” (*ibid.* 344-345). In line with this aspect, they also indicate the ownership structure of the hospital organizations, which regulates the decisions in hospital administration and management, influenced by either the state policies of medicine and health care – predominantly in public or government hospitals – or interests of capital, mostly in private hospitals (*ibid.* 345). Meanwhile, they argue that such influences are realized by the efforts of hospital boards and hospital administrators (*ibid.*). Their argument implies that as the leverage of hospitals in a medical system increases in a society, the dominative position of biomedicine will be reinforced, while biomedical principles of health care are more adaptable to the structure of modern hospitals than any other forms of medical traditions. Concerning this issue, two case studies in Chinese hospitals (Henderson and Cohen, 1984; Schneider, 2001) were exemplified (Baer, et al. *ibid.* 348-350). Quoting the findings of ethnographic research in Chinese hospitals where both biomedical doctors and TCM doctors work in a single hospital organizations, Baer et al. argue that even in China – where traditional medicine legally achieved an equal status with biomedicine – it is observed that biomedicine occupies a considerably higher status than traditional medicine in reality (*ibid.* 352). In sum, they argue that hospital organization is a place where biomedical dominance over other forms of medicine is accomplished and observed.

Their viewpoints on medical pluralism, paying particular attention to biomedical dominance, are deeply related to their broader theoretical perspectives on medical anthropology, a critical medical anthropology (CMA) perspective, as they recognize themselves as critical medical anthropologists in their own work (Baer et al. *ibid.* viii; Singer & Baer, 2007: 13). CMA, also called “political economic medical anthropology” (Baer et al. 2003; Morsy, 1996), refers to

the “theoretical perspective in medical anthropology which stresses the importance of political and economic structures, especially global capitalism, on the health of human populations (also known as the political economy of health),” emphasizing “the significance of how politics and economic powers take part in the influence of welfare and sickness, and the human experience of health and illness.”<sup>46</sup> Concerning the range of the level of analysis, Singer argues that CMA is interested in “the interaction between the macro level of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions, the micro level of illness experience, behavior, and meaning, human physiology, and environmental factors” (Singer, 1995: 81).

As important theoretical backgrounds that influenced CMA, Witeska-Mlynarczyk (2015) adduces the following intellectual traditions: 1) the Marxist Tradition, connected with the notion of health and illness shown in Friedrich Engels’ “The Condition of the Working Class in England” (1845), which analyzed “disease understood as socially conditioned and dependent on power and class relations” (Witeska-Mlynarczyk, *ibid.* 386); 2) the intellectual interdisciplinary movement known as the “political economy of health,” which refers to “a theoretical framework used to study health inequalities” analyzing “the relationship between health status and political-economic institutions throughout the world, with particular emphasis on the detrimental health effects created by capitalist relations of production and sustained by specific political-economic arrangements” (Morgan, 2005: 401) influenced by the emergence of Marxist scholarship, the world system theory, and various social movement such as feminism, civil rights, and the anti-war movements in the late twentieth century; 3) Michel Foucault’s poststructuralist concept of “biopower” (1973), referring to “a new form of social control based on specific modern regimes of knowledge and practice achieved through dissemination of knowledge, which appears natural and normal to people and becomes the basis for their behaviors, choice-making and self-perceptions, in an institutionalized form in the context of a modern nation state” (Witeska-Mlynarczyk, *ibid.* 386); and, 4) phenomenological approaches “penetrating the subjective dimension of health and sickness, treating patients as furnished with agency” (*ibid.* 386).

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<sup>46</sup> From: Merril Singer, “What Is Critical Medical Anthropology?” Medical Anthropology Online, retrieved 26 May 2016 from <http://dcarbontica.weebly.com/critical-medical-anthropology.html>.

From the influences of such intellectual traditions we can infer the characteristics of CMA, which is interested in inequality in the field of health and illness and the macro structure of power relations in the state's societies that result in such inequality, on the one hand, and, on the other hand, those that have a particularly "strong applied orientation for promoting health equity" (Witeska-Mlynarczyk, *ibid.* 385) compared to other theoretical perspectives within the discipline of medical anthropology sorted by various anthropological theorists, such as "empiricist, cognitive and meaning-centered paradigms" by Good (1994), "environmental, evolutionary and cultural theories" by Hahn (1995), "medical ecological and interpretive theories" by McElroy and Townsend (1996), and "interpretive, ecological/evolutionary and applied medical anthropology" by Joralemon (2006). In line with CMA's theoretical orientations, Singer shows seven key concepts of CMA (Singer, 2004): health, disease, syndemics, suffer experience, medicalization, medical hegemony, and medical pluralism. Amongst these, the concept of medical pluralism is listed as an important key issue, along with medicalization and medical hegemony,<sup>47</sup> both of which give a hint of critical medical anthropologists' standpoint on medical pluralism, which "tends to mirror the wider sphere of unequal social relationships, with the patterns of hierarchy among co-present medical systems being based upon the reigning structure of class, caste, racial, ethnic, regional, religious, or gender distinctions" (*ibid.* 29). In short, critical medical anthropologists' great concern in the phenomenon of biomedical dominance in situations of medical pluralism originates in the main theoretical perspective of CMA, seeking "to uncovering hidden causes of poor health as they relate to capitalism and neoliberal economics while examining health structures on a macro and micro level."<sup>48</sup>

There are several critiques of CMA approaches from other theoretical perspectives. Amongst them, Andrea Wiley (1992) – in an article defending her biocultural standpoints that emphasizes the notions of evolution and adaptation in medical culture – severely criticizes CMA regarding its lack of scientific objectiveness due to its politically biased standpoints

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<sup>47</sup> As a critical medical anthropologist, Singer defines medicalization as "the absorption of ever-widening social arenas and behaviors into the jurisdiction of biomedical treatment through a constant extension of pathological terminology to cover new conditions and behaviors," while defining medical hegemony as "the process by which capitalist assumptions, concepts, and values come to permeate medical diagnosis and treatment" through the process of medicalization (Singer, *ibid.* 28).

<sup>48</sup> From: "Critical Medical Anthropology," Medical Anthropology Wiki, retrieved 26 May 2016 from <https://medanth.wikispaces.com/Critical+Medical+Anthropology>.

laying undue emphasis on “an explicit advocacy of political activism and social transformation” (ibid. 225). Although I think her viewpoint on scientific objectiveness also reflects her own viewpoints in terms of the debate on the possibility of value-free science, the CMA perspective always has a risk of wresting concrete phenomena in the real world to their grand theoretical assumptions. Namely, it will also be at risk mechanically juxtaposing the conflicts between medical subsystems with the conflicts in terms of class, race, gender or ethnicity within wider society, which can be blamed as oversimplification. Nevertheless, critical medical anthropologists’ concept on biomedical dominance in situations of medical pluralism provides a useful frame to analyze power relations between biomedicine and traditional indigenous and alternative medicine, which is a main concern in my study, as well as to take a broader view within or between national states regarding the role of the states in medical systems. In other words, even if I do not fully agree with the general assumptions of CMA based on the political economy of medicine and its strongly-applied orientation as related to political ideology, I acknowledge that the CMA perspective provides positive inspiration for the study of the power relations between biomedicine and traditional medicine within a medical system. For this reason, I will carefully consider CMA’s explanations and analytical framework when analyzing the findings of the fieldwork in my study to examine the relationship between KM and biomedical doctors in the WKCT process in South Korea.<sup>49</sup>

In this chapter I introduced the concept of medical pluralism with its history of debates and typologies of plural medical systems, followed by examining the concept of biomedical dominance in the situations of medical pluralism, with critical medical anthropologists’ arguments as the central figure, as a basic conceptual framework to examine the power relations between biomedicine and traditional or alternative medicine. In the next chapter I will introduce previous research related to the relationship between KM and biomedical doctors in the process of the WKCT within the disciplines of social science. Subsequently, I will explain the scope and significance of this study.

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<sup>49</sup> As this study is an inductive empirical study influenced by the grounded theory approach, I did not have in mind any certain theoretical framework of medical anthropology until starting the fieldwork and the analysis of the data. More details on the methods of the research will be explained in Part III ‘Research methods.’

## **2. Previous Research on the WKCT in Hospital Settings in South Korea**

Over the last decade, a considerable number of studies have been conducted on the WKCT, mostly based on statistical surveys reporting the current situation or presenting policy proposals. However, several studies concerning this issue have taken a closer look based on in-depth interviews with biomedical- and KM doctors and hospital administrators or ethnography in WKCT hospitals. Amongst them, this chapter introduces three pieces of qualitative research published in the last decade, taking notice of the relevance to my research topic, namely, how the relationship is situated between biomedical- and KM doctors in clinical settings while they participate in the WKCT process: Kye-Hyun Kim's research on biomedical Doctors working with KM doctors for the WKCT (2004); Myeong-se Sohn and Won-chul Lee's research report to the South Korean government concerning WKCT hospitals (2010); and Jongyoung Kim's doctoral dissertation on the scientific character of KM, interrelated to natural science and biomedicine (2005).

### **2.1 Survey Research on the Current Features of the WKCT Additionally Conducted with Qualitative Research Methods: Kye-hyun Kim (2004), Myeong-se Sohn and Won-chul Lee (2010)**

Kye-hyun Kim's research on biomedical doctors working with KM doctors for the WKCT (2004) was conducted as a short-term project of the 'Research Institute for Healthcare Policy,' directly responsible to the KMA in 2003, around the time when the issue of the Integration of Medical System with KM was actively being discussed in the KMA. In this study he analyzed biomedical doctors' main tasks in the hospitals when they work with KM doctors for the WKCT, as well as their viewpoints on the WKCT, through examining survey questionnaires and additional in-depth interviews with biomedical doctors who work with KM doctors in 6 hospitals. According to his interviews, the size of their working hospitals and the frequency of contact between biomedical- and KM doctors varies between doctors, with greater possibilities for biomedical doctors in smaller hospitals to have a personal contact with KM doctors during the process of diagnosis and treatment, compared to larger hospitals. However the degree of cooperation is very much limited even in small hospitals, given that there is no such case that both biomedical- and KM doctors conduct a co-

management for patients from the beginning to the end of diagnosis and treatment. Instead, biomedical doctors usually respond to the request from KM doctors, sending and receiving their patients in separate places. As one interviewee stated, biomedical doctors' main task is "to hire out biomedical information and treatment to KM doctors" (ibid. 45), based upon KM doctors' needs.

Myeong-se Sohn and Won-chul Lee's research report (2010) submitted to the Ministry of Health and Welfare summarizes the actual conditions of the WKCT, suggesting various improvement strategies for the cooperation, such as the development of curricula for the WKCT in biomedical- and KM schools and standardized clinical practice guidelines in WKCT hospitals. After reviewing the statistical results of the current situation of the hospitals participating the WKCT, they additionally conducted in-depth interviews with biomedical- and KM doctors as well as hospital administrators in 7 WKCT hospitals (4 biomedical hospitals, 2 KM hospitals, and 1 dental hospital), to ascertain the problems impeding the WKCT's process in clinical settings. Among various categories related to the WKCT in this report, I found several significant issues that provide clues concerning the relationship between biomedical- and KM doctors during the process of the WKCT. Firstly, in terms of the responsibility of medical actions during the WKCT, it was reported that in the case of a private biomedical hospital, the director of the hospital decides who takes responsibility for the treatment during the WKCT in most cases, although there were also some cases in two biomedical hospitals where both biomedical and KM doctors involved with the treatment collectively take responsibility (ibid. 23). Secondly, concerning the storage and usage of patients' medical records, none of the hospital has integrated medical records while 6 out of 7 hospitals store the records separately in each sector, regardless of whether or not they are equipped with an electronic medical record (EMR) system (ibid. 26). For this reason, it is systematically difficult to communicate between biomedical- and KM doctors through written medical records, although KM doctors often refer to the biomedical records of their patients. Lastly, concerning the principal agent deciding the WKCT, patients' demands were reported to be more important than the recommendations of clinicians in charge of their treatments (ibid. 44). In the case of private hospitals, the hospital owner or director's positive standpoints concerning the WKCT is even more important than those of clinicians in charge. In case there are hospital coordinators for the WKCT in hospitals, it was reported that they



additionally play a role in the promotion of the WKCT.

## **2.2 Jongyoung Kim's Ethnographic Research on the Hybridizing Character of KM (2005)**

Jongyoung Kim's doctoral dissertation "hybrid modernity: the scientific construction of Korean Medicine in a global age" (2005) predominantly deals with "the ways in which KM reconstructs its knowledge, identity, and community in relation to science and biomedicine" (ibid. iii), focusing on 'how KM mixes with science and biomedicine in laboratory and clinical settings' (ibid.). For this project, he conducted fieldwork research based on multi-sited ethnography in the KM school of Kyung-Hee University and Kyung-Hee Medical Center in Seoul. Examining the Herbal Pharmacology Lab at the Graduate School of East-West Medical Science, scientific research on acupuncture in the Meridianology Department of KM, as well as the networking process between natural scientists and KM doctors in the Physiology Department of the KM school, he found the diverse transformations of KM through its scientific reconstruction in a laboratory setting, "open-ended tuning process" (ibid. 3) between KM- and biomedical instruments, and an ongoing relationship between KM researchers and the industry sector to make profits from traditional herbology. In his study, he argues that "the interaction between local knowledge and global sciences/biomedicine involves multiple negotiations and conflicts among traditional doctors, the Korean government, and biomedical professionals of South Korea" (ibid. iv), whilst showing the hybrid formation of KM: "the open-ended tuning process between traditional medicine and science/biomedicine through which different knowledge systems are combined and mixed" (ibid.). Accordingly, he refutes the idea of "diverse dichotomies such as East/West, traditional medicine/science, and the local/global" relevant to Thomas Kuhn's concept of 'paradigm' which "tends to interpret science and traditional medicine as closed cultural systems" (ibid. v).

Although Jongyoung Kim's research mainly focuses on the internal process of KM's hybridization, it also provides very useful clues concerning the relationship between biomedical- and KM doctors during the process of the WKCT. In his fieldwork in the East-West Stroke Center (EWSC) of Kyung-Hee Medical Center – a university hospital together with the biomedical and KM school of Kyung-Hee University – he examines how KM

doctors work together with biomedical doctors in a clinical setting. As mentioned in his research, EWSC is the only WKCT hospital in South Korea where both biomedical- and KM doctors regularly admit patients for diagnoses and treatments in a single joint consulting room.<sup>50</sup> However, both biomedical- and KM doctors diagnose and treat their patients together with each other in this room only once a week for four to eight hours, spending the rest of the time on the medical management in their own clinic in separate rooms in the hospital (ibid. 213). Furthermore despite sticking with each other in the joint consulting room, they separately conduct diagnoses and treatment for their patient one after another, juxtaposing “biomedical skills and KM skills without integrating the two methods or inventing a new way of treatment” (ibid.). In this regard, hybridization of KM knowledge does not ‘progress’ between biomedical- and KM doctors during the WKCT, but rather is ‘utilized’ in the process of the WKCT with biomedical doctors. In addition, biomedical doctors usually do not show an interest in KM skills or ask any questions regarding such skills to KM doctors during the session in the joint consulting room for the WKCT, whereas KM doctors pay particular attention to biomedical doctors’ diagnostic process concerning their patients, using their hybridized knowledge.

In addition to these different attitudes toward their counterpart’s knowledge and medical skills,<sup>51</sup> Jongyoung Kim indicates the “embedded power structure in the EWSC” (ibid. 226), directly related to the main issue of my research question, namely the debates of biomedical dominance over traditional medicine and hierarchical medical pluralism. According to Dr. Moon (KM doctor) with whom Jongyoung Kim held an interview during his field research, the biomedical doctor “monopolizes the entire examination process in the EWSC” (ibid.) due to the MSA which prohibits KM doctors from conducting biomedical skills. Moreover, he argues that his patients usually “prefer Dr. Lim to him,” referring to his biomedical partner in the consulting room, who “gains more trust and authority from patients” (ibid.).

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<sup>50</sup> According to the interview with DB2 in my field research (2012), Wonkwang University hospital in Jeonbuk, also managed joint consulting rooms for the WKCT in the early 2000s. However, neither biomedical- nor KM doctors used these rooms for the actual management of their patients; they remained in name only, before soon falling out of use. According to my field research for this study, there has been no such case in any WKCT hospital in Busan thus far.

<sup>51</sup> I experienced the same attitudes during my own fieldwork, which I labeled as ‘asymmetry’ between KM and biomedical doctors in the coding process in the analysis of interview data. Further details will be followed in Chapter V.2.3 ‘Ways of communication between KM and biomedical doctors in WKCT hospitals.’

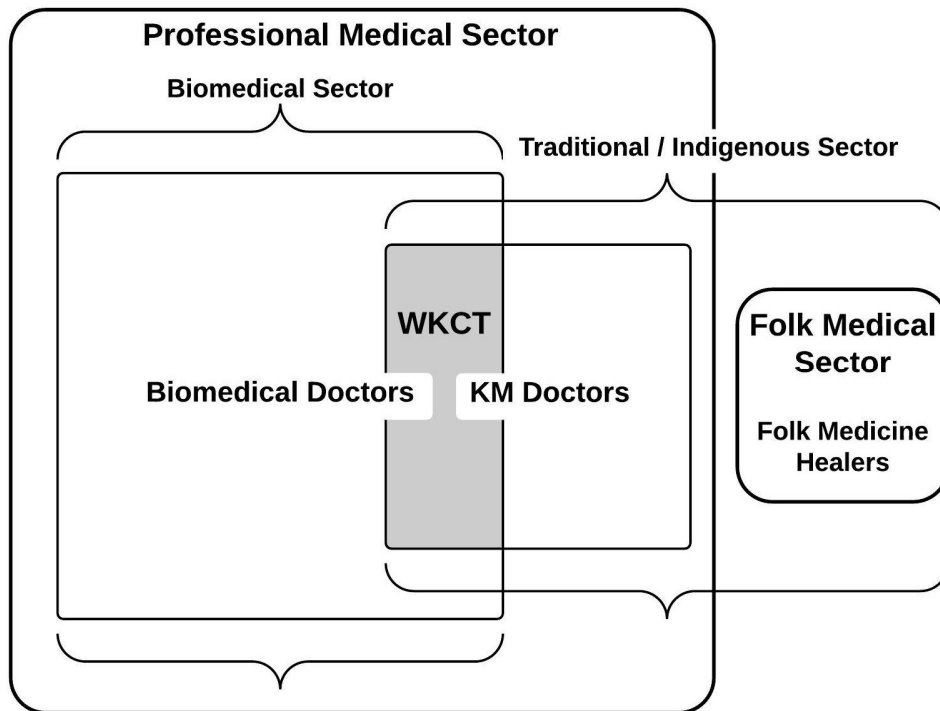
In short, Jongyoung Kim's research offers us several useful and important implications related to my study. Firstly, KM doctors' biomedical knowledge originates from their own educational background and experience outside of the clinical setting in the WKCT hospitals with biomedical doctors, namely, it is not the result of their interaction with biomedical doctors during the WKCT in their workplace. Secondly, the interaction between biomedical- and KM doctors is very much limited during the WKCT, even in Kyung-Hee Medical Center, where the clinical setting for the WKCT is nationwide known to be friendlier than any other WKCT hospitals in terms of the interaction between biomedical- and KM doctors. Lastly, there is an implication that the aspects of biomedical dominance or hierarchical medical pluralism could be observed during the process of the WKCT, even when two different medical professionals with legally equal status work together in the same place. However, it remains unclear how and to what extent biomedicine dominates over traditional medicine in the daily clinical setting, and is implemented during the process of diagnosis and treatment within clinical settings, which is to be further analyzed in my field research.

### **3. Scope and Significance of Study**

This study aims to examine the relationship between two medical doctors – biomedical doctors and KM doctors – in the process of the WKCT for their patients in hospital settings to analyze the power relations between the biomedical and traditional indigenous medical sector in actual clinical practices within a professionalized medical area. In this regard, the study mainly focuses on the area of professional medical suppliers within the South Korean medical system, excluding the areas of medical consumers and folk medical healers. Amongst various hospital settings, I exclusively limited this study to observing the hospitals where both KM and biomedical doctors work together in either the same hospital institutions or two different hospital institutions in the same or neighboring hospital buildings, namely where the WKCT process is observed. In this regard, hospitals comprising only KM or biomedical sectors – which account for the majority of South Korean hospitals and clinics – are excluded from the main concern for the research.

Concerning the main focus of the physicians' medical actions in WKCT hospitals, I mainly focus on their work involved with their counterparts in the process of their patient management. In other words, I do not aim to capture the entire view of the South Korean medical system encompassing the areas of medical consumers and folk medical healers, and KM and biomedical doctors' medical actions not involved with the WKCT in this study, but rather I examine the relations between two different kind of professional practitioners – considering their differing medical knowledge and their medical jurisdictions – in the process of their mutual clinical activities within hospital settings. Moreover, the role of patients and hospital administrators and the influence of medical policy of government will be examined based upon interviews with the physicians as external factors that could influence the process of the WKCT and the physicians' decisions within it. However, all those external factors examined in this study are described in the eyes of the KM and biomedical doctors, focusing on how the physicians perceive themselves as being influenced by such external factors, rather than their own views about such external factors themselves. Concerning the scope of this study, let us have a look at Figure II.2 below.

Figure II.2 Scope of the Research



This model was developed under the influence of Kleiman’s model, “Local health care system: internal structure” (Kleinman, 1980: 50). However, it was modified to exclusively describe the sectors of medical suppliers. In addition, boundaries in this model describe the working areas of practitioners or the boundaries of their medical jurisdictions acknowledged by the state, rather than the boundaries of medical knowledge between biomedicine and traditional or indigenous medicine. The overlapping part labeled as ‘WKCT’ also denotes clinical areas where both KM and biomedical doctors work together in clinical practices, rather than the area of mixed or integrated medical knowledge of KM and biomedicine. Accordingly, the scope of this study is limited to examining the physicians’ (KM and biomedical doctors) relationship in the process of their mutual clinical involvement within the professional sector, rather than their general relationship in the comprehensive perspective of the entire South Korean medical system.

Concerning the significance of this study, there are several aspects to be considered within the disciplines of medical sociology and anthropology. First, whereas previous research on medical systems as well as micro-level research in hospital settings in medical sociology and

anthropology have predominantly tended to focus on physician-patient relationships as indicated by Baer et al. (2003: 347), this study mainly deals with the physician-physician relationship, namely between KM and biomedical doctors in order to concentrate on their power relations. Second, most previous social scientific research on the WKCT in South Korea has mainly explored current situations of the WKCT (e.g. Dong-huei Lee, 1994; Kye-hyun Kim, 2004; Mun-ju Oh, 2007; Jung-hun Kim, 2011, et al.) and its utility or improvement direction for South Korean health care policy (e.g. Dong-huei Lee, 1998; Kang, Seol & Choi, 2005; Woo-young Shin et al. 2011; Go-eun Lee, 2012, et al.). As one of a few exceptions, Jongyoung Kim (2001, 2005, 2006) conducted thorough sociological research on the characteristics of KM as a hybridized form of medical science within the frame of sociology of knowledge and science. However, in his research, KM doctors' relationship with biomedical doctors in the process of the WKCT was only partly examined while he mainly focused on KM and KM doctors' own hybridization process. Even when he examined relations of KM with other sectors (2005), he focused more on its relations with science and industry rather than biomedicine and biomedical doctors, as there is more actual interaction and cooperation observed with such sectors than with biomedical doctors in the professional medical sector. This study tries to bring the issues on the WKCT to the field of debate concerning biomedical dominance in situations of medical pluralism, more directly focusing on KM and biomedical doctors' power relations.

Second, within the debates on biomedical dominance in situations of medical pluralism, South Korean situations have not been actively discussed so far, although there have been many appealing and distinctive features in South Korean medical systems in comparison with the cases in Western countries or developing countries, including the Chinese medical system which is considered most similar to the South Korean situation in the sense that the traditional sector has achieved the highest level of professionalization with an equal legal status to the biomedical sector. Compared to Chinese situations – within which many medical anthropologists have examined the notions of medical pluralism or biomedical dominance (e.g. Henderson & Cohen, 1984; Hsu, 1999; Schneider, 2001; Scheid, 2002, 2009) – the influence of the state on physicians' decisions in clinical practices has been less strong in South Korea, while the South Korean medical system has been more open to the free market system than the Chinese socialist regime, with more autonomous space for hospital staff –

including physicians – in their clinical decisions.<sup>52</sup> Under this circumstance, it will be easier to examine the power relations between biomedicine and traditional medicine less influenced by the state policies. By contrast, the areas of medical actions are more strictly divided between KM and biomedical doctors in the South Korean medical system than in China. While TCM doctors in mainland China are allowed to utilize biomedical inspection and prescribe biomedical drugs – let alone the existence of integrative medicine doctor system – it is strictly banned for KM doctors by the MSA to apply such biomedical inspection and therapies alone without biomedical doctors, as well as for biomedical doctors to use herbal medication and acupuncture alone without KM doctors. In this situation where the biomedical and traditional sectors are more strictly divided according to biomedical doctors' and KM doctors' exclusive authorities, it will be easier to analyze the power relations in terms of medical knowledge separate from the power relations between medical professions. Apart from that, concerning the argument regarding the hospital as “the primus locus of biomedicine” by Baer et al. (2003: 344) – as introduced in Chapter II.1.3 (pp. 41) – I will devote particular attention to the hospital settings of the WKCT hospitals, exploring whether there are any biomedicine-friendly aspects in the process of the WKCT between KM and biomedical doctors and – if so – how and to what extent such hospital settings have an effect on their power relations in clinical practices in relation with the size and the ownership structure of hospitals.

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<sup>52</sup> Further details on this issue will be introduced in Chapter IV.1.4 ‘Modernization of Korean Medicine and the establishment of a dual medical system in the postcolonial period (1945 –).’

#### 4. Summary of Part II

Part II introduced the conceptual framework of this study, the concepts of medical pluralism and biomedical dominance over traditional indigenous medicine in situations of medical pluralism, together with the previous qualitative research related to the WKCT in the field of social science. Subsequently, it illustrated the scope and the significance of this study regarding this conceptual framework and previous research on the WKCT. Chapter II.1 started by introducing the concept ‘medical pluralism’ – defined as “the co-existence in a society of differing medical traditions, grounded in different principles or based on different world-views” (Cant, 2004: 183) – adopted by medical anthropologists, sociologists and historians who devoted attention to the current situations and historical events in which modern biomedicine and indigenous traditional medicine or CAM coexist within a single society. After illustrating various typologies of medical systems regarding the shapes of medical pluralism by WHO (2002: integrative system, inclusive system, and tolerant system), Young (1994: intolerant- and tolerant orthodoxy, parallel independent traditions, collaboration/combination, and integration) and Last (1996: exclusive systems, tolerant systems, and integrated systems), this chapter proceeded to introduce the debates on biomedical dominance over traditional indigenous medicine in situations of medical pluralism. Many of the scholars have indicated the dominant position of biomedicine over other forms of medical traditions in their studies on the issues of medical pluralism. Amongst them, critical medical anthropologists (e.g. Baer et al. 2003) have paid particular attention to this phenomenon by connecting it to their theoretical perspectives that emphasize the way in which political and economic power relations have an effect on the issues of health care. According to their argument, a medical system reflects the conflicts of various power relations – in terms of class, gender, ethnicity, etc. – within a broader society to which the certain medical system belongs (Singer & Baer, 2007: 121). As a result, they argue that it formulates certain hierarchical structures in which biomedicine dominate other forms of medical traditions, called ‘biomedical dominance/hierarchy in medical pluralism.’ In their explanations on biomedical dominance, they emphasize the role of hospital structure in particular, as a central place where biomedicine exerts their dominance.

Chapter II.2 introduced previous qualitative research work in the discipline of social science



related to the process of the WKCT and the relations between KM and biomedical doctors in this process. Kye-hyun Kim (2004) reports that the degree of KM and biomedical doctors' actual cooperation is very much limited regardless of the degree of their personal contacts in hospitals (ibid.). Sohn and Lee (2010) explicated that the majority of the WKCT hospitals store medical records of KM and biomedicine in separate places, which systematically makes it difficult to communicate between KM and medical doctors through the written records. They also argue that patients' demands on certain therapies or inspections and hospital administrators' suggestions are often more important for the decision for the WKCT than KM and biomedical doctors' own decisions for it. In his ethnographic research on the hybridized character of KM, Jongyoung Kim (2005) argues that the place where biomedicine and traditional medicine encounter is not observed in the communication between KM and biomedical doctors, but rather within the field of KM. In this study, I will confirm whether such findings are actually observed in the clinical process of the WKCT, as well as examining how and to what extent they have an effect on the power relations between KM and biomedical doctors.

Chapter II.3 introduced the scope and significance of this study. As this study aims to examine the relationship between KM and biomedical doctors when they are involved with patient management in the same place in the clinical settings, I restricted the scope of the research exclusively to their mutual medical actions observed in WKCT hospitals, which means that only a part of the South Korean professional medical sector, excluding hospital settings where either KM or biomedical doctors work without their counterparts in the professional sector, and the non-professional sector of traditional medicine and CAM, for instance, where folk medical healers conduct medical actions. Therefore, the findings of this study should not be understood as covering the general relationship between KM and biomedical doctors or biomedicine and traditional indigenous medicine. Concerning the significance of the research, this study aims to provide a unique example of the situations in medical pluralism given that the South Korean situation has not been widely discussed within the conceptual framework of medical pluralism to date; however, more importantly, the South Korean case of the relationship between KM and biomedical doctors – in which the phenomenon of biomedical dominance will be less extrinsically observed than any other cases due to the equal status of KM doctors as biomedical doctors and their strictly divided

medical jurisdictions – serves as a more challenging case to the debates on biomedical dominance in the situations of medical pluralism that used to focus on more explicit ways of biomedical dominance through its legal superiority and higher socio-economic status of its medical consumers.

## **Part III. Research Methods**

Given that this study focuses on the process of the WKCT, namely how KM and biomedical doctors are involved in the diagnosis and treatment for their patients working together in various hospital settings, I tried to find a suitable research method that can vividly describe the daily process of their work in clinical settings as far as hospital circumstances permit, where they are usually known for being closed to the outside to protect patients' confidentiality and ensure physicians' clinical autonomy. In this part, I will start by demonstrating my personal experience in the course of the research process in terms of why I chose the certain methods for the research, under the title, "developing through trial and error" (Silverman, 2005: 307), followed by case selection and data collection for the fieldwork in four WKCT hospitals in the city of Busan. In this part, I will also introduce the demographic profiles of the interviewees in four hospitals, followed by introducing the coding process in the process of the analysis.

## **1. The Natural History of the Research: “Developing through Trial and Error” (Silverman, 2005: 307)**

After I finished my additional bachelor’s degree in physical therapy with physical therapist license in South Korea,<sup>53</sup> I was looking for an interdisciplinary research topic for a doctoral dissertation that can integrate my academic backgrounds (history, sociology, and health science) within the discipline of medical sociology/anthropology, together with my clinical experience in KM- and biomedical hospitals during the period of actual training in the school of physical therapy. I decided to conduct an empirical research in hospital settings concerning the medical system in South Korea, which enables me to take a closer look into hospital settings as a physical therapist. Accordingly, I proposed a research project on the relationship between KM and biomedical doctors who work together in the same places for patients, as an example of a distinctive feature of the South Korean medical system.

The topic of the research partly originates from my personal experience in hospitals in Busan. During the period of training in several biomedical- and KM hospitals, I noticed that the attitudes of KM and biomedical doctors towards physical therapists significantly differed. For instance, KM doctors showed more respect to physical therapists and their therapies than biomedical doctors, which could result from the fact that only biomedical doctors have an official ascendancy over the physical therapists to prescribe physical therapy.<sup>54</sup> Aside from this, I also heard from other physical therapists that KM doctors usually tend to spend more time with their patients for diagnoses and treatments compared to biomedical doctors. Although I could not gain further experience concerning the relationship between KM and

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<sup>53</sup> I previously majored in history as my first bachelor’s degree in South Korea, followed by my master’s degree in sociology in Germany, before taking part in this additional bachelor’s degree course.

<sup>54</sup> According to Article 1 and 2 of the Medical Technicians, etc. Act of the Republic of Korea (*Uiryogisa Deung-e Gwanhan Beop-ryul*, Enacted on 5 Jan. 1995, Act No. 4912, Revised on 22 Nov. 2011, Act No. 11102), medical technicians such as physical therapists, radiological technologists, medical laboratory technologists, dental technicians and dental hygienists work under the direction of biomedical doctors or dentists. Accordingly, tasks of medical technicians are considered to belong to the domain of biomedicine, while KM doctors do not have medical guidance over medical technicians. However, KM doctors usually order physical therapy to physical therapists through a ‘perfunctory’ permission of biomedical doctors working in the same hospitals, which has been practically called ‘co-signing’ among KM doctors as a kind of an expedient to order physical therapy to their patients (From: interview with DK3). Further details on this issue will be examined in Chapter V.2.2.1 ‘KM doctors’ WKCT request to biomedical doctors, 3) Uptake of biomedical technicians – in the case of the WKCT requests for physical therapy.’

biomedical doctors due to limits on information as an apprentice physical therapist, I noticed KM and biomedical doctors' different attitudes towards patients and other health professionals. When I was looking for a dissertation topic related to medical system in South Korea, I recalled such an experience concerning the differences between KM and biomedical doctors' attitudes. As I ascertained through literature research that this kind of dualized institutional medical system is not commonly observed outside East Asian countries, I selected the relationship between KM and biomedical doctors in the WKCT hospitals within the concept of medical pluralism as a main research topic, because the settings of the WKCT hospitals can demonstrate their juxtaposition more clearly than other hospital settings.

Prior to initiating the fieldwork, I had mainly paid attention to verbal and nonverbal communications between KM and biomedical doctors during the process of the WKCT, presupposing that there should be significant active interactions between KM and biomedical doctors facing each other with their patients. In this regard, I planned to conduct intensive participation observation in two WKCT hospitals, taking part in the process of diagnosis and treatment of their patients. However, during the first few interviews in the first two hospitals, I realized that communication between biomedical- and KM doctors is much more limited than I had expected, whereby they simply send their patients to their counterpart for additional diagnoses or treatments without active communication. Indeed, this should be termed a coexistence rather than cooperation, despite being known to the public as 'cooperative treatment.'

For this reason, I had to modify the previous research question during the fieldwork, from analyzing actual communication between KM and biomedical doctors during the process of the WKCT to describing how and why KM and biomedical doctors are involved with the WKCT while sending their patients to the counterparts. Meanwhile, I discovered 'asymmetric' or 'unbalanced' aspects between KM and biomedical doctors concerning the WKCT during the interviews in the first two hospitals: KM doctors were more in favor of or more willing towards the WKCT, whereas biomedical doctors were not as strongly interested in or were more passive towards it as KM doctors, simply allowing their patients to have additional treatments, usually upon KM doctors' or patients' requests. Having noticed these 'asymmetric' or 'unbalanced' situations surrounding KM and biomedical doctors, I decided to choose two

further hospitals to compare the situations with the first two hospitals to examine whether these situations are rather general or originated from certain hospital structures. Such comparison was enabled by the fact that the first two hospitals could be categorized as KM-oriented hospitals, in that over ten KM doctors work with a biomedical doctor in the first hospital, and professors of a KM school work together with biomedical doctors with short-term contracts in the second hospital. For this reason, I selected two extra WKCT hospitals where biomedical doctors take the lead over KM doctors in hospitals. In line with such an expansion of the fieldwork areas, the main research method was also changed from participating in the process of discussion between KM and biomedical doctors during the WKCT process to conducting open-ended qualitative interviews with them in different hospital settings.

During the time between the first and second fieldwork periods, I realized that the trial-and-error during my first fieldwork mentioned above resembles the process of grounded theory approach in many points, reflecting the notions of theoretical sampling and saturation (Glaser & Strauss, 1967; Corbin & Strauss, 1990; Charmaz, 2006). Subsequently, I decided to apply a 'light version' of grounded theory approach to more systematically explain the procedure of social action in hospital settings, although I do not try to discover or develop 'theories' grounded from the data. After having finished the fieldwork in the first three hospitals and while conducting the coding process, I also discovered literature dealing with hierarchical aspects of medical pluralism and biomedical dominance in the debates of medical pluralism that can explain my situation I experienced in the fieldwork condignly, which I previously labeled as 'asymmetric' or 'unbalanced.'

Together with my aforementioned research trajectory, I also need to clarify the aspects of my own identity as a researcher, between a doctoral researcher in the field of social science, and a South Korean physical therapist, reminding of a well-known anthropological issue of insider/emics and outsider/etics (Pike, 1954; Geertz, 1976; Headland et al. 1990; Morris et al. 1999; Kanuha, 2000, et al.). This question was particularly raised during the period of fieldwork, while I prepared for, conducted and analyzed interviews with physicians and administrators in hospitals. My personal identity as a physical therapist had a positive effect in terms of gaining access to the field, such as designing the research topic, selecting hospital

settings, being introduced to interviewees through colleagues and understanding biomedical terms during the interviews. However, I also experienced interview participants demonstrating more amicable and cooperative attitudes towards me when I introduced myself as a researcher of social science studying in Germany, rather than a physical therapist. In the case of interviews with biomedical doctors, they might have been reluctant to provide ingenuous answers concerning their actual work in hospitals to a physical therapist, someone who is professionally inferior to biomedical doctors who regulate and order physical therapists' work under their instructions. On the other hand, I noticed that KM doctors tended to cooperate more actively during the interviews than biomedical doctors to disseminate the excellence of medical tradition of Korea and professionalism of the KM and KM doctors, as well as more willingly explaining their present situation working with biomedical doctors to a researcher outside their discipline. During the interviews, a number of biomedical doctors mentioned biomedical articles concerning the effect of complementary and alternative medicine that have been published in international journals written by German biomedical scientists to support their standpoints on CAM, as they were aware that I belong to a German academic institution. I conducted fieldwork analysis bearing in mind that these aspects can be associated with their different viewpoints and differing attitudes on the WKCT. Meanwhile, I also took into consideration that my own prejudices concerning the physicians could have an effect on examination process of the fieldwork, including a possible overestimation on their professional self-esteem or authoritarian personalities over medical technicians and other disciplines, and thus I tried to ensure that these prejudices did not intervene over the fieldwork period and analysis of the data. To summarize, I tried to comprehend the situation in hospital settings while I recognized my identity as an insider who was examining the situation in South Korea as both a health care worker and an outsider, namely a social scientist outside hospital settings.

In short, when considering this personal history of the research process thus far, modified and developed by the continual process of trial- and errors, I believe that this study can be broadly categorized within the field of a grounded theory approach. It could possibly be called 'grounded theory-lite,'<sup>55</sup> given that I do not attempt to develop theories in this research and

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<sup>55</sup>From: "I'm Not Sure Whether to Use Grounded Theory or Thematic Analysis– What's the Difference?", The University of Auckland School of Psychology: Frequently Asked Questions, retrieved 26 May 2016 from

the coding process is not as dense as classical grounded theory approach demands, or at least I could argue that my research has a considerable resemblance to grounded theory approach given that my own actual process of the research takes after the process of grounded theory approach through employing an inductive research method – with initiating fieldwork without having a fixed theoretical perspectives – theoretical sampling with the constant comparative method and theoretical saturation. In the next chapter, I will introduce further details on the case selection and the process of the data collection.

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<https://www.psych.auckland.ac.nz/en/about/our-research/research-groups/thematic-analysis/frequently-asked-questions-8.html#41663f5798010827566a5f658efd7613>.

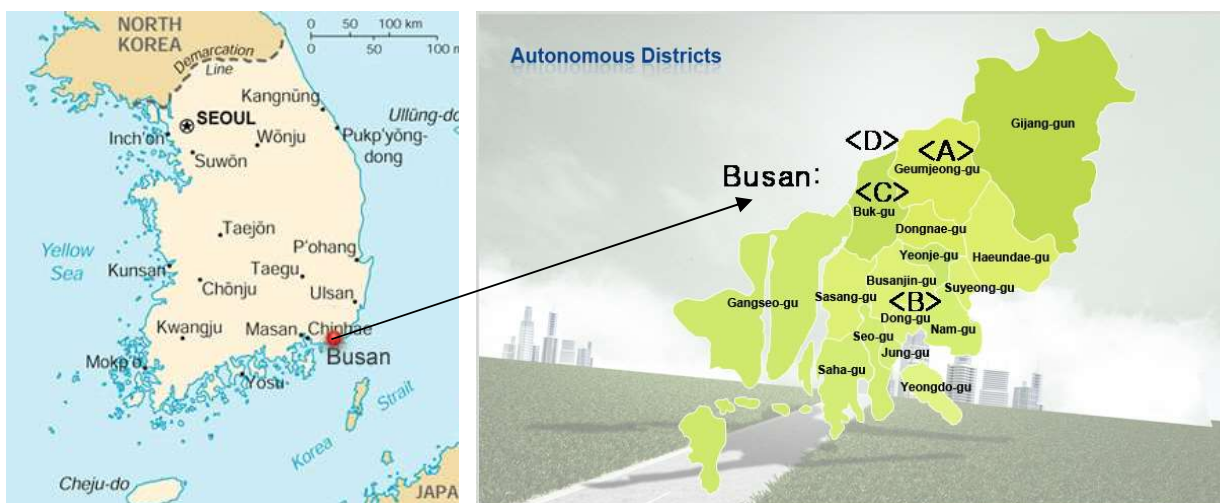


## 2. Case Selection: Four Hospital Settings in the City of Busan

As mentioned above, I conducted fieldwork based upon in-depth interviews with KM and biomedical doctors working in WKCT hospitals from March to July 2011 and February to April 2012,<sup>56</sup> to understand the process of the WKCT between them, including their perspectives on this process. For this purpose, I selected four hospital settings in the city of Busan as an example of the places where both KM and biomedical doctors work together. In this chapter, I will first demonstrate why I chose the city of Busan for the fieldwork, followed by introducing the four WKCT hospitals.

### 2.1 An Introduction to the City of Busan

Figure III.1 Map of Busan (Including the locations of ‘A’ to ‘D’ hospitals for fieldwork)<sup>57</sup>



Busan is the second largest city in South Korea, with a population of approximately 3.6 million.<sup>58</sup> Seoul,<sup>59</sup> the capital city of South Korea, is about 400km away to the northwest of

<sup>56</sup> A Pilot study including the venue contact for the first two hospitals was conducted in September and October 2010.

<sup>57</sup> Photos from: “Busan, South Korea,” Sister Cities of Los Angeles, retrieved 27 May 2016 from <http://sistercities.lacity.org/html/07.htm>; “Autonomous Districts” (modified from the original photo with an arrow and letter symbols A to D), Homepage of Busan Metropolitan City, retrieved 26 May 2016 from [http://english.busan.go.kr/portal/Page.bs?parcode=MNU\\_00000015529&prgcode=CMS\\_00000017015](http://english.busan.go.kr/portal/Page.bs?parcode=MNU_00000015529&prgcode=CMS_00000017015).

<sup>58</sup> From: “Busan at a Glance,” Busan Metropolitan City, retrieved 26 May 2016 from [http://english.busan.go.kr/portal/Page.bs?parcode=MNU\\_00000015526&prgcode=CMS\\_00000017047](http://english.busan.go.kr/portal/Page.bs?parcode=MNU_00000015526&prgcode=CMS_00000017047).

<sup>59</sup> Population: 10,442,426, as of 2013. From: “Seoul Population 2013,” World Population Statistics, retrieved 26 May 2016 from <http://www.worldpopulationstatistics.com/?s=seoul>.

Busan. It is the largest port city in South Korea, located on the Southeastern coast of Korean Peninsula, adjoining the Korea Strait between Japan and South Korea. The area of ‘Busan Metropolitan City’ (the official name of the city of Busan) is divided into fifteen autonomous districts (‘*gu*’) and an autonomous county (‘*gun*’).<sup>60</sup>

There are two main reasons why I selected Busan for the place of fieldwork for the research. Firstly, Busan was considered as one of the place where an average level of the WKCT can be observed, compared to Seoul, or other urban/rural areas in South Korea. According to the spread of the number of KM hospitals,<sup>61</sup> the most typical form of the WKCT hospitals, a large majority of KM hospitals are located in urban areas. Amongst them, I considered that the cases in Busan will cover more general features of the WKCT than in Seoul, because I found during the period of pilot study that some cases in WKCT hospitals in Seoul showed an exceptionally higher level of the WKCT in terms of the communication between KM and biomedical doctors.<sup>62</sup> Secondly, I also considered the better accessibility to the field in terms of permission for interviews with medical professions, where I would be better able to utilize my personal network in Busan, where I finished my additional bachelor’s degree in physical therapy. The professors of the department of physical therapy in my home university introduced to me KM and biomedical doctors working in Busan, while my former colleague therapists also helped me to provide information on the situations of the WKCT hospitals in Busan where they work. For these reasons, I chose four hospitals in Busan where both KM and biomedical doctors work in the same hospital institutions to examine the common features of the WKCT while trying to minimize regional bias.

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<sup>60</sup> From: “Autonomous Districts,” Busan Metropolitan City, retrieved 26 May 2016 from

[http://english.busan.go.kr/portal/Page.bs?parcode=MNU\\_00000015529&prgcode=CMS\\_00000017015](http://english.busan.go.kr/portal/Page.bs?parcode=MNU_00000015529&prgcode=CMS_00000017015).

<sup>61</sup> From: Homepage of Korean Medicine Hospitals’ Association (KOMHA), retrieved 26 May 2016 from

<http://www.komha.or.kr/info/info.php>.

<sup>62</sup> For instance, in the case of Kyung-hee University hospital mentioned in the study of Jongyoung Kim (2005), there used to be a joint consulting room for the WKCT where both KM and biomedical doctors regularly visited to work together for patients (ibid. 215). Aside from that, in the case of a branch of Kyung-hee University hospital, the structural units of the hospital organization were not classified by KM and biomedical sectors, but rather as centers for certain diseases, such as the center of vertebral disease and center of stroke, etc., whereby both KM and biomedical doctors belong to the same unit. However, those settings are still considered as exceptional cases, comparing most of cases in WKCT hospitals in South Korea (from: interview with DK3).

## 2.2 Selection of Four WKCT Hospitals in Busan

I selected four hospitals in Busan where both KM and biomedical doctors work together for their patients under the name of the WKCT. In this chapter, I will briefly introduce the four hospitals, two KM-oriented and two biomedicine-oriented WKCT hospitals, as well as introducing the process of selecting the hospitals in further detail.

Having learned through the literature search and a pilot study in 2010 that the most typical form of the WKCT can be observed in medium-scale KM hospitals working with a biomedical clinic in a single hospital building (Young-ju Yun, 2005: 2),<sup>63</sup> I selected ‘A’ hospital as the first place for the fieldwork, as an example of KM-oriented hospital where a large number of KM doctors work with a small number of biomedical doctors. Around the same time, I selected ‘B’ hospital as a case of a larger-scale hospital than ‘A’ hospital, paying attention to any correlation between the size of hospitals and the types of the WKCT process. Fieldwork in ‘A’ and ‘B’ hospitals were conducted from February to July 2011, based upon open-ended interviews.

As mentioned in the previous chapter, I selected two further hospitals after noticing an ‘unbalanced’ or ‘asymmetric’ relationship between KM and biomedical doctors in the first two hospitals in terms of their degree of interest in the WKCT and the frequency of sending patients to their counterpart for the WKCT. For this reason, I conducted fieldwork at ‘C’ hospital in June 2011 as an example of a medium-scale biomedicine-oriented WKCT hospital where a relatively large number of biomedical doctors work with a small number of KM doctors within a single hospital building.<sup>64</sup> Finally, ‘D’ hospital was selected as an example of a large-scale biomedicine-oriented WKCT hospital, given that one of the largest and oldest university biomedical hospitals in Busan has started working with a newly-established KM university hospital, neighboring each other in the university campus. Interviews in ‘D’

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<sup>63</sup> Further details on the history and organizational features of the WKCT will be introduced in Chapter IV. 3. ‘Western-Korean Cooperative Medical Treatment.’

<sup>64</sup> This kind of biomedicine-oriented WKCT hospital has rapidly increased since 2009 with the revision of the MSA, which allows KM and biomedical doctors to work within the same hospital organization, while it was previously necessary to establish two different hospital organizations on a legal basis for them to work together for the WKCT. More details are discussed in the chapter IV 3.3 ‘Legal Regulations on the WKCT.’

hospital were carried out from February to April 2012. Demographic profiles of interviewees in each hospital are summarized in the tables below.<sup>65</sup>

Table III.1 Four WKCT Hospitals for the Fieldwork

Style Size	KM-oriented	Biomedicine-oriented
	Medium	‘A’ Hospital
Large	‘B’ Hospital	‘D’ Hospital

Table III.2 Demographic Profile of the Interviewees in ‘A’ Hospital

ID <sup>66</sup>	Position	Year of Experience in WKCT hospitals <sup>67</sup>	Gender
AA1	Head of hospital administration department	8 months	Male
AB1	Director of the biomedical practice, internal medicine	3 years	Male
AK1	Head, department of acupuncture and Moxibustion, KM rehabilitation	8 years <sup>68</sup>	Male
AK2	Head of KM internal medicine	6 years <sup>69</sup>	Female
AK3	Resident, KM rehabilitation department	2 years	Male
AK4	Resident, KM gynecology	2 years	Female

<sup>65</sup> Further details concerning the overview and organizational structures of each hospital will be introduced in Chapter V.1 ‘Overviews and organizational features of hospital settings in Busan.’

<sup>66</sup> The first letter of each ID stands for the initial of the four hospitals (A, B, C, D), while the second letter stands for the profession of the interviewees (A: hospital administrator, B: biomedical doctor, K: KM doctor, KS: KM student).

<sup>67</sup> This column only includes the number of years’ experience that each interviewee had in hospitals where both KM and biomedical doctors work in the same place.

<sup>68</sup> Four-year experience in ‘B’ hospital as intern and resident.

<sup>69</sup> Four-year experience in ‘B’ hospital as intern and resident.

Table III.3 Demographic Profile of the Interviewees in ‘B’ Hospital

<b>ID</b>	<b>Position</b>	<b>Year of Experience in WKCT hospitals</b>	<b>Gender</b>
<b>BA1</b>	Former coordinator for the WKCT, nurse, professor of school of nursing at ‘B’ college	18 years	F
<b>BB1</b>	Former head of neurosurgery	9 months	M
<b>BB2</b>	Head of neurosurgery	4 months	M
<b>BK1</b>	Head of the 1 <sup>st</sup> KM internal medicine, professor of KM School	Over 15 years	M
<b>BK2</b>	Head of the 2 <sup>nd</sup> KM internal medicine, professor of KM School	Over 10 years	M
<b>BK3</b>	Former president of ‘B’ hospital, former director of WKCT Center at ‘B’ hospital, former dean of KM school	Over 20 years	M
<b>BK4</b>	Resident, KM internal medicine	4 years	M

Table III.4 Demographic Profile of the Interviewees in ‘C’ hospital

<b>ID</b>	<b>Position</b>	<b>Year of Experience in WKCT hospitals</b>	<b>Gender</b>
<b>CA1</b>	Head of hospital administration department, nurse	Over 10 years	F
<b>CK1</b>	Head of the KM department, KM gynecology	15 years <sup>70</sup>	F

<sup>70</sup> 9 months experience in ‘A’ hospital

Table III.5 Demographic Profile of the Interviewees in ‘D’ hospital

<b>ID</b>	<b>Position</b>	<b>Year of Experience in WKCT hospitals</b>	<b>Gender</b>
<b>DA1</b> <sup>71</sup>	Former director of the biomedical hospital, professor of anesthesiology department at ‘school of medicine, biomedical Doctor (anesthesiology, medical ethics)	3 years	M
<b>DB1</b>	Head of neurology department	3 years <sup>72</sup>	M
<b>DB2</b>	Head of rehabilitation medicine, professor of Rehabilitation Medicine at School of Medicine	11 years	M
<b>DB3</b>	Head of neurology department, professor of neurology at school of medicine, director of integrative medical center at ‘D’ Hospital		M
<b>DK1</b> <sup>73</sup>	Department of KM allergy and immunity, professor of integrative Medicine at school of KM	6 years	F
<b>DK2</b>	Professor of division of longevity and bio-functional medicine at school of KM	1.5 years	M
<b>DK3</b>	Professor of division of humanities and social medicine at school of KM	5 years	M
<b>DKS1</b> <sup>74</sup>	A fourth year student at school of KM (previously majored in history)		F
<b>DKS2</b>	A fourth year student at school of KM (previously majored in pharmacy)		M

<sup>71</sup> He is a biomedical doctor and professor at biomedical school. However, I categorized him as a hospital administrator because he does not work there as a clinician but the director of biomedical hospital, trying to promote the WKCT to KM and biomedical doctors.

<sup>72</sup> One-year experience in ‘B’ hospital.

<sup>73</sup> She has both KM- and biomedical license. However, I categorized her as a KM doctor because she experienced her intern and resident only in KM hospital as a KM doctors, and because she works in KM hospital as a professor of KM school.

<sup>74</sup> KS: Student of KM School.

### 3. Data Collection and Analysis

Having selected hospital settings in Busan where the WKCT was to be observed, I conducted in-depth interviews with KM and biomedical doctors in each hospital as a primary method of data collection for the research, in order to apprehend the process of the WKCT and their viewpoints concerning it.<sup>75</sup> Additional interviews were carried out with hospital administrators in each hospital to examine the process of the WKCT in diverse organizational structures of hospital settings, as well as double-checking the findings concerning the actual process as ascertained through interviews with the physicians. Based upon ‘snowball sampling’ method,<sup>76</sup> I proceeded with the interviews as follows. I was introduced to a physician or administrator in each hospital for the first interview, in most cases by my former colleague physical therapists or professors of physical therapy at my alma mater, who have acquaintances in the hospitals that I selected for the research. During the interview, I either asked the interviewee to introduce other physicians for the next interviews or personally tried to make contact with those who were perceived to play an important role in the process of the WKCT based upon the content of the previous interviews.

In this way, I interviewed twelve KM doctors, two senior students of a KM school in ‘D’ hospital,<sup>77</sup> six biomedical doctors, and four hospital staff members in charge of hospital administration. For reference, all the interviews were conducted with the interviewees’ signed written agreement prior to the initiation of the interview, which mostly took between 50 and 70 minutes. Most interviews took place in participants’ offices in their hospitals without other persons, to ensure confidentiality. In a few cases, I conducted the interviews in staff lounges or hospital cafeterias, still trying to ensure participants’ privacy undisturbed by others as much as possible. All the interviews were recorded with an MP3 recorder and transcribed after each interview session. In case the participants were reluctant to talk or requested not to

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<sup>75</sup> Most of interviewees are directly involved with the WKCT as clinicians. However, in the case of ‘D’ hospital, a university hospital of KM and Biomedicine, two teaching- and research-oriented KM professors (DK2, DK3) and a professor of biomedicine (DB3) were also included as interviewees as they have experience of cooperative research for the WKCT, despite not having been involved with the WKCT routinely in clinical settings.

<sup>76</sup> “A form of non-probability sampling in which the researcher begins by identifying an individual perceived to be an appropriate respondent” (Jupp 2006: 281).

<sup>77</sup> After I found out through the interviews that KM doctors’ biomedical knowledge plays an important role for the process of the WKCT, I conducted an additional interview with two senior students (DKS1, DKS2) to examine the process of building biomedical knowledge of KM doctors from their education in KM schools.

record certain parts of the interview due to the sensitivity of the issue, I turned off the recorder and took notes instead. If required, I made additional inquiries after the main interviews via e-mail, phone conversation or revisiting the hospitals for additional brief interviews to fill in any missing questions. Together with the interview materials as the main source of the research, I also examined written documents that were relevant to the contents of the interviews for the analysis, including medical records of patients, brochures and billboards of hospitals introducing the WKCT, as well as research papers on the WKCT that the participants mentioned or took part in writing during the interview.<sup>78</sup> I also made use of general information concerning the hospitals, which I obtained during the process of the contact with interviewees as a kind of ethnographic information for the fieldwork to comprehend the situation in each hospital.

During the interviews, I mainly focused on the following issues:

- The concrete process of the WKCT in each hospital, including the decision-making process of initiating the WKCT in each hospital setting, relevant to the size and organizational structure of the hospitals.
- The relationship between KM and biomedical doctors in the process of the WKCT: the frequency and way of their communication within and outside the process of the WKCT.
- Promoting and impeding external factors of the WKCT: the role of patients and the hospital administration department, the influence from colleague physicians outside their hospitals, etc.

Regarding the tool for the analysis of the data, I made use of atlas.ti, “one of a number of Computer Assisted Qualitative Data Analysis Software (CAQDAS) programs” (Jupp, 2006: 10) for qualitative research, primarily used to support grounded theorizing. With this data base program, I firstly set all the transcripts of interviews in order, labeling them by participants’ professions (KM or biomedical doctors, hospital administrators) and their

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<sup>78</sup> Non-interview material includes the following documents in detail: written medical records of two facial nerve paralysis patients in ‘A’ hospital (relevant to the interview with AK2 and AK4), brochures and billboards introducing the WKCT in ‘B’ hospital (relevant to the interview with BK1 and BK2) and conference proceedings on the WKCT co-hosted by ‘D’ hospital (relevant to the interview with DK1 and DB2).



working places ('A' to 'D' hospitals). This was followed by coding processes from “an initial phase involving naming each segment of data” to “a focused, selective phase” to develop integrative categories from the initial phase and proceeding further to conduct “contextual analyses of actions and events” in the process of the WKCT in hospital settings, inspired by Charmaz’s notion of “constructing grounded theory” (Charmaz, 2006: 46). Through the analysis of the data, I schematized the process of the WKCT as an integrated model based upon common features in various hospital organizations.

#### 4. Summary of Part III

In Part III, I introduced the research process of this study in terms of the research method. First, I illustrated the personal history of the research process in Chapter III.1 under the heading of “developing through trial and error” (Silverman, 2005: 307). Recalling my own personal experience in a WKCT hospital during the practical training for physical therapy – which motivated my interest in KM and biomedical doctors’ differing attitudes and their relationship in hospital settings – I selected the examination of the relationship between KM and biomedical doctors in clinical practices in the process of the WKCT as a dissertation topic, focusing on the way of their actual communication for their cooperative medical actions to understand how they cooperate with each other despite their different viewpoints on health and illness, planning to conduct participant observation through accompanying patients who receive WKCT treatments from the beginning to the end. However, in the process of the pilot study, I realized through interviews in the first two hospitals and literature research that their communication regarding patient management is much more limited than expected from the term ‘cooperative treatment.’ In addition, I also noticed significantly differing attitudes between KM and biomedical doctors regarding their interest in their counterparts and the process of the WKCT, which I labeled ‘asymmetry’ in the coding process of interview analysis later on. In this process, the main focus of this study was gradually changed to clarify KM and biomedical doctors’ such different attitudes regarding their power relations in clinical settings, whereas the method of the research was also limited to qualitative interviews with physicians and administrators from the full-scale participant observation. Such a process of ‘trial and error’ in my study resembles a ground theory approach to a considerable extent, although I did not strictly follow the coding process that grounded theory demands and I did not try to generate a new concept or theory in this study.

Subsequently, in Chapter III.2 I introduced the case selection and data collection for the fieldwork in four WKCT hospitals in the city of Busan, followed by introducing the demographic profiles of the interviewees in each hospital. I selected four hospital settings where both KM and biomedical doctors are mutually involved with patient management in the same hospital building or hospital complex, reflecting different scales (smaller and larger hospitals) and styles (KM- and biomedicine-oriented) of hospitals. I conducted qualitative

interviews with KM and biomedical doctors, together with a hospital administrator in each hospital. During the fieldwork, I mainly focused on the concrete process of the WKCT, the working relationship with their counterparts and external factors having an effect on the process of the WKCT. This was followed by the coding process inspired by the grounded theory approach.



## **Part IV. Medical Pluralism in South Korea and ‘Western-Korean Cooperative Medical Treatment’**

Before examining the findings of the fieldwork in Part V, this part introduces historical and current social aspects of the South Korean medical system as well as the historical development and current features of the WKCT, which shape the basic milieu of current clinical settings in WKCT hospitals. First, I will summarize the history of medicine in Korea, devoting particular attention to the relationship between traditional forms of medical practices and ‘Western’ medicine from its inflow in the late-19<sup>th</sup> century to the present in the post-colonial era. Second, I will introduce the current structure of the South Korean medical system, characterized as a dual medical system of professionalized medicine. In this chapter, I will focus on the issues of medical jurisdiction of KM and biomedical doctors and conflicts between them, as well as their legal and social status. Finally, I will briefly address the historical development, current features and legal regulations of the WKCT as a kind of ‘lead-in’ guiding the Case Study in Part V.

## 1. History of Medicine and Medical Professions in Korea

This chapter reviews the historical changes in the Korean medical system, from the ancient to the post-colonial period (1945- ).<sup>79</sup> As a post-colonial country in the ‘third world,’ South Korea also experienced an influx of modern Western medicine with the intervention of imperial powers at the end of the 19<sup>th</sup> century and colonialization of the state by Japan in the first half of the 20<sup>th</sup> century. In this process, traditional medicine and the medical system in Korea – a local medicine developed endemically within Korean natural and cultural circumstances with the influence of traditional Chinese medical principles – have experienced competition, conflict, subordination, and re-acknowledgment from the state, as well as coexistence and cooperation in the face of the relationship with Western biomedicine. Within this context, I will examine the development and characteristics of traditional Korean medicine and the medical system, the process of Western biomedicine’s inflow, the colonial medical policy of Japan, the establishment of the post-colonial medical system, and the professionalization of KM in South Korea, resulting in the current dualized professional medical system of South Korea, which provides a basic background to understand the situations around KM and biomedical doctors working in WKCT hospitals.

First, Chapter IV.1.1 briefly introduces the main characteristics of traditional Korean medicine and the medical system before the inflow of Western biomedicine in the late-19<sup>th</sup> century. In this chapter, I will devote particular attention to the influence of Chinese medicine, together with considering the originality of Korean medicine. Subsequently, the process of ‘Western’ biomedicine’s inflow into Korea in the late-19<sup>th</sup> century will be introduced with the response of the *Joseon* Dynasty (1392-1910) and traditional physicians in Chapter IV.1.2, followed by the examination of the Japanese colonial period (1910-1945) in Chapter IV.1.3, when Western biomedicine was officially recognized as the superior form of medicine while KM still remained in existence as “a second class medicine” (Jongyoung Kim, 2005: 46) due to the practical needs in terms of the medical policy of the colonial ruler. Finally, Chapter IV.1.4 will explore the process of establishing the National MSA of Republic of Korea (South Korea) during the beginning of the post-colonial period in 1951, which shaped the

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<sup>79</sup> As North and South Korea were divided after the liberation of the country from Japan following the end of World War II in 1945, this chapter will exclusively deal with South Korean medical situations in the post-colonial period.

fundamental foundation of the current South Korean dual medical system, acknowledging traditional practitioners as ‘KM doctors’ being equally recognized with biomedical doctors. In this chapter, I will introduce concrete features of the historical events and interpretation essentially depending on “History of Medicine in Korea” (In-sok Yeo et al. 2012), published by Research Institute for Medical Policy, the affiliated organization of the KMA, as well as “History of Korean Medicine” (Ki-wook Kim et al. 2006), published under the initiative of Korean Society of Medical History, an academic division of the AKOM, as the main texts for the reference.

### **1.1 Development of Traditional Korean Medicine from the Ancient Times**

The main characteristic of medicine in Korea prior to the inflow of Western medicine in the late-19<sup>th</sup> century can be summarized as an indigenous medicine originating from its own environmental settings, including geographical features, climate and vegetation, as well as part of East Asian medicine sharing fundamental medical principles originating from ancient China and exchanging information with neighboring East Asian countries such as China and Japan. According to the discovery of prehistoric remains and ancient documents, it has been estimated that stone and bone needles – often considered a primitive prototype of acupuncture – as well as various foods and herbs such as garlic, wormwood and geranium herbs were widely used for medical treatments in ancient Korea, which can be traced back as far as 3,000 B.C. (DiLeva, 2001). During this period of theocracy, it is estimated that medicine men played an important role as healers under the shelter of ancient rulers (In-sok Yeo et al. 2012: 43). In the second century B.C. when a Korean regional dynasty first encountered frontiers with the Chinese ‘*Han*’ dynasty, Chinese medicine and the medical system made inroads into the medical situation in Korea. Since then, the Korean medical system has been deeply influenced by that of China. In the period of the Three Kingdoms,<sup>80</sup> when Buddhism was introduced from China (late fourth century A.D.), Buddhist medicine also flowed into the Three Kingdoms, gradually being combined together with indigenous medical traditions.

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<sup>80</sup> The period of Three Kingdoms of Korea refers to “the period (from c. 57 B.C. to A.D. 668) when the country was divided into the kingdoms of Shilla, Koguryō, and Paekche.” From: “Three Kingdoms of Korea,” Encyclopædia Britannica Online, retrieved 26 May 2016 from <http://www.britannica.com/topic/Three-Kingdoms-period>.

During the period of the ‘Unified *Shilla* Dynasty’ (668 – 935), Chinese medical contents and systems under the *Tang* dynasty had an influence on the Korean medical system in earnest. Under such an influence, ‘*Uihak*’ – the first ever state-dominated medical education institution – was established in 692 (In-sok Yeo et al. *ibid.* 66; Ki-wook Kim et al. *ibid.* 80). In-sok Yeo et al. (*ibid.*) consider the establishment of this institution as the starting point of medieval medicine of Korea.<sup>81</sup> Subsequently, including the period of the *Goryeo* dynasty (918 - 1392), official medical physicians raised in such state educational institutions and state examinations were mainly in charge of the upper classes, including royal families and government officials.<sup>82</sup> Meanwhile, folk healers including Buddhist monks and Confucian scholars in the provincial areas played an important role particularly for the lower classes. Another important aspect of the Korean medical system in this era is that various medical texts were imported from China and interpreted by medical scholars and healers in Korea in terms of medical principles. Furthermore, the usage of indigenous herbs raised in Korea (called ‘*Hyangyak*’ 鄉藥) was also constantly studied for clinical practices in parallel (In-sok Yeo et al. *ibid.* 74). Such duality results from the fact that there was a consistent deficit of supply of medical herbs introduced in Chinese medical texts regarding difficult-to-obtain wild herbs in Korea due to the different natural environments, although various Chinese medical texts based upon the principle of *Yin-Yang* and Five Elements were studied and accepted by Korean researchers and widely applied to clinical practices. For this reason, there was a steady need to utilize fungible herbs naturally grown in Korea, which resulted in the systematic research on *Hyangyak* in Korea.

During the period of the *Joseon* dynasty (1398 – 1910), claiming to advocate a physiocratic Confucian state based upon the taxation and military service of peasants, research on

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<sup>81</sup> They argue that “East Asian medical systems provided themselves with universality and compatibility from this era, through accepting medical texts and systems of *Tang* dynasty as a standard, which is the main characteristic of medieval medicine in Korea, comparing to the era of ancient medicine which still used to have characteristic of local indigenous medicine” (In-sok Yeo et al. *ibid.* 73).

<sup>82</sup> However, the governmental physician system based upon state examinations in pre-modern Korean and Chinese dynasties should not be misunderstood as the modern concept of medical license system that gives official permissions exclusively to the license holders for medical care. Instead, medical examinations in this period were implemented to select governmental officials in charge of medical care for the royal family and state policy, which does not mean that those who did not pass the examinations were not allowed to conduct certain medical activities (In-sok Yeo, 2008a: 18).



*Hyangyak* was more widely supported by the state than previously, as the official state medical care undertaken by medical officials was gradually expanded to the medical service for peasants and lower classes in regional provinces. Meanwhile, there was an effort to integrate various ancient and emerging medical theories developed in China and Korea, as well as clinical research on the usage of indigenous herbal medication and acupuncture developed in Korea. Such an effort was brought to fruition with the publication of ‘*Dong-ui Bogam*’ in 1613 (2003),<sup>83</sup> written by Jun Heo (1539-1615), a court physician working at a royal clinic (called ‘*Naewiwon*’) in the early-17<sup>th</sup> century. This book is evaluated as “a successful systemic integration of various competing East Asian medical principles sharing the basic medical principle of *Yin-Yang* and Five Elements originated from *Huangdi Neijing* (黃帝內經, Emperor’s Inner Canon),<sup>84</sup> and indigenous Korean clinical texts on the study of *Hyangyak*” (Ki-wook Kim et al. *ibid.* 205). In this regard, In-sok Yeo et al. (*ibid.*) and Ki-wook Kim et al. (*ibid.*) proceed to argue that the publication of *Dong-ui Bogam* in the 17<sup>th</sup> century clarifies the independent medical achievement of Korean medicine differing from Chinese medical traditions, despite sharing basic medical principles of East Asian medicine. Concerning the originality of Korean medical traditions that *Dong-ui Bogam* stands for, *Sa-am* acupuncture (*Sa-am Chim-beop*, 舍岩鍼法)<sup>85</sup> developed in the 17<sup>th</sup> century and *Sa-sang* constitutional medicine (*Sa-sang Uihak*, 四象醫學, four-typology constitutional medicine)<sup>86</sup>

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<sup>83</sup> *Dong-ui Bogam* literally means ‘mirror, or model’ (*Bogam*, 寶鑑) of ‘Eastern medicine (*Dong-ui*, 東醫).’ Jun Heo disclosed in the preface of the book that he adopted the term “Eastern medicine” while contrasting two different schools (he called them “Northern” and “Southern medicine”) of medical traditions developed in China, supposedly to emphasize the originality of medical traditions in Korean medicine (In-sok Yeo et al. *ibid.* 137; Ki-wook Kim et al. *ibid.* 229).

<sup>84</sup> It is known as the earliest written text of Chinese medicine, written in the third century B.C., “providing the theoretical concepts for TCM that remain the basis of its practice today.” From: “Traditional Chinese medicine,” Encyclopædia Britannica, retrieved 26 May 2016 from <http://www.britannica.com/topic/traditional-Chinese-medicine>.

<sup>85</sup> *Sa-am* acupuncture was developed by a Korean monk whose name is unknown but is believed to be called *Sa-am* in the 17<sup>th</sup> century. The main characteristic of the *Sa-am* method is that the acupuncture is applied exclusively on the forearms, hands, lower legs and feet, differing from other conventional acupuncture methods developed in China and Japan, which usually apply to all parts of body including trunks. This method is still widely used for clinical practices in KM clinics. From: “*Sa-am Chim-beop*” (*Sa-am* Acupuncture), Doosan Encyclopedia, retrieved 26 May 2016 from [https://www.doopedia.co.kr/doopedia/master/master.do?\\_method=view&MAS\\_IDX=110129001174952](https://www.doopedia.co.kr/doopedia/master/master.do?_method=view&MAS_IDX=110129001174952); Manyong Park & Sunghul Kim, 2015: 1.

<sup>86</sup> *Sa-sang* constitutional medicine was developed by Je-ma Lee (2002) in his book *Dong-ui Suse-bowon* (東醫壽世保元, Longevity and Life Preservation in Eastern Medicine) in 1894. It categorizes four different types of

developed in the 19<sup>th</sup> century are widely acknowledged as the best-known examples representing the uniqueness of Korean medical traditions differing from other East Asian medical traditions. Aside from this development of unique Korean medical knowledge and treatments in the late *Joseon* dynasty, medieval and modern Western medical principles and techniques were introduced and studied by some Confucian scholars, who criticized existing the dogmatic and theoretical Confucianism during the 18<sup>th</sup> and 19<sup>th</sup> centuries (In-sok Yeo et al. *ibid.* 172-177; Ki-wook Kim et al. *ibid.* 346-353). However, such Western medical principles and techniques were not widespread for clinical practices at that time, given that they were not acknowledged by official medicine until the late-19<sup>th</sup> century, the era of ‘opening port’ by the imperial powers.

The traditional Korean medical principles and practices before the inflow of Western medicine can be summarized as a mixture of intercommunity of the basic East Asian medical principles – such as *Yin-Yang* and the Five Element theory originating from ancient China – and the gradual transformation or unique development within the peculiar geographic/climatic and historic/cultural environments of the Korean peninsula. Regarding the medical institutional traditions, there was a coexisting dualism between the official medical sector strictly regulated by the state including national medical officials and medical examinations originally for royal families and high-ranking officials but also gradually expanding to the health care for the public, as well as the folk medical sector connected to Buddhism or Confucianism mainly for the lower class and people in rural areas. Such a traditional medical system faced a sharp turning point with the influx of modern Western medicine through the opening of the ports by imperialist powers in the late-19<sup>th</sup> century.

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constitutions: *Tae-Yang* (太陽), *Tae-Eum* (太陰), *So-Yang* (少陽) and *So-Eum* (少陰). Each constitution has different physiological, pathological and pharmaceutical characteristics. In this concern, he argued that therapists should decide to apply therapies suitable to each constitution. Since then, this constitutional concept has been widely accepted to the majority of KM doctors and is well known among the public in South Korea at present. From: “Sa-sang constitutional medicine,” (*Sa-sang Chejil*), Doosan Encyclopedia, retrieved 26 May 2016 from

[https://www.doopedia.co.kr/doopedia/master/master.do?\\_method=view&MAS\\_IDX=101013000877621](https://www.doopedia.co.kr/doopedia/master/master.do?_method=view&MAS_IDX=101013000877621).

## 1.2 Inflow of ‘Western’ Biomedicine with the Opening of the Ports to the West (1876-1910)

With the coercive opening of the ports to imperialist powers by military force in the late-19th century – first by Japan (1876) and followed by the U.S. (1882), the U.K. and Germany (1883), Russia and Italy (1884) and France (1886) – modern biomedicine was brought into the *Joseon* dynasty of Korea in earnest in the name of ‘Western’ medicine mainly by Japan and the U.S. After experiencing the superiority of Western medicine particularly regarding surgery for the injured, together with the technique of quarantine and hygiene, the *Joseon* dynasty actively tried to embrace Western medicine as “a kind of ‘new learning’ (from the West) to achieve national prosperity and defense against imperial powers” (Woo-yong Jeon, 2007: 52). In this process of learning ‘Western’ medicine, the *Joseon* dynasty favored working with the U.S. American missionary medicine rather than Japanese military medicine, which was more directly connected with the imperial expansionism (*ibid.*).<sup>87</sup> For this reason, the first official Western medical hospital in Korea – named *Jejungwon*<sup>88</sup> – was established by the *Joseon* dynasty in cooperation with Horace Allen – a protestant medical missionary and a diplomat from the U.S. to Korea – in the city of Seoul in 1885 (In-sok Yeo et al. *ibid.* 199).

Meanwhile, pre-existing examination for medical officials – based upon traditional Korean medical knowledge – was officially abolished in 1894, as the traditional state civil service examination (called ‘*Gwageo*,’ 科擧) was repealed. Instead, the first modernized state medical school (called ‘*Uihakgyo*,’ 醫學校)<sup>89</sup> was established in 1899, as a three-year course mainly based upon biomedical subjects.<sup>90</sup> The first graduates were turned out in 1902,

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<sup>87</sup> As another important background for *Joseon* dynasty’s preference for U.S. missionary physicians to Japanese military physicians, Woo-yong Jeon (*ibid.* 53) indicates the financial deficiency of the *Joseon* dynasty, arguing that for the *Joseon* dynasty it would be more realistic choice to cooperate with the American missionary, who would willingly provide medical services and education as long as the *Joseon* dynasty merely permits missionary work, which had been strictly banned.

<sup>88</sup> 濟衆院. It literally means ‘a house (office) for relieving people.’ The name of the hospital connotes the main purpose of the organization, not serving the royal family and officials but rather the public.

<sup>89</sup> It literally means ‘a medical school ( In-sok Yeo et al. *ibid.*)

<sup>90</sup> When the court of *Joseon* dynasty resolved the establishment of the state medical school, it aimed to teach both Western biomedicine and traditional Korean medicine in the curricula of the school. However, in reality, most of the curricula of the school comprised Western biomedical subjects such as (biomedical) anatomy,

most of whom worked at state organizations as military physicians, instructors at *Uihakgyo* or physicians at state hospitals after their graduation (In-sok Yeo, 2008a: 34, In-sok Yeo et al. 2012: 231). However, traditional physicians still played a pivotal role for medical practices nationwide during this period, in a situation where only a small minority of foreign physicians worked as biomedical doctors in Seoul and opening port areas.<sup>91</sup> Many traditional medical officials also participated in the newly established state biomedical institutions (hospitals and medical schools) as administrators and clinicians, being open to utilizing biomedicine. For instance, Seok-young Ji – a traditional medical physician who was first initiated into the cowpox vaccination by Japanese biomedical physicians in Busan and disseminated it nationwide – worked as the first principal of *Uihakgyo* (In-sok Yeo et al. *ibid.* 229). As another example in the case of *Naebu Byeongwon*<sup>92</sup> – a state hospital established in 1899 where mostly traditional physicians worked – both biomedical drugs and traditional herbs were widely used by the traditional physicians (In-sok Yeo, 2008a: 31).<sup>93</sup> Likewise, in the process of quarantine and hygiene influenced by Western biomedicine, the *Joseon* dynasty utilized traditional physicians working all across the country. Within this process, they also had the opportunity to experience biomedical knowledge and skills. Meanwhile,

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physiology, and pathology, as most of the hands-on staffs in the school including lecturers – the majority of whom were foreign biomedical doctors – favored biomedical subjects (Yunjae Park, 2005: 126). In this regard, *Uihakgyo* can be safely categorized as a biomedical school, although the fact that it originally aimed to teach both biomedical and traditional medical knowledge and its administrative work was mostly managed by traditional medical officials.

<sup>91</sup> For instance, in 1908, there were only 302 Western biomedical doctors registered nationwide, most of whom were Japanese and American physicians, while the number of traditional practitioners was 2,984 (Jongyoung Kim, 2005: 43).

<sup>92</sup> 内部病院. It was renamed *Gwangjewon* (廣濟院) in 1900 (In-sok Yeo et al. 235).

<sup>93</sup> For instance, according to *Hwangseong Sinmun* (daily newspaper, 1899), out of 8,197 patients hospitalized in this hospital from June to December 1899, 4,755 were given biomedical drugs, while only 3,436 patients received traditional herbal drugs. Considering that this hospital was conducted by traditional physicians, it can be inferred that the then-traditional healers were not reluctant to utilize Western medication (*Hwangseong Newspaper*, 20 Sep. 1899, as cited in In-sok Yeo, 2008b: 31). With regard to the interpretation of this feature, In-sok Yeo (2008b: 32) argues against the idea that this can be considered as a prototype of the WKCT, while emphasizing that the then-traditional practitioners merely utilized Western medical drugs without any understanding of biomedical principles and without consulting biomedical physicians. From my perspective, I agree with his argument in the sense that the then-biomedical and -traditional physicians did not cooperate or were involved together with certain medical actions. However, such a phenomenon bears a certain degree of resemblance to the WKCT process in current clinical settings in WKCT hospitals in which KM doctors – who do not have authority to prescribe biomedical drugs – make a WKCT request to biomedical doctors for the biomedical drugs based upon their own decision without any serious discussion with their biomedical counterparts. More details on this type of the WKCT request will be examined later in Chapter V.2.2.1 ‘KM doctors’ WKCT request to biomedical doctors.’

traditional physicians established a newly formed traditional medical school called *Dongje Uihaakgyo* (東濟醫學校), emulating the newly introduced biomedical school system. In this school, traditional medical knowledge was mainly taught, together with basic biomedical subjects and natural science (In-sok Yeo et al. 2012: 232-233). In connection with this situation, according to a newly established “Physician Ordinance” (*Uisa-gyuchik*, 醫士規則) in 1900 by Korean Empire (1897-1910)<sup>94</sup> – which declared the establishment of a modernized medical license system based upon the state examination and modernized medical education system – those who worked as traditional physicians were also acknowledged as licensed medical physicians (Yunjae Park, 2005: 138).

To summarize, Western medicine was introduced during the ‘opening port’ period in the late-19<sup>th</sup> century, mainly as a form of military medicine from Japan and medical missionary from the U.S. Experiencing its superiority particularly regarding its surgery skills and the management of infectious disease, the *Joseon* dynasty actively tried to embrace it while attracting foreign biomedical doctors to work and support establishing biomedical hospitals in Korea as well as educational institutions for fostering biomedical doctors. However, existing traditional physicians still played an important role in medical services nationwide, while they remained in charge of medical care for the majority of the public and took part in governmental medical work. Based upon the influx of Western medicine, they had to accept and adopt Western medical skills such as anti-epidemic measures, while they tried to elaborate and modernize their own medical educational system in response to the newly established biomedical education system. To borrow Yunjae Park’s words, it was a period of “coexistence of East and West” (2005: 109). However, such an obscure situation of power between biomedicine and traditional medicine was dramatically changed to evince biomedical dominance with the Japanese annexation of Korea in 1910.

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<sup>94</sup> Korean Empire (*Daehan Jeguk*) is the official name of *Joseon* Dynasty from 1897 to 1910, proclaimed by King *Gojong* of the *Joseon* dynasty on 12 October 1897, lasting until the promulgation of the Japan-Korea annexation treaty on 29 August 1910. From: “Korean Empire,” (*Daehan Jeguk*), Doosan Encyclopedia, retrieved 26 May 2016 from [https://www.doopedia.co.kr/doopedia/master/master.do?\\_method=view&MAS\\_IDX=101013000835528](https://www.doopedia.co.kr/doopedia/master/master.do?_method=view&MAS_IDX=101013000835528).

### 1.3 Biomedical Dominance and the Survival of Traditional Medicine in the Japanese Colonial Period (1910-1945)

After the victory over Russia in the Russo-Japanese war (1904-1905), Japan deprived the Korean Empire of its diplomatic sovereignty through the Japan-Korea Protectorate Treaty of 1905, followed by complete colonization through the Japan-Korea annexation treaty of 1910. Subsequently, Japan tried to transplant modern Japanese medical policy based upon biomedicine to Korea. In 1906, the Japanese Resident-General of Korea changed *Gwangjewon* (previously called *Naebu Byeongwon*) – a state hospital established by the Korean Empire managed by traditional physicians – to a biomedical hospital, dismissing traditional physicians and replacing with Japanese biomedical doctors (In-sok Yeo et al. *ibid.* 250). Following the annexation treaty, biomedicine and biomedical doctors were officially acknowledged as the orthodox mainstream medicine and medical doctors through the newly established Physician Ordinance (*Uisa Gyuchick*, 醫師規則) in 1914 promulgated by the Japanese Government-General of Korea, similar to what they did in the late-19th century in Japan, abolishing the traditional medical system. According to this rule, exclusively those who graduated from biomedical schools with the state examination based upon biomedical subjects were awarded a license as medical doctors, whereas the old Physician Ordinance by Korean Empire in 1900 included converting existing traditional medical physicians into medical doctors. In this regard, private and state biomedical schools – together with state medical examinations and biomedical hospitals – were established to train biomedical doctors during the colonial period. Concerning the background of this policy, In-sok Yeo (2008a: 14) indicates that Western scientific technology served for imperialist countries “not only as an instrument to materialize the colonization over the third world, but also as an ideological tool for ‘justifying’ their colonial rules” while representing modernity and revealing the superiority of the colonial powers over their colonies. Likewise, the superiority of Western biomedicine was emphasized by the Japanese government, in contrast to the ‘backwardness’ of the prevalent traditional medicine in Korea.

However, the Japanese Government-General could not leave medical care exclusively to biomedical doctors and could not ignore existing traditional physicians nationwide in a

situation where biomedical doctors were desperately lacking.<sup>95</sup> In this situation, the Japanese Government-General could not avoid utilizing traditional physicians. Consequently, an Ordinance of *Uisaeng* (*Uisaeng Gyuchik*, 醫生規則) was established in the same year as the Physician Ordinance.<sup>96</sup> It regulated the legal status of existing traditional therapists as being explicitly inferior to biomedical doctors,<sup>97</sup> together with the examination regulations for *Uisaeng*, whose test items were mostly based upon basic biomedical knowledge (In-sok Yeo et al. 2012: 272).<sup>98</sup> While biomedical doctors mainly worked in Seoul and larger cities in provincial areas in hospitals or private practices for upper classes, *Uisaeng* were more in charge of medical treatments for people living in rural areas as well as lower classes in the urban areas, while also taking part in sanitary affairs and anti-epidemic measures planned by the state (ibid.). Nevertheless, the numbers of biomedical doctors constantly increased owing to the strength of the Japanese medical policy, while the numbers of *Uisaeng* constantly decreased throughout the entire colonial period,<sup>99</sup> as illustrated below in table V.1.

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<sup>95</sup> As of 1914, there were 641 biomedical doctors (including 497 foreign physicians), which could not cover the medical care for fifteen million people living in Korea. The ratio of biomedical doctors as a percentage of the Korean population was only 5 percent of those in Japan (In-sok Yeo et al. 2012: 272).

<sup>96</sup> *Uisaeng* (醫生) literally means ‘medical trainee or apprentice’ in Korean. This word was presumably adopted to more clearly indicate traditional physicians’ lower status than biomedical doctors (*Uisa*, 醫師).

<sup>97</sup> According to *Uisaeng Gyuchik*, those over 20 years old who previously worked as traditional physicians for over two years were awarded a license of *Uisaeng*. Accordingly, the Japanese Government-General tolerated that pre-existing traditional physicians worked as they used to do in their traditional medical practices (In-sok Yeo, 2008b: 41).

<sup>98</sup> As of 1914, the number of registered *Uisaeng* was 5,827, nine times as many as that of biomedical doctors in the same year (In-sok Yeo et al. ibid. 272).

<sup>99</sup> Jongyoung Kim (2005: 44) argues that such changes concerning the gradual increase of biomedical doctors and decrease of *Uisaeng* mainly resulted from the constant increase of biomedical schools and graduates according to Japanese medical policy, whereas there was no such educational institute for traditional medicine. For this reason, there was lack of newly licensed *Uisaeng* since pre-existing traditional physicians were acknowledged as *Uisaeng* in the first few years of the establishment of *Uisaeng Gyuchik* in 1914. On the other hand, in the case of traditional practitioners working in rural areas, In-sok Yeo (2008b: 41-42) indicates that there was no significant difference between having a license and working without one as a kind of folk medical healer. For this reason, he argues that the folk medical healers in rural areas did not need to acquire the license of *Uisaeng* (ibid.).

Table IV.1 Numbers of *Uisa* and *Uisaeng* in the Japanese Colonial Period<sup>100</sup>

	1915	1920	1930	1940
<i>Uisa</i> (Biomedical doctors)	954	1111	1972	3660
<i>Uisaeng</i> (Traditional therapists)	5804	5376	4594	3604

In the process of responding to such a policy placing biomedicine and biomedical doctors as the center of the medical system, traditional physicians were in a situation of systemizing their knowledge and organization, facing modernized hospital organizations and the educational system of biomedicine. Accordingly, they were in need of ‘modernizing’ themselves against – or in line with – the biomedical system of hospital organization and education. In terms of modernized signs of traditional medicine and therapists during this era, In-sok Yeo (2008a: 17-20) indicates three aspects: 1) the establishment of the license system of *Uisaeng* in 1914; 2) the establishment of an organization by *Uisaeng* as an interest group in 1911; and 3) the publication of various academic journals of traditional medicine since 1911. However, he indicates that their efforts were clearly bounded in terms of the following aspects. First, their medical license as *Uisaeng* clearly stipulated their inferior position compared with biomedical doctors. Second, they lacked the organizational integrity and financial capability to establish traditional hospitals and schools, together with facing an inadequate situation for in-depth discussions among themselves in a situation where they received no public support from the Japanese Government-General. By contrast, they comprised disparate groups lacking commonness in terms of their varying educational backgrounds and non-monolithic medical knowledge due to the different academic traditions in terms of medical principles (In-sok Yeo, 2008b: 53). Nevertheless, they still played a considerable role in medical care during the colonial period despite the Japanese colonial policy giving preference to biomedicine, based upon the continuing preference for traditional therapies among the general public – particularly in cases of internal diseases – together with lower costs and better accessibility compared to biomedicine (ibid. 53-55).

During the 1930s, medical herbs imported from China were lacking in Korea and Japan, as Japan was involved with the series of warfare in China including the Manchurian Incident

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<sup>100</sup> From: Jung Wee Park (1994); as cited in Sunsam Na (2012: 48).



(1931-1932) and the Second Sino-Japanese War (1937-1945). For this reason, the Japanese Government-General encouraged the local production of medical herbs by Korean peasants, together with holding an exhibition in 1933 and establishing state institutes in 1936 for cultivating and studying traditional medical herbs (In-sok Yeo et al. *ibid.* 279–280). Against Western imperial powers competing with Japan in East Asia and Pacific areas, including the Pacific War (1941-1945) against the U.S. and British colonies, Asian values were particularly emphasized in Japan with the concept of the so-called “Greater East Asia Co-prosperity Sphere,”<sup>101</sup> shedding new light on Asian medical traditions. Consequently, utilizing traditional Korean medicine was encouraged by the Japanese Government-General during this decade. For instance, in the case of the examination for *Uisaeng*, the proportion of questions concerning the usage of traditional herbs increased (Kyu-hwan Shin, 2008: 118). In addition, the committee of investigation on traditional herbs was established in 1937 (In-sok Yeo et al. *ibid.* 281). In this background, a series of debates on the revival of traditional Korean medicine were unfolded through a daily newspaper in 1934, among two biomedical doctors who were pro and against the usage of traditional medicine as well as two academic scholars in favor of traditional therapy.<sup>102</sup> Through this debate, traditional therapists’ pride in their traditional ways of healing and interest in traditional medicine among the general public increased (In-sok Yeo et al. *ibid.* 287). However, such increased interest in traditional forms of medicine had a clear limitation in that the Japanese Government-General was merely interested in the scientific remedial effect of herbal medicine in the situation of increasing demand for medical drugs during the wartime. Indeed, it showed no interest in other

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<sup>101</sup> ‘The Greater East Asia Co-Prosperity Sphere’ (*Daedong-a Gongyeong-gwon*, 大東亞共榮圈), literally describing an occupied zones of East Asian nations for their mutual prosperity, is a political propaganda by the Japanese government and military in the period of the Second World War justifying their warfare in East Asia. From: “The Great East Asia Co-Prosperity Sphere” (*Daedong-a Gongyeong-gwon*), Doosan Encyclopedia, retrieved 26 May 2016 from [https://www.doopedia.co.kr/doopedia/master/master.do?\\_method=view&MAS\\_IDX=101013000854340](https://www.doopedia.co.kr/doopedia/master/master.do?_method=view&MAS_IDX=101013000854340).

<sup>102</sup> The debates were carried out through a then-leading daily newspaper ‘*Joseon Ilbo*’ as a form of column over 30 times from February to November 1934. This series of debates has been actively examined by historians and sociologists in South Korea since the 1990s, labeled as “the Debate of Revival for Korean Medicine” (*Hanuihak Buheung Nonjaeng*) or “Debates on Eastern-Western Medicine” by historians and sociologists in South Korea (e.g. Byung-mook Lim, 1996; Geun-Sik Jeong, 1996; Dong-Won Shin, 1999; Haelee Jeon, 2011, et al.), considered as “one of the best historical example of examining the situation in the Japanese colonial period tangled with the concepts of modernity/pre-modernity, science/non-science, and East/West” (Dong-Won Shin, *ibid.* 346). Concerning this historical debate, sociologist Geun-Sik Jeong (*ibid.*) interpreted this debate as an example showing that Western medicine seized the institutional hegemony through the Japanese colonial policy but failed to seize the hegemony of knowledge.

traditional therapies such as acupuncture and moxibustion, without shedding new light on the principles of traditional medicine or changing the legal status of *Uisaeng*. In fact, Yunjae Park (2008: 73) evaluates that what the Japanese colonial authority needed was merely “herbs going through the verification of Western medicine”: more concretely, “ingredient of herbs.”

In sum, the Korean medical system under the regime of Japan can be summarized as medical pluralism based upon the newly established biomedical hegemony approved by the state, together with the acknowledgment of traditional medicine being labeled as inferior yet still necessary due to the realistic needs to fulfill the medical demands that biomedicine could not fully cover. In other words, it was “a result of compromise between the ideology of biomedical hegemony and the reality of clinical need” to receive help from the ‘inferior’ traditional medicine (Yunjae Park, *ibid.* 59). ‘Western’ biomedicine – brought into Korea in the late-19th century – officially occupied the position of mainstream orthodox medicine as an important part of colonial policy with the Japanese annexation of Korea in 1910. Subsequently, the biomedical system gradually has expanded its influence through the establishment of state examinations, state and private biomedical schools, clinical practices and hospital organizations with Seoul and larger cities in provincial areas as the centers. However, traditional medicine and its practitioners “survived as a second class medicine” (Jongyoung Kim, 2005: 46), continuing to play a non-negligible role in fulfilling medical demands particularly for people living in rural areas and lower classes in urban areas, although the traditional physicians were officially downgraded to *Uisaeng* by the Japanese colonial government. Meanwhile, traditional healers tried to survive by ‘modernizing’ traditional medical system throughout this era in the face of such a situation of biomedical dominance. Despite not coming to full fruition under Japanese colonial rule, their efforts played a role as a stepping-stone for the modernization of traditional medicine to KM with an equal legal status as biomedical doctors following the liberation from Japan in the post-colonial era.

#### **1.4 Modernization of Korean Medicine and the Establishment of a Dualized Medical System in the Post-colonial Period in South Korea (1945 - )**

In the aftermath of the Second World War with the Japanese declaration of surrender in August 1945, the Soviet Union and the United States occupied Korea, dividing the country

into the North (managed by the Soviet Union) and the South (managed by the U.S.) along the 38th parallel north to disarm Japanese military in the Korean peninsula, while assuring the independence of Korea “in due course.”<sup>103</sup> However, this temporary division became permanent under the influence of the Cold War between the Eastern and Western Bloc, as the governments in the South and North were separately established in 1948 after the transitional period of military government by the U.S. and Soviet Union, followed by the Korean War (1950-1953). In the case of the South Korean medical system, the U.S. model of a free market-based medical system was first adopted by the U.S. military government and followed by the South Korean government, which mainly entrusted health care in the hands of private hospitals as well as encouraging the expansion of the private sector (In-sok Yeo, 2008c: 81). This was supported by the succeeding ‘pro-American’ South Korean government against the authority of communist North, as well as the majority of biomedical doctors who were sent to study medicine in the U.S. and played a key role in the government’s decision concerning medical policy. In this regard, the number of private hospitals/practices, biomedical doctors and biomedical schools constantly increased nationwide (In-sok Yeo et al. 2012: 309-311). As a result, the biomedical sector has settled not only as the mainstream but also as the most popular medical sector in both name and reality, regarding the medical supply (the numbers of biomedical hospitals and doctors) and demand (the numbers of patients treated within the biomedical sector) in this post-colonial era.

Meanwhile, the liberation from the Japanese colonial regime provided a turning point for traditional practitioners, who used to play a pivotal role as the mainstream medical experts until the end of the *Joseon* dynasty and survived in the Japanese colonial period as *Uisaeng*, the ‘second class’ medical therapists inferior to biomedical doctors. From the beginning of the post-colonial period, they engaged a multilateral effort into the reinstatement of traditional medicine and their legal status. Shortly after the Japanese declaration of surrender and retreat from the Korean peninsula in August 1945, traditional practitioners newly organized the Association of Korean Medical Doctors (*Joseon Uisa-hwe*, 朝鮮醫士會) in November of the same year (Ki-wook Kim et al. 2006: 511), while arguing for their official acknowledgment as medical doctors (*Uisa*), replacing the ‘depreciating’ term *Uisaeng*

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<sup>103</sup> From: “Cairo Communiqué,” 1 Dec. 1943, National Diet Library of Japan, retrieved 26 May 2016 from [http://www.ndl.go.jp/constitution/e/shiryō/01/002\\_46/002\\_46tx.html](http://www.ndl.go.jp/constitution/e/shiryō/01/002_46/002_46tx.html).

previously denoted by the Japanese Government-General. In line with the establishment of this association, the Society of East Asian Medicine (*Dongyang Uihak-hwe*, 東洋 醫學會) was found to promote academic research within the field of traditional medicine in 1947, followed by the establishment of a traditional medical college in Seoul called *Dongyang Daehak-gwan* (東洋 大學館) in 1948 (Ki-wook Kim et al. *ibid.* 511, 520).<sup>104</sup>

The newly established South Korean government's biomedicine-friendly yet non-interference medical policy and traditional physicians' efforts to restore their medical authority as officially acknowledged medical doctors collided in the process of establishing the National Medical Service Act (*Gukmin Uiryobeop*) in 1951.<sup>105</sup> During the previous year, two bills were proposed for the regulation of medical experts. The first bill – proposed by the Health Ministry presumably with reference to the U.S. medical system – excluded traditional practitioners in the category of medical doctors, while the second bill – proposed by the Committee of Education and Social Affairs of the National Assembly – included the regulation of traditional practitioners in an explicitly inferior position under biomedical doctors, similar to the regulation in the Japanese colonial period in which the traditional physicians were downgraded to *Uisaeng*. Both of the bills failed to be submitted to plenary sessions by the strong opposition of politicians representing traditional physicians' stance, pending to the next Assembly (In-sok Yeo et al. *ibid.* 324).

In 1951, during the middle of the Korean War (1950-1953), the debates concerning establishing the National MSA were resumed. Following intensive debates between those who represented the stance of biomedical doctors severely criticizing traditional medicine as non-scientific and those who supported traditional practitioners emphasizing the usability and practicality of traditional medicine as well as its nationalistic identity, it was concluded in the

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<sup>104</sup> The years required for graduation from this college was not clearly corroborated. However, considering that there is a record of the first graduates in May 1950 (Nam-il Kim, 2011: 96), it can be estimated that it was a two-year program to start with. This college was renamed as Seoul East-Asian Medical College (*Seoul Hanuigwa Daehak*) and reorganized as a four-year college in 1953. Afterwards, it was changed to a six-year program in 1964, followed by a merger with *Kyung-hee* University in 1965. Since then, it has remained the College of KM at *Kyung-hee* University up to present (Ki-wook Kim et al. *ibid.* 520).

<sup>105</sup> The National Medical Service Act (*Gukmin Uiryobeop*, Enacted on 25 Dec. 1951, Act No. 221) was renamed as the Medical Service Act in 1962. From: "Revision of National Medical Act," National Archives of Korea, retrieved 26 May 2016 from <http://www.archives.go.kr/next/search/listSubjectDescription.do?id=001559>.

Assembly plenary session in September that traditional practitioners should be acknowledged as ‘Oriental’ (East Asian) medical doctors (*Han-uisa*, 漢醫師, In-sok Yeo et al. *ibid.* 325; Ki-wook Kim et al. *ibid.* 516),<sup>106</sup> encompassing (bio-) medical doctors (*Uisa*, 醫師) and dentists (*Chigwa-uisa*, 齒科醫師).<sup>107</sup> Accordingly, traditional practitioners eventually regained their legal status as medical doctors from the title ‘*Uisaeng*’ (medical apprentice) named by the Japanese Government-General.<sup>108</sup> This decision formulated the basic frame of the dualistic medical system of South Korea that persists at present, in which biomedical and KM doctors are situated in an equal legal status. Concerning the backgrounds of such a decision in the traditional physicians’ favor, Ki-yong Jung et al. (2010: 113-115) indicate the following aspects. First, as of 1951, there were only 5,082 registered biomedical doctors nationwide, for whom it would be impossible to cover the 20 million South Korean population.<sup>109</sup> Moreover, the majority of biomedical hospitals and private practices were located in urban areas. They argue that the *laissez-faire* medical system of the U.S. military government and the South Korean government aggravated the situation of urban concentration and the problem of ‘doctorless village’ (called *mu-uichon*, 無醫村) originating from the beginning of the Japanese colonial period. By contrast, due to the high costs of biomedical care – including expensive biomedical drugs imported from abroad – it was still not affordable for the general public to receive costly biomedical care, even in urban areas. For this reason, traditional therapists and their practices still played an important role in providing medical services in rural areas as well as for the lower classes in urban areas, as before the liberation from the Japanese regime. In this situation, Ki-yong Jung et al. (*ibid.*) suppose that the traditional therapists’ argument for the reinstatement of traditional medicine

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<sup>106</sup> As already mentioned in Chapter I.1.2 (pp. 9), it was changed to ‘Korean medicine doctor’ (*Han-uisa*, 韓醫師) by the revision of the MSA in 1986, with the result of efforts of the AKOM (Ki-wook Kim et al. *ibid.* 537-539).

<sup>107</sup> The bill was passed by an overwhelming majority with 61 ayes and 18 noes out of 116 participants in the plenary session of the National Assembly in July, followed by its promulgation in September 1951 (Ki-wook Kim et al. *ibid.* 516).

<sup>108</sup> According to Article 13 of the National MSA established on 25 September 1951 (Act No. 221), “those who intend to become medical doctors, dentists or Oriental medical doctors shall meet the qualification of Bachelor’s degree of medical science, dentistry or Oriental medical science at a college authorized by the Minister of Education, followed by passing the relevant national examination.” As an exception, according to Article 3 of the Addenda of the National MSA, a licensed *Uisaeng* at the time when this act entered into force was entitled to be an Oriental medical doctor.

<sup>109</sup> Physicians per 10,000 population: 25. From: Korean Health Yearbook Compilation Committee (1956), as cited in Ki-yong Jung et al. (*ibid.* 113).

was more persuasive to the members of National Assembly than the government's original proposal in favor of biomedical doctors. Together with this, it should also be considered that the demands for medical care and the mood of nationalism were particularly high during the wartime conditions at the beginning of the post-colonial period.

As a result of the establishment of the National MSA in 1951, traditional practitioners were also acknowledged in a category of medical doctors, achieving equal legal status as biomedical doctors and dentists. This regulation formulated the fundamental framework of the country's unique medical system that remains at present, whereby a dualized medical system of biomedicine and KM was established as professional forms of medicine. Consequently, it served as momentum for the modernization of traditional medicine, followed by the establishment of the first six-year KM school in 1964 (Ki-wook Kim et al. *ibid.* 520), the first hospital-level medical institution in 1970 (Seong-hyeon Jang, 2014), the inclusion of KM treatments into the NHI in 1987 (In-sok Yeo et al. 2012: 340)<sup>110</sup> and the introduction of the KM medical specialist system in 2000 (Hyun-ji Lee, 2008: 113).<sup>111</sup> Concerning the main reason for KM's successful modernization process, Hyun-ji Lee (*ibid.* 44-47) indicates the South Korean government's non-interference medical policy. She argues that despite the South Korean government's biomedicine-oriented policy,<sup>112</sup> such a non-interference medical policy stance has not been fundamentally changed until recently, particularly in terms of the policy for medical suppliers, which provided KM doctors with free space to modernize themselves as much as they wanted against the 'already-modernized' biomedical sector (*ibid.*).

Regarding the establishment of such a dualized professional medical system, Baek-hyu Lee and Pyeong-su Lee (2011: 23) cite the advantages that it can improve the academic and clinical qualities of each medical sector with their own theoretical characteristics being maintained, as well as providing medical consumers with a wider range of choices. By

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<sup>110</sup> Nationwide NHI was established in 1977. Accordingly, from 1977 to 1986, KM inspections and treatments were excluded from the reimbursement schemes of NHI (In-sok Yeo et al. 2012: 342).

<sup>111</sup> The medical specialist system in the biomedical sector was first introduced in South Korea in 1952 (Hyun-ji Lee, *ibid.* 112).

<sup>112</sup> The South Korean government's biomedicine-oriented medical policy can be surmised from the fact that all the national (state-owned) hospitals and medical schools had been biomedical organizations until the first national KM school was established in 2008 (Sunsam Na, 2012: 49).

contrast, they also argue that such a dualized system could lead to confusion in the selection of medical services and increase medical costs, caused by unnecessary over-treatment. Moreover, it often results in multi-dimensional conflicts to date between KM and biomedical doctors in terms of the concrete domains of medical jurisdictions within the professional sector, as well as between KM doctors and non-licensed folk medical healers such as acupuncturists/moxibustionists and hand acupuncturists based upon traditional notions of medical care.<sup>113</sup>

Chapter IV.1 introduced a brief summary of Korean medical history to understand the current South Korean medical system, particularly concerning the development of the dual medical system of KM and biomedicine in the professionalized medical sector. Traditional Korean medicine has been developed as an indigenous medicine reflecting its own natural and cultural environments, as well as a form of East Asian medicine sharing basic concepts of *Yin-Yang* and the Five Components theory originated from ancient China as a common denominator of East Asian medicine with neighboring countries. Meanwhile, under the influence of the long tradition of Confucian bureaucracy, the state-oriented medical system has been well developed with the state examination for medical officials and state medical organizations, interconnecting with the folk medical sectors. With the port opening and the Japanese colonization from the late-19<sup>th</sup> century, biomedicine achieved its superior position by the state and gradually expanded its medical influence to the public in the name of ‘modern Western’ medicine, while traditional medicine still played a role in supplying medical demands among the public in the face of biomedical dominance. During the mid-20<sup>th</sup>

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<sup>113</sup> The license of acupuncturist/moxibustionist (*Chim-gusa*) was introduced as another kind of traditional medical therapist by the Japanese Government-General in 1914. After the license of Oriental/East-Asian (KM) doctor was newly established in 1951 by the South Korean government, it was officially abolished in 1962. However, those who previously received its license before the abolishment were allowed to maintain their practices. Since then, there have been constant conflicts between KM doctors and them until now (Ki-wook Kim et al. *ibid.* 541-543). As for the *Koryo* hand acupuncture developed by Tae-woo Yoo, an expert of traditional natural therapy in the 1970s (from: homepage of Koryo *Koryo Sujichim* (Koryo Hand Acupuncture), retrieved 26 May 2016 from <http://www.seokeum.com/>), this therapy has become popular through mass media and its open lectures to the public since the 1980s due to its ease of application as well as collaborative work with biomedical doctors interested in CAM. Meanwhile, KM doctors severely criticize it as an illegal pseudo medical practice that arrogates KM doctors’ medical authority (from the interviews with DK1 and DB3). However, as this study mainly focuses on the relationship between KM and biomedical doctors within the field of professional medical sector, I will not introduce further details on the conflicts between KM doctors and the folk medical healers.

century, traditional medicine regained its legal status as equivalent with biomedicine through the establishment of the National MSA in the situation of its practical needs for public health care due to the lacking biomedical services during the beginning of the post-colonial period. Together with this change, the traditional sector proceeded to modernize with the professionalization and institutionalization process in terms of its education system and hospital organization. Meanwhile, the biomedical sector went on to expand its influence on the clinical fields covering the majority of the medical demands in terms of the number of physicians, educational and clinical organizations. In this process, a peculiar dual medical system of current South Korea was established, which could be understood as an interesting example among the post-colonial states in the third world. Such a medical system has positive aspects in terms of making the best use of traditional medicine with its professionalized development in the current society, which could bring about synergic effects with biomedicine on the public health. However, this situation of dualism could cause a series of conflicts within the professional medical sector, namely between KM and biomedical doctors. In the next chapter, I will introduce the current South Korean medical system characterized as a dual system of KM and biomedicine, including its current statistical features, the medical domains of KM and biomedicine, as well as conflicts between KM and biomedical doctors.



## **2. Current Structure of the South Korean Medical System**

As summarized in the previous chapter, the South Korean medical system has been developed under the influence of the long tradition of a state-oriented medical system interconnected with China and other East Asian countries' medical traditions on the one hand and the rapid inflow of modern Western medicine by imperial powers and the colonial regime on the other, resulting in a peculiar dual medical system of KM and biomedicine in the professional medical sector during the post-colonial period. Such a dual medical system in the professional medical sector where traditional practitioners are acknowledged as medical doctors enjoying equivalent legal status with biomedical doctors is also observed in other East Asian countries sharing the experience of (semi-) colonial experience, such as China, Taiwan, North Korea and Vietnam. Such examples stand in contrast to the rest of the world, where biomedical doctors are exclusively positioned as licensed medical doctors. In this regard, the South Korean medical system can be categorized as an 'integrative system' in that KM is "officially recognized and incorporated into all areas of health care provision" (WHO, 2002: 8) according to the typology of WHO, while non-biomedical traditions are actively used with the public – similar to Chinese models according to the typology of Last (1996) – as introduced in Chapter II.1.2 'Typologies of medical systems.' However, even compared with other East-Asian countries there are several distinctive features of the South Korean medical system concerning the concrete medical authority of traditional medical doctors and their relationship with biomedical doctors. In this chapter, prior to dealing with the WKCT and the relations between KM and biomedical doctors, I will introduce the current South Korean medical system, centering on the issues of the medical dualism in the professional medical sector between KM and biomedicine. First, I will present the statistical features of KM and biomedical sector, followed by legal regulations, particularly concerning the respective medical domains of KM and biomedical doctors. Finally, the conflicts between KM and biomedical doctors concerning such medical domains and jurisdictions originating from the dualized medical system will be introduced.

### **2.1 Statistical Features of the KM and Biomedical Sector**

With both being licensed physicians, KM and biomedical doctors are in charge of medical

care in the professional medical sector of the dualized South Korean medical system, respectively taking charge of the traditional and biomedical sectors of health care. The numbers of physicians, medical institutions, medical schools and graduates in 2011 – when the fieldwork started – are listed below in Table IV.2.

Table IV.2 Statistical Features of the Professional Medical Sector: KM and Biomedicine  
(As of 2011)<sup>114</sup>

	<b>Biomedicine</b>	<b>KM</b>	<b>Total</b>
<b>1) Number of Physicians</b>	104,397 (84%)	19,912 (16%)	124,309 (100%)
<b>2) Number of Medical Institutions<sup>115</sup></b>	30,448 (70.9%)	12,483 (29.1%)	42,931 (100%)
<b>Hospitals<sup>116</sup></b>	2,539 (93.4%)	178 (6.6%)	2,717 (100%)
<b>Clinics</b>	27,909 (69.4%)	12,305 (30.6%)	40,214 (100%)
<b>3) Number of Inpatient Care Beds (Hospitals/Clinics)</b>	505,124 (97.7%) (418,547/86,577)	11,947 (2.3%) (10,643/1,304)	517,071 (100%)
<b>4) Number of Medical Schools</b>	41 (77.4%)	12 (22.6%)	53 (100%)
<b>5) Number of Graduates per Year (Estimated Figure)</b>	App. 3,000 (80%)	App. 750 (20%)	App. 3,750 (100%)

As illustrated above, the KM sector is surpassed by the biomedical sector in terms of its scales in every category, reflecting less than 30 percent of the professional sector, aside from forming over 30 percent in terms of the number of clinics. Taken together with the small

<sup>114</sup> From: Ministry of Health and Welfare, 2012a: 145-173; Yun-hyeong Jang, 2011; “(Bio-) Medical School of Republic of Korea” (*Uigwa Daehak*), Wikipedia (Korea), retrieved 27 May 2016 from [https://ko.wikipedia.org/wiki/%EB%8C%80%ED%95%9C%EB%AF%BC%EA%B5%AD%EC%9D%98\\_%EC%9D%98%EA%B3%BC%EB%8C%80%ED%95%99;](https://ko.wikipedia.org/wiki/%EB%8C%80%ED%95%9C%EB%AF%BC%EA%B5%AD%EC%9D%98_%EC%9D%98%EA%B3%BC%EB%8C%80%ED%95%99;)

“KM School of Republic of Korea” (*Hanuigwa Daehak*), Wikipedia (Korea), retrieved 27 May 2016 from <https://ko.wikipedia.org/wiki/%ED%95%9C%EC%9D%98%EA%B3%BC%EB%8C%80%ED%95%99.>

<sup>115</sup> In the category of 2) and 3), specialized hospitals (tuberculosis hospital, leprosy hospital, mental hospital), dispensaries and midwifery clinics were omitted from the total, as such organizations are classified neither as biomedical nor as KM institutions in the Statistical Yearbook of Ministry of Health and Welfare (2012a: 166-173).

<sup>116</sup> The MSA (Paragraph 1 – 3 of Article 3) classifies medical institutions as ‘clinics’ (up to 30 patient beds), ‘hospitals’ (not less than 30 beds) and ‘general hospitals’ (over 100 beds). In this table, ‘general hospital’ was included into the category of ‘hospital’ for convenience.

number of KM hospitals (6.6 percent) and inpatient hospital beds (2.3 percent) compared with the numbers of biomedical hospitals (93.4 percent) and inpatient hospital beds (97.7 percent), it can be inferred that a large majority of KM clinical services are provided at clinic-level medical institutions mainly for outpatient care, rather than in the larger-scale hospital-level institutions.<sup>117</sup>

Concerning the overwhelming dominance of the biomedical sector over the KM sector in the post-colonial period, let us consider the following table and graphs describing the changes in the numbers of KM and biomedical doctors from 1951 to 2010.

Table IV.3 Numbers of Biomedical and KM Doctors from 1951 - 2010<sup>118</sup>

	Biomedical Doctors <sup>A</sup>	KM Doctors <sup>B</sup>	Total <sup>A+B</sup>	Density of Physicians <sup>A+B</sup> (Total Number per 1000 Population)
1951	5,082 (76.4%)	1,566 (23.6%)	6,648 (100%)	0.3 <sup>119</sup>
1960	7,765 (72.7%)	2,922 (27.3%)	10,687 (100%)	0.43
1970	14,932 (82.1%)	3,252 (17.9%)	18,184 (100%)	0.6
1980	22,564 (88.2%)	3,015 (11.8%)	25,579 (100%)	0.7
1990	42,554 (88%)	5,792 (12%)	48,346 (100%)	1.1
2000	72,503 (85.7%)	12,108 (14.3%)	84,611 (100%)	1.8
2010	101,443 (84.1%)	19,132 (15.9%)	120,575 (100%)	2.2

<sup>117</sup> Such an inference becomes clearer considering that 85.2 percent of KM doctors work at clinic-level institutions, whereas 58.3 percent of biomedical doctors work at hospital-level institutions (Ministry of Health and Welfare, 2012a: 153-155). However, concerning this issue, Hyun-ji Lee (2008: 57-58) argues that the center of KM clinical service has been rapidly changing from small-scale clinics to larger hospital-level institutions since the 1970s, with the number of KM hospitals having sharply increased over 30 times between 1975 (5 KM hospitals) and 2004 (154 KM hospitals), while KM clinics increased only three times during the same period (ibid. 57). Her argument is reasonable when we focus on the changes within the KM sector. Nevertheless, compared to the biomedical sector, it is still unrepealed to say that a great majority of KM medical care is enacted in clinic-level institutions mainly for outpatients.

<sup>118</sup> From: "The Statistics Yearbook for Health and Social Welfare 1955," Statistic Data Base of Ministry of Health and Welfare (*Bogeon Bokji Tong-gye Portal*), retrieved 27 May 2016 from <http://stat.mohw.go.kr/front/statData/mohwAnnalsWpView.jsp?menuId=14&bbsSeq=1&nttSeq=84&nttClsCd=01&searchKey=&searchWord=&nPage=7>; Ministry of Health and Welfare (2012a: 145-146); Korea National Statistical Office (2008).

<sup>119</sup> As of 1953 (Korea National Statistical Office, ibid. 31)

Figure IV.1 Changes in the Numbers of KM and Biomedical Doctors from 1951 – 2010<sup>120</sup>

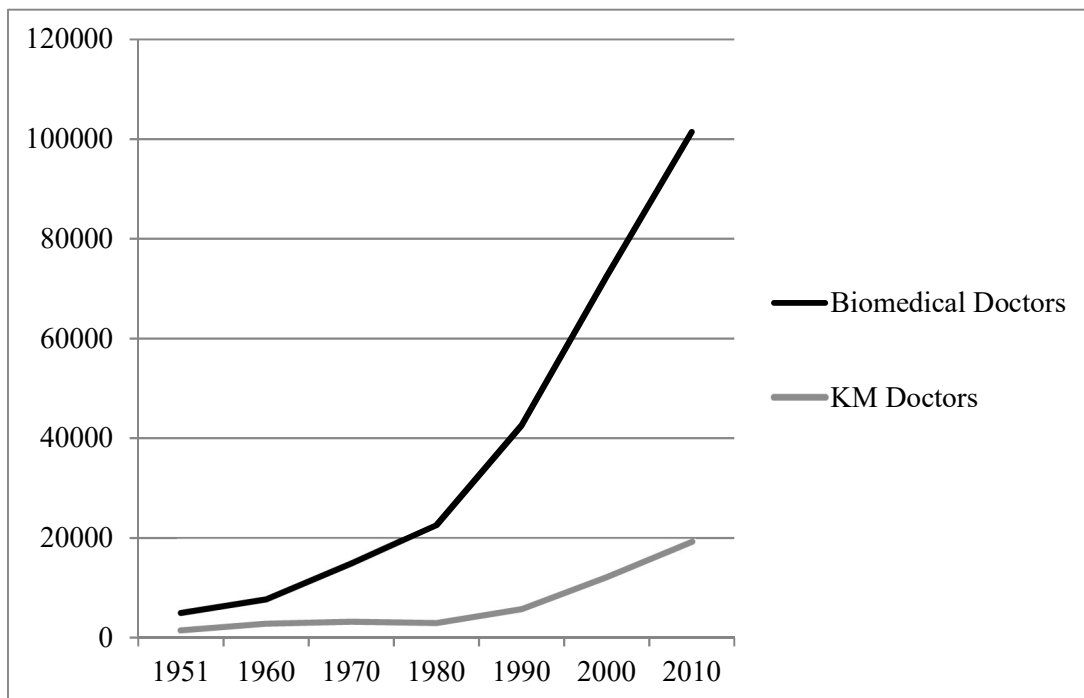
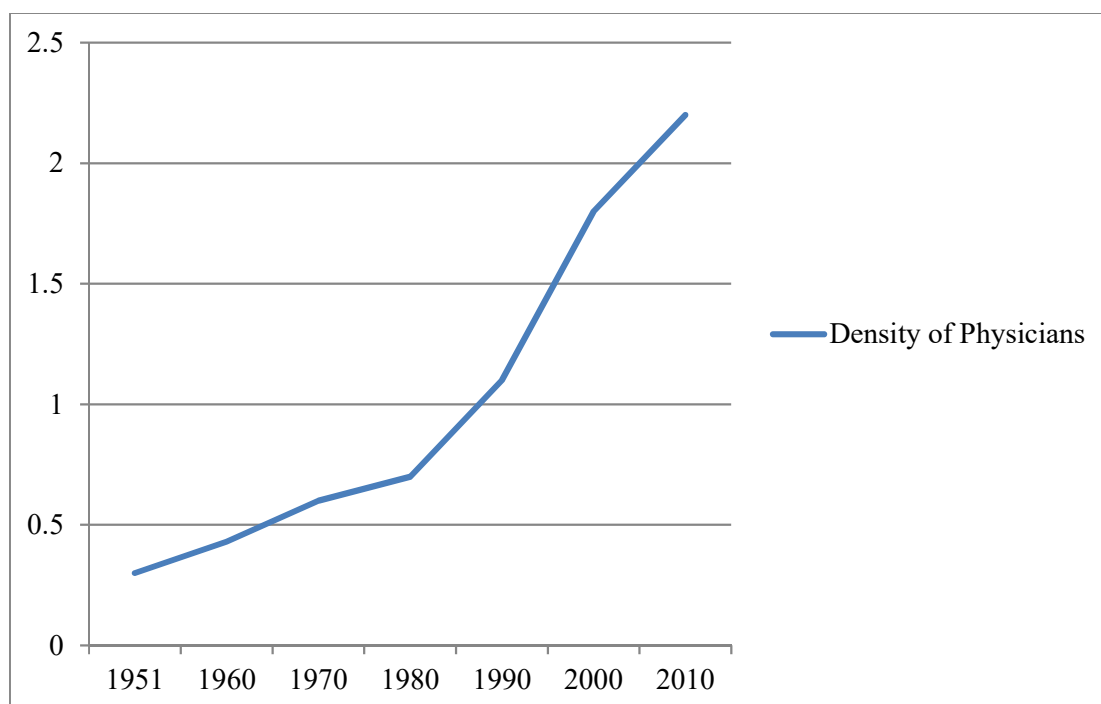
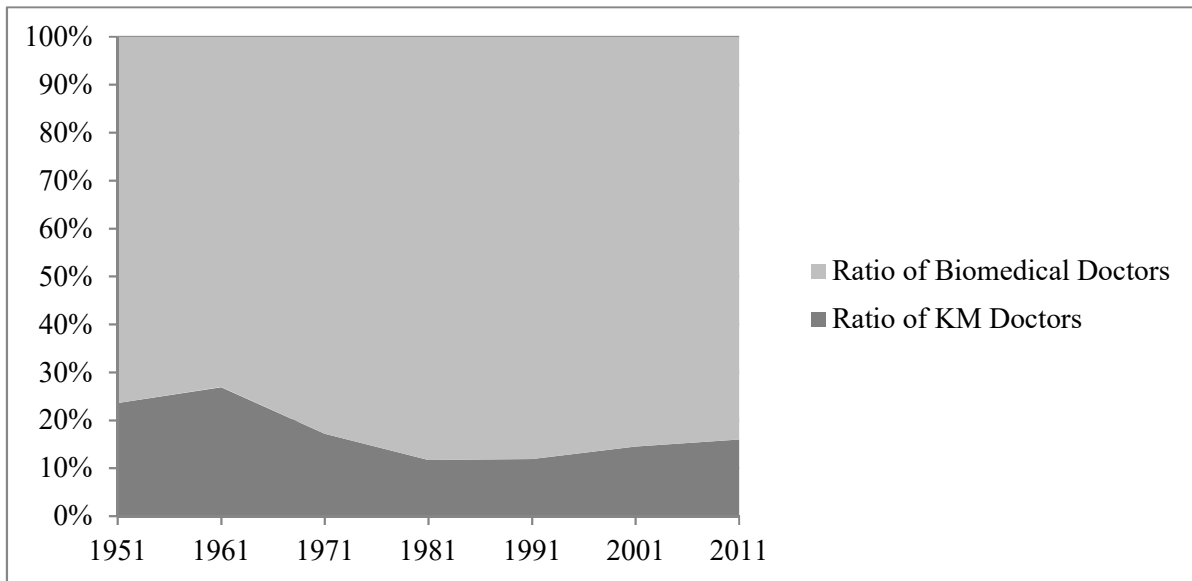


Figure IV.2 Density of Physicians (KM + Biomedical Doctors) from 1951 - 2010  
(Total Number per 1,000 Population)



<sup>120</sup> Figures IV.1, IV.2 and IV.3 are drawn from the results of Table IV.3.

Figure IV.3 Changes in the Ratio of KM and Biomedical Doctors from 1951 – 2010



As shown in Table IV.3, Figure IV.1 and Figure IV.2, the numbers of both KM and biomedical doctors steadily increased from 1951 to 2010, together with the density of physicians.<sup>121</sup> Figure IV.3 describes the changes in the ratio of KM and biomedical doctors in the professional medical sector. It shows that the ratio of KM doctors was over 20 percent in the 1950s and 1960s, before decreasing to 11 percent in the 1970s and 1980s, followed by a gradual recovery in 2000s and 2010s to over 15 percent.<sup>122</sup> Describing the data above, biomedicine has steadily dominated over the KM sector within the professional sector in the South Korean medical system in terms of its scale since the beginning of the post-colonial period, while the KM sector also has maintained its meaningful influence in the professional health care system despite its smaller scale compared with the biomedical sector.

<sup>121</sup> Both of the graphs show a rapid increase in the total number and density of physicians from 1980. It can be interpreted as a result of the increase of medical demands through the establishment of NHI in 1977 and its expansion of beneficiaries during the 1980s, followed by an increase in newly established KM and biomedical schools in the 1980s and 1990s (In-sok Yeo et al. *ibid.* 340-343; Ki-wook Kim et al. *ibid.* 520-524).

<sup>122</sup> From the 1950s to 1960s, the ratio of KM doctors was relatively higher despite the lack of KM educational institutions (only one KM school until 1972), as pre-existing *Uisaeng* were officially acknowledged as Oriental medical doctors with the establishment of the National MSA in 1951. However, as the number of biomedical schools increased over the 1960s and 1970s, the difference in the ratio between KM and biomedical doctors widened until the early-1990s. Such a gap between the number of KM and biomedical doctors seems to have been gradually shrinking with the increase in the establishment of KM schools from the 1980s, resulting in the recovery of the ratio of KM doctors within the professional medical sector in the 2000s (inferred from Ki-wook Kim et al. 2006; Ministry of Health and Welfare, 2012a).

Table IV.4 Average Monthly Income of Biomedical and KM Doctors<sup>123</sup>

(As of 2008, Gross Income)

	Average of Lower 25%	Average Monthly Income	Average of Upper 25 %
Biomedical Doctors	KRW 3 Million (US\$ 2,723) <sup>124</sup>	<b>KRW 5.559 Million</b> <b>(US\$ 5,054)</b>	KRW 7.5 Million (US\$ 6,807)
KM Doctors	KRW 3 Million (US\$ 2,723)	<b>KRW 4.796 Million</b> <b>(US\$ 4,352)</b>	KRW 6 Million (US\$ 5,445)

Concerning KM and biomedical doctors' socio-economic status and occupational prestige, it is useful to consider their average income and the entrance scores of KM and biomedical schools. As described above in Table IV.4, the average monthly income of KM doctors is US\$ 4,352, about 14 percent lower compared with biomedical doctors (US\$ 5,054). Nevertheless, both of them can be categorized as high-paying professions in South Korea, considering that their incomes overwhelmingly exceed the average monthly income across all South Korean employees in the same year (US\$ 2,323 per month). Regarding the difficulty of entrance into KM and biomedical schools,<sup>125</sup> it is widely known that those given the highest scores in the college entrance exam (*Daehak Suhak Neungryeok Siheom*, College Scholastic Ability Test, CSAT) can enter biomedical and KM schools.<sup>126</sup> Concerning this issue, Sunsam Na (2012: 48) argues that the economic development in the 1970s was connected with the higher demands on KM treatments, which was reflected in the increased entry achievements

<sup>123</sup> From: Korea Employment Information Service, 2009: 188, 192.

<sup>124</sup> Calculated based upon the average exchange rate of 2008 (US\$ 1 = KRW 1,101.88. From: Bank of Korea: Economic Statistics System, retrieved 27 May 2016 from [ecos.bok.or.kr](http://ecos.bok.or.kr).

<sup>125</sup> Both of them have the same number of years required for graduation: six years for high school graduates in the cases of biomedical/KM colleges or four years for bachelor's degree holders in the cases of biomedical/KM graduate schools (Ki-wook Kim et al. 2006; In-sok Yeo et al. 2012).

<sup>126</sup> No official concrete records of the successful candidates in each college have been disclosed to the public. Instead, there have been tables on expected average scores of CSAT for each departments of the universities nationwide, developed by preparatory schools and consulting experts. According to one of the tables for CSAT 2015 posted on the internet, it was estimated that at least the top 0-2 percent scorers of the CSA can apply for biomedical schools, the top 1.4-3 percent for KM schools and the top 0.3-2.1 percent for dental schools. Even if we do not completely trust the concrete figures shown in this table, we can infer that entering KM schools demands very high scores, at least secondary to biomedical and dental schools From: "Result of Entrance Exam 2015 for Biomedical, Dental, KM, and Veterinary Medical schools" (*2015 Haknyeondo Ui-Chi-Han-Su Ip-gyeol*), Theqoo.net, retrieved 27 May 2016 from <http://theqoo.net/square/55539419>. The majority of the physicians who I interviewed during the fieldwork – including biomedical doctors – indicate that the average scores of CSAT for KM schools were even higher in the 1990s and the early-2000s than the 2010s.

of KM schools during this era.

According to the current statistical features of the South Korean medical system, the biomedical sector predominates over the KM sector in terms of the numbers of physicians and clinical/educational institutions. However, the KM sector also plays a significant role in the South Korean medical system, having survived and developed as a professionalized traditional medical form. As a profession, being a KM doctor is also considered a highly-paid specialized job, rivaling biomedical doctors and dentists in terms of income and educational prestige. In the next chapter, legal regulations concerning the medical authorities and jurisdictions of KM and biomedical doctors will be introduced, followed by the series of conflicts to date resulting from the legal ambiguity of their occupational territories.

## **2.2 Legal Regulations on KM and Biomedicine**

The current South Korean medical system shares its dualistic character in terms of the coexistence of the professionalized biomedical and traditional medical sector with the medical systems of its neighboring East Asian regimes such as North Korea, China, Taiwan and Vietnam, albeit not with the Japanese biomedicine-oriented unified system (Gang-jae Yoon, 2013). However, among them, the South Korean system has the peculiar characteristic of being “a strictly exclusive license system” (ibid. 91) between two professional sectors in that KM and biomedical doctors’ medical domains are strictly divided by legal regulations, whereas in the systems in the other East Asian countries the applications of medical actions of the counterpart are partly or entirely accepted by law (ibid.). As previously introduced in Chapter I.1, both “(bio-) medical doctors (*Uisa*)” and “oriental medical (KM) doctors (*Han-uisa*)” belong to “medical person” together with dentists, nurses and midwives (Paragraph 1 of Article 2 of the MSA). Paragraph 2 of article 2 of the MSA proceeds to stipulate that “(bio-) medical doctors” are in charge of “administrating ‘medical treatment’ and providing guidance for health” (subparagraph 1), while “oriental medical (KM) doctors” are in charge of “administrating ‘oriental medical treatment’ and providing guidance for health based on ‘oriental medicine’” (Subparagraph 3). On the other hand, Paragraph 1 of Article 27 of the MSA specifies that “any non-medical person shall not perform medical practice, and even a medical person shall not perform any medical practice other than those licensed.” Accordingly, in case KM or biomedical doctors’ apply any medical treatments outside the

boundaries of their medical domains, they are considered as illegal and unlicensed treatment by the MSA.<sup>127</sup> Through such regulations, the MSA strictly declares separating the medical domains of KM and biomedical doctors while acknowledging their exclusive authority in each sector (Kyung-chul Beom, 2009: 359). In this context, it is important how each domain is legally defined, although there is no concrete regulation in the MSA or Enforcement Decree/Rule of the MSA concerning which medical instruments or treatment methods belong to the KM or biomedical area. Therefore, this results in constant conflicts regarding the usage of certain medical technologies or instruments between KM and biomedical doctors.<sup>128</sup> In this situation, it is necessary to examine judicial precedents or administrative interpretations in each concrete case (B. Lee & P. Lee, 2011: 14). Nevertheless, we can infer the legal domains of KM from the definition of Korean medicine regulated in the ‘Korean Medicine and Pharmaceutics Promotion Act.’<sup>129</sup> According to this act, ‘Korean medicine and pharmaceutics’ is defined as follows:

*Article 2 (Definition)*

1. "Korean medicine and pharmaceutics" shall mean any medical treatment services based on Korean Medicine, as traditionally handed down from the nation's ancestors and scientifically developed and applied in the present...

According to this paragraph, Korean medicine is a medical diagnosis and treatment “based on the traditional principles of medical care developed in Korea” from the past, although it also includes any modernized scientific accomplishment of medical technologies originated in the traditional medical principles. Accordingly, it emphasizes the medical principle of each medical action as the legal classification criteria of KM and biomedicine. In this regard, Seoul Administrative Court indicated in its judgment that “in terms of whether a medical action corresponds to the one that belongs exclusively to ‘(bio-) medical doctors’ or ‘oriental medical (KM) doctors,’ it should be judged in accordance with what academic principle it is

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<sup>127</sup> In case of KM or biomedical doctors’ breach of this paragraph, their licenses are “suspended with a three-month suspension of business to the related hospital institution” (Paragraph 1 of Article 64 of the MSA) and they shall be “sentenced to imprisonment for a term of not more than five years or receive a fine not exceeding 20 million won” (US\$ 16,438.97, as of 20 Jan. 2016, Article 87 of the MSA).

<sup>128</sup> Concrete examples of such conflicts will be examined later in Chapter IV.2.3.

<sup>129</sup> Korean Medicine and Pharmaceutics Promotion Act (*Han-uyak Yukseong-beop*), Enacted on 6 Aug. 2003 (Act No. 6965), Revised on 22 Oct. 2010 (Act No. 11524).



based upon.”<sup>130</sup> Baek-hyu Lee and Pyeong-su Lee (ibid. 15) rearranged South Korean court’s understanding concerning the principles of KM and biomedicine after analyzing its judicial precedents from 2006 to 2008 in Table IV.5 below, reflecting the current general public understanding of differences between KM and biomedicine.

Table IV.5 Differences between Biomedicine and KM based upon the Analysis of Judicial Precedents (Baek-hyu Lee & Pyeong-su Lee, 2011: 15)

		Biomedicine	KM
Academic Principles		Realistic, empirical, objective	Subjective, intuitive, holistic, experiential
Understanding of the Human Body		An anatomical organ (based on experimental results through physic-chemical methods)	Life, energy ( <i>qi</i> ), and microcosm
Main Characteristics		Analytic, Experimental	Comprehensive
Main Focus		Exploration of material organization	Observation of biological phenomena
Disease	Meaning	Something appearing as a result of changes in certain parts of the body	A process of change in body, resulting from certain causes
	Cause	Mostly due to external factors, e.g. bacteria or virus	Mostly due to internal factors, e.g. weakened inner energy
Diagnosis	Methods	A medical examination by interview, an ocular inspection, auscultation, a medical examination by touching patients’ body	An ocular inspection, a medical examination by interview, auscultation, a medical examination by touching patients’ body
	Theories	Theories of anatomy, histology, biochemistry, etc.	‘Five Function Theory’ of the five viscera, 12 meridian theory, etc.
	Characteristics	Inspecting through biochemistry, endocrinology, immunology, radiology, etc.	Ocular inspection, eight characteristics ( <i>Palgang</i> , 八綱): <i>Eum</i> (陰), <i>Yang</i> (陽), <i>Pyo</i> (表, surface), <i>Ri</i> (裏, inside), <i>Han</i> (寒, coldness), <i>Yeol</i> (熱, warmth), <i>Heo</i> (虛, lack), <i>Sil</i> (實, excessiveness), etc.

The South Korean court judges over cases of medical jurisdictions between the KM and

<sup>130</sup> Seoul Administrative Court (*Seoul Haengjeong Beopwon*), Court Decisions of 10 Oct. 2008, Case No. 11945.

biomedical sectors based upon their basic medical principles, as illustrated above. Likewise, the Ministry of Health and Welfare guides the usage of certain medical instruments or methods to them through these criteria (B. Lee & P. Lee, *ibid.* 16-17). However, the differences of concrete contents on the principles of KM and biomedicine are obscure or both of the principles share their concrete methods of diagnosis or therapies, as illustrated in Table IV.5.<sup>131</sup> In the next chapter, I will introduce the conflicts between KM and biomedical doctors concerning the usage of medical instruments and certain therapy methods originated from such ambiguity regarding the classification.

### **2.3 Conflicts between KM and Biomedical Doctors over Their Medical Territory**

As explained in the previous chapter, KM and biomedical doctors exclusively take charge of the KM and biomedical sectors based upon the MSA. In this regard, their medical actions are supposed to be strictly separated. However, in a situation where there is a lack of concrete legal regulations concerning the usage of certain therapies or medical instruments, there have been persisting potential conflicts between them regarding the respective medical domains. Such conflicts have been deepened with the development of medical skills with new technologies and methods from both KM and biomedicine. As representative examples among various issues regarding such conflicts between them, this chapter takes a closer look at the conflicts concerning the usage of intramuscular stimulation (IMS) and ‘pharmacupuncture’ therapy as cases of conflicts with respect to the aspects of medical treatments, as well as the usage of modern medical inspection equipment including X-ray imaging, CT/MRI scans and ultrasonography as an example regarding medical diagnosis.

#### **2.3.1 KM Doctors’ Claims against Biomedical Doctors’ Application of IMS**

Intramuscular stimulation therapy (IMS) – also called ‘trigger point needling’ – is defined as “the insertion of solid needles into sensitive or painful body parts in order to alleviate musculoskeletal, myofascial, or nerve pain,”<sup>132</sup> or “a method developed by Dr. Chan Gunn;

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<sup>131</sup> For instance, in the category of diagnosis methods in Table IV.5, there are no significant differences in biomedical and KM inspection methods. This is deeply related to the current conflicts on the usage of modern diagnostic instruments between KM and biomedical doctors, which have been exclusively permitted to biomedical doctors. More details on this issue will be introduced in the next chapter.

<sup>132</sup> From: “Intramuscular Stimulation,” *Medical Dictionary* (2009), Farlex and Partners, retrieved 27 May 2016

uses acupuncture to relieve chronic pain of neuropathic origin by releasing muscle shortening, which presses on nerves.”<sup>133</sup> It was developed in the 1970s by Dr. Chan Gunn, a Chinese Canadian clinical professor at Washington University.<sup>134</sup> In South Korea, this therapy has been widely researched and applied in the academic and clinical fields as a new biomedical technology since the early-2000s (Young-jin Lee, Kang Ahn & Sang-chul Lee, 2006: 3). In response, KM doctors strongly opposed biomedical doctors’ usage of IMS while arguing that IMS therapy is not different from their acupuncture therapy in itself, which is the core domain of KM (Hee-kyung Choi, *ibid.* 258). Regarding this issue, the biomedical doctors argued that the main principle of this therapy is based upon biomedical neurological anatomy and physiology utilizing the fusimotor and spinal reflex, completely unrelated to any meridian theories of KM, as well as emphasizing Dr. Gunn’s educational and professional background of biomedicine (B. Lee & P. Lee, *ibid.* 47). Meanwhile, KM doctors contradicted the biomedical doctors’ argument while claiming that IMS therapy originates in Chinese acupuncture therapy as well as emphasizing Dr. Gunn’s ethnicity as a Chinese immigrant.<sup>135</sup>

Concerning this issue, the Ministry of Health and Welfare previously presented an authoritative interpretation in 1998,<sup>136</sup> suggesting that biomedical doctors’ therapeutic application of acupuncture/needling does not correspond with an unlicensed medical action as long as the therapy is applied by biomedical principles. In line with this, Ministry of

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from <http://medical-dictionary.thefreedictionary.com/intramuscular+stimulation>.

<sup>133</sup> From: “Intramuscular Stimulation,” Jonas: Mosby’s Dictionary of Complementary and Alternative Medicine (2005), Elsevier, Inc, retrieved 27 May 2016 from

<http://medical-dictionary.thefreedictionary.com/intramuscular+stimulation>.

<sup>134</sup> From: “Clinic: Dr. Gunn,” The Institute for the Study and Treatment of Pain, retrieved 27 May 2016 from

<http://www.istop.org/drgunn.html>.

<sup>135</sup> Dr. Gunn answered a question in an interview in 2002 concerning whether IMS is in fact a form of acupuncture as follows: “IMS borrows its needle technique from traditional Chinese acupuncture, but updates and enhances it with anatomy and neurophysiology. I like to think that it brings Western and Eastern medicine together. But whereas medical diagnosis and examination, and knowledge of anatomy, are not applicable in acupuncture, they are crucial to IMS. It follows that prompt objective results can be anticipated from IMS, which is not always true of acupuncture. But my research does provide the theoretical underpinning that explains why the ancient technique of acupuncture often does work” (from: “Clinic: Dr. Gunn,” The Institute for the Study and Treatment of Pain, retrieved 27 May 2016 from <http://www.istop.org/drgunn.html>). In this interview, he argues that IMS is a biomedical method in the light of traditional Chinese medicine. An important point regarding the South Korean situation is that such a hybridized medical therapy always has issues within the South Korean dual medical system divided into biomedicine and KM.

<sup>136</sup> Ministry of Health and Welfare, Authoritative Interpretation. *Uijeong* 65507-799, 25 Sep. 1998; *Uijeong* 65507-920, 20 Nov. 1998.

Construction and Transportation determined that IMS therapy would be newly included within the items of automobile insurance fee as an item of biomedical treatments (Jae-yeon Jeong, 2005). However, the ministry suspended this decision the very next month due to the fierce opposition of the AKOM, indicating that it would wait for the definitive authoritative interpretation of the Ministry of Health and Welfare. However, there has been no clear decision made by the Ministry of Health and Welfare to date, against the background of severe conflicts between KM and biomedical doctors regarding this issue. In this situation, IMS therapy has been widely used for chronic pain control by biomedical doctors in clinical settings, while there have been frequent lawsuits against biomedical doctors' clinical application of IMS accused by KM doctors. To summarize judicial precedents on this issue thus far, biomedical doctors' application of IMS itself is not established as a case of unlicensed medical actions (Jin-yeong Song, 2016). However, in case the location and depth of inserted needles are similar to the ways of KM acupuncture therapy corresponding to the points of meridian system or applying the acupuncture needle superficially underneath the skin, this shall be in violation of the MSA as an unlicensed medical action encroaching upon KM doctors' medical authority (Baek-hyu Lee & Pyeong-su Lee, *ibid.* 43). However, there remains controversy about this issue concerning how to interpret biomedical doctors' concrete clinical medical actions of IMS.

### **2.3.2 Conflicts on KM Doctors' Application of 'Pharmacopuncture' Therapy**

In contrast to the case of biomedical doctors' application of IMS, KM doctors' application of pharmacopuncture therapy has been repeatedly questioned by biomedical doctors as a violation of biomedical doctors' medical domain. According to the Korean Pharmacopuncture Institute established by KM doctors in 1990, pharmacopuncture is defined as follows.<sup>137</sup>

*Pharmacopuncture is a new form of therapy derived from the conjunction of herbal medicine and acupuncture therapy. Herbal extraction is used as a stimulus measure for a meridian point. Various substances are injected into and stimulate a specific part of a human body.*

Put simply, pharmacopuncture is an injection of herbal extraction into the acupuncture points

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<sup>137</sup> From: "Definition," Korean Pharmacopuncture Institute, retrieved 27 May 2016 from [www.pharmacopuncture.co.kr/sub\\_eng/sub\\_2\\_1\\_1.html](http://www.pharmacopuncture.co.kr/sub_eng/sub_2_1_1.html).

through a syringe, i.e., acupuncture therapy with medicinal injection. It can be understood as a synthesized therapy of acupuncture and herbal medicine belonging to the domain of KM, enlisting the help of a modernized injection technique originally developed in the biomedical sector. The Korean Pharmacopuncture Institute explains that this therapy was developed independently by South Korean KM scholars in the 1960s, “comparable with the principles of Chinese hydro-acupuncture therapy and European Homeopathy.”<sup>138</sup> Since the 1990s, it has been widely applied in clinical settings in KM practices for various purposes for diagnoses and treatments, such as allopathic treatment, improving the immune function as well as harmony between the body and *Qi* for fatigue recovery and disease prevention.<sup>139</sup>

Pharmacopuncture therapy is officially acknowledged as a KM therapy by the government through authoritative interpretations,<sup>140</sup> emphasizing that it is based upon the KM principles of acupuncture and herbal medicine. This was followed by the decision of Health Insurance Review and Assessment Service,<sup>141</sup> which classified it as a KM non-payment item of NHI (B. Lee & P. Lee, *ibid.* 73). However, biomedical doctors have severely criticized the government’s decision in the way that such already processed and blended forms of herbal extracts legally belong to the category of biomedical drugs,<sup>142</sup> while the injection as a medical action belongs to the biomedical area given that it was developed within the principles of biomedical pharmacology and physiology while emphasizing the delicacy of invasive methods of injection. Moreover, they emphasize the possibility of an allergic or adverse reaction originating from the fast-acting effect of the injection method. In this regard, they argue that this therapy may not be allowed for KM doctors, as non-experts of

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<sup>138</sup> From: “Background” (*Yakchim-ui Baegyeong*), *ibid.* retrieved 27 May 2016 from [http://pharmacopuncture.co.kr/sub/sub\\_2\\_1\\_2.html](http://pharmacopuncture.co.kr/sub/sub_2_1_2.html).

<sup>139</sup> From: “Types,” *ibid.* retrieved 27 May 2016 from [www.pharmacopuncture.co.kr/sub\\_eng/sub\\_2\\_2\\_1.html](http://www.pharmacopuncture.co.kr/sub_eng/sub_2_2_1.html).

<sup>140</sup> Ministry of Health and Social Affairs. Authoritative Interpretation, *Uije* 01254-3379, 13 Jan. 1987; Ministry of Health and Welfare. Authoritative Interpretation, *Hanbang* 65507-129, 10 June 1998.

<sup>141</sup> A governmental organization under the Ministry of Health and Welfare for reviewing and assessing health care costs cooperating with NHIS. From: “President’s Message,” Health Insurance Review and Assessment Service, retrieved 27 May 2016 from [www.hira.or.kr/eng/about/01/president.html](http://www.hira.or.kr/eng/about/01/president.html).

<sup>142</sup> According to the Korean Medicine and Pharmaceuticals Promotion Act, herbal medicine is defined as follows: “herbal medicines are largely made from botanical extracts, ... they are natural medicines, in unprocessed form, whereby natural ingredients are simply dried and cut, or at times ground into a powder and rolled into a pill” (from: Paragraph 4, Article 2 of Korean Medicine and Pharmaceuticals Promotion Act, Enacted on 6 Aug. 2003, Act No. 6965, revised on 22 Oct. 2010, Act No. 11524). Grounded upon this article, biomedical doctors argue that KM doctors’ action of blending and processing herbal extracts for pharmacopuncture exceed their medical authority (B. Lee & P. Lee, *ibid.* 68).

biomedicine (B. Lee & P. Lee, *ibid.* 71). Unlike the conflicts concerning biomedical doctors' application of IMS therapy raised by KM doctors, pharmacopuncture therapy is more stably acknowledged as a KM therapy by the government and the general public without particularly serious legal conflicts between KM and biomedical doctors, because the South Korean government stands on relatively firmer ground on this issue than the case of IMS, while acknowledging that the principle of pharmacopuncture originates in the principles of KM acupuncture therapy and herbal medication. Nevertheless, biomedical doctors still raise issues regarding KM doctors' application of pharmacopuncture as a therapy beyond the KM authority.

### **2.3.3 Issues of KM Doctors' Claims for the Usage of Biomedical/Modern Diagnostic Equipment**

Unlike other East Asian countries where traditional physicians are allowed to utilize modern diagnostic equipment such as X-rays, CT/MRI scans, ultrasonography and blood testers, the South Korean medical system exclusively allows this for biomedical doctors in principle, having juristically interpreted them as biomedical instruments based upon the anatomical knowledge developed within the principle of biomedicine.<sup>143</sup> By contrast, KM doctors are allowed to apply traditional ways of diagnosis such as directly taking the pulse of patients by the physicians' hands (*Jinmaek*, 診脈) and utilizing modernized instruments based upon the traditional principle of KM such as an electronic pulsimeter. In this regard, aside from "basic and unharmed (biomedical) diagnostic instruments" such as "thermometers, manometers and stethoscopes,"<sup>144</sup> KM doctors need biomedical doctors' help in principle when they are in need of utilizing biomedical diagnostic instruments for their patients.<sup>145</sup> However, KM doctors have been consistently against this policy whereby such diagnostic instruments are classified as 'biomedical,' arguing that utilizing such 'modern' instruments does not run contrary to the principle of KM in itself and that such instruments are not the outputs of

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<sup>143</sup> E.g. Seoul High Court (*Seoul Godeung Beopwon*), Court Decision of 30 June 2006, Case No. 2005 Nu 1758.

<sup>144</sup> Ministry of Health and Social Affairs, Authoritative Interpretation, *Uije* 01254-23088, 15 Oct. 1986; Ministry of Health and Welfare, Authoritative Interpretation, *Uijeong* 01254-12855, 16 Oct. 1998.

<sup>145</sup> This was the most frequently appearing case of KM doctors' WKCT requests to biomedical doctors found in the fieldwork. More details on this issue will be examined in Chapter V.2.2.1 'KM doctors' WKCT request to biomedical doctors.'

biomedical developments but rather modern engineering technology.<sup>146</sup> Meanwhile, they emphasize that traditional Korean medicine also accumulated anatomical knowledge within its discipline long before, which has a thread of connection with modern/Western biomedical anatomy.<sup>147</sup> Such insistence among KM doctors has been particularly ascertained since the 2010s with the government's new policy for economic deregulation and the development of the medical industry as a way of revitalizing the national economy (Young-seok Seo & Chang-hee Kang, 2015). In this regard, there have been various authoritative interpretations and judicial precedents in this era that are more permissive to the KM doctors' argument than before, including the usage of automated hematology chemistry analyzers and urine analyzers,<sup>148</sup> ocular tonometry and audiometers,<sup>149</sup> while mentioning that the such instruments share their basic principles with the principles of traditional KM and does not have any possible harmful effects in the course of their clinical usage. On the strength of such decisions, the AKOM proceeded to argue for KM doctors' usage of X-rays, CTs, MRIs and sonography in the mid-2010s (Jin-kyu Park, 2015a),<sup>150</sup> followed by the government's positive gesture towards the KM doctors' such demands together with the expectation of the manufacturers of medical instruments (Jin-gu Kim, 2015).<sup>151</sup>

In this situation, biomedical doctors have severely criticized the KM doctors' demand and the government's positive consideration in that it denies the professionalism of biomedical doctors and their medical authority and thus will "strike the fundamental basis of dualized South

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<sup>146</sup> From: Homepage of the AKOM, retrieved 27 May 2016 from <http://www.akom.org/>. Relevant to their argument, it is worthwhile to review Table IV.5, particularly the column of diagnosis methods. In this column, most of the diagnostic methods of biomedicine and KM overlap with each other.

<sup>147</sup> *ibid.*

<sup>148</sup> Ministry of Health and Welfare, Authoritative Interpretation, Mar. 2014 (as cited in Seon Choi, 2015; Min-soo Kim, 2016).

<sup>149</sup> Constitutional Court Korea (*Heonbeop Jaepanso*), Court Decision of 26 Dec. 2013, *Heon-ma* 551 and *Heon-ma* 561 (Case No. 2012).

<sup>150</sup> Unlike the AKOM president's contention revealed in the interview with Jin-kyu Park in January 2015 (*ibid.*), Tae-ho Kim – director of planning at AKOM – expressed a revised assertion of AKOM at a public hearing organized by the National Assembly in April of the same year, stating that AKOM officially limited their demands to the usage of X-ray and sonography, excluding CT and MRI, respecting the specialized field of (biomedical-) radiology specialists (Young-ku Yang, 2015; Jeong-hye Min, 2015).

<sup>151</sup> Jin-yeop Jeong – newly appointed minister of Health and Welfare in September 2015 – answered a question on the issue of KM doctors' usage of sonography in a parliamentary inspection of the Ministry of Health and Welfare, stating that he personally would not oppose it and the ministry is positively considering its permission (Jin-gu Kim, *ibid.*).

Korean medical system and its license system” (Wan-bae Kim, 2015). In response to KM doctors’ arguments for the usage of modern diagnostic instruments, they strongly argue for maintaining their exclusive authority of their usage while emphasizing that such diagnostic instruments are developed within the principle of biomedical anatomy (e.g. Seok-ha Kang, 2015). Such different viewpoints on the issue of KM doctors’ usage of modern diagnostic equipment have resulted in severe conflicts between the KMA and the AKOM to date.<sup>152</sup> In this sharp conflict between KM and biomedical doctors, the government’s definitive decision on this issue – which was supposed to be announced by the end of 2015 (Jin-kyu Park, 2015b) – remains suspended as of March 2016.

Besides the aforementioned examples, there have been various issues on the conflicts between KM and biomedical doctors over the 2010s, including biomedical doctors’ protests against KM doctors’ clinical application of IPL (B. Lee & P. Lee, *ibid.* 57-67; Hannah Kim & Kye-hyun Kim, 2015: 4-5),<sup>153</sup> the issue of the South Korean government’s promotion policy on ‘Wonder Drugs by Using Natural Substances’ (natural product drug)<sup>154</sup> (Hye-seon Lee,

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<sup>152</sup> As an example, the president of the KMA went on a hunger strike against the permission for KM doctors’ usage of modern diagnostic equipment (20-25 Jan. 2015), followed by the AKOM president’s another hunger strike to carry through its plan (28 Jan. – 10 Feb. 2015. Myeong-ryong Kim, 2015; Sang-jun Eum, 2015). Such a severe conflict between them has been widely known to the public through mass media and various campaigns conducted by the KMA and the AKOM respectively during 2015. From: Homepage of the KMA, retrieved 27 May 2016 from [www.kma.org](http://www.kma.org); Homepage of the AKOM, retrieved 27 May 2016 from [www.akom.org](http://www.akom.org).

<sup>153</sup> Intense Pulsed Light. “Treatment of the Skin with flash lamps of prescribed wavelengths, fluence, and Pulse durations which target specific chromophores to induce photothermolysis at specific locations in the Skin such as at the Hair Follicle or Spider Veins” (from: “Intense Pulsed Light,” Medical Dictionary Online, retrieved 27 May 2016 from, <http://www.online-medical-dictionary.org/definitions-i/intense-pulsed-light-therapy.html>). KM doctors argue that IPL is a kind of modernized application technology originated in a traditional ways of irradiating sun light on the site of lesion against dermatological diseases, grounded upon ‘Emperor’s Inner Canon (*Huangdi Neijing*, 黃帝內經. B. Lee & P. Lee, *ibid.* 59).

<sup>154</sup> According to Paragraph 2 of Article 2 of “Promotion of The Research and Development of Wonder Drugs by Using Natural Substances Act” (*Cheonyeonmul Sinyak Yeongu Gaebal Chockjinbeop*, Enacted on 12 Jan. 2000, Act No. 6165, Revised on 18 Jan. 2010, Act No. 9932), “the term ‘wonder drugs by using natural substances’ means medicines researched and developed by using the ingredients of natural substances, which have new elements and effects.” In western terms, it can be classified as “a category of ‘crude drug,’ ‘herbal medicinal preparation,’ ‘botanical drug’ or ‘herbal medicinal product’” (Sang-hyeon Seong & Jin-ho Park, 2006). As defined as processed to “have new elements and effects,” wonder drugs by using natural substances are legally classified as biomedical drugs, not KM herbal drugs (in accordance with Paragraph 4, Article 2 of Korean Medicine and Pharmaceuticals Promotion Act). With this regard, as of 2015, KM doctors’ prescribing such drugs is decided as an unlicensed medical action by the court (Seoul High Court, *Seoul Godeung Beopwon*, Court Decision of 20 Aug. 2015, Case No. 2014 Nu 1758). Concerning this policy, both KM and biomedical doctors



2014), the issue of KM doctors' demands for ascendancy over medical technicians (B. Lee & P. Lee, *ibid.* 28-35)<sup>155</sup> and biomedical doctors' complaint against English transcription of 'KM' and 'KM doctors' officially changed by the AKOM.<sup>156</sup> These can be interpreted as types of territory conflicts between professional groups related to their economic concerns in a situation of legal ambiguity regarding the concrete boundary of their areas (Hee-Kyung Choi, 2007: 295). Such conflicts have been strengthened with the recent trends of KM doctors' efforts towards modernizing traditional medicine and biomedical doctors' growing interest in CAM. It reveals a fundamental weakness of the dualized South Korean medical system, being artificially divided into the areas of biomedicine and KM by the MSA. In the situation of the exclusive medical system between KM and biomedicine, the WKCT – the main topic of this study – can be understood as a way of KM and biomedical doctors supplementing each other. However, considering such ongoing severe conflicts between them, the WKCT – KM and biomedical doctors' collaborative work for patients in clinical settings – can also be understood as a kind of irony. Bearing in mind such a historical background and current features of the dualized South Korean medical system, in the next chapter I will introduce the definitions, history and current features of the WKCT, before examining the fieldwork findings in Part V.

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criticize the South Korean government's promotion policy, albeit based upon different grounds: biomedical doctors are reluctant to utilize them while being suspicious about safety and effectiveness of them; whereas by contrast, KM doctors strongly argue that they must belong to KM drugs in that their ingredients are not different from those of KM herbs in itself, while initiating legal proceedings to obtain the right to prescribe them (Hye-seon Lee, *ibid.*).

<sup>155</sup>According to Paragraph 1, Article 2 of Medical Technicians, etc. Act, medical technicians are defined as "a person who is engaged in diagnosis or examination on medical chemistry tests under the instruction of medical doctors or dentists," excluding KM doctors. It implies that medical technicians' medical actions are judicially categorized as the biomedical area based upon biomedical principles. The AKOM officially demanded the revision of this paragraph in the early-2010s, only to fail due to the strong objection of the KMA (Seung-woo Lee, 2011; Ji-hwan Kim, 2012).

<sup>156</sup> For more details on this issue, see Chapter I.1.2 'Korean Medicine (KM, *Han-uhak*), KM Doctor (*Han-uisa*).'

### 3. ‘Western-Korean Cooperative Medical Treatment’ (WKCT, *Yang-Hanbang Hyeop-Jin*)

#### 3.1 Definition of the WKCT and Its Actual Meaning in Clinical Settings

As briefly mentioned in Chapter I.1.3, ‘Western-Korean cooperative medical treatment’ (WKCT) is usually understood as “a medical treatment system where KM and biomedical doctors inspect and diagnose together and decide the most effective treatment for patients” (Dong-huei Lee, 1994: 5), presupposing an ‘actual cooperation’ between two sectors in terms of the literal meaning. However, in reality, this term has been merely used to describe medical actions conducted in clinical settings where both KM and biomedical doctors work in the same or neighboring hospitals while sending their patients to their counterpart, regardless of whether or not there is an actual cooperation and in-depth communication between them during the patient management. In this respect, Dae-hwan Kim (2002) briefly modified this term for his research on CVA<sup>157</sup> patients’ attitudes towards the WKCT to ‘Western-Korean **Reciprocal Treatment**’ (*Yang-Hanbang Sangho Bangmun Jinryo*), while Yang-kyu Lee (2002: 5) further assorted this term into the theoretical and operational definition in his empirical research on inpatients in WKCT hospitals.

*Theoretical definition: a medical system where KM and biomedical doctors cooperate to examine and find an appropriate and effective treatment.*

*Operative definition: a simultaneous medical treatment in which inpatients are treated by KM and biomedical doctors on a certain disease in one hospital.*

Concerning such an ambiguity of the meaning of the WKCT, Myeong-se Sohn and Won-chul Lee (2010: 149-150) introduces Barron and White’s explanation of the differences among consultation, referral and co-management (2009: 193-195) to explain various possible spectrums of the WKCT, as shown in Table IV.6 below.

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<sup>157</sup> Cerebrovascular accident (Stroke). “An abnormal condition of the brain characterized by occlusion by an embolus, thrombus, or cerebrovascular hemorrhage or vasospasm, resulting in ischemia of the brain tissues normally perfused by the damaged vessels. The sequelae of a cerebrovascular insult depend on the location and extent of ischemia.” From: “Cerebrovascular Accident” (CVA), Mosby’s Medical Dictionary, 9th edition (2009), retrieved 27 May 2016 from <http://medical-dictionary.thefreedictionary.com/cerebrovascular+accident>.

Table IV.6 Clarifying Definitions of Clinical Consultation, Referral, and Co-Management  
(Barron & White, 2009: 194; M. Sohn & W. Lee, 2010: 150)<sup>158</sup>

<b>Types of Interaction</b>	<b>Goals</b>	<b>Focus</b>	<b>Responsibility for Clinical Outcomes</b>
<b>Clinical Consultation</b>	To enhance patient care and/or improve skills and confidence of consultee	Consultant may or may not see patient directly  Degree of focus on consultee's skill is negotiated with consultee	Remains with consultee, who is free to accept or reject the advice of consultant
<b>Referral</b>	To enhance patient care by relinquishing care (or aspects of care) to another professional whose expertise is perceived to be more essential to care than that of the professional making the referral	Establish connection between patient and professional who is accepting referral  Negotiate responsibilities for outcomes	Negotiated, but responsibility is often assumed (at least for aspects of care) by professional accepting referral
<b>Co-management</b>	To enhance patient care through availability of expertise of two (or more) professionals working together to optimize outcomes	Both professionals see patient directly and coordinate their care with and coordinate their case with one another (e.g. physician may monitor complex medication regimen while APN( <i>advanced practice nurses</i> ) focuses on adaption and human responses)	Shared

Categories in this table above are originally concerned with the interaction between medical doctors and advanced practice nurses. However, these categories can be still a useful tool to understand the various types and the degrees of cooperation between biomedical- and KM doctors. According to Barron and White (*ibid.*), the main difference of consultation, referral, and co-management is “the degree to which one assumes responsibility for the direct clinical management of a problem that falls within one’s area of expertise” (2009: 193); in the case of

<sup>158</sup> In the original text (Barron & White, 2009: 194), ‘supervision’ is included in the types of interaction with consultation, referral, and co-management. However, as it explicitly presumes a hierarchical relationship between groups, e.g. doctors and nurses, Sohn and Lee (2010: 149-150) seems to have excluded it when dealing with the cooperative action between biomedical- and KM doctors.

medical consultation, it is usually consultees who take the responsibility for the whole management process, but in the case of referral, the responsibility of the medical management is often moved from the one to the other, because referral is a kind of action in which a clinician “sends their patients to another physician” for the management of a problem (Segen, 1992), while medical consultation is a process in which “the help of a specialist (Anderson, Anderson & Glanze, 1994: 386)” for his/her “opinion or advice” (Segen, *ibid.*) is provided for the problems in patient management. Whereas the theoretical definition of the WKCT – e.g. by Yang-kyu Lee (2002: 5) – corresponds to the concept co-management, the concept of the WKCT in clinical settings is closer to consultation or referral in reality, given that it has been scarcely observed that KM and biomedical doctors coordinate the care with one another according to the previous research on the actual condition of the WKCT in clinical settings (e.g. Yang-kyu Lee, *ibid.*; Dae-hwan Kim, *ibid.* et al.).

This ambiguity of the definition of the WKCT mainly originates from the fact that there has been no clear-cut definition of it in the MSA until now, while this concept emerged and has developed from the clinical level in hospitals confronting various medical environments without strict regulations. Concerning this issue, I will introduce the emergence and development of the WKCT, followed by its legal regulations and public medical insurance policy with current features of the WKCT in the next chapters.

### **3.2 History and Development of the WKCT**

The history of the concept of the WKCT should be considered within the context of the dualized professional medical system in South Korea, which officially originated from the establishment of the MSA in 1951 (Ki-yong Jung et al. 2010, 2012; The National Institute of Health Care Management, 1997). As described in Chapter IV.1.4, traditional practitioners officially gained their authority as KM doctors through the legislation of the MSA with equal legal status as biomedical doctors and dentists, as well as an exclusive competence over traditional medical treatment against biomedical doctors and non-licensed healers of traditional folk medicine. Subsequently, the issue of the medical system’s integration has been constantly raised by the biomedical sector since the 1960s,<sup>159</sup> which was commonly

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<sup>159</sup> This issue was brought up by biomedical doctors over the 1960s, and was shaped as the establishment of ‘the

interpreted by KM doctors as a kind of unequal merger of KM into biomedicine in a situation where KM was only recently acknowledged as a professional medical sector by the MSA. For this reason, the idea of medical integration was “absolutely rejected” among KM doctors during the 1960s and 70s (Byung-mook Lim, 2009: 97), while they urged biomedical doctors to truly recognize the professionalism of KM and KM doctors, before raising the issue of the medical integration (Dae-hee Han, 1989: 254). As an alternative, KM doctors raised the concept of ‘cooperative treatment’ (*Hyeop-jin*) between KM and biomedical doctors respecting each other in the 1970s. It began with the establishment of the “East-West Medical Science Research Institute” for collaborative academic research in 1971 and “East-West Medical Center” for the development of clinical treatments at Kyung-Hee University Hospital in Seoul in 1977 (Yoon-hyeon Lee, 2000: 89). In other words, the concept of the WKCT emerged as a tool for KM doctors to be against the arguments concerning the medical integration in order to protect their independent authority from biomedicine during the period in which KM was not considered as socially prestigious as biomedicine yet, although it newly experienced an institutional authority. On the other hand, as larger KM institutions were established as a process of its modernization and institutionalization, more KM doctors were interested in the concept ‘WKCT’ regarding their clinical needs in KM hospitals; they needed durational biomedical inspection and medication within their hospitals, especially for the management of inpatients and patients with acute diseases, but without biomedical doctors it is not possible for them to have access to biomedical information in their workplace. With this regard, the WKCT was considered as a kind of “detour” for KM doctors to gain access to biomedical diagnoses and therapies for their patients (Yoon-hyeon Lee, *ibid.* 95).<sup>160</sup>

Throughout the 1980s and 1990s, KM continued to develop its professionalism through the inclusion of KM methods into NHI in 1987 and an increase in KM- schools and hospitals, as well as growing demands placed on KM through the economic development of South Korea

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Committee on Medical Integration’ within the KMA in the year of 1974. This committee submitted a recommendation on the integration of medical system in cooperation with Korean Pharmaceutical Association to the Ministry of Education and the Ministry of Health and Social Affairs in 1977 (Dae-hee Han, 1989: 253-255; Hong-gwan Seo, 2000: 288).

<sup>160</sup> In addition to the fact that around 50% of curricula in 6 year- KM school comprise biomedical subjects (Hyun-ji Lee, 2008), many KM doctors seem to believe that they can judge the situation by themselves or with help from biomedical doctors, in terms of when or whether their patients need biomedical inspection and additional biomedical treatments. I found this during the interviews with KM doctors within the field research. More details on the issue of KM doctors’ biomedical knowledge will be discussed in Chapter V.3.2.

and a corresponding increase in chronic diseases (Ji-seon Ryu et al. 2009: 30), originating from the increase of aging population (Min, Ryu, & Yun, 2012: 16). Meanwhile, small- and medium-scale private biomedical hospitals have begun to pay attention to the concept of the WKCT as a marketing strategy to patients in order to raise further revenue for the hospitals. On the other hand, the South Korean Government tried to find a way to integrate the medical system between biomedicine and KM as an effective remedy against continuously increasing health-care costs and discord among biomedical- and KM doctors (Jae-kook Cho, 2010: 4). In response, more KM doctors have started to positively participate in the debates concerning the integration of medical system, considering the WKCT as the first step of the integration process with biomedical sector, although the majority of KM doctors still remain skeptical about this issue.<sup>161</sup> For instance, at a policy gathering for the integration of medical system in 2009 hosted by Hong-jun Ahn (2009), member of The National Assembly and biomedical doctor, professor Byung-mook Lim (KM doctor) of Pusan National University School of Korean Medicine agreed with a general plan for the medical integration raised by the KMA in 2002 (Research Institute for Healthcare Policy, 2002), namely that biomedical doctors participate in the cooperative treatment with KM doctors in hospitals as the first step for the integration with KM.<sup>162</sup>

To summarize, the concept of the WKCT mainly originated from KM doctors who were

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<sup>161</sup> This changed standpoint of KM doctors concerning the integration with biomedicine appears in the survey research by Chung-yeon Hwang et al. (2007: 35), within which; 61.8% of KM doctors came out in favor of the integration of medical system with biomedicine, with those who work with biomedical doctors in WKCT hospitals being particularly more in favor of it than those who only work with KM doctors. However, the AKOM officially denies that the issue of medical integration with biomedicine has not been discussed as an official agenda in the association thus far (Eun-ju Shin, 2013). Apart from that, as an unrevealed reason for the increase in KM doctors' growing interest in the issue of medical integration, some biomedical doctors indicate a reduced profit of KM hospitals since the beginning of the 2000s due to the decrease usage of herbal medicines exclusively prescribed by KM doctors, resulting from the development of various health functional foods such as red ginseng and biomedical impotency drugs such as Viagra (Tae-kwon Jeong, 2010).

<sup>162</sup> Of the suggestions raised by groups of biomedical doctors, this plan is the most amicable towards KM doctors. There are still more hostile suggestions against KM for the integration; e.g. immediate abrogation of the KM license, merger of KM schools into biomedical schools, etc. without considering the WKCT as a process for the integration (Jae-kook Cho, 2010). It reflects that there is no monolithic standpoint concerning the way of integration both between and within groups, along with the result of Chung-yeon Hwang's research on KM doctors (2007: 35); one third of KM doctors are still against the plan of the integration with the biomedical sector. Hyun-ju Min et al.'s systemic literature research based on academic literature published between 1997 and 2009 (2012: 28) also argues that biomedical doctors' positive attitudes toward the WKCT declined during this period despite their increased awareness of it.

against the idea of medical integration raised by biomedical doctors during the period in which KM was newly accepted by the state, although the professionalization was yet to have been fully achieved. However, as KM doctors gradually stood on more equal footing with biomedical doctors during the 1980s and the 1990s thanks to the professionalization process of KM and increased demands on KM treatment, the concept of the WKCT also began to be discussed within the frame of issues of medical integration – which has been continuously raised by biomedical doctors – as the first step in the integration process.

### 3.3 Legal Regulations on the WKCT

According to the MSA from 1951 to 2009,<sup>163</sup> there was no legal provision for the term WKCT. Biomedical doctors were only allowed to work in biomedical hospitals, and KM doctors only in KM hospitals, with biomedical doctors not allowed to hire any KM doctors in their hospitals, and vice versa. Accordingly, the WKCT was managed in an unofficial manner over a number of decades (Yoon-hyeon Lee, 2000: 86). Yoon-hyeon Lee (ibid. 95) mentions the two most typical types of the WKCT hospitals in this era, the first of which is that a KM hospital additionally establishes an affiliated private biomedical practice in the same place, in order for KM doctors to more easily access the results of biomedical diagnoses of their patients within their workplace, such as blood test results and X-ray inspections. The second type is that a biomedical hospital launches an affiliated KM private practice in their hospital building, in order to offer more varied medical services and attract more patients to the hospital.

Following discussions on medical integration among the state, KM- and biomedical sectors during the 2000s, the MSA was revised in January 2009 before taking effect in January 2010,<sup>164</sup> finding grounds to support the legal basis for the WKCT. According to Article 43 of the MSA revised in 2009, general hospitals, hospitals, and dental hospitals<sup>165</sup> can retain KM doctors and establish KM departments in their hospitals, while KM hospitals can hire

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<sup>163</sup> Including the National Medical Service Act (1951 – 1962).

<sup>164</sup> Act No. 9386.

<sup>165</sup> According to the MSA (Article 3, Section 3 and 4), ‘general hospitals’ (*Jonghap Byeongwon*, biomedical sector) should have more than 100 beds, and ‘hospitals’ (*Byeongwon*, biomedical sector), ‘dental hospitals’ (*Chigwa Byeongwon*) and ‘KM hospitals’ (*Hanbang Byeongwon*) should have more than 30 beds.

biomedical doctors and establish biomedical departments in their own hospitals. According to Article 41 of the revised enforcement regulation in the MSA,<sup>166</sup> general hospitals can establish all the departments of KM, while hospitals (biomedicine) can establish the departments of KM internal medicine, constitutional medicine, and acupuncture and moxibustion. Additionally, they can also manage other departments of KM clinics which can cooperate with existing biomedical departments (e.g. the department of KM gynecology can be opened if there is a department of obstetrics and gynecology in their hospital). KM hospitals can establish the biomedical departments of internal medicine, family medicine, and anesthesiology and pain clinic, and if the KM hospitals manage one or more biomedical department, they can additionally establish the biomedical department of radiology and laboratory medicine.<sup>167</sup> Moreover, similar to the case of biomedical hospitals, KM hospitals can also open up other biomedical departments which can cooperate with existing KM departments (e.g. biomedical pediatric department can be established in KM hospitals if there is a KM pediatric department). Dental hospitals can manage the department of KM internal medicine and acupuncture/Moxibustion, and if they have a department of pedodontics, they can also establish the KM pediatric department, while biomedical- and KM hospitals can establish the department of oral medicine and pedodontics (if they have either a biomedical- or KM pediatric department). Owing to this reform, the WKCT, which used to be unofficially managed, could run in a more stable way with a legal basis, particularly promoting more biomedical hospitals take part in the WKCT, whereas biomedical hospitals used to be less in favor of the WKCT, prior to the revision of the MSA (M. Sohn & W. Lee, 2010).<sup>168</sup>

In terms of the regulations of the National Health Insurance Service (NHIS) related to the WKCT, a ‘medical consultation fee’ (*Hyeopui Jinchalryo*), an additional fee for diagnoses and treatments for the same disease of inpatients by non-attending physicians (Health

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<sup>166</sup> Enforcement Decree of the Medical Service Act (*Uiryobeop Sihaeng Gyuchick*), Enacted on 14 Apr. 1962 (Presidential Decree No. 659), Revised on 15 Mar. 2010 (Presidential Decree No. 22075).

<sup>167</sup> This regulation seems to have established that the KM hospitals should not only set the department of radiology or laboratory medicine, in order that they can obtain the minimum information of biomedical diagnoses for their KM treatment without actual cooperation with other biomedical sectors.

<sup>168</sup> According to Sohn and Lee’s survey (2010: 13), the numbers of biomedical hospitals taking part in the WKCT dramatically increased between 2009 and 2010; before the enforcement of the revision of the MSA in 2009, only 8 (16%) out of 50 respondent hospitals claiming to implement the WKCT were biomedical hospitals, compared to 38 (61.3%) out of 62 after the enforcement of the revision.



Insurance Review and Assessment Service, 2012: 406), can only be claimed to NHIS once a month (Sohn and Lee, 2010: 154).<sup>169</sup> For this reason, most of the WKCT's healthcare costs are charged separately by the KM and biomedical sector, when the patients are managed by the WKCT more than once a month. According to the administrative interpretation of the Ministry of Health and Welfare on 'application criteria for medical care expenses by the concurrent treatment of biomedicine and KM,'<sup>170</sup> in the case of patients who are treated by biomedical and KM department for an identical disease within a single medical corporation in one day, the medical cost for the first treatment done by either biomedical- or KM doctors is covered by the NHI, but all (outpatients) or about half (inpatients) of the costs for the second treatment undertaken by the counterpart of the first treatment is defrayed by the patients. It implies that the WKCT is considered as a kind of parallel treatment or overtreatment in terms of the NHI policy by the state on the one hand. On the other hand, the WKCT is considered as a selective and expensive treatment by patients and physicians because the patients should accept additional expenses resulting from the WKCT, which consequently overburdens the patients with medical costs, compared to the treatments exclusively conducted by either biomedical- or KM sector.

### 3.4 Current Features of the WKCT<sup>171</sup>

Until the 1980s, the WKCT was usually implemented in university hospitals where both biomedical- and KM schools were established, starting with Kyung-Hee University Medical Center in Seoul (comprising two different medical corporations: Kyung-Hee Hospital and

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<sup>169</sup> A 'Medical Consultation Fee' was introduced in NHI in 2000, in order to control the consultation process between medical departments in hospitals mainly within each medical sector (i.e. either between biomedical doctors or between KM doctors in different departments). Since it was legally admitted in 2010 that the WKCT was possible within a single medical corporation as a result of the revision of the MSA, there have been discussions concerning the increase in the frequency of the allowance for the consultation fee more than once a month per patient among KM and biomedical doctors, NHIS, and Health Insurance Review and Assessment Service, but it remains unchanged at present due to the failure of the multilateral agreement; while the association of KM hospitals was more in favor of the increased frequency to once a week, the association of biomedical hospitals did not want to change it, or was even rather skeptical about the WKCT itself (M. Sohn & W. Lee, 2010: 165).

<sup>170</sup> Ministry of Health and Welfare, Authoritative Administration. *Geupyeo* 65720-1901, 31 Dec. 2001.

<sup>171</sup> There has been no complete survey on the WKCT hospitals nationwide. All the statistical results in this chapter are based on the survey respondents of each research (e.g. Dong-yun Seo, 2000; Dong-yun Seo et al. 2001; Kye-hyun Kim, 2004; M. Sohn & W. Lee, 2010, et al.).

Kyung-Hee KM hospital) in 1971 (Kye-hyun Kim, 2004: 4), followed by Wonkwang University Hospital in Jeonbuk in 1984 and Dongguk University Hospital in Kyeongbuk in 1988.<sup>172</sup> In 1989, 11 out of 18 KM hospitals (61.1%) nationwide were involved with the WKCT, whereas in 1998, 78 out of 111 KM hospitals (70.3%) and in 1999, 93 out of 122 KM hospitals (76.2%) identified themselves as WKCT hospitals (Dong-yun Seo, 2000: 12-13). According to Dong-yun Seo's survey research investigated in 1999 (2002), 65 WKCT hospitals out of 90 hospitals (70%) answered were KM-based hospitals and 25 (30%) were biomedicine-based hospitals, most of which were launched after 1997.<sup>173</sup> This corresponds with the fact mentioned in the previous chapter that the concept of the WKCT was the idea of KM doctors against the discussions raised by biomedical doctors concerning the integration of the medical system. Kye-hyun Kim's survey (2004) reported that 106 out of 150 KM hospitals (70.6%) conducted the WKCT in 2003.

Sohn and Lee's research report to the Ministry of Health and Welfare on hospitals participating in the WKCT (2010), mainly based upon questionnaire survey analysis, explains various aspects of the WKCT in the current situation, following the revision of the MSA in 2009 further detail. According to this report, 15 biomedical institutions (7 general hospitals and 8 hospitals) newly took part in the WKCT in 2009, although after the revision of the MSA in 2009, 44 biomedical institutions (6 general hospitals and 38 hospitals) were newly reported to conduct the WKCT in 2010. Therefore, around 3 times as many biomedical hospitals were newly involved in the WKCT in 2010, compared to 2009. Sohn and Lee (ibid. 13) indicate that the revision of the MSA enabled more biomedical hospitals to take part in the WKCT, establishing new KM departments in their hospitals.

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<sup>172</sup> From: Young-ju Yun, 2005: 1;

Homepage of Kyung-Hee University Medical Center, <http://www.khmc.or.kr/eng/>; Wonkwang University Hospital, <http://www.wkuh.org/language/English/index.asp>; Dongguk University School of Medicine, [http://med.dongguk.ac.kr/index\\_c.php](http://med.dongguk.ac.kr/index_c.php); Dongguk University School of Korean Medicine, <http://site.dongguk.ac.kr/wiz/user/orient/> (all retrieved 27 May 2016).

<sup>173</sup> During this era (prior to 2010), it was not allowed that biomedical- and KM doctors could work together within a single medical institution. In this context, WKCT hospital means that either two different medical corporations coexist in the same building or in two neighboring places, or that a single medical corporation runs two different medical institutions (one for biomedicine and the other for KM). The most typical form of the WKCT hospital in this era was KM hospitals with over 30 beds coexisting with a private biomedical practice with one single biomedical doctor, in order that KM doctors can easily access the results of biomedical diagnoses through biomedical doctors in their hospital (Dong-yun Seo, *ibid.*).

Concerning the newly established departments for the WKCT in biomedical hospitals in 2010, the department of General Korean Medicine was newly launched the most (33.3%), followed by the department of KM internal medicine (30.3%), acupuncture and moxibustion (21.2%), and KM rehabilitation medicine (15.2%), while the department of family medicine was the most newly launched biomedical department in KM hospitals (37.5%), followed by internal medicine (31.3%), neurology (18.8%), radiology (18.8%), and rehabilitation medicine (12.5%, *ibid.* 16). Major diseases managed by the WKCT are musculoskeletal diseases (69.4%, plural responses), gastrointestinal diseases (51.6%), and neurologic diseases (37.1%), and it was reported that there were no significant differences between biomedical- and KM hospitals managing the WKCT (M. Sohn & W. Lee, 2010: 17). However, previous survey has indicated different results concerning this issue; according to Dong-yun Seo (2000), there are slight differences in the rankings of the main diseases among KM hospitals managing- and not managing the WKCT, as well as biomedical hospitals conducting the WKCT. In those KM hospitals without cooperation with biomedical doctors, the most frequently reported disease of their patients was musculoskeletal disorders (34.6%), followed by back pain (27.3%) and CVA (18.2%). In the case of KM hospitals managing the WKCT, CVA (37.5%) was the most common disease; ahead of back pain (27.3%) and CVA (18.2%). The most common disease of patients in biomedical hospitals managing the WKCT was musculoskeletal disorders, followed by CVA and hypertension disorders (Dong-yun Seo, *ibid.*).<sup>174</sup>

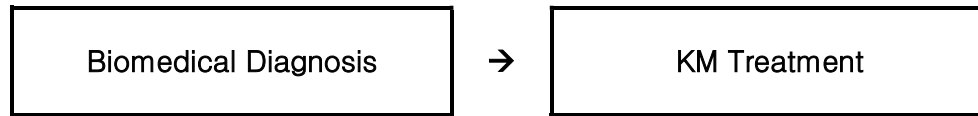
In terms of the patterns of the WKCT process, Jae-kook Cho et al. (1999: 65-68) categorized 5 possible models of cooperative treatments of KM with biomedicine based on sequential procedures from diagnosis to treatment: 1) KM treatment supported by biomedical diagnosis; 2) biomedical treatment supported by KM treatment; 3) primary biomedical treatment followed by additional secondary KM Treatment after cooperative biomedical- and KM diagnoses; 4) primary KM Treatment followed by additional secondary biomedical treatment after cooperative biomedical- and KM diagnoses; and 5) simultaneous cooperative treatment

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<sup>174</sup> If I draw an inference from this data for the context of these differences, KM doctors require a biomedical doctor's help, namely their prescription of biomedical medication especially for acute patients, which involves KM hospitals conducting the WKCT having more CVA patients than those working without biomedical doctors. By comparison, biomedical hospitals conducting the WKCT try to attract patients with musculoskeletal diseases to their hospitals through prescribing acupuncture or moxibustion, which are generally well known to the public in South Korea as very effective treatments for pain control and the recovery of patients.

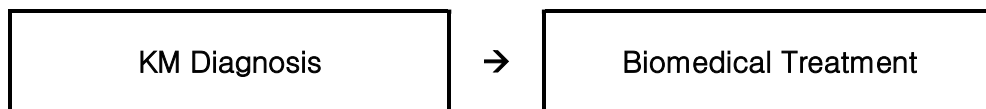
of biomedicine and KM after cooperative biomedical- and KM diagnoses.

Figure IV.4 WKCT Model 1: KM Treatment Supported by Biomedical Diagnosis



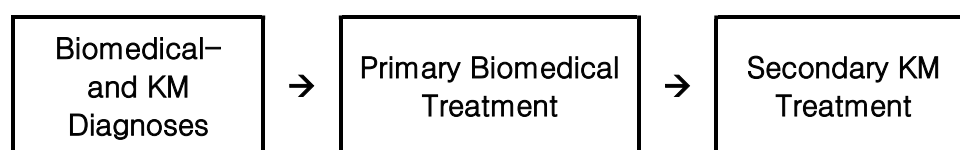
The first model is a combination of biomedical diagnosis and KM treatment, and is considered the most realistic and commonly seen type of the WKCT (ibid. 65) in KM hospitals working with a small number of biomedical doctors. This was the typical way of establishing WKCT hospitals by KM doctors in order to attract patients with more varying types and phases of the diseases before the revision of the medical law in 2009. As a drawback of this model, Jae-kook Cho (ibid.) indicates that it could often be difficult for the KM doctors to maintain their own KM principles from the beginning of the medical management process.

Figure IV.5 WKCT Model 2: Biomedical Treatment Supported by KM Treatment



In the second model, KM doctors are only in charge of diagnosis, with treatment conducted by biomedical doctors. However, this type of cooperative treatment is rarely observed in clinical level in reality; in the case of biomedical hospitals hiring a small number of KM doctors, biomedical doctors would not leave diagnoses entirely to the hands of KM doctors. By contrast, in KM hospitals conducting the WKCT with biomedical doctors, KM doctors would be involved in the treatment process in any sense, based on the result of KM diagnosis.

Figure IV.6 WKCT Model 3: Primary Biomedical Treatment Followed by Additional Secondary KM Treatment after Cooperative Biomedical and KM diagnosis



This type of cooperation comprises the concurrent diagnoses of biomedicine and KM,

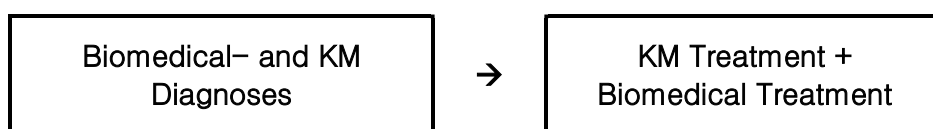
followed by the primary biomedical treatment and the secondary KM treatment. According to Jae-kook Cho (ibid.), this type originated from Japan, where biomedical doctors can freely prescribe traditional herbal medicine and acupuncture, given that there is no such traditional doctor equally entitled as biomedical doctors as in South Korea. Accordingly, biomedical doctors are confident to use herbal medicine through their own clinical experience and accumulated knowledge. In the case of South Korea, this model can be usually seen in KM hospitals actively involved with the WKCT (ibid. 66). The degree of cooperation in this type is evidently higher than the first model, given that both sectors take part in the process of diagnosis and treatment. However, each sector is separately involved in the process of treatment. For this reason, this type should be more precisely termed as a “sequential or parallel treatment,” rather than an “actual cooperative treatment” (ibid.).

Figure IV.7 WKCT Model 4: Primary KM Treatment Followed by Additional Secondary Biomedical Treatment after Cooperative Biomedical and KM diagnoses



This model is similar to the third model, aside from the fact that KM treatment precedes biomedical treatment. Yong-nam Kim (2001) mentions that this type of cooperative treatment can often be seen in China, when Traditional Chinese Medicine (TCM) doctors manage patients as their chief medical attendants, working with biomedical doctors for diagnostic information and additional treatments.

Figure IV.8 WKCT Model 5: Simultaneous Cooperative Treatment of Biomedicine and KM after Cooperative Biomedical and KM diagnoses



In this model, KM and biomedical doctors are simultaneously involved in both diagnoses and treatments, which are based upon their mutual agreement. This model shows the highest level of cooperation, corresponding to Barron and White’s concept of co-management (2009: 192),

mentioned in Chapter IV.3.1. This model is usually considered by most KM doctors to be a goal for the WKCT (Dong-huei Lee, 1998: 80). All of these five patterns illustrated above do not reflect what is actually observed in clinical settings in South Korea, but theoretically possible patterns of cooperative treatment. With this regard, further research is needed to examine how the WKCT is conducted in the field.

In Chapter IV.3, I introduced the definition and historical development of the WKCT, followed by its legal basis with its current features. The WKCT is understood as ‘sending their patients for additional diagnosis or treatment’ between KM and biomedical doctors (referral) or ‘consulting the counterpart about their patients’ (consultation) in actual clinical settings, rather than KM and biomedical doctors’ ‘actual communication and cooperation for their patients’ (co-management, Barron & White, 2009). The concept of the WKCT was developed originally by KM doctors for inpatient management in KM hospitals in 1970s. However, this concept has been partly accepted to biomedical doctors who are interested in applying traditional treatments to their patients since 1990s, with growing interest in chronic- and geriatric diseases. As a result of discussions among KM-, biomedical doctors and the South Korean government concerning the integration of medical system over the 2000s, it was allowed for both KM and biomedical doctors to work in a single hospital organization through the revision of medical law in 2009, which officially blazed the way for the WKCT. However, with regard to the policy of NHIS, the WKCT is still considered as a kind of overtreatment, in which patients should shoulder the extra cost involved. In Part V ‘Case study,’ I will introduce four cases of the WKCT hospitals from my own field research to examine the relationship between KM and biomedical doctors during the diagnosis and treatment in various types of the WKCT hospitals within the frame of medical pluralism.

#### 4. Summary of Part IV

As a historical and structural background towards understanding the relationship between KM and biomedical doctors in WKCT hospitals, Part IV summarized the historical development and current features of the South Korean medical system before examining the findings of the fieldwork in Part V. After briefly introducing the main characteristics of traditional Korean medicine as an indigenous medicine developed under the influence of geographic, climatic, and socio-cultural environments as well as part of East Asian medicine – which shares medical principles originated from ancient China – Chapter IV.1 illustrated the historical process of the dualized professional medical system in South Korea through examining the settling-down process of biomedicine, from the period of its inflow into the Korean peninsula by the Western imperial powers in the late 19th century through the colonization process in the Japanese colonial period in the first half of the 20th century to the post-colonial period (1945-). Moreover, it also examined the degradation and survival of traditional medicine in the colonial period and its reinstatement as KM as a professional form of traditional medicine in consequence of its modernization process in the colonial and post-colonial era in South Korea.

Chapter IV.2 presented the current features of the KM and biomedical sector in the South Korean medical system. As of the 2010s, the biomedical sector comprises over 70 percent of the entire professional sector in terms of the numbers of physicians, hospital organizations and medical schools. However, the KM sector also plays an important role in the professional medical sector as a fully professionalized and institutionalized form of medicine on an equal footing with the biomedical sector in terms of the legal and socio-economic status of KM doctors and the superior standards of KM schools and students. Concerning the medical jurisdiction of KM and biomedical doctors, the state strictly separates their medical areas through the MSA: it is considered as an illegal unlicensed medical action in case they apply any medical treatment or inspection that belongs to the area of their counterpart. However, due to the lack of the concrete legal regulations on certain therapies or diagnostic inspections – together with the collaborative trends of biomedicine with CAM, and the modernization of TM – there have recently been increasing conflicts between KM and biomedical doctors concerning the application of certain medical actions, as exemplified in the debates on the

usage of IMS, pharmacopuncture therapy and modern diagnostic equipment.

Chapter IV.3 summarized the definition, historical development, legal regulations and current features of the WKCT and WKCT hospitals. First, contrary to expectations based upon the term ‘cooperative’ treatment, the WKCT is widely understood by those who are familiar with the situations in WKCT hospitals – through working experience or through research – as follows: “a simultaneous medical treatment in which inpatients are treated by KM and biomedical doctors on a certain disease in one hospital” (Yang-kyu Lee, 2002: 5). A WKCT hospital – which is not a legally defined form of hospital institution by the MSA – has been widely understood as a hospital where KM and biomedical doctors are mutually involved with the patient management in the same hospital buildings or neighboring buildings, within a single medical institution (since 2010 with the revision of the MSA in 2009) or between neighboring medical institutions. The concept of the WKCT was raised in the 1970s by KM doctors who were against biomedical doctors’ argument for the integration of the South Korean medical system, while they blamed the biomedical doctors’ such argument as an unequal merger of KM into biomedicine. Rather than the ‘integration,’ they urged the WKCT, cooperative medical action between KM and biomedical doctors in equal position, in the context of the 1970s when hospital-level medical institutions of KM were first established and thus KM doctors were in need of biomedical doctors’ clinical help for inpatient management. Since the 1990s, the term ‘WKCT’ has also become widely used amongst biomedical doctors interested in KM therapies for chronic patient management, with increasing numbers of biomedical hospitals launching an additional KM clinic within their hospital complex to conduct the WKCT. Together with the South Korean government’s interest in the WKCT as the first step towards the integration of the medical system, the WKCT was widely discussed by the state, KM doctors and biomedical doctors during the 2000s. As a result, together with the revision of the MSA in 2009 that newly allowed KM and biomedical doctors work in the same hospital corporations, WKCT hospitals have rapidly increased in number from the late-2000s until now. However, concerning the NHI policy, the WKCT is still considered a kind of ‘overtreatment’ given that it does not fully cover the expenses of inspections and treatments conducted through the WKCT, which has a negative effect on promoting the WKCT in clinical settings.



## **V. Case Study: The Implementation of a Medical Pluralism in Hospital Settings in South Korea**

Part V – the main part of this study – examines the findings of the fieldwork conducted in four WKCT hospitals in Busan based upon qualitative interviews with KM and biomedical doctors as well as hospital administrators in each hospital. In Chapter V.1, I will introduce general information about each hospital – including the year of establishment, institutional structure and the size of the hospitals (number of physicians and hospital beds) – before analyzing the detailed process of the WKCT and the relationship between KM and biomedical doctors in each hospital in earnest. In Chapter V.2, I will reconstitute the concrete process of the WKCT in each hospital, dividing the process into KM doctors' WKCT requests to biomedical doctors and biomedical doctors' requests to KM doctors. Thereafter, I will examine the ways of contact and communication between KM and biomedical doctors, and external factors – patients, hospital administrators, and the government policy and regulations related to the WKCT – that influence the KM and biomedical doctors' decisions in the process of the WKCT. In chapter V.3, based upon the findings described in Chapter V.2, I will analyze the relationship between KM and biomedical doctors in the clinical practices when they are mutually involved with the process of the WKCT in clinical practices. In this chapter, I will examine the various aspects of their asymmetrical relations discovered in the fieldwork, comparing the previous research on the debates concerning biomedical dominance in the issue of medical pluralism. In this analysis, I will devote particular attention to KM doctors' biomedical knowledge and their ways of adaptation in the circumstances of the WKCT hospital settings.

## 1. Overviews and Organizational Features of Hospital Settings in Busan<sup>175</sup>

### 1.1 ‘A’ Hospital (A Medium-Scale KM-Oriented Hospital)

Figure V.1 The Front View of ‘A’ Hospital<sup>176</sup>



<sup>175</sup> Information in this chapter is mainly based upon interviews with persons in charge of hospital administration in each hospital (ID of the interviewees: AA1, BA1, CA1, and DA1). Some specific data from other documents will be addressed with their source. The number of hospital beds and physicians are as of the year of fieldwork (‘A,’ ‘B,’ ‘C’ hospital: 2011, ‘D’ hospital: 2012).

<sup>176</sup> Photo taken on 4 Nov. 2015. The name of the hospital is obscured from the original picture.

Table V.1 A Brief Overview of ‘A’ Hospital

<b>Year of Establishment</b>	<b>1999 (A private KM clinic launched in 1969 was reopened as a KM hospital with a biomedical clinic)</b>
<b>Institutional Structure of Hospital</b>	<b>‘A’ KM hospital with ‘A’ biomedical clinic in the same building, owned by a KM doctor</b> Trainee hospital for KM doctors (Since 2000)
<b>Number of Hospital Beds</b>	KM: 75 Biomedicine: 0
<b>Number of Physicians</b>	<b>KM doctors: 12</b> (staff: 6, intern: 2, residents: 4. KM internal medicine, KM gynecology, KM rehabilitation medicine, acupuncture and moxibustion). <b>Biomedical doctor: 1</b> (internal medicine)

‘A’ hospital is located in the northern tip of Busan, near a middle-class residential area of the city. It is a medium-scale KM hospital combined with a biomedical clinic in the same building owned by a KM doctor, who opened this hospital in 1999 with his son (KM doctor), expanding his own KM clinic, which originated in Busan in 1969. As introduced in Chapter IV.3.3, this is the most common type of the WKCT hospital, where a majority of KM doctors work with one or a few biomedical doctors for the WKCT.<sup>177</sup> Despite the revision of the MSA in 2009, which allowed a KM hospital to launch biomedical departments and hire biomedical doctors from the next year, the biomedical clinic remained separate from the KM hospital.<sup>178</sup> Although the biomedical clinic is registered as an independent medial institution

<sup>177</sup> Biomedical doctors in this type of the WKCT hospital are the director of the biomedical clinic, separated from the KM hospital in the same building on paper. In most cases, however, they are hired and paid by KM hospitals in reality.

<sup>178</sup> According to the interview with the head of the Hospital Administration Department (AA1), there are two main reasons why the existing biomedical clinic remained separate without consolidating with the KM hospital. First, newly revised regulation on the establishment and management of medical equipment does not allow a KM hospital hiring biomedical doctors under 100 beds to have a facility for CT scanning. However, it grants exceptions for hospitals under 100 beds that already owned it before the enforcement of this regulation.

on a legal basis, this clinic should be considered practically as a part of the KM hospital, given that the director of the clinic (biomedical doctor) is engaged in biomedical diagnosis and treatment of patients of KM doctors in the same building as a routine, under the support and mediation of hospital administration department of the KM hospital.

Table V.2 Floor Information of ‘A’ Hospital<sup>179</sup>

Floor	Description
6 <sup>th</sup> - and 7 <sup>th</sup> floor	Ward
5 <sup>th</sup> floor	KM doctor’s night duty room, ward
4 <sup>th</sup> floor	Ward
3 <sup>th</sup> floor	Nurse’s room, ward
2 <sup>nd</sup> floor	<b>Rooms for head of KM internal medicine, gynecology, room for physical therapy, test room (X-ray and CT)</b>
1 <sup>st</sup> floor:	<b>Room for KM hospital director, head of KM Rehabilitation medicine, Acupuncture and Moxibustion, director of the biomedical clinic, anathomopathology, administration</b>
Basement	Room for Pharmacology, equipment room

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Therefore, in order to maintain this facility, it was not possible to merge the biomedical clinic with the KM hospital. Secondly, if the existing biomedical doctor, the director of the separated biomedical clinic works inside the KM hospital as a head of biomedical department, he can only cover the treatment of his specialty (e.g. internal medicine in the case of the interviewee AB1), while he used to manage all kinds of diseases as a general practitioner beyond his specialty as the biomedical clinic was not integrated into the KM hospital. For this reason, the director of the KM hospital decided not to merge the biomedical clinic into the KM hospital to avoid restricting the role of the biomedical doctor in his hospital (From: Interview with AA1).

<sup>179</sup> Retrieved 1 Feb. 2014 from Internet homepage of ‘A’ hospital.

In this hospital, KM and biomedical doctors have their own outpatients. However, KM doctors are in charge of all the inpatients, while the biomedical doctor only participates in their management through acceding to the request on the consultation/referral from KM doctors. Nevertheless, the biomedical doctor regularly makes his or her rounds for KM doctors' inpatients in the ward. In the case of WKCT requests for inpatients in the ward, KM doctors usually visit the biomedical doctor's office on the first floor for any biomedical test for diagnoses, or biomedical treatments. Concerning equipment for biomedical diagnosis, this hospital provides facilities for X-ray and CT thanks to the existence of the biomedical doctor. When it is necessary to have more accurate reading of the results, the original films of x-rays and CT are sent to a neighboring clinic of radiology as a form of external consultation. In terms of the storage of medical records, this hospital has separate paper-based KM and biomedical records. However, both KM and biomedical records are stored together, bound as a single file for each patient in the Department of Hospital Administration (for outpatients and discharged inpatients) or the nurse's room in the ward (for inpatients).

Open-ended interviews in 'A' hospital were conducted with four KM doctors (AK1, AK2, AK3, AK4) and the director of the biomedical clinic (biomedical doctor, AB1) between February and May in 2011. An additional interview was carried out with the head of hospital administration (AA1) in June 2011 to obtain general information about this hospital and the role of the hospital administration concerning the WKCT process between KM and biomedical doctors.

## 1.2 ‘B’ Hospital (A Large-Scale KM-Oriented Hospital)

Figure V.2 The Front View of ‘B’ Hospital (Main building)<sup>180</sup>



Table V.3 Brief Overview of ‘B’ Hospital

<b>Year of Establishment</b>	<b>Establishment of the Hospital: 1990</b> (Premedical school for KM was opened in the faculty of Natural Science in 1987, followed by the establishment of KM school as an independent faculty in 1989) <sup>181</sup>
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<sup>180</sup> Photo taken on 10 Mar. 2011. The name of the hospital is obscured from the original picture.

<sup>181</sup> Retrieved 2 Feb. 2014 from Internet Homepage of ‘B’ University.

<b>Institutional Structure of Hospital</b>	<b>‘B’ University KM Hospital and ‘B’ Biomedical Hospital in the same building complex under the integrated name, ‘B’ Medical Center</b> , owned by the school corporation of ‘B’ University (private university) Trainee hospital for KM and biomedical doctors
<b>Number of Hospital Beds</b>	<b>KM: 139</b> <b>Biomedicine: 453</b>
<b>Number of Physicians<sup>182</sup></b>	<b>KM: 54</b> (staff: 17, intern and resident: 37) <b>Biomedical Doctors: 82</b> (staff: 53, intern and resident: 29)

‘B’ hospital is located in the central part of Busan, fairly close to a new downtown of the city with relatively good transportation city-wide. This hospital is combined with a private university hospital of KM as the first KM hospital launched in Busan, as well as a biomedical general hospital in the same building complex, under the integrated name of ‘B Medical Center,’ which is the widely-known name of this hospital to the public. It is owned by the school corporation of ‘B’ University, in which there is a school of KM, the oldest KM school in Busan. In this regard, ‘B’ hospital is widely known as one of the best known KM hospitals in this city. In addition, most of the heads of KM departments in this hospital are simultaneously professors of the KM school, while biomedical doctors only work as clinical practitioners, most of whom are usually changed much more often than KM doctors. For this reason, ‘B’ hospital is usually considered as a KM-oriented hospital despite the fact that there are more hospital beds in biomedical wards with more biomedical physicians than the counterpart. However, according to BA1, the biomedical sector brings more financial profits with more patients than the KM sector, as the actual size of the biomedical sector is larger than that of KM regarding the number of hospital beds and physicians.

In comparison with ‘A’ hospital, both KM and biomedical doctors have their own inpatients in ‘B’ hospital with separate wards for KM and biomedicine, whereas only KM doctors are mainly in charge of all the inpatients in ‘A’ hospital. In terms of the management of the emergency department, both KM and biomedical doctors share a single emergency room,

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<sup>182</sup> As of March 2014. From: Telephone interview with a person in charge of the hospital administration department in ‘B’ hospital, 24 March 2014.

while patients are allocated to either the KM or biomedical sector by hospital coordinators according to the type and severity of illness, with the agreement of the patients or their families. The department of hospital administration covers both the KM and biomedical sector to support and regulate them. This is significantly different from the situation in ‘D’ hospital, where each sector has its own administration department. Regarding the usage and storage of medical records, each sector had paper-based medical records stored separately in each ward, until an integrated EMR system was newly introduced in 2007.

Table V.4 Floor Information of ‘B’ Hospital (Main Building)<sup>183</sup>

Floor	Description
10 <sup>th</sup> Floor	<b>KM ward</b> , Room for moxibustion (KM), Room for KM test and diagnosis
9 <sup>th</sup> Floor	<b>KM ward</b>
8 <sup>th</sup> Floor	<b>Biomedical ward</b>
7 <sup>th</sup> Floor	<b>Biomedical ward</b> , operation room, delivery room, recovery room, newborn infant room,
6 <sup>th</sup> Floor	<b>Biomedical ward, biomedical hospital director room, KM hospital director room</b> , nursing division, department of hospital administration,
5 <sup>th</sup> Floor	<b>Biomedical ward</b> , waiting room for intensive care
4 <sup>th</sup> Floor	<b>Biomedical ward</b> , intensive care unit, health promotion center, general medical checkup office, library
3 <sup>rd</sup> Floor	<b>Biomedical care room for outpatients</b> , central test room, receipt for outpatient, social service room, medical treatment support center
2 <sup>nd</sup> Floor	<b>KM care room for outpatients</b> , rehabilitation center, radiology division, emergency medicine, receipt for emergency room, receipt for outpatient
1 <sup>st</sup> Floor	<b>Customer support team for biomedicine, customer support team for KM, consulting room for the WKCT</b> , KM pharmacy, biomedical pharmacy, treatment room for foreigner, injection room
Basement	Restaurant, nutrition care service, electric generation room, medical information room

<sup>183</sup> Retrieved 2 Feb. 2014 from Internet Homepage of ‘B’ hospital.



'B' hospital was selected for fieldwork as a large-scale WKCT hospital to compare the situation in 'A' hospital with a larger hospital institution, because I noticed during the first few interviews in 'A' hospital that the intensity of communication between both sectors could depend on the size of the hospital. During the fieldwork in 'B' hospital, I conducted interviews with two biomedical doctors (BB1, BB2), four KM doctors (BK1, BK2, BK3, BK4) and a hospital administrator (BA1), mostly from March 2011 to July 2011,<sup>184</sup> to ascertain the relationship between KM and biomedical doctors during the process of the WKCT.

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<sup>184</sup> The interview with BK1 was conducted prior to the others as a pilot study in October 2010.

### 1.3 ‘C’ Hospital (A Medium-Scale Biomedicine-Oriented Hospital)

Figure V.3 The Front View of ‘C’ Hospital<sup>185</sup>



Table V.5 Brief Overview of ‘C’ Hospital

<b>Year of Establishment</b>	<b>Establishment: 1996 in Changwon<sup>186</sup></b> <b>(Moved to Busan in 2000)</b> <b>KM department was abolished in July 2011</b> <b>Closure of the hospital in February 2012</b>
<b>Institutional Structure of Hospital</b>	<b>1996 – 2009: A biomedical hospital with a KM clinic</b> <b>2010 – 2011: A biomedical hospital with the department of KM</b> (The KM clinic was legally integrated into the biomedical hospital as a single department in the hospital) Privately owned by a former pharmacist
<b>Number of Hospital Beds</b>	100 (Mostly in charge of biomedical doctors)
<b>Number of Physicians</b>	<b>KM doctors: 2</b> (KM internal medicine, KM pediatrics, KM gynecology, KM ENT, <sup>187</sup> acupuncture and moxibustion) <b>Biomedical doctors: 7</b> (internal medicine, neurology, orthopedics, and rehabilitation medicine)

<sup>185</sup> Photo taken on 28 Feb. 2011.

<sup>186</sup> A city approximately 50km away to the west of Busan.

<sup>187</sup> Ear, nose, and Throat.

‘C’ hospital is located in the northwestern part of Busan, in a new town of the city mostly inhabited by middle-classes persons residing in newly constructed apartment complexes, which were first constructed in the early-2000s. This hospital used to comprise a medium-scale biomedical hospital and a KM clinic (separate from the biomedical hospital on a legal basis) in the same building, diametrically opposite to the ‘A’ hospital, combined with a KM hospital and a biomedical clinic. Since the revision of the MSA in 2009, which allowed the KM and biomedical sectors to integrate into a single hospital institution, the KM clinic has merged into the biomedical hospital as the department of KM. In this regard, this hospital can be categorized as a biomedicine-oriented hospital, in contrast with ‘A’ and ‘B’ hospitals, leaving aside the fact that seven biomedical doctors work with two KM doctors and that only biomedical doctors are mainly in charge of inpatients in most cases. This is why I chose this hospital for the fieldwork in June 2011, after completing the interviews in ‘A’ and ‘B’ hospital, namely to ascertain any differences between KM- and biomedicine-oriented hospitals regarding the actual process of the WKCT and the relationship between KM and biomedical doctors. However, it was reported that the department of KM in this hospital was closed in July 2011, one month after completing the interviews, owing to “a bottleneck in hospital management.”<sup>188</sup> According to CA1’s statement, the cooperative treatment with KM does not have a positive effect on hospital management, without bringing extra profit to the hospital, and it will not hold great promise for the future, considering government policy linked to NHIS, which regards the WKCT as a kind of ‘overtreatment.’ Instead of the department of KM, an additional biomedical doctor of gastrointestinal internal medicine was newly hired for colonoscopy in July 2011,<sup>189</sup> while one of the previous KM doctors opened a KM clinic near the hospital, caring for the remaining inpatients who had been treated by the WKCT. Subsequently, ‘C’ hospital was permanently closed due to the problems with hospital management in January 2012. The majority of the biomedical doctors in this hospital were sent to work in its branch hospital in Kimhae,<sup>190</sup> while the hospital building was sold to a neighboring biomedical hospital.<sup>191</sup>

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<sup>188</sup> From: an e-mail interview with CA1 (29 September 2011).

<sup>189</sup> Colonoscopy is “a medical procedure where a long, flexible, tubular instrument called the colonoscope is used to view the entire inner lining of the colon (large intestine) and the rectum.” From: “Colonoscopy,” Gale Encyclopedia of Medicine (2008), retrieved 27 May 2016 from <http://medical-dictionary.thefreedictionary.com/colonoscopy>.

<sup>190</sup> A city approximately 20km away to the west of Busan.

<sup>191</sup> From: an additional interview with CK1 (16 February 2012).

Table V.6 Floor Information of ‘C’ Hospital

Floor	Description
6 <sup>th</sup> Floor	Ward, Room for the chief director
4 <sup>th</sup> and 5 <sup>th</sup> Floor	Ward
3 <sup>th</sup> Floor	Nurse’s room, ward
2 <sup>nd</sup> Floor	<b>Rooms for KM doctors</b>
1 <sup>st</sup> Floor:	<b>Rooms for biomedical doctors</b> , physical therapy, anathomopathology, and hospital administration
Basement	Room for biomedical diagnosis and test, equipment room

As mentioned above, biomedical doctors are mainly in charge of inpatients in ‘C’ hospital, whereas KM doctors respond to the request for the WKCT from biomedical doctors for the inpatients. With respect to outpatients, both KM and biomedical doctors have their own patients, while they send them to the counterpart in the case of the WKCT. Medical records of KM and biomedicine had been stored separately before the KM clinic merged into the biomedical hospital. Subsequently, both KM and biomedical records were integrated into a single EMR in 2010. I held interviews with the head of hospital administration (CA1) and a KM doctor (CK1) in this hospital in June 2011.<sup>192</sup>

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<sup>192</sup> I did not interview any biomedical doctor in ‘C’ hospital because I failed to gain approval for the interviews with them. For this reason, the findings of the WKCT process in this hospital could be more biased standing for the view of KM doctors than the other hospitals.

## 1.4 ‘D’ Hospital (A Large-Scale Biomedicine-Oriented Hospital)

Figure V.4 Buildings of ‘D’ Hospital<sup>193</sup>



(From the left to the right: KM hospital, dental hospital, inpatient building of the biomedical hospital, main building of the biomedical hospital, children’s hospital)

Table V.7 Brief Overview of ‘D’ Hospital

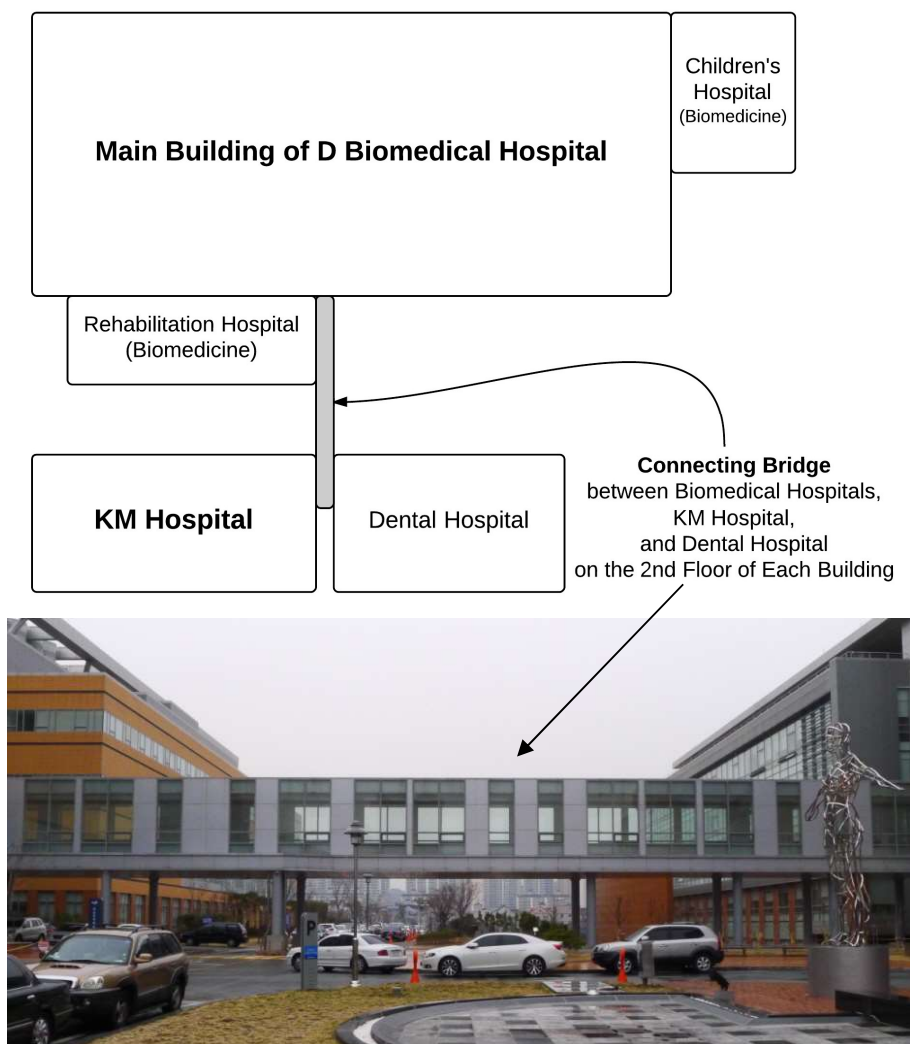
<b>Year of Establishment</b>	<p><b>Biomedical hospital and Children’s hospital (biomedicine): 2008</b></p> <p><b>Dental hospital: 2009</b></p> <p><b>KM hospital: 2010</b></p> <p><b>Rehabilitation hospital (biomedicine) : 2011</b></p> <p><b>(Establishment of Biomedical school: 1955, KM school: 2008)</b></p>
<b>Institutional Structure of Hospital</b>	National university hospital with biomedical hospitals (including children’s hospital and rehabilitation hospital) and KM hospital in separate buildings
<b>Number of Hospital Beds<sup>194</sup></b>	<p>Biomedicine (including children’s hospital and rehabilitation hospital): 1010</p> <p>KM: 101</p>

<sup>193</sup> Photo taken on 10 April 2016. The name of the hospital is obscured from the original picture.

<sup>194</sup> As of March 2014. From: Telephone interview with a hospital administrator of KM- and biomedical hospitals.

<b>Number of Physicians</b> <sup>195</sup>	Biomedical doctors: 318 (including 158 interns and residents) KM doctors: 46 (including 22 interns and residents)
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Figure V.5 Building Layout (View from above) of ‘D’ Hospital<sup>196</sup>



‘D’ hospital is located in Yangsan,<sup>197</sup> a satellite city of Busan to the northwest, and comprises a biomedical general hospital, a children’s hospital, a rehabilitation hospital, a dental hospital and a KM hospital as a branch of ‘D’ University hospital (biomedicine) in Busan. It is a teaching hospital of ‘D’ national university in Busan, whose faculties related to medical

<sup>195</sup> As of March 2014. Ibid.

<sup>196</sup> Photo taken on 12 Mar. 2012.

<sup>197</sup> Geographically, ‘D’ hospital is located outside of Busan, about 10km away from the city limits to the northwest. However, I categorized it as a hospital in Busan in a broad sense, given that its home university and main hospital are still in Busan, while the majority of patients visiting this hospital are from Busan.

science (school of biomedicine, KM, dentistry, and nursing) moved to Yangsan campus from Busan in 2009, with the establishment of this hospital complex. This hospital is situated approximately an hour from the central area of Busan by public transport, and is known as the largest hospitals around Busan with over 1,000 hospital beds. In contrast with the other three hospitals, KM and biomedical sectors are spatially separated from each other in different buildings, which are connected with an indoor bridge on the second floor of each building. KM and biomedical sectors are managed by different hospital administration units, although the university authority tries to mediate between them through diverse strategies.<sup>198</sup> According to the findings of the fieldwork, the spatial and administrative separation of the KM and biomedical sector has a significant effect on the process of the WKCT, together with the size and location of 'D' hospital.

Given that this is a teaching hospital, the majority of both KM and biomedical doctors teach at the KM and biomedical school as professors. This differs from the situation in 'B' hospital, where only KM doctors are in charge of teaching in the college, as there is no biomedical school in 'B' university. Another difference is that 'B' university is a private university, and thus the owner of the hospital has greater influence on physicians' work than in 'D' university hospital, a national university with no private owner. On the other hand, biomedical school of 'D' university is the oldest and largest biomedical school in Busan,<sup>199</sup> while KM school was established recently in 2008. For this reason, compared to 'B' hospital, 'D' hospital can be considered as a biomedicine-oriented hospital, setting aside the size difference between the biomedical and KM sector. Another important feature of this hospital is that joint research projects on the WKCT are often conducted between KM and biomedical doctors, mainly because both KM and biomedical doctors – who are professors of each school at the same time – are requested to participate as proposed by the government or the university authority. By contrast, the cases of the WKCT in actual clinical reasons are not as frequent as in the other three hospitals, partly because both KM and biomedical hospitals were recently established and they have not yet accumulated sufficient experience of the WKCT, together

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<sup>198</sup> Along with the separated administration departments, the KM sector belongs to the main university hospital in Busan as a department of KM on a legal basis, while biomedical hospitals here are legally separate from the main hospital in Busan as an independent medical corporation.

<sup>199</sup> It was the only biomedical school in the region from 1955 to 1979, and remains the largest biomedical school in Busan in terms of the number of students.

with the fact that the biomedical and KM sectors are spatially separated in different buildings, each with their own administrative departments. Furthermore, the independence level of each sector is higher than the other cases, as exemplified through the separated buildings and administration departments, although they share integrated medical records as EMR.

During the fieldwork in 'D' hospital, I conducted interviews with three KM doctors (DK1, DK2, DK3), three biomedical doctors (DB1, DB2, DB3) and a hospital administrator (DA1) between February and April 2012.<sup>200</sup> Additionally, I conducted interviews with two students of the KM school (DKS1, DKS2) to examine the experience when the students simultaneously learn both KM and biomedical knowledge.

In this chapter, I briefly introduced four WKCT hospital settings in Busan where the fieldwork was conducted, in terms of their histories, sizes, spatial characteristics and styles (biomedicine- or KM-oriented). As already mentioned in Table III.1 (pp. 66), each hospital setting has different characteristics: medium-scale KM-oriented hospital ('A' hospital), large-scale KM-oriented hospital ('B' hospital), medium-scale biomedicine-oriented hospital ('C' hospital), and large-scale biomedicine-oriented hospital ('D' hospital). On the other hand, 'B' and 'D' hospital have characteristics of university hospitals in which conducting academic research plays an important part of their work. Together with 'A' hospital, they also have characteristics of trainee hospitals in which interns and residents are trained. In addition, compared with the other three hospitals, 'D' hospital has the characteristic of being a state-owned national hospital, whereby the state could more easily exert its influence in terms of its medical policy. Considering such various characteristics of each hospital setting, I will examine the concrete process of the WKCT with the relationship between KM and biomedical doctors in the actual process of patient management.

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<sup>200</sup> A pilot interview with DK1 was conducted in September 2010, followed by the main interview in March 2012.



## 2. Findings

### 2.1 Actual Meaning of the WKCT in Clinical Practices

*“Many of us nowadays translate the WKCT into ‘co-management’ in English. In this regard, The WKCT should be something that we should achieve for patients through cooperating with each other. However, in reality, almost over 99 percent of what we are doing in the name of the WKCT is just a “consultation,” sending patients to the other part without any actual cooperation. If ‘coexistence’ is what describes the reality, ‘cooperation’ is what only some of us argue for to achieve.”*  
(DK1, professor of integrative medicine at ‘D’ school of KM, department of KM allergy and immunity, both KM- and biomedicine-licensed Doctor)

Regardless of different hospital settings, the WKCT, Western-Korean cooperative medical treatment, was observed in common in four hospitals as an action taken by KM or biomedical doctors sending their own patients to their counterpart for diagnosis or treatment and receiving the results of diagnostic tests or treatments in the form of consultation/referral,<sup>201</sup> while the patients are sent to physicians from the counterpart over a relatively short period,<sup>202</sup> before returning to their physicians in charge. In this context, ‘cooperative medical treatment’ does not mean that both KM and biomedical doctors provide a diagnosis and cure together at the same time in the same place with active communication; rather, they both intervene in certain parts of the diagnosis and treatment process for patients, either regularly through the promotion of hospital administrators or intermittently upon the request of their own patients under their own decision or permission. Concerning such a clinical situation, it can be argued that it would be better categorized as ‘coexistence’ or ‘parallel treatment’ rather than ‘actual

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<sup>201</sup> According to Table IV.6, ‘Clarifying Definitions of Clinical Consultation, Referral, and Co-Management,’ the situation mentioned above describing ‘sending patients to the other part’ is closer in meaning to the term referral rather than consultation. However, during the fieldwork, I ascertained that “consultation” was widely used by physicians as a field term covering the action of both consultation and referral, while they spoke in Korean of “consult-hada” (do consultation). In this regard, I use the term consultation/referral as a single term without strictly differentiating between these two concepts in the process of the WKCT, considering the participants’ own usage of the term in the clinical setting. In case I use the term ‘consultation’ to reproduce interviewees’ wording in Korean, I will write it in italics with double quotation marks.

<sup>202</sup> The patients usually visit the office of the physicians from the counterpart. However, there are also a few cases in which physicians from the counterpart visit the patients’ ward for the WKCT, as observed in the case of severely injured or critical patients in ‘B’ hospital.

cooperation,' especially in the eyes of patients or non-medical practitioners who expect more cooperative medical actions. Regarding these differing expectations concerning 'cooperative treatment' between physicians and patients, DK3 indicates different perspectives on the meaning of the WKCT as follows.

*It is also a kind of the WKCT in a broad sense to send their patients to a radiology clinic outside their hospital only to receive a radiological finding, because it follows a "consultation" procedure from the KM- to biomedical sector; but the patients will expect more than that, when they call a cooperative treatment to their mind... People (non-practitioners) will think of the WKCT as a treatment which both KM and biomedical doctors provide joint-treatments working together and helping each other. Patients coming to the WKCT hospitals will also expect as such. (DK3, professor of division of humanities and social medicine at 'D' school of KM, KM doctor)*

An article in the conference proceedings on the WKCT introduced by DK1, originally written by a biomedical doctor who was invited to a conference hosted by 'D' hospital, also illustrates different conceptualizations of the WKCT between patients and clinicians in the WKCT hospitals as below:

*What is the WKCT?*

● *Patients:*

› *It is a joint-management between KM and biomedical doctors, expecting a synergistic effect.*

› *KM and biomedical doctors discuss the best way for the treatment with each other.*

● *Physicians (KM and biomedical doctors)*

› *It is a parallel treatment, rather than a cooperative treatment.*

› *We (biomedical doctors) recognize that our patients are now being treated by the counterpart, but we do not know what exactly our counterpart is doing for our patients.<sup>203</sup>*

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<sup>203</sup> This demonstrates biomedical doctors' typical attitudes towards the WKCT, corresponding with the findings based upon the interviews with the biomedical doctors. They do not know exactly the contents of treatment conducted by KM doctors who provide treatment during the process of the WKCT, whereas most of KM doctors

Corresponding these differences between the expectations of patients concerning the WKCT and what is actually done in the clinical settings in reality, the majority of KM doctors who I interviewed tend to differentiate between an ‘active’ cooperative treatment and a ‘passive’ cooperative treatment, while criticizing the current situation in their working place as the latter form and wishing for a more active cooperation with biomedical doctors. With regard to this issue, BK2 mentions the following example:

*A direct communication (between KM and biomedical doctors) could be also possible, though. For instance, usually when we request a “consultation” to biomedical doctors, we just send a consultation request form where we write patients’ diseases and conditions, and demands on biomedical diagnosis or treatment, without meeting biomedical doctors in person and discussing patients’ problems or negotiating the way of the medication. This is a kind of passive WKCT. However, we could directly telephone the biomedical doctors and negotiate with them, for example, ‘as the patient need an endoscopy,<sup>204</sup> I would like you to hold a thrombolytic drug.’<sup>205</sup> This could be called as a form of an active WKCT, although such cases are actually uncommon in reality. (BK2, KM internal medicine)*

As the WKCT is conducted as a form of consultation/referral in most cases,<sup>206</sup> either a KM or

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understand the contents of biomedical diagnosis and treatment based upon their biomedical knowledge. This is connected with a very important feature of understanding the relationship between KM and biomedical doctors in terms of their power relations; further details will be provided later in Chapter V.2.3 ‘Ways of communication between KM and biomedical doctors in WKCT hospitals’ and V.3.2 ‘KM doctors’ biomedical knowledge as the core element connecting KM and biomedical doctors in the process of the WKCT.’

<sup>204</sup> “A type of medical examination in which an instrument called an endoscope is passed into an area of the body (the bladder or intestine, for example). The endoscope usually has a fiberoptic camera, which allows a greatly magnified image to be projected onto a video screen, to be viewed by the operator...”

From: “Endoscopy,” Gale Encyclopedia of Medicine, retrieved 27 May 2016 from <http://medical-dictionary.thefreedictionary.com/endoscopy>.

<sup>205</sup> “A drug causing the break-up of a blood clot.” From: “Thrombolytic drug,” Collins English Dictionary, retrieved 27 May 2016 from <http://www.thefreedictionary.com/Thrombolytic>.

<sup>206</sup> ‘Transfer’ between the departments of KM and biomedicine was also occasionally observed, usually in the case of inpatients in larger hospital organizations such as ‘B’ and ‘D’ hospitals where both KM and biomedical wards are established on a large scale. It mainly refers to the process in which patients’ main doctors in charge are changed from KM to biomedical doctors or vice versa, while they are transferred to another ward of the counterpart. Although it could be also categorized as a kind of the WKCT in a broad sense, I excluded it from my main concern, given that it mainly refers to the change of main doctors in charge from KM to biomedical doctors or vice versa with the change of main therapy, regardless of whether the patients are treated both by KM

biomedical doctor takes the main responsibility in the whole process of the WKCT, while the other only takes partial responsibility as a physician who receives a WKCT request from the main doctor in charge from the counterpart. Accordingly, KM and biomedical doctors involved with the WKCT do not equally share responsibility for certain patients at the same level. All the participants in the four hospitals suggested that this kind of consultation/referral-based WKCT is the form conducted in their hospitals in reality. In contrast with this finding, I discovered through literature research and interviews<sup>207</sup> that there used to be some exceptional cases in several WKCT hospitals in Seoul and Jeonbuk<sup>208</sup> in the early-2000s, in which joint consult rooms for the WKCT were newly set up to promote cooperative work for diagnosis and treatment together with KM and biomedical doctors. However, this policy was short-lived and returned to the old way based upon consultation/referral, because neither KM nor biomedical doctors were willing to work together in a shared room without prospecting any positive clinical outcomes, as well as because hospital administrators were concerned about the difficulty of clarifying where the responsibilities lie between them, particularly in case of medical accidents. Accordingly, although the degree of cooperative work and communication between two sectors could vary in each hospital, consultation/referral is the most typical form of the WKCT.<sup>209</sup> Viewed in this light, the actual meaning of the WKCT observed in the four hospitals is an action of KM and biomedical doctors sending their patients to the counterpart for additional diagnoses or treatments, as well as checking the result of the consultation/referral, initiated by their own decisions, requests from patients or suggestions from hospital administrators.

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and biomedical doctors or not, setting aside the fact that it is much less to be seen than consultation/referral in actual clinical settings.

<sup>207</sup> From: Jongyoung Kim (2005: 215); Interview with DB2.

<sup>208</sup> A Southwestern Province of South Korea about 300km away from Seoul.

<sup>209</sup> As most of the medical actions through the WKCT are conducted in the form of consultation/referral, in which physicians in charge of certain patients (either KM or biomedical doctors) send their patients to their counterparts for additional diagnostic inspections or medical treatments, the hospital administrators who I interviewed (AA1, BA1, CA1, DA1) mention that the patients' attending doctors are mainly responsible for general patient management; however, their counterparts who received WKCT requests are also responsible for certain medical actions conducted through the WKCT process. If needed, hospital administrators say that they actively mediate in clarifying the locus of responsibility between them.

## **2.2 Process of the WKCT in Hospital Settings**

This section takes a closer look at the concrete process of the WKCT being conducted in the four hospitals from KM and biomedical doctors' perspective, including the decision and initiation of the process, and the confirmation and interpretation of the diagnostic inspection or treatment results undertaken by the counterpart. As I defined the WKCT in the foregoing chapter as a kind of consultation/referral process, sending their patients to the counterpart for additional diagnosis and treatment and receiving the result, I will firstly demonstrate general processes of the WKCT, divided into two routes: consultation/referral from KM to biomedical doctors and from biomedical to KM doctors. Meanwhile, I will pay attention to the commonality and difference of the process among different hospital settings, regarding the hospital size and organizational structure.

### **2.2.1 KM Doctors' WKCT Request to Biomedical Doctors**

This section examines the cases in which KM doctors ask biomedical doctors for additional diagnostic inspections or medical treatments for their patients. During the analysis of the interviews, I ascertained three main reasons for KM doctors' request to biomedical doctors for the WKCT: 1) Biomedical Inspection to Confirm Diagnosis, 2) Acute Patient Care and Intense Pain Control, and 3) Uptake of Biomedical Technicians – In the Case of the WKCT Requests for Physical Therapy. In each category, I will focus on various reasons of the request for the WKCT to the counterpart answered by the physicians.

#### **1) Biomedical Inspection to Confirm Diagnosis**

Regardless of various hospital settings, most KM doctors' patients are sent to the biomedical sector for basic biomedical inspections such as a blood tests and radiography (x-ray), as a routine check-up when they are newly hospitalized. All KM doctors in the four hospitals answered that biomedical inspections are conducted for all hospitalized inpatients, with no exceptions. Only some KM doctors' outpatients with chronic diseases were reported to be diagnosed exclusively within the KM sector without biomedical backup. In this process of biomedical inspections for KM patients, the existence of biomedical doctors in each hospital

setting provides a legal basis for biomedical inspections for KM doctors' patients within their hospital. However, the roles of biomedical doctors are very much passive and limited in this process, whether: 1) they approve KM doctors' request immediately as a mere formality (mostly in 'C' and 'D' hospital); 2) they are notified ex post (mostly in 'A' hospital); 3) one single biomedical doctor is designated to take full charge of the request from KM doctors for biomedical inspections (exclusively observed in 'B' hospital); or 4) KM doctors send their patients directly to biomedical inspecting rooms without notifying biomedical doctors in each case, under the tacit consent from biomedical doctors and hospital administrators (some cases in 'A' hospital). The results of the biomedical inspections are sent back to the KM doctors through paper-based or electronic records.

Concerning the question of why they request biomedical diagnosis for their patients, the first impression that I gained during the interviews was that the majority of KM clinicians take biomedical inspections for their patients for granted. Nonetheless, they tended to indicate and problematize the fact that KM doctors do not have the right of biomedical inspection, as can be seen in the following quotations.

*The most difficult thing for us when we work at hospitals is that we do not have right of diagnostic inspection. Even KM doctors who are skeptical with the cooperation with biomedical doctors are not against making use of biomedical inspection, because the patients prefer numerical results of biomedical inspections. But we do not even have access to it single-handed. In China, TCM doctors can freely make a diagnosis without biomedical doctors, but we are not allowed to do it. This is the first reason why we need cooperation with biomedical doctors. (BK1, KM internal medicine)*

*I request the diagnostic imaging of patients to the biomedical doctor before I treat them with KM therapies, because we don't have the right to apply it according to the MSA.*

*(Question: Do you always check biomedical imaging before starting with KM treatment?)*

*Yes, it is necessary, especially for orthopedic patients... (AK1, KM rehabilitation,*

*acupuncture & moxibustion)*

Both KM doctors recognize the need for biomedical inspection for their patients. A conspicuous feature with respect to the terminology is that when they mention inspection equipment legally categorized within the biomedical domain during the interviews, they do not tend to specify them as ‘biomedical’ or ‘western medical’ diagnostic equipment, simply calling it ‘diagnostic equipment.’ When they were asked about the usage of biomedical inspection, they tended to emphasize that KM doctors do not have the right of biomedical inspection, rather than reasoning the usage of biomedical inspection. In this connection, BK1 mentions TCM doctors’ right of biomedical inspection in China as an alternative example, while AK1 considers biomedical diagnostic imaging as an essential pre-process before initiating KM treatments for orthopedic patients. To summarize, KM doctors’ WKCT requests for basic biomedical inspections of KM doctors’ newly hospitalized patients are widely considered as a routine process by KM doctors. In other words, at least KM ‘clinicians’ – who I interviewed – managing patients’ diseases in all four hospital settings do not raise a problem in terms of using basic biomedical inspections through the WKCT.<sup>210</sup>

Compared to basic biomedical inspections for newly hospitalized KM patients, additional biomedical tests during their stay in hospitals are selectively requested based upon their KM doctors’ decisions. Additional biomedical inspections such as CT/MRI scans and endoscopy are conducted either when the physicians in charge consider that basic inspection is insufficient to accurately diagnose or when new problems occur in patients during the treatment. In this context, the important thing is that it is KM doctors who mainly decide whether to send their patients to biomedical doctors for an additional biomedical diagnosis, after checking their patients’ condition by themselves. During the interviews with KM doctors in the four hospitals, none of them showed any kind of antipathy against additional biomedical inspections for their patients, while they suggested that they recommend their patients to undertake those additional biomedical inspections when they deem it necessary. A

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<sup>210</sup> DK2, professor of KM preventive medicine at D school of KM, was the only KM doctor who showed a rather negative perspective on biomedical inspections for KM doctors’ patients. He expressed concern about the possibility that regular biomedical inspection to KM patients will influence the patients predominantly viewing health and illness from biomedical perspectives. His critical perspective on the phenomenon of KM doctors’ general usage of biomedical inspection to their patients through the WKCT process can be understood as reflecting his position as a KM scientist rather than a clinician.

KM internal medicine doctor's (AK2) following remark holds relevance in this respect:

*If a KM doctor (in charge of a patient with back pain) said that he does not care about the term disc herniation, MRI, or SLR test;<sup>211</sup> instead, he has his eyes on whether this is 'back pain of coldness' (han-yotong)<sup>212</sup> or 'back pain of Qi' (qi-yotong)<sup>213</sup> ... then he applies a medicine against han-yotong or qi-yotong,' I wouldn't say that it would be the best way to treat the patient... While we examine the result of X-ray or MRI, we can make a prognosis more accurately. (AK2, KM internal medicine)*

However, a former hospital administrator in B hospital (BA1) revealed a different story about KM doctors' view concerning additional biomedical inspections.

*(Question: Have you also experienced KM doctors' antagonism on biomedical inspections?)*

*Yes, sure. Even there are still many KM doctors who are reluctant to send their patients to the counterpart for endoscopy. They seem to think that the flow of Qi is disturbed when foreign substance enters the body during the endoscopy. I know quite a few KM physicians against the regular endoscopy for people over forty years old, which biomedical doctors recommend. (BA1)*

BA1's comment implies that a certain proportion of KM doctors in WKCT hospitals are reluctant to send their patients to their counterpart for additional biomedical inspections in reality, despite no KM clinician explicitly expressing antipathy against these inspections

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<sup>211</sup> Straight-leg-raising test. "A physical examination technique to determine abnormality of the sciatic nerve or tightness of the hamstrings. The presence of sciatica is confirmed by sciatic nerve pain radiating down the limb when the supine person attempts to raise the straightened limb." From: "Straight-leg-raising test", Mosby's Medical Dictionary, 8<sup>th</sup> edition, retrieved 27 May 2016 from

<http://medical-dictionary.thefreedictionary.com/straight-leg-raising+test>.

<sup>212</sup> A KM term referring to "a symptom of back pain resulted from cold energy." From: "han-qi," Daum Online Korean Dictionary, retrieved 27 May 2016 from

<http://dic.daum.net/word/view.do?wordid=kkw000285725&q=%ED%95%9C%EC%9A%94%ED%86%B5>.

<sup>213</sup> A KM term referring to "a symptom of back pain resulted from weakness of natural energy (qi) and a problem with blood circulation in human's body." From: "Qi-yo-tong," Daum Online Korean Dictionary, retrieved 27 May 2016 from

<http://dic.daum.net/word/view.do?wordid=kkw000036972&q=%EA%B8%B0%EC%9A%94%ED%86%B5>.



among the interviewees in the four hospitals. Another important aspect of the reason for KM doctors' request for biomedical inspection is that they require biomedical evidence materials on their patients to present a legal basis of their medical treatments to medical insurance companies or other public institutions, especially to NHIS. Let us consider the following quotations from AK1.

*(Comparing to small private KM practices) we have more serious patients in the hospital level, not only having simple muscle pain. In severe cases, we need data for legal grounds preparing for civil suits... We need to explain why and how we applied this treatment and need to have grounds for the treatment. That's why we need (biomedical) imaging equipment... (AK1, KM rehabilitation, acupuncture & moxibustion)*

*(Question: When you confirm and write the diagnosis on this patient with facial nerve paralysis in the medical record, I think you can use either Bell's palsy<sup>214</sup> or Wa-sa-pung.<sup>215</sup> Which one do you use?)*

*Diagnosis codes of similar biomedical- and KM illnesses for NHI are usually integrated into one single category... The name of this patient's disease is Bell's palsy, according to the code of NHI. (AK4, resident, KM gynecology)*

*(Question: When you confirm your patients' diagnosis to show it to the NHIS, do you see any problem? For instance, the concepts of KM and biomedicine may be in conflict with each other?)*

*Well, I wouldn't say the concepts bump with each other, but biomedical diagnosis can go into more detail, while KM diagnosis is rather more obscure. For instance, in the case of neck pain, we can use the code 'spinal disc herniation on cervical spine' through biomedical inspection, but without biomedical diagnosis we can only use a general KM term 'Gyeong-chu-tong' ('neck pain')... Since the biomedical-*

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<sup>214</sup> "Unilateral facial paralysis of sudden onset due to a lesion of the facial nerve, resulting in characteristic facial distortion" From: "Bell's palsy," Dorland's Medical Dictionary for Health Consumers, retrieved 27 May 2016 from <http://medical-dictionary.thefreedictionary.com/facial+palsy>.

<sup>215</sup> (also called as 'Gu-an-wa-sa') KM term of facial nerve paralysis. It is a symptom of "getting crooked mouth and having difficulty in closing the eyes due to the paralysis of facial muscles" From: "Wa-sa-pung," Establishment Committee of Oriental Medical Terminology, 2006: pp 46.

*and KM disease codes of NHI were integrated, we have been rarely using KM disease codes. Instead, we use biomedical disease codes.*<sup>216</sup> (AK1, KM rehabilitation, acupuncture & moxibustion)

In addition to the foregoing aspects, patients' preference for biomedical diagnosis was also mentioned as the reason for KM doctors' request for biomedical diagnosis. It is useful to quote from a KM doctor and a KM student in this connection.

*People want numerically measured biomedical inspection, but KM doctors cannot have access to it alone... If KM doctors explain their patients' problems only with Qi (natural energy) and Hyeol (blood flow) to their patients, they cannot persuade their patients properly for the therapy.* (BK2, KM internal medicine)

*Professors tell us (KM students) to learn as much as possible without choice whether it is KM- or biomedical knowledge, and don't neglect biomedical knowledge although we will be KM doctors, because it will be especially useful for us when we communicate with patients in clinical settings.* (DKS2, senior student, 'D' university school of KM)

Both of them acknowledge that biomedical explanations of patients' diseases play a crucial role for KM doctors to communicate with their patients, because the majority of patients prefer a biomedical explanation over a KM explanation, whose terms and concepts are unfamiliar for ordinary people in South Korea in the present age. In this respect, the results of biomedical inspections are used as a useful tool for KM doctors to connect them with their patients when they explain their health condition before applying KM therapies.

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<sup>216</sup> Statistics Korea, a central government organization for statistics, introduced the sixth revision of the Korean Standard Classification of Diseases (KCD-6), newly unifying KM and biomedical disease codes in 2010, influenced by WHO's 10<sup>th</sup> revision of international classification of diseases (ICD-10), after prior consultation with the NHIS, Health Insurance Review & Assessment Service, Korean Medical Association, Korean Dental Association, the Association of KM and Korean Nurses Association. Since January 2011, the unified disease codes have been applied when both KM and biomedical hospitals claim insurance money to NHIS (Statistics Korea, 2010: 7). More details on this issue will be followed in Chapter V.2.4.3 'Influences of legal regulations, government policy and National Health Insurance (NHI) on the WKCT' (pp. 210).

To summarize, biomedical inspections for KM doctors' patients in WKCT hospitals are conducted as either a routine procedure for newly hospitalized patients or an option for additional inspection in the middle of the hospitalization period, sending their patients to the biomedical sector through the WKCT requests in their hospitals, albeit without actual communication between KM and biomedical doctors in most cases. In this process, KM doctors request a WKCT to biomedical doctors for biomedical inspection in order for themselves to understand patients' condition, to explain it more easily to their patients in biomedical terms, and provide evidentiary material on patients' diagnosis to health insurance companies or other relevant organizations. Meanwhile, biomedical doctors in each hospital occupy the role of providing the legal grounds for biomedical inspections being conducted in their hospital, allowing KM doctors' patients to go through biomedical examinations.

## **2) Acute Patient Care and Intense Pain Control**

As the most frequently conducted case in need of biomedical doctors' help during the treatment (rather than the process of diagnosis) of their patients, KM doctors mention two situations: patients who are in an acute phase, and those who complain of intense pain. Such cases are more commonly observed in KM-oriented hospitals ('A' and 'B' hospital) where KM doctors are more actively involved with the inpatient care than in biomedicine-oriented hospitals ('C' and 'D' hospital), where the KM doctors tend to be more occupied with chronic patient care because acute patients are hospitalized more frequently in biomedical wards than KM wards. Regarding these cases, patients in an acute phase of nervous system diseases such as CVA and facial nerve paralysis and orthopedic patients with intense pain most commonly experience this process in all four hospitals.

In the case of acute patient control, both KM and biomedical doctors who I interviewed commonly agreed that biomedical treatment should precede KM treatment to more effectively control patients' vital signs, although the concrete process on the management of acute patients varies in each hospital. Accordingly, a selection of KM and biomedical doctors' comments concerning this issue are presented below.

*When we think of biomedicine first, we usually recall ... very much emergent*

*situations or acute diseases. In such cases biomedicine definitely has merit... It is not true that KM cannot handle with such cases at all, but somehow... KM is more advantageous for chronic diseases or management after acute phase. (AK2, KM internal medicine)*

*KM cannot manage a critical situation. So even in this hospital ('B' hospital, a KM-oriented WKCT hospital) KM doctors do not mainly treat the patients in their acute phase. For instance, if a patient with CVA who may need an operation, in a life-or-death situation, in such phase, I don't recommend KM.*

*(Question: Is that what KM doctors also agree with?)*

*KM doctors do not see patients in such a situation or in an acute phase. They cannot control patients with unstable vital signs. They will admit that. When it comes to life and death, it can't be helped to them. (BB2, Neurosurgery)*

It is apparent in these extracts that there is a general consensus among biomedical and KM doctors that biomedical treatments precede KM treatments in the cases of acute patient management.<sup>217</sup> Along with the cases of acute patient management, in the case of intense pain control – whether in the acute phase or during the long-term management in hospitals – KM doctors also frequently request biomedical medication to their counterpart. Let us consider the following extracts from two KM doctors (AK1, AK4) in 'A' hospital.

*In case one of my patients complains of intense pain, for instance... I request a "consultation" to a biomedical doctor for prescribing painkiller, because an intense pain does not wear off through KM treatment in a day. Biomedical painkiller has an excellent effect against intense pain. 'An excellent effect' means here rather more a fast-acting effect for pain relief than actual curative effect. But it is still important to relieve severe pain, isn't it? (AK1, KM rehabilitation, acupuncture & moxibustion)*

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<sup>217</sup> However, there is a slight difference in viewpoint between KM and biomedical doctors concerning the point at which the KM therapies start to intervene for acute patient management. Further details will be examined with the issues of communication between KM and biomedical doctors in Chapter V.2.3.1 'Communication for patient management in the process of the WKCT' (pp. 177).

*In the case of musculoskeletal inpatients who are usually hospitalized for about two or three weeks, we request (biomedical) painkillers or muscle relaxants to the biomedical doctor in advance and we keep them... When we see that the patients have severe pain, we decide to apply biomedical medication. (AK4, resident, KM gynecology)*

The above-mentioned examples in ‘A’ hospital are cases of management for orthopedic/musculoskeletal inpatients, of whom KM doctors are in charge, complaining of severe pain with non-life-threatening injuries. In such cases, AK1 states that he requests a “consultation” from biomedical doctors to prescribe biomedical medication for pain control, acknowledging the advantage of biomedical medication owing to its rapid inhibitory effect against severe pain. What is interesting is that it is KM doctors who hold off biomedical medication until they judge it necessary to medicate or when their patients complain of severe pain, after they request and receive biomedical painkillers or muscle relaxants in advance. In other words, the KM doctors in ‘A’ hospital have autonomy over when to medicate biomedical drugs to their patients once they receive such drugs from biomedical doctors through the WKCT process. This implies that KM doctors are either in need of or already maintain biomedical knowledge on the medication of the biomedical drugs about the remedial effects and side effects to make a decision regarding the proper time for the medication.

Similar to the aforementioned cases, it is common that KM doctors in all four hospitals request consultation/referral from biomedical doctors in their hospitals for acute patient care and intense pain control. However, concrete ways and appearances vary in each hospital. KM doctors’ WKCT requests to biomedical doctors in such cases are most commonly observed in ‘A’ hospital, where a large number of KM doctors work with a single biomedical doctor, because KM doctors are in charge of all the inpatients in this hospital, whereas a biomedical doctor provides them additional biomedical services while acceding to the KM doctors’ request. When acute patients arrive in the hospital’s emergency room, duty doctors (KM physicians, usually residents) decide whether they hospitalize the patients there or transfer them to other neighboring biomedical hospitals, according to the seriousness of the patient’s condition. In case an urgent patient visits hospital during the biomedical doctor’s on-duty

hours (the whole day from Monday to Friday, as well as Saturday morning), the biomedical doctor provides advice to KM doctors, helping out with their decision concerning the patient's hospitalization. If the acute patient does not require an immediate surgical operation without severe damage, KM doctors decide to hospitalize the patient at 'A' hospital. During the acute phase – usually for the first two weeks – the patient is managed with intensive biomedical care through the WKCT with the help of the biomedical doctor. Subsequently, the patient is mainly cared with KM therapies. In this process of acute patient management in 'A' hospital, the vast majority of the interviewees in this hospital agree that the biomedical doctor's specialty subject has an effect on the KM doctors' decisions regarding acute patients' hospitalization to their hospital. For instance, if a biomedical doctor in this hospital is a neurology or neurosurgery specialist, KM doctors will be able to manage more serious acute patients with a stroke, compared to other biomedical doctors specialized in internal medicine or ophthalmology. This implies that the KM doctors still rely upon biomedical doctors' medical knowledge, although they actively utilize their own biomedical knowledge to make clinical decisions for their patients.<sup>218</sup>

In the case of 'B' hospital, where both KM and biomedical wards are located in the same building, separately managed by KM and biomedical doctors yet sharing an emergency room, acute patients or their caretakers can choose either KM or biomedical wards for the treatment in principle. In practice, however, BA1 states that most severe patients are sent to the biomedical wards, while rather less serious acute patients or chronic patients are predominantly sent to KM wards, with the advice of hospital coordinators in charge of inpatient hospitalization. For this reason, KM doctors' requests for the WKCT for acute patients are not as frequently observed as in 'A' hospital, given that most acute patients are managed in the biomedical wards in 'B' hospital, while the less serious acute patients in KM wards are intensively managed by biomedical treatments through the WKCT process.

Compared to 'A' and 'B' hospitals, KM doctors' requests for biomedical treatment for acute patients are rarely seen in 'C' and 'D' hospitals. In 'C' hospital, biomedical doctors are in charge of inpatient care in most cases, while KM doctors, who mainly work in the outpatient

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<sup>218</sup> Further details on the issues of KM doctors' biomedical knowledge and their relationship with biomedical doctors will be discussed in Chapter V.3.2 'KM doctors' biomedical knowledge as the core element connecting KM and biomedical doctors in the process of the WKCT.'

clinic, provide additional KM therapies to biomedical doctors' inpatients. In case KM doctors' outpatients complain of severe pain, KM doctors request biomedical medication to biomedical doctors. In 'D' hospital, where KM and biomedical hospitals are located in different neighboring buildings, emergent acute patients are not hospitalized in the KM sector, because an emergency room only exists in the biomedical sector. For this reason, KM doctors in this hospital generally manage non-emergency patients, mostly with chronic diseases.

In short, WKCT requests from KM to biomedical doctors for acute patient management and severe pain control are the most typical cases of KM doctors requesting biomedical doctors for therapeutic reason. However, this usually happens when KM doctors are actively involved with inpatient management as their physicians in charge.

### **3) Uptake of Biomedical Technicians – In the Case of the WKCT Requests for Physical Therapy**

Another typical case of KM doctors' therapeutic request to biomedical doctors is observed when KM doctors require therapeutic help from medical technicians such as physical, occupational and speech therapists, whose tasks are exclusively supervised by biomedical doctors. During interviews with physicians in four hospitals, the matter of physical therapy was particularly commonly mentioned as an important reason for KM doctors' request for the WKCT to biomedical doctors. Compared to acute phase and severe pain control, usually conducted for inpatients, physical therapy is more commonly requested for both in- and outpatients of KM doctors. As the reasons for the request, physical therapy was conducted either as a routine treatment for certain diseases (e.g. facial nerve palsy in the incipient stage, CVA in the sub-acute or chronic stage) by KM doctors' decision for improving rehabilitation or treatment effect, or upon the patients' own request for receiving physical therapy.

KM doctors' request for physical therapy to biomedical doctors resembles the way of requesting diagnostic inspection for X-rays and blood tests utilizing radiological and medical laboratory technologists working under biomedical doctors' supervision. As a rule, biomedical doctors are supposed to prescribe physical therapy to KM doctors' patients in this process, sending them to physical therapists after receiving KM doctors' request for physical

therapy. However, in practice, there are several variations in each hospital regarding the degree of biomedical doctors' intervention and recognition concerning this process. In the case of 'A' hospital, KM doctors tend to directly make contact with physical therapists without any actual prior consultation with the biomedical doctor. Let us have a look at AK4's statement concerning physical therapy in 'A' hospital.

*When it comes to physical therapy... as a rule, biomedical doctors are supposed to prescribe it. That is the ground rule, but in fact... (under the premise of the biomedical doctor's consent) it is us (KM doctors) who give orders for it... In the case of facial nerve palsy, for instance, physical therapy is prescribed as a routine, just like acupuncture, moxibustion and herbal medication.*

*(Question: Concerning the supervision of physical therapists, you said KM doctors place an order for physical therapy. Then, who takes charge of physical therapists' work?)*

*Well, usually we know more about our patients' conditions than the biomedical doctor. So... that's why it is us as the KM doctors who give an order for the physical therapy...*

*(Question: The biomedical doctor knows that the physical therapy was ordered for the patients in each case, doesn't he?)*

*I think he knows, but not for every single detail... When it comes to the specific content of physical therapy, he is scarcely concerned with it... In the case of Mrs. L (one of AK4's patients in her ward), we directly ordered traction therapy to physical therapists for her cervical herniated discs.*

*(Question: Do the physical therapists regularly report directly to the KM doctors concerning the patients' changed condition through their therapy?)*

*Not really... we (KM interns or residents) see the patients every day, so they don't need to report on it to us additionally. We see the same patients three or four times a day, so... Sometimes the patients tell us that certain therapies were good or bad for them. Then we tell the physical therapists that they stop or proceed with those therapies... (AK4, resident, KM gynecology)*

Due to the existence of the biomedical doctor, it is allowed to employ physical therapists and



claim insurance payment from national health insurance for physical therapy in 'A' hospital, given that biomedical doctors exclusively maintain official ascendancy over physical therapists based upon Medical Technicians, etc. Act. However, in reality, KM doctors directly place orders to the physical therapists for physical therapy in the treatment process. In this process, the biomedical doctor does not undertake the actual therapeutic role; rather, he simply allows the KM doctors to send their patients to the physical therapy room for the therapy, respecting the KM doctors' own decision on the biomedical therapy. This is similar to the case of the KM doctors' request for biomedical inspections to the biomedical doctor in 'A' hospital. In this process, the KM doctors play an actual role in ordering and regulating physical therapists' tasks. As AK4 explains, it is the KM doctors who decide the application of physical therapy to their patients. In addition, the KM doctors evaluate the effects of the physical therapy, as well as making the therapists modify the contents of the therapy, if necessary.

In the case of 'B' hospital, where large numbers of biomedical doctors work in various biomedical wards, KM doctors make a request for physical therapy to the biomedical doctors in the department of rehabilitation medicine, on whose prescription physical therapists usually work. BK2 and BK3 state the matter concerning this issue.

*Our (KM doctors') patients would also sometimes like to have physical treatment. There are also some cases in which we think it is necessary for them. In such cases, biomedical doctors in the department of rehabilitation medicine prescribe physical therapy for us. (BK2, KM internal medicine)*

*When the physicians in the department of rehabilitation medicine prescribe physical or occupational therapy for our (KM doctors') patients, they go to the treatment room in the biomedical ward.*

*(Question: Does that mean the case in which KM doctors ask for their patients' physical therapy to the biomedical wards?)*

*Yes, after we send our patients to biomedical doctors in the department of rehabilitation medicine, in case we think that it is necessary, they prescribe suitable therapies for each patient. After that, the patients go to the therapy room, or in the*

*case of severe patients, physical therapists visit the patients' room in KM wards.  
(BK4, KM internal medicine)*

To summarize the situations in 'B' hospital described above:

- KM doctors are in charge of the decision for their patients' treatment for physical therapy which belongs to the biomedical domain.
- After the KM doctors make a request for physical therapy to biomedical doctors, who typically work in the department of rehabilitation medicine, the biomedical doctors prescribe suitable physical therapy for each patient.
- Compared to 'A' hospital, it is more likely that biomedical doctors decide upon the detailed contents of the physical therapy for KM doctors' patients, while it is KM doctors who are in charge of it in 'A' hospital, where the biomedical internal medicine doctor takes charge of all the requests from the KM doctors for the WKCT.<sup>219</sup>

In this sense, biomedical doctors in 'B' hospital have a slightly more prominent role than in 'A' hospital, whereby they are relatively more actively involved in prescribing the therapy, while the KM doctor in 'A' hospital is merely notified by KM doctors that their patients are sent to physical therapists. Nevertheless, their role in this process remains limited in that the KM doctors are still in charge of deciding about physical therapy for their patients, which is made without actual communication with biomedical doctors.

KM doctors in 'C' hospital request biomedical doctors' intervention for physical therapy more often than is the case for acute patient management or intense pain control, because they are mostly in charge of outpatients, whereas biomedical doctors manage both in- and outpatients. KM doctors play an active role in this process when they decide to send their patients to the biomedical sector for physical therapy as the one who decides to initiate the process, as with KM doctors in 'A' and 'B' hospitals. In the case of 'D' hospital, where the physical therapy room is located in the biomedical hospital building, separate from the KM

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<sup>219</sup> This merely reflects the situation that I observed during the fieldwork in 2011, when a biomedical internal medicine doctor was employed as a sole biomedical doctor in 'A' hospital. If an employed biomedical doctor had specialized in rehabilitation medicine or neurosurgery, more directly related to physical therapy, I think that the biomedical doctor might have been more actively involved in KM doctors' request for the WKCT than the one with other specialties.

hospital building, KM doctors' requests to biomedical doctors for physical therapy were rarely observed compared to the other four hospitals, although in principle it is possible to send their patients to the biomedical building through the WKCT process with biomedical doctors. Instead, there is a special KM treatment room inside the KM building, where various additional KM therapies are offered to KM patients, playing a corresponding role to physical therapy in a biomedical hospital. Concerning this issue, it should also be considered that the KM sector was newly launched in 'D' hospital, whereby there had been no such communication and cooperation on the level of clinical practice between the KM and biomedical sectors as in the other three hospitals. In addition, the geographical setting of the hospital should also be considered, given that the biomedical hospital building is located separately from the KM building, about 50m away, meaning that it would be more difficult for patients to ambulate to the other sector than in the other three hospitals.

To summarize KM doctors' requests for physical therapy through the WKCT process with biomedical doctors, KM doctors in each hospital can send their patients to the biomedical sector for physical therapy through WKCT requests. In this process, biomedical doctors play a role in enabling KM doctors' patients to receive the treatment by physical therapists within each hospital, while KM doctors decide and allow their patients receive the treatment. This process is very similar to the WKCT process for KM patients' biomedical inspection in the sense that it is the KM doctors rather than the biomedical doctors who decide to apply biomedical action for their patients. However, compared to the WKCT request for biomedical inspection, which is considered an essential process for patient management by most KM doctors, physical therapy is regarded as a kind of additional and optional treatment. For this reason, the frequencies of the WKCT for this treatment vary depending upon the circumstances in each hospital.

In chapter V.2.2.1, we have seen the cases in which KM doctors send their patients to the biomedical sector through the process of the WKCT with biomedical doctors. First of all, a WKCT request for biomedical inspection was the most frequently observed case of the request from the KM to the biomedical sector, regardless of the different hospital settings in four hospitals. Secondly, in case KM doctors are in charge of acute patients or their patients complain of severe pain, they routinely call for help from biomedical doctors through a

WKCT request. It was also commonly observed that KM doctors make a request for the WKCT to the biomedical sector for additional therapies, such as physical therapy for pain control and rehabilitation. In all three cases, it is KM doctors who make a decision for biomedical inspection or treatment for their patients in this process based upon their biomedical knowledge, while biomedical doctors allow the KM doctors' patients to be treated in the biomedical sector in each hospital. In the next chapter, I will examine the cases in which biomedical doctors send their patients to the KM sector, compared to the situations in which KM doctors make requests to the biomedical doctors for the WKCT.

### **2.2.2 Biomedical Doctors' WKCT Request to KM Doctors**

Compared to KM doctors' WKCT request to their biomedical colleagues, the most notable difference of biomedical doctors' request to KM doctors is that there is no consultation/referral request exclusively for KM-based diagnosis from biomedical doctors, whereas biomedical inspection for diagnosis is considered an essential process to KM doctors for their patients, particularly for hospitalized inpatients. None of the interview participants in four hospitals answered that they exclusively receive or request KM inspection. In other words, biomedical doctors' WKCT requests to KM doctors are not for diagnostic information but rather entirely for therapeutic treatments. In this process, KM doctors make their own KM-based diagnosis before they conduct a KM treatment requested by biomedical doctors. However, the result of the KM diagnosis is not reported to the biomedical doctors who made a request in most cases, while the contents and results of the KM therapies conducted for patients are briefly reported to the biomedical counterpart. In this chapter, I will firstly introduce typical cases for biomedical doctors' request for KM treatment observed in four hospitals: 1) the relief of symptoms and pain control for non-fatal yet intractable diseases; 2) additional treatments for irreversible diseases with sequelae in the chronic phase; and 3) management for incurable or end-state diseases. Subsequently, common characteristics of the aforementioned cases and the reasons for biomedical doctors' WKCT request will be examined, while considering different circumstances in the four hospitals.

## 1) Relief of Symptoms and Pain Control for Non-Fatal yet Intractable Chronic Diseases

This case refers to the clinical situations in which biomedical doctors' patients with non-serious diseases are sent to the KM sector for additional treatments to promote the relief of symptoms or pains. For instance, Bell's palsy, muscular skeletal pains and chronic prostatitis belong among this category. Let us have a look at statements of interviewees in 'B' hospital about the process of the WKCT for facial nerve palsy.

*Well... in the cases of Bell's palsy, vertebral diseases and hemiparalysis due to the after-effect of brain diseases, I think the WKCT is necessary ... as far as I know within the area of neurosurgical diseases. (BB2, neurosurgery)*

*Bell's palsy, for example, when patients tell me that they would like to receive acupuncture treatment, we run parallel with KM therapy. (BB1, neurosurgery)*

*When it comes to Bell's palsy, actually there is nothing biomedicine can do after the acute phase. So, it was easy for me as the president of the hospital to persuade the biomedical doctors to join the WKCT with us (KM doctors) for the treatment. That was also good for them... I mean... biomedical doctors are content with sending their patients with Bell's palsy to us for KM therapies... Bell's palsy is the most cooperative case in which biomedical doctors are open to sending their patients to the KM sector. (BK3, former president of 'B' hospital. KM doctor)*

*In view of biomedicine, Bell's palsy is not a disease, but a symptom. According to the biomedical textbook, it is automatically cured within 10 to 24 days without any other special medication. So, biomedical doctors recommend outpatient treatment as long as it is not as serious as grade three or four, but the patients usually do not just wait until they are recovered. (BA1, former WKCT coordinator, nurse)*

According to the statements above, physicians and hospital administrators in 'B' hospital consider Bell's palsy as one of the most typical diseases for which biomedical doctors demonstrate a cooperative attitude to send their patients to the KM sector for the WKCT.

When their patients want additional KM therapies (BB1) or when they are asked for the WKCT by hospital administrators (BK3), biomedical doctors send their patients to the counterpart. In terms of the reason for the biomedical doctors' favorable attitudes on the WKCT for patients with Bell's palsy, BK3 and BB1 both indicate biomedicine's lack of treatment after the acute phase. They argue that the WKCT with KM doctors enables them to provide their patients with additional treatments, in the situation where there is no particular treatment for non-acute care in the biomedical domain. With this, the biomedical doctors can reassure their patients more easily during the hospitalization, in the sense of reflecting a more effective way of patient management.

Similar to the case of Bell's palsy, chronic prostatitis and xerophthalmia (dry eye syndrome) were introduced as collaborative research projects for the WKCT in a symposium for the WKCT in 'D' hospital.<sup>220</sup> As the reason for selecting both diseases for the projects, a project participant (a biomedical doctor) mentioned that both diseases are not fatal but are difficult to be completely cured with biomedical therapies. In other words, the biomedical doctors tend to easily accept cooperative research for the WKCT with KM doctors in such diseases, whereby they can 'fill in a therapeutic gap' with help from the KM sector. Another example in this category is the cases in which biomedical doctors send their patients to the KM sector for orthopedic pain management. In most cases, acupuncture and moxibustion are usually asked to the KM doctors as additional treatments for the patients. Indeed, this was commonly observed in all four hospitals.

## **2) Additional Treatments for Irreversible Diseases with Sequelae in the Chronic Phase**

The most typical case corresponding to this category is observed when biomedical doctors are involved with care for patients suffering from permanent hemiplegia due to CVA. In a broad sense, it includes all the cases of patient management after the acute phase of CVA. However, in most cases, biomedical doctors already have a premonition that the damage will be irreversible with biomedical therapies when they send their patients to the KM sector for additional therapies. Such patients who are managed by biomedical doctors usually tend to

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<sup>220</sup>It was held on 18 March 2012. Professors of KM- and biomedical schools in 'D' hospital presented their erstwhile and future research projects for the WKCT. Both KM and biomedical doctors working in 'D' hospital participated in each project.

receive additional KM therapies slightly later than those who are managed by KM doctors in KM wards (observed in 'A' and 'B' hospital). Accordingly, the majority of biomedical doctors are reluctant to send their patients to the KM sector for additional KM therapies in the acute phase, while KM doctors tend to already apply KM therapies to their inpatients in their wards in parallel with biomedical therapies through the WKCT process during the acute phase. Regarding this issue, DB2 points out his perspective concerning when to allow their acute patients to have KM therapies through the WKCT as below.

*(Question: Is there any general treatment guideline for the WKCT that you follow here in 'D' hospital?)*

*No, there is no such thing generally applicable in this hospital, but... I have my own principle. That is... I don't recommend that any patients have additional KM treatments in their acute phase. For instance, in the case of CVA, within the first two or four weeks after the accident we don't let them receive any (biomedical) rehabilitation therapy, because it might damage the brain. When it comes to acupuncture, it may calm down the brain, but it may also stimulate it. If it is stimulated through the acupuncture therapy, metabolism may increase around there, which may aggravate the damage. I know that what I am saying may be a kind of superficial idea, but that's what I think... (DB2, rehabilitation medicine)*

Like the statement above, when biomedical doctors are mainly in charge of acute patients with CVA, many of them tend to refrain the WKCT with the KM sector during the acute phase in their own sight on KM therapies, while KM doctors who are mainly in charge of such patients are already involved with the care during the acute phase. Unlike KM doctors – the vast majority of whom believe that additional KM therapies have a positive effect on the improvement of acute patients' condition without any harmful side effects, despite acknowledging the priority of biomedical care in acute phase – most of the biomedical doctors tend to allow the patients in their wards to receive additional KM therapies after the acute phase by the requests from the patients or the patients' family members, by the recommendation from hospital administrators or KM doctors or through their own decision.

### 3) Management for Incurable or End-State Diseases

End-of-life care such as management for patients with terminal cancers belongs to this category. As a matter of fact, biomedical doctors' requests for KM treatments for their patients with such problems were not so frequently observed as the first two categories above at the clinical level in four hospitals. However, it was observed in 'B' and 'D' hospital that biomedical doctors have shown rather open-minded views on cooperative work with KM doctors for cancer treatment. In 'B' hospital, BK1 (KM internal medicine) mentions that he is trying to launch a new WKCT program in cooperation with biomedical physicians, many of whom have shown friendly attitudes to this program, demonstrating more interest in KM therapies for cancer than other diseases. In the case of 'D' hospital, a cooperative research project between biomedical and KM doctors concerning lung cancer was introduced in the WKCT symposium in 2012. According to the sourcebook of this symposium, patients with lung cancer hospitalized in the division of pulmonology (a biomedical ward) who had been receiving chemotherapy were invited to receive additional acupuncture therapy in the KM sector for 10 days. The result of the research shows that the KM acupuncture therapy has significantly positive effects on the patients' condition in terms of the degree of fatigue (FACT-F)<sup>221</sup> and the quality of life (FACT-L).<sup>222</sup> A participant in this project (biomedical doctor) expressed positive prospects with more frequent cooperation with KM doctors for cancer patients. From this aspect, despite not being observed in the clinical level during the fieldwork in four hospitals, it follows from what has been said thus far that biomedical doctors are much less reluctant to send their patients with cancer to the KM doctors for additional KM therapies than other diseases for which the WKCT is not yet actively conducted. It seems that biomedical doctors expect pain relief on the one hand and provide their patients with an opportunity to have an alternative therapy through the WKCT on the other, in a situation whereby the disease is inextirpable in terms of the biomedicine.

Concerning the common features of the aforementioned cases, namely 1) the relief of

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<sup>221</sup> "Functional Assessment of Cancer Therapy: Fatigue. A questionnaire assessing fatigue and anemia-related concerns in people with cancer." From: "Fact-F," American Thoracic Society, retrieved 27 May 2016 from <http://qol.thoracic.org/sections/instruments/fj/pages/fact-f.html>.

<sup>222</sup> "Functional Assessment of Cancer Therapy: Lung. Physical, social/family, emotional, and functional well-being; lung cancer subscale." From: "Fact-L," American Thoracic Society, retrieved 27 May 2016 from <http://qol.thoracic.org/sections/instruments/fj/pages/fact-l.html>.



symptoms and pain control for non-fatal and/or intractable diseases, 2) additional treatments for irreversible diseases in the chronic phase, and 3) the management of incurable or end-state diseases, the following aspects were observed during the fieldwork. Firstly, all of them are diseases for which there is practically nothing to intervene to improve or completely cure with biomedical managements, given that they are either naturally cured over time without any specific treatment, they remain with permanent disability or after-effect, or remain fatal and incurable. Accordingly, biomedical doctors tend to consider the WKCT as providing their patients with a kind of ‘residual space’ for additional treatments. Secondly, and as previously mentioned, all the WKCT requests from biomedical doctors to KM doctors are requests for treatments rather than diagnosis; biomedical doctors do not send their patients to the KM sector exclusively for KM diagnosis in any case. The KM doctors who received the WKCT requests conduct KM diagnoses autonomously before applying KM therapies as requested from the biomedical doctors. However, the results of the KM diagnosis are not reported to the biomedical doctors who originally requested the KM therapies; rather, only the general contents of the therapies that the KM doctors undertook for therapies are roughly reported either in writing or verbally to the biomedical doctors who previously requested KM therapies for their patients. Thirdly, biomedical doctors generally prefer acupuncture and moxibustion to herbal medication as additional KM treatments for their patients. This tendency is particularly pronounced when the patients are being treated with biomedical medication. Regarding this issue, let us consider BB2’s statement below concerning his view on herbal medication.

*In most cases, I allow my patients to have acupuncture or moxibustion if they want. When it comes to KM medication, if their liver somatic index or their kidney is ok, I let them take herbal medicine, but if not, it can be harmful, or even poisonous... I don't let them take additional KM drugs if they have to essentially take biomedical drugs. Usually, there are officially verified cross coupling effects of biomedical drugs, but there is no such thing between biomedical drugs and KM drugs. (BB2, neurosurgery)*

Here, we notice that BB2 tries to avoid their patients taking both biomedical and KM drugs simultaneously, being afraid of KM drugs’ unverified interaction effect with biomedical drugs. By comparison, acupuncture therapy is not as unacceptable to him as KM medication. As an

example;

*If I have a chance to talk with Western people, I would not tell them anything positive about KM drugs, but... I would definitely tell them that I have a lot of experience of the positive effect of acupuncture on patients' recovery. It is certain that 'acupuncture works.' How to work is another matter, but... it works, somehow... (DB2, rehabilitation medicine)*

We should consider that DB2 has a relatively long-term experience of cooperative work with KM doctors, even before he came to work in 'D' hospital, and that he sends his patients to the KM sector for the WKCT more commonly than other biomedical doctors who I interviewed. However, many other biomedical doctors provided positive answers regarding the acupuncture therapy, even though most of them do not know the concrete mechanism of it.

Concerning the reason for biomedical doctors' requests on the WKCT, several aspects were observed. Firstly, patients' expectations and requests for additional KM treatment are very important factors in making biomedical doctors send their patients to KM doctors. As the hospital administrators in all four hospitals point out, most patients who come to WKCT hospitals already expect cooperative treatment of biomedicine and KM. In this situation, the biomedical doctors state that they are obliged to fulfill their patients' expectation as much as possible. Secondly, the suggestion of the hospital administration department for the WKCT should also be considered. Although the physicians mainly in charge of the patients have a say in the decision, hospital administrators' recommendations or programs launched for the promotion of the WKCT in hospitals have an effect on biomedical doctors' decision for the WKCT to a certain extent. However, the degree of influence varies according to the ownership structure of the hospitals. According to the interviews with physicians and hospital administrators, private hospitals ('A,' 'B' and 'C' hospital) tend to be more influential in physicians' decisions compared with public hospitals ('D' hospital), because the owners of the private hospitals can push their policy more directly than the executive managers in public hospitals. Indeed, this is one of the reasons why the WKCT from the biomedical to the KM sector in 'D' hospital is not as commonly conducted as in the other hospitals. Nevertheless, the influence of hospital administrators has a clear limitation given that the clinicians have authority for the medical decisions for their own patients, which was observed

in all four hospitals.<sup>223</sup> Thirdly, in the cases of university hospitals ('B' and 'D' hospital), cooperative research projects requested by their universities or other public organizations induce biomedical doctors to work with KM doctors for the WKCT in the clinical level as the data for their research. Finally, some biomedical doctors showed an interest in KM as an alternative medicine, or have personal acquaintance with KM doctors in their hospitals, which usually have a positive effect on biomedical doctors' more frequent requests on the WKCT in many cases, although this is not always the case.<sup>224</sup>

In this chapter, we have explored the situation in which biomedical doctors request KM treatments for their patients. In contrast to KM doctors' WKCT requests to biomedical doctors, there is no request exclusively for KM diagnoses, but rather for KM treatments. They usually tend to send their patients to the KM sector when there is no particular biomedical therapy left to improve patients' conditions, when the diseases are either naturally remedied over time without biomedical treatments, intractable or incurable. Usually upon the request from their patients or recommendation from the hospital administrators, rather than their own interest in KM therapies as an alternative medicine, biomedical doctors allow their patients to have an opportunity to receive additional KM treatments through WKCT process. In the next chapter, I will examine the ways of communication between KM and biomedical doctors during the process of the WKCT in their hospitals, followed by their perspectives on the WKCT and their counterparts.

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<sup>223</sup> Further details on this issue will be examined in Chapter V.2.4.2 'The role of hospital administrators in promoting the WKCT.'

<sup>224</sup> By contrast, there was a case in which biomedical doctors' interest in alternative medicine has a negative effect on cooperative work with KM doctors. DB3 (neurology), who has been conducting research on hand acupuncture with hand acupuncturists (non-KM licensed healers who are in conflict with KM doctors), severely criticized cooperative work with KM doctors within the frame of the WKCT, stating that KM doctors do not try to explain the principles of KM therapies logically with modern scientific terms.

## **2.3 Ways of Communication between KM and Biomedical Doctors in WKCT Hospitals**

This chapter reviews various ways of communication between KM and biomedical doctors in four hospitals, based upon the findings of the WKCT process examined in Chapter V.2.2. The frequency of the contact and the sites where the communication takes place will first be introduced, followed by the contents of the communication and the ways of how the physicians obtain the results of the WKCT from their counterpart, together with the coupling media that enables the communication between them. Subsequently, I will introduce other ways of contact between them that are not directly related to the WKCT process. In each part, I will explore the common features of the ways of communication encompassing different hospital settings, after reviewing the situations in each hospital.

### **2.3.1 Communication for Patient Management in the Process of the WKCT**

The most suitable way of describing the communication regarding patient management in the process of the WKCT is that there is no such frequent and intensive communication between KM and biomedical doctors throughout the entire period of the WKCT process. Indeed, contrary to the term ‘cooperative treatment,’ they merely send their patients to their counterpart in a relatively short period and receive the results of the diagnoses or treatments from their counterparts without any in-depth face-to-face discussion concerning therapy decisions for their patients during the WKCT process. In this regard, written or spoken communication between them restrictedly appears before and after sending their patients in most cases in all four hospitals, when they request diagnostic inspections or additional treatments from their counterpart and when their patients are sent back to their ward with the result of the diagnosis or treatment conducted in their counterpart’s sector.

In the process of the initiation of the WKCT by physicians’ decisions, it was observed in all four hospitals that requests for the WKCT were conducted through making phone calls, sending a formal request message through EMR or an informal message through online messenger programs (such as MSN messenger or Facebook), making their trainee doctors (predominantly observed in ‘A’ and ‘B’ hospital for inpatient managements) or nurses (predominantly observed in ‘A’ hospital for the biomedical doctors’ outpatients managements

and in ‘C’ hospital for in- and outpatient managements) in charge of the patients accompany their patients and convey their requests, or leaving a written request directly in the hands of the patient, who is subsequently sent to the counterpart. When their patients return to their wards after the management from their counterpart, the physicians confirm the result of the WKCT through written reports in medical records in which their counterpart answers their requests (mostly in the cases of the requests for diagnoses), additional medical prescriptions from the counterpart (mostly in the cases of the requests for treatments) or an extra informal paper with a brief and crude explanation regarding the contents of the treatments (mostly in the cases of biomedical doctors’ requests for KM therapies to KM doctors).

Concerning the concrete ways of communication in each hospital, one of the most conspicuous features in ‘A’ hospital – a medium-scale KM-oriented hospital where KM doctors work with a single biomedical doctor – is observed in the connecting role of KM training doctors (KM interns and residents) in the process of the WKCT between their superiors and the biomedical doctor. As for the WKCT for inpatients in ‘A’ hospital,<sup>225</sup> KM training doctors meet AB1 – the only biomedical doctor present during the fieldwork period – more frequently than their superiors, the heads of departments (KM specialists) who take the ultimate responsibility for the inpatient management. Compared with KM specialists’ direct contacts to AB1, it is more often the case that KM training doctors accompany their patients to AB1’s office to convey the requests of their superiors and explain the patients’ conditions. On the other hand, all the KM training doctors must be well informed about biomedical diagnoses and treatments, especially in pursuance of writing SOAP notes,<sup>226</sup> a form of progress notes describing their patients’ changing conditions. For this reason, they often inquire to AB1 about biomedical explanations concerning their patients’ conditions or

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<sup>225</sup> As previously mentioned in Chapter V.1.1 (pp. 131), all the inpatients in ‘A’ hospital are managed by KM doctors as their main medical attendants.

<sup>226</sup> A SOAP note is “a device for conceptualizing the process of recording the progress notes in the problem-oriented record. S indicates subjective data obtained from the patient and others close to him; O designates objective data obtained by observation, physical examination, diagnostic studies, etc.; A refers to assessment of the patient's status through analysis of the problem, possible interaction of the problems, and changes in the status of the problems; P designates the plan for patient care.” From: “SOAP,” *Dorland's Medical Dictionary for Health Consumers* (2007), retrieved 27 May 2016 from <http://medical-dictionary.thefreedictionary.com/SOAP>. Another interesting feature in this context is that KM doctors also widely use SOAP notes, which were originally developed in biomedical hospitals for the managements of their inpatients, for their inpatients in the KM wards.

possible biomedical treatments when they visit AB1's office. In this process, the biomedical doctor performs a role akin to an instructor to the KM training doctors for biomedical knowledge. In the cases of the biomedical doctor's (AB1) WKCT requests to the KM sector for his outpatients, nurses working in the biomedical sector usually accompany with the patients, delivering their medical records.

In 'B' hospital, verbal communication directly in person or through a telephone conversation was generally found relatively less than in 'A' hospital. Concerning this lack of direct communication for the WKCT between physicians in 'B' hospital, the majority of the interviewees highlight that both KM and biomedical doctors lack sufficient time to contact their counterparts for the WKCT due to the excessive work in their own wards. What stands out here in this hospital is that there is a significant difference in the ways of communication between the WKCT requests from the KM to the biomedical sector and the biomedical to the KM sector. In the case of KM doctors' requests for the WKCT to biomedical doctors, KM training doctors usually accompany their patients to the biomedical sector and explain their patients' condition and convey their supervisors' requests verbally, often with a written form of the WKCT request, albeit without KM medical records. In the case of biomedical doctors' requests for the WKCT to the KM doctors, biomedical records are directly sent to the KM doctors with their patients mostly without being accompanied by biomedical training doctors. In this process, the KM doctors who receive the request for the WKCT from the biomedical doctors obtain the patients' biomedical information through the biomedical records written in the biomedical wards, while the biomedical doctors who receive the request for the WKCT from the KM doctors usually acquire the patients' information directly from KM training doctors, who explain the patients' condition exclusively in biomedical terms, without examining the KM medical records written with KM terminology. In terms of writing the medical records, KM training doctors in 'B' hospital also describe biomedical diagnoses and treatments in detail in the form of SOAP notes when their patients are treated in the biomedical sector for the WKCT, such as exact numerical values of biomedical inspection, as well as concrete names and doses of medication, similar to in 'A' hospital. However, biomedical interns and residents do not describe concrete details of KM treatments when they write progress notes for their patients, because they are not informed of the KM treatments conducted for their patients from the KM sector in sufficient detail. In fact, this is because

KM doctors already know that their biomedical partners do not have any in-depth knowledge of KM, even if they are interested in KM therapy.

As for ‘C’ hospital – a medium-scale biomedicine-oriented hospital without training doctors – nurses play a more active role in the process of the WKCT than in the other three hospitals. In most cases of inpatient management,<sup>227</sup> nurses on wards transmit the patients’ demands for additional KM treatments to the biomedical attending doctors. After the biomedical doctors allow the patients’ demands, the patients visit KM doctors’ offices on the second floor in the same building, accompanied by the nurses. Responding to these requests, the KM doctors receive information on the patients’ conditions through the nurses’ verbal reports, together with the biomedical records. After the KM therapies are finished, the results are briefly reported to the biomedical doctors in charge through the nurses. According to CA1 and CK1, in some infrequent cases the physicians directly respond to each other; for instance, in case biomedical doctors forbid a patient with bone fractures from receiving an additional acupuncture therapy from KM doctors when the patient has already visited the KM sector for acupuncture therapy, or in case the KM doctors ask additional questions to the biomedical doctors concerning their patient’s condition after the patient was sent back from the biomedical sector following biomedical inspections. However, in the majority of cases, the nurses in ‘C’ hospital have a more active role in connecting the KM and biomedical doctors – shuttling between them in the process of the WKCT – compared to the physicians’ direct communication; indeed, the role of nurses in ‘C’ hospital is similar to what KM training doctors do in ‘A’ and ‘B’ hospital.

In ‘D’ hospital, given that the KM sector was newly established and its building is located separately from the biomedical sector in the university campus, there were no such active cases of the WKCT found at the clinical level during the fieldwork, unlike the other three hospitals. However, in the level of academic research, many KM and biomedical doctors were actively involved in cooperative research projects through administrative support and recommendation of the university and the hospital, which would have a positive effect on cooperative work to promote the WKCT at the clinical level.<sup>228</sup> According to DK1 and DB2,

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<sup>227</sup> Most of inpatients in ‘C’ hospital are managed by biomedical doctors as their main medical attendants.

<sup>228</sup> This will be discussed in further detail in Chapter V. 2.4.2 ‘The role of hospital administrators for the

who previously participated in several collaborative research projects and often subsequently exchange their patients for the WKCT, both KM and biomedical doctors in 'D' hospital can make a request for the WKCT by e-mail, directly connected through the integrated EMR system, as well as via direct phone calls, although such cases of the WKCT requests remain rare in 'D' hospital.

An important common feature of the ways of contact between KM and biomedical doctors in the process of the WKCT in all four hospitals is that there is a significant difference between KM and biomedical doctors in terms of their interests in their counterpart's medical treatments. Concerning this difference, let us consider the situation in 'B' hospital with the statements below.

*(Question: Do you describe all the biomedical diagnoses and treatments through the WKCT in detail when you write the progress notes for your patients?)*

*Yes. We (KM training doctors) write down all incoming information on patients' conditions, including the contents of treatments, the results of the inspections and a prognosis, whether it is KM or biomedical information.*

*(Question: When you receive the WKCT requests from the biomedical sector, in how much detail do you write the KM treatments in the request forms that you send to the biomedical doctors?)*

*We don't use any detailed KM-based technical terms when we answer the requests from the biomedical doctors for the WKCT. For instance, when we ask additional biomedical therapies for our patients with diabetics to the endocrinology department (biomedicine), the biomedical doctors report to us what time the glucose tolerance test<sup>229</sup> was done, how the result of the test was with the concrete numerical figure and how many milligrams of Diabex<sup>230</sup> was prescribed... in such*

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promotion of the WKCT.'

<sup>229</sup> It is "a test to evaluate the body's capability to metabolize glucose and based upon the ability of the liver to absorb and store excess glucose as glycogen." From: "Glucose Tolerance Test," The American Heritage Stedman's Medical Dictionary (2002), retrieved 27 May 2016 from [http://dictionary.reference.com/browse/glucose tolerance test](http://dictionary.reference.com/browse/glucose%20tolerance%20test).

<sup>230</sup> It is "a blood sugar lowering drug suitable for children over 10 years and adults whose blood sugar levels fail to improve as a result of dietary and exercise management." From: "Diabex," Virtual Medicine Centre, retrieved 27 May 2016 from <http://www.myvmc.com/drugs/diabex/>.



*a manner. However, when we report KM treatments to the biomedical doctors for their patients, we just write; 'we did acupuncture therapy,' or 'we applied herbal medication.' Nothing more than that... It is very different from when we explain my patients to my KM colleagues for cooperative work. Biomedical doctors are not interested in detailed KM treatments for their patients. If they were interested, we would gladly give them every single detail of KM treatments, but... (BK4, resident, KM internal medicine)*

*(Question: Do KM doctors report their treatments for your patients in detail? Do you sometimes refer to KM medical records (written by KM doctors with KM terminology) when you are requested to do biomedical treatments for their patients?)*

*No. We (biomedical doctors) don't even know the basic principle of KM, let alone any specific KM terms... Reading KM records? As we have no idea about KM terms, you know, how could we understand their records? We just get information on their patients through KM training doctors' explanations of their patients' conditions (which is explained with biomedical terms). (BB2, neurosurgery)*

BK4 and BB2's statements above describe KM and biomedical doctors' differing circumstances and their own attitudes regarding their counterparts in the process of the WKCT in clinical practices. As shown in BK4's statement above, KM doctors working in 'B' hospital steadily experience and develop biomedical knowledge in the process of the WKCT, whereby they exchange biomedical information on their patients' condition and the results of biomedical inspections and therapies with their biomedical partners. By contrast, biomedical doctors in 'B' hospital are not reported with concrete KM explanations from their counterpart; rather, they merely receive sketchy information on KM therapies – such as 'acupuncture' or 'herbal medication' – without any further explanation on the grounds for certain medication or acupunctural stimulation. Such a phenomenon was not only observed in 'B' hospital but also commonly in all four hospitals. In this process, the biomedical doctors' opportunities to experience the concrete knowledge of KM are very limited in this process of the WKCT in clinical settings. This implies a significant informational 'asymmetry'<sup>231</sup> between KM and

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<sup>231</sup> The concept 'asymmetry' between KM and biomedicine in the process of the WKCT appeared from the

biomedicine in the process of the WKCT in clinical practices. In this context, it is necessary to address the question of how the WKCT is possible despite the biomedical doctors' lack of concern or ignorance about detailed KM knowledge. In order to answer this question, we should consider several aspects of the WKCT process as follows. First, as already described in 'B' hospital from BK4 and BB2's statements, when KM doctors ask biomedical diagnoses or treatments for their patients to the biomedical doctors, KM and biomedical doctors exchange information on the patients' conditions and the results of biomedical actions with biomedical terms. Second, in most cases of biomedical doctors' WKCT requests to KM doctors, the biomedical doctors decide whether to allow their patients to receive additional KM treatments based upon the patients' status, as measured by biomedical information. In this process, the biomedical doctors also tend to utilize their biomedical knowledge when they interpret the contents and the results of KM treatments. Concerning the biomedical doctors' interpretation of KM treatments, let us consider the quotations from BB2 and DB2.<sup>232</sup>

*(Question: In what cases do you allow or not allow your patients to receive a KM treatment when they ask for it?)*

*When it comes to acupuncture, cupping or moxibustion, I usually let my patients go to be treated in the KM sector; in most cases. As for KM herbal medication, if the result of the blood test is ok, I allow them to take it, but if their liver or kidney somatic index does not show normal values..., in such cases, KM medication may do harm to their health. I tell them in such a way. You know, if the KM doctors adduced any scientific evidence of the effects and side-effects of their medicine, I would let my patients take it, but... (they wouldn't.) (BB2, neurosurgery)*

*(Question: Is there any general treatment guideline for the WKCT that you follow here in 'D' hospital?)*

*No, there is no such thing generally applicable in this hospital, but... I have my own principle. That is... I don't recommend that any patients have additional KM*

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process of the data analysis of interviews as a core category, which will be discussed later in Chapter V. 3.3 'KM doctors adapting to a 'biomedical world': multi-layered biomedical dominance in the process of the WKCT,' with the existing debates on the concept of biomedical dominance in situations of medical pluralism.

<sup>232</sup> The quotation from DB2 is recalled from page 165.

*treatments in their acute phase. For instance, in the case of CVA, within the first two or four weeks after the accident we don't let them receive any (biomedical) rehabilitation therapy, because it might damage the brain. When it comes to acupuncture, it may calm down the brain, but it may also stimulate it. If it is stimulated through the acupuncture therapy, metabolism may increase around there, which may aggravate the damage. I know that what I am saying may be a kind of superficial idea, but that's what I think... (DB2, rehabilitation medicine)*

As BB2 mentions above, most biomedical doctors who I interviewed decide whether to allow their patients to take KM medication based upon their biomedical knowledge with the result of the biomedical diagnostic tests, under the shared premise that the ingredients, efficacy and side-effects of KM herbal medication are not 'scientifically' corroborated and thus KM medication may have a negative effect, particularly on patients who are suspected of having liver or kidney problems. Furthermore, as shown in DB2's statement on the mechanism of acupuncture with his own biomedical understanding – a kind of nerve stimulation therapy – some biomedical doctors more actively proceed to analogize the mechanism of KM therapy in a biomedical way when they decide whether to send their patients to the KM sector for the additional KM therapy, without having any concrete KM knowledge. In this process, the biomedical doctors do not need to understand or develop knowledge on KM treatments in order to work with KM doctors, while exchanging the patients with the KM doctors who understand the biomedical terms. This is in clear contrast to KM doctors' need for biomedical knowledge to take part in the process of the WKCT with biomedical doctors. This kind of 'asymmetric' situation regarding the exchange of information between KM and biomedical doctors was observed more or less in the same way overall in all four hospitals.<sup>233</sup>

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<sup>233</sup> A general treatment principle 'biomedicine-centered patient management in the acute phase of CVA' is widely applicable in all four hospitals. However, it is slightly different concerning the point at which the KM therapies intervene for acute patient management in each hospital. With all the interviews taken together, the intervention of the KM treatment for acute patients depends on who mainly takes charge of patient management; in case KM doctors are mainly in charge of inpatient management as the main attending physicians in KM wards, they tend to intervene with KM therapies earlier than the cases in which biomedical doctors take the lead in the WKCT as attending doctors mainly in charge of the patients. For this reason, it can be said that the intervention of KM therapies for acute patients are usually initiated earlier in 'A' hospital and in the KM wards in 'B' hospital – where KM doctors are the main attending physician of the patients – than 'C' hospital and the biomedical wards in 'B' and 'D' hospital (The KM wards in 'D' hospital scarcely take charge of acute patients in their KM wards). This phenomenon shows that main attending doctors have a greater

Accordingly, KM doctors working in the WKCT hospitals constantly have to review, learn and accumulate their biomedical knowledge in the WKCT process, whereas biomedical doctors do not need to learn any detailed knowledge on KM treatment. In this process, KM doctors' biomedical knowledge plays a crucial role as a coupling medium between KM and biomedical doctors in the process of the WKCT in clinical settings.

### **2.3.2 Communication Outside of the WKCT Process**

Aside from communication during the WKCT process for patient management, KM and biomedical doctors in each hospital have various opportunities to meet and communicate with each other extrinsic to the process of the WKCT for their patient management, such as during joint conferences, steering committees and private meetings. A joint conference was observed in 'B' and 'D' hospital – both large-scale university hospitals – whereas KM and biomedical doctors' attendance in the steering committee was more dominantly observed in medium-scale hospitals such as 'A' and 'C' hospital. Particularly in 'D' hospital, a symposium on the WKCT was observed during the fieldwork period, releasing cooperative research projects of KM and biomedical doctors. In terms of private meetings – such as having lunch together or joining a congregated dinner organized by hospital administrators – such occurrences were observed in all four hospitals.

Joint medical conferences in which both KM and biomedical doctors took part were observed in 'B' and 'D' hospital. These conferences are usually hosted by KM doctors or hospital administrators, although it was also observed that some biomedical doctors in 'B' hospital who often receive the WKCT request from KM doctors suggested the conference to the KM sector. However, attendance at the conference was not compulsory, whereby only a small number of physicians voluntarily attended the meeting. According to BK1 and BA1's statements, there was a regular joint conference in 'B' hospital twice a month from 2007 to 2008, hosted by 'WKCT Center'<sup>234</sup> and KM doctors in a project to promote the cooperative

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influence in the process of the WKCT than the physicians in the counterpart, in a situation where a general guideline of the WKCT process has not been fully established in each hospital, together with a lack of direct and frequent communication between KM and biomedical doctors in the process.

<sup>234</sup> WKCT Center in 'B' hospital will be examined later in further detail in Chapter V. 2.4.2 'The role of hospital administrators for the promotion of the WKCT.'

work between KM and biomedical doctors. During the fieldwork period in 2011, another joint conference was found, suggested by BB2 and his colleagues in the department of neurosurgery (biomedicine), one of the most frequently requesting biomedical departments to the KM sector for additional KM therapies for their patients, according to BB2. He mentions that it was launched in March 2011, while biomedical doctors in the department of neurosurgery and the department of pain clinic voluntarily participated in the conference together with KM doctors in the department of acupuncture and KM internal medicine, taking place every two weeks. In each session, KM and biomedical doctors make a presentation in rotation, whereby biomedical doctors explain biomedical diagnoses and treatments on certain diseases, while KM doctors introduce general basic principles of KM. In the case of ‘D’ hospital, DK1 – a KM and biomedical doctor license holder working in the KM sector as a KM doctor – organized joint conferences several times in 2011 and 2012 in line with the hospital administration department’s efforts to promote the WKCT, utilizing her personal network with biomedical doctors in ‘D’ hospital. According to DB2 – who was invited to this conference – it was a kind of introductory course to KM, covering the basic principles of KM – such as the meaning of *Qi*, ‘*Yin* and *Yang*’ and the principles of Five Elements (*O-Haeng*) – “roughly” for biomedical doctors. A notable feature of joint conferences in both hospitals is that there is no concrete discussion on the treatment of certain patients who are actually being treated in the process of the WKCT in each hospital, in contrast with general medical conferences within KM and biomedical sector dealing with certain specific patients’ management in most cases. In this sense, the joint conferences between KM and biomedical doctors do not have an immediate influence on the process of the WKCT in clinical settings, although it could make it easier for each other to participate in the WKCT while gaining acquaintance with each other in the conference.

KM and biomedical doctors’ collaborative research projects were observed in ‘B’ and ‘D’ hospital and were especially prominent in the latter, where both KM and biomedical doctors work as professors in the KM and biomedical school at the home university of ‘D’ hospital. As briefly introduced in Chapter V.2.2 (pp. 166), a public symposium on the WKCT was observed during the fieldwork period of 2012 in ‘D’ hospital. This symposium was convened as a part of long-term project of the promotion of the WKCT in ‘D’ hospital, organized by the medical research institute of ‘D’ university and managed by ‘D’ hospital, under the financial

support of the South Korean government. In this symposium, 11 research projects were presented to the public,<sup>235</sup> in all of which both KM and biomedical doctors joined together, except for one presentation reporting the current statistical state of the WKCT in ‘D’ hospital. During the session, two research articles on the result of the WKCT for inpatients in ‘D’ hospital were introduced: research on the effects of additional acupuncture therapy on patients with lung cancer, as well as the effect of additional acupuncture on the periocular area in patients with xerophthalmia (dry eye syndrome). For these research projects, biomedical doctors in each project chose voluntary applicants of participants among their patients being treated in their wards and made the applicants visit their counterparts in the KM department for additional acupuncture therapies. According to the results on the therapies on patients with lung cancer, it was reported that additional acupuncture therapy in parallel with biomedical chemotherapy had a significantly positive effect on the patients’ conditions in terms of degree of fatigue (FACT-F) and quality of life (FACT-L), while additional acupuncture therapy in parallel with biomedical medication (restasis)<sup>236</sup> significantly shortened the therapeutic period in patients with xerophthalmia. In this process, both KM and biomedical participants in the research experienced the actual WKCT process at the clinical level, which corresponds with the ways of the WKCT processes in the other three hospitals observed in the fieldwork. In this regard, interviewees in ‘D’ hospital expressed their expectation that this experience of collaborative academic research would have a positive effect on more frequent contact between KM and biomedical doctors for the WKCT at the clinical level in ‘D’ hospital. However, this research process does not show any further degree of communication than the clinical processes in the other three hospitals, given that the area of patient treatment was strictly divided between the KM and biomedical sector and separately managed by KM and biomedical doctors, despite establishing the research topics in union. In addition, the criteria for the evaluation of the treatment results and their interpretation were all biomedicine-based terms – such as FACT-L and FACT-F – which can be observed overall in the actual process of the WKCT for patient management in the other

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<sup>235</sup> In this symposium, three projects on the actual state of the WKCT with statistical data in ‘D’ hospital, two projects on the results of the WKCT in clinical settings, five projects on the suggestion for future plans of cooperative work for the promotion of the WKCT and one project on the education on the WKCT in KM and biomedical schools in ‘D’ hospital were introduced.

<sup>236</sup> “Restasis (cyclosporine) is an immunosuppressive agent. Cyclosporine may reduce inflammation in the eye(s). Restasis is used to treat chronic dry eye that may be caused by inflammation.” From: “Restasis,” Drugs.com: Source of Drugs Online, retrieved 27 May 2016 from <http://www.drugs.com/restasis.html>.

three hospitals.

In the cases of ‘A’ and ‘C’ hospital – smaller hospitals without medical schools compared with ‘B’ and ‘D’ university hospitals – there were no such joint conferences or collaborative research projects observed during the fieldwork period. Instead, the KM and biomedical doctors have more opportunities to meet together in the steering committee organized by the department of hospital administration. During this monthly meeting, hospital administrators report various administrative issues and make requests to the physicians in light of hospital management. According to CA1, issues on the WKCT are also discussed in the meeting, e.g. asking the physicians to allow their patients to receive the WKCT in certain cases of diseases. However, more detailed contents in the process of the WKCT are not further discussed, because such detailed contents belong to physicians’ own areas of decisions. In this sense, there is no in-depth discussion between KM and biomedical doctors concerning the process of the WKCT during the session of the steering committee. Regarding private interpersonal communication between KM and biomedical doctors, physicians in smaller hospitals such as ‘A’ and ‘C’ hospital have more opportunities to meet each other in person during working hours than in ‘B’ and ‘D’ hospital, where each sector of KM is so large that the physicians have fewer chances to meet the physicians outside of their wards. It was reported that KM and biomedical doctors in ‘A’ and ‘C’ hospital often have lunch together and engage in conversation. As for ‘B’ and ‘D’ hospital, such opportunities only arise during congregated dinners officially organized by hospital administrators. Regarding these private meetings, all the interviewees stated that they do not mention or discuss any concrete matters related to the process of the WKCT.

Put briefly, meetings of KM and biomedical doctors extrinsic to the process of the WKCT – i.e. in joint conferences, steering committees and other private meetings – are disconnected with the concrete process of the WKCT. While they may play a positive role in terms of prompting more frequent requests for the WKCT by presenting more opportunities to get to know each other, they do not appear to subserve the lack of communication between KM and biomedical doctors in the process of the WKCT in the actual clinical practices.

In Chapter V.2.3, we examined the ways of communication between KM and biomedical

doctors in the process of the WKCT for their patients in four hospitals. Exploring the common features in four hospitals, they can be summarized as follows:

- The WKCT process starts with sending patients to the counterpart for additional diagnoses or treatments based upon the decision of their main attending doctors and it ends with receiving the results of the diagnoses or treatments from the counterpart. Once they have decided to send their patients to the counterpart for the WKCT, KM and biomedical doctors tend to entrust their counterparts with the diagnoses or treatments while their patients are being treated outside of their area. In this process, there is no active discussion concerning their counterparts' treatments between KM and biomedical doctors involved with the WKCT for certain patients. The contents of the requests and the results of inspections or treatments are more often delivered to the attending physicians who made WKCT requests by nurses, training doctors or patients, rather than directly by the physicians involved with the WKCT.

- When KM and biomedical doctors exchange information on patients' conditions and the results of the diagnoses and treatments, biomedical terms are widely used as a means of communication. For this reason, KM doctors steadily utilize and have to develop their biomedical knowledge while they are involved with the WKCT with biomedical doctors. By contrast, biomedical doctors are not exposed to learning or experiencing detailed KM knowledge during the process of the WKCT with KM doctors.

- Various ways of contact between KM and biomedical doctors extrinsic to the actual process of the WKCT were observed in each hospital, including joint conferences, collaborative research projects and private meetings, such as having lunch together or being invited to congregated dinners. Although such contacts may have a positive effect on more frequent WKCT requests, possibly promoting a better understanding of each other, they do not directly affect the concrete process of the WKCT in clinical practices.

The next chapter examines external factors that exert an influence on physicians' decisions in the process of the WKCT. In this part, we will take a closer look at the roles of patients, hospital administrators and legal regulations involved with the WKCT, examining how and to what extent they have an effect on the physicians' decisions in the process of the WKCT.



## **2.4 External Factors Related to the Process of the WKCT**

In the previous chapters in Part V.2, we have examined the process of the WKCT in clinical practices and the ways of communication between KM and biomedical doctors in such a process. In this chapter, we will consider external factors that influence KM and biomedical doctors' decisions in the process of the WKCT. During the interviews with KM and biomedical doctors, I discovered several common extrinsic factors that the physicians believe influences physicians' decisions and actions in the process of the WKCT. This chapter begins to examine the role of patients who are actually involved with the WKCT process, including how KM and biomedical doctors react to their patients' therapeutic needs and expectations, which influence physicians' decisions in the process of the WKCT. In connection with this, the general clinical preferences of South Koreans will also be introduced. Moreover, hospital administrators' roles in each hospital will be discussed in terms of their efforts to promote the WKCT to the physicians. Finally, legal regulations, government policy, and national health insurance policy related to the WKCT will be introduced as environmental factors that influence the physicians' decisions in the process of the WKCT.

### **2.4.1 The Role of Patients in the Process of the WKCT**

In the process of the WKCT, patients are sent between the KM and biomedical sectors. In this sense, they may seem passive agents concerning the medical actions of the physicians in each ward. However, most of the physicians who I interviewed mentioned that their patients have a crucial effect on their decisions for the WKCT. In this part, I will examine how KM and biomedical doctors conceive the role of their patients in the process of the WKCT. After examining the influence of the patients who actually receive the WKCT, I will proceed to introduce how they consider being influenced by medical consumers' general preferences for clinical care in South Korea at present, as their latent patients in a broad sense.

Concerning the role of patients who receive the WKCT in the process of the WKCT, they are involved with the decision of the WKCT process through either agreeing with their physicians' suggestions or asking for the WKCT directly to their attending physicians in charge of their care, already expecting collaborative care of KM and biomedicine when

hospitalized to WKCT hospitals in many cases. As for KM doctors' WKCT requests for acute patient care and intense pain control, most of the KM doctors answered that their patients follow their instructions for the biomedical treatments through the WKCT in most cases. Aside from some cases observed in chronic patient managements in KM wards, it is mostly when the patients are hospitalized in biomedical wards that they have to decide whether to agree/disagree or ask for the WKCT request for additional KM therapies. As shown in Chapter V.2.2.2, biomedical doctors respond to their patients' demands or expectations for additional KM treatments and make a WKCT request to KM doctors as long as they consider that the additional KM treatments would not have a negative effect on their biomedical care. In this context, it is necessary to ascertain the clinical preference of the patients who choose to receive medical care in WKCT hospitals. Concerning this issue, let us compare the situation in B hospital, – one of the oldest and best-known WKCT hospitals in Busan – to that in D hospital, which is better known for its biomedical sector – the largest biomedical hospital in the city of Busan – than the newly launched KM sector.

*The main character of this hospital ('B' hospital) known to the public is that both the KM and biomedical sector co-exist in one place. So, the patients already expect the WKCT when they come here. You know, there are many other larger general hospitals near here in this city. Most of those who visit here expect to receive both KM and biomedical care in one place at the same time.... (BK3, former president of 'B' hospital, MK doctor)*

*About 70 percent of the patients coming to us ('B' hospital) already allow for the fact that this is a WKCT hospital... When it comes to strokes, patients also know that biomedical care has precedence over KM in the acute phase. So many of them choose to stay in biomedical wards, but after some time we often send them to the KM sector for additional KM care. Some of us (biomedical doctors) are reluctant to do this, but the majority of us allow them to have additional KM treatments, as long as they want such therapies. (BB2, neurosurgery)*

*As the majority of the patients coming to 'B' hospital basically know the concept of the WKCT, biomedical doctors there try to meet the needs of the patients anyhow.*

*For instance, most of the stroke patients there receive KM acupuncture therapy. In the case of 'B' hospital, in a situation with such an atmosphere (the majority of the patients already expect the WKCT), most of the patients express their wish to receive additional KM treatments of their own accord. Then the biomedical doctors in charge of them just say, "OK, I see." You know, like this... But here ('D' hospital), first of all, there are not many patients who already know about the existence of the KM sector in this hospital complex, and secondly, even if they ask us for the WKCT, there is a kind of nuance from quite a few of us (biomedical doctors); "well, I doubt the effect of KM therapies," you know... (DB1, neurology)<sup>237</sup>*

According to the statements of BK3, BB2 and DB1, most KM and biomedical doctors in 'B' hospital recognize that many of their patients already expect the WKCT even without their suggestion when the patients have chosen to visit this hospital, as 'B' hospital is well known among the public as a WKCT hospital. Meeting their patients' expectations, the majority of physicians in charge make a request to their counterpart for the WKCT. Such a state of affairs was especially remarkable in 'B' hospital, best known as a WKCT hospital in the city of Busan, with a reputation with its KM school since the early-1990s. Such an attitude was similarly observed in 'A' and 'C' hospital, which have over 10 years' experience of the WKCT. By contrast, for 'D' hospital – which has little experience of the WKCT and was still not well known to the public as a WKCT hospital during the fieldwork in 2012 – expectations about the WKCT of hospitalized patients were not as high as in the other hospitals, which resulted in the lower frequency of the WKCT requests, especially in the case of biomedical doctors' requests for additional KM treatments. Indeed, this is seemingly because additional KM therapies through WKCT requests are considered as not essential, but rather a kind of adjuvant therapy.

Concerning the aspect of the patients' preferences for KM treatments in 'A,' 'B' and 'C' hospital, both KM and biomedical doctors generally mention KM-friendly attitudes among the general public in South Korea concerning certain diseases, such as CVA, chronic orthopedic pains and other chronic diseases. In this context, patients with such diseases

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<sup>237</sup> He had previously worked in 'B' hospital as head of neurology for one year before working in 'D' hospital.

hospitalized in biomedical wards in these hospitals have certain expectations about additional KM therapies. In response to such expectations, the biomedical doctors in charge of them make a request to KM doctors for additional treatments, while expecting to increase patients' treatment satisfaction through the KM therapies. In addition, in case there is no other special biomedical care available – such as for patients with terminal cancer or patients with Bell's palsy after the acute phase – the biomedical doctors also tend to consider these additional KM treatment requests as a better way to improve patient management, even though many of them remain skeptical about KM therapies' scientific effects. Concerning this issue, let us consider DB1's statement, expressing his view on KM acupuncture therapy for his patients.

*As for research papers on the effect of acupuncture presented in South Korea (mostly conducted by KM doctors), we (biomedical doctors) doubt their reliability regarding the sampling of object groups, and even if the sampling is done accurately with a randomized controlled trial in some papers, it still sticks out to us that their research methods are not precise enough. So, I put more trust in German articles on the effect of acupuncture therapy than South Korean ones. But the results of most German papers show that the patients are satisfied with the acupuncture therapy, in terms of a patient satisfaction index, although there are no research results providing objective evidence for positive clinical effects of acupuncture in any diseases. This means that the real positive effect of acupuncture has not been objectively proven yet, but it is clear that patients are satisfied with the acupuncture therapy. You know, patients' satisfaction is a very important thing to us in everyday clinical settings... At this point, as long as the treatment is harmless, we can allow or recommend our patients to receive this treatment, even if there is a lack of evidence for the treatment effect and it lays an extra burden on the patients due to additional medical costs. (DB1, neurology)*

To put DB1's statement above differently, it can be summarized as follows; 'if my patients ask whether the acupuncture therapy is effective, I would rather give a negative answer to them, because there has been no fully scientific evidence about its curative effect thus far and I still doubt the real therapeutic effect. However, if they ask me whether I could let them receive acupuncture because they want it, I would allow them as long as it does not harm

their health, because it is very often reported that patients are satisfied with the acupuncture after receiving it.' Accordingly, biomedical doctors working in WKCT hospitals often utilize additional KM therapies through the WKCT process as a way of patient management for their patients' satisfaction. In this way, patients' preferences for additional KM treatments have an effect on biomedical doctors' decisions for KM therapies through WKCT requests.

Compared with the patients' preference for KM therapies in the case of certain diseases illustrated above, it was much more frequently observed that patients' 'biomedicine-friendly' attitudes have an enormous effect on the process of the WKCT, and particularly on KM doctors' WKCT requests for biomedical care. First, in the cases of the WKCT requests for biomedical diagnosis, most KM doctors responded that they often feel forced to request the WKCT for biomedical inspection to better communicate with their patients, not only due to their own clinical needs to check up their patients' condition. Regarding this situation, it is useful to examine the statements of BK2 and AK1, as follows.

*For instance, if I explain to one of my patients (with KM principles), 'you have a temperature on your liver, so that you should receive a therapy that lowers the fever on your liver,' they wouldn't understand what I mean, because KM is non-mainstream medicine at present. After all, in order to make them understand, such as 'you have liver problems, or you have a fatty liver,' we need a numerical way, either using a liver somatic index through blood tests or using an ultrasound imaging (which belongs to the biomedical domain) to check up whether the patient has a fatty liver... At this point, we need to 'steal' biomedical inspection... (BK2, KM internal medicine)*

*As a KM doctor, I make use of KM diagnosis methods, and I am proud of it, but I need biomedical knowledge to make conversation with my patients. That's why we need biomedical knowledge. When it comes to a patient with a hernia of intervertebral discs, it is one of the most widely known diseases to folks: you know, there is no one who hasn't heard of it. So, biomedical terms of diseases and biomedical inspection to diagnose a case affords us (KM doctors) the means of communicating with the patients. For this, we need X-rays or MRI scans. These are*

*also useful to decide prognosis more accurately. (AK1, KM rehabilitation, acupuncture & moxibustion)*

As exemplified in the statements above, most KM doctors commonly share that they need to account for their patients' conditions with biomedical terms and principles rather than the principles of KM, because the patients are much more familiar with biomedical explanations and terms. As illustrated in the episode of a patient with liver disease, BK2 expresses his distress over making his patients understand his KM-based explanation of his patient's condition. For this reason, he stated the need to request biomedical inspections through the WKCT with help from biomedical doctors to adduce biomedical evidence that can be better understood by his patients, aside from his own clinical need. Likewise, AK1 also explains an example with his patient with back pain, whereby he needed to check up through biomedical diagnostic devices whether his patients' intervertebral discs are herniated. In many cases, this is undertaken to make his patients understand their diagnostic conditions more easily rather than to simply have more accurate information on his patient's condition for better treatments, even though he thinks his own judgment with KM diagnosis is sufficient to determine the diagnosis. On the other hand, at the end of his statement above, AK1 mentions an aspect of measuring prognosis as another advantage of biomedical diagnosis over KM. DK2 expounds on this issue in further detail as follows, comparing biomedical and KM diagnoses.

*A weak point of KM is that it is more difficult to judge a prognosis of diseases than biomedicine. The concept of prognosis, whether the patients are recovered from certain diseases or not, and if they are recovered how long it will take to be recovered, has not been developed well within the concept of traditional Korean medicine ... KM diagnosis has more difficulty in answering such questions than biomedical diagnosis. However, people nowadays would like to know more exactly whether and when they will be recovered when they are ill. This is also one of the reasons why we are often dependent on the WKCT with biomedical doctors for biomedical inspection. (DK2, KM doctor, professor of division of longevity and biofunctional medicine)*

As another important factor whereby patients have an effect on KM doctors' decisions for biomedical inspection through the WKCT, DK2 indicates the matter of prognosis. Compared

with biomedical diagnoses, KM has a weakness in judging the accurate prognosis of certain specific diseases. According to his further explanation on the traditional conceptualization of health and illness, KM has mainly focused on the overall balance of the body – such as avoiding weakness or strengthening the whole body – rather than a cure for a certain specific disease, which is mainly dealt within the biomedical concept. For this reason, he proceeds to explain that it is not easy within the frame of KM to develop a concrete prognosis of a certain disease, due to KM's holistic paradigm on health and illness. In this situation, it is necessary for KM doctors to utilize biomedical diagnoses to inform their patients with a more accurate prognosis, which the patients would like to know.

Aside from patients' aforementioned KM preference for certain chronic diseases, patients' general preferences for biomedical therapy are also widely observed in line with their preference for biomedical inspections. It is related to their skeptical attitudes about KM treatments not being a serious curative care, having more trust in biomedicine for certain diseases or increased awareness and familiar attitudes about the contents of biomedical treatments, which is connected to their preference for the biomedical diagnoses. The following remarks of AK1 and BK2 hold relevance regarding this point.

*Even in a situation where we (KM doctors) can effect a complete cure with KM therapies without any help from biomedical treatment, not only biomedical doctors but also the patients often consider KM therapy just as a kind of a general restorative, not a real therapeutic agent. From the viewpoint of KM, we provide them with a 'treatment,' a 'therapy' to cure their illness, but they often consider our treatment as an adjuvant clinical help, just like a kind of functional food for health. (AK1, KM rehabilitation, acupuncture & moxibustion)*

*As for fever, there are quite a few cases from the view of KM that we don't have to bring it down immediately, but from the view of biomedicine there is no such case; once anyone has a fever, it should be lowered... When we (KM doctors) tell the patients with such cases that 'it is better to leave it as it stands, let's wait and see whether the fever breaks without using a fever reducer while we give you a KM therapy,' of course, some of the patients follow us as we recommend. But much more in general, they would say, 'I heard that in such cases the fever must be*

*immediately lowered with (biomedical) antifebrile.’ If they say so, after all, a need to reduce the fever arises. (BK2, KM internal medicine)*

As shown in the examples above, AK1 and BK2 complain about the situation that they experience in the clinical settings, in which KM is often underestimated in its immediate healing capacity by biomedical doctors and patients, not being fully recognized as a curative medicine. BK2 proceeds to argue that such attitudes have an effect on KM doctors’ more frequent requests for biomedical treatments, even in the cases whereby they consider that additional biomedical treatments are not essential or urgent for patients’ management. The example of a patient with a fever – mentioned by BK2 – describes another situation in which not only the understanding of diseases connected with the diagnostic concepts but also the understanding of the ways of the treatment are more friendly with biomedical principles than KM among the public in South Korea. Accordingly, in the case of a patient with fever, KM doctors are requested by their patients to ask for biomedical medication through the WKCT request to biomedical doctors to alleviate the fever, even if they consider that it is not necessary from the view of KM principles, because most of their patients take such a biomedical way of treatment for granted. Regarding these situations in clinical settings, DK2 provides us with a more detailed historical and theoretical background as follows.

*It hasn’t been long since KM claimed to stand for curative medicine. Originally, KM clinics used to be a place where people were provided with a ‘restorative’ treatment. Of course, ‘restorative’ here doesn’t mean simply to ‘recover energy’ in general... KM attributes the main cause of illness to the lack of inner energy in the human body, so the concept of restoring energy in patients’ bodies is essentially connected to the concept of curing the patients’ illness, in the sense of the traditional concept of KM. Simply put, to restore the energy is to cure the illness. For this reason, KM was developed as restorative medicine, described with modern terminology. However, since KM has become professionalized in the modern era, KM doctors have been increasingly interested in curing various kinds of diseases compared with before. The problem is that such patients with various diseases would not come to KM clinics; instead, they go to see a biomedical doctor. (DK2, KM doctor, professor of division of longevity and biofunctional medicine)*



DK2's statement implies that the traditionally inherent characteristic of KM – namely, curing illness through restoring the body's inner energy – does not fully correspond with the modernized concept of health and illness widely accepted by the public in South Korea, originating from the principles of biomedicine, aiming at the standardization of diagnosis, accurate prognosis and the immediate cure of patients' diseases with improving symptoms. His statement also suggests that KM clinicians' difficulty in proceeding with KM therapies to their patients lies in the fact that the concept of health and illness has become biomedicine-friendly over time. Regarding such changes in the concept of health and illness in Korea, let us examine further statements of KM doctors (BK2, AK3, DK2) below.

*If a traditional KM doctor had told his or her patients in the period of the Joseon dynasty (1394 – 1910), 'you have a serious fever in your stomach, and it has a negative effect on your liver,' they would have understood all that the KM doctor meant, but you know, as the universal terms at present are biomedical terms, we need to 'borrow' biomedical diagnostic tools. (BK2, KM internal medicine)*

*Some elderly patients often clearly understand what we explain in the way of KM, but if we (KM doctors) explain the problems to younger generations only with KM terms, they would take our cure (KM doctors) with much less reliability... Then, they would go away from us sometime. (AK3, resident, KM rehabilitation)*

*In the past, people used to take it for granted that when they had a fever, they would work up a sweat while eating hot and spicy foods to generate heats in their body, but now, people take a fever reducer when it is over 38 degrees Celsius after taking their temperature with a thermometer. (DK2, KM doctor, professor of division of longevity and biofunctional medicine)*

Concerning the reason for the patients' preferences for biomedical explanations over KM ones, most KM doctors indicate that the concept of health and illness in Korea has changed from a KM- to biomedicine-oriented conceptualization. After all, this results in KM doctors' more frequent WKCT requests for biomedical care, corresponding to the patients' preferences

for biomedicine. Such preferences for biomedicine over KM particularly emerge when KM and biomedical doctors have different views on patient management in the process of the WKCT. Regarding this issue, let us consider the following quotations of a KM doctor (BK1) and a biomedical doctor (BB2) in 'B' hospital.

*For instance, suppose a patient of mine needs to take biomedical drugs through the WKCT while taking KM drugs. If a biomedical doctor in charge of the patient's biomedical care told me, 'you should prove that there are no side-effects and interactions with biomedical drugs in your herbal medicine' (if you can't, you should hold off herbal medication), we would be disconcerted. Then we should give the patient a choice. In such a situation, patients tend to be obedient to the biomedical doctors, because they usually advocate it much more strongly than we do. (BK1, KM internal medicine)*

*(Question: When you receive a WKCT request from KM doctors, how do you mediate between you and KM doctors?)*

*When patients from a KM ward come to me (a biomedical doctor) for biomedical care and ask me whether they can take herbal KM medicine and biomedical drugs at the same time, about 90 percent of them do as I recommend. If I say, 'it's better not to take herbal medicine while you are taking biomedical drugs here,' they usually do not take it for the meanwhile (in order to take biomedical drugs). You know, as biomedical medication is statistically verified and the prognosis of each drug is already specified, there is no such case that KM doctors say no to taking biomedical drugs when their patients ask to allow them to receive biomedical care. (BB2, neurosurgery)*

The statements above describe clinical situations in which KM and biomedical doctors are in conflict regarding simultaneous medication from KM and biomedicine in the process of the WKCT.<sup>238</sup> In the examples mentioned above, biomedical doctors who received a WKCT

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<sup>238</sup> Such conflicts between KM and biomedical doctors are not frequently observed in the process of the WKCT in clinical practices, because in most cases the WKCT process is initiated with the decision of the attending physicians directly in charge of the patients in each ward, while the care in the counterpart is entrusted to the physicians in there. The situation described above is one of the most typical rare cases in which the conflicts

request from KM doctors argue for holding off KM medication while biomedical drugs are needed for patients, expressing concern about unknown side-effects or extra stress on the liver, whereas KM doctors want to continue KM medication. In such cases, both BK1 (KM doctor) and BB2 (biomedical doctor) recognize without a dissenting voice that the patients tend to follow the biomedical doctors' advice over that of KM doctors. In this situation, BK1 acknowledges that KM doctors are in a disadvantageous position in terms of carrying out their own intentions. Although this situation may result from the fact that KM herbal medication is usually applied to boost patients' general conditions while biomedicine is applied more directly to solve the immediate problems regarding patients' conditions in many cases, in such situations the patients place their trust more in biomedicine and biomedical doctors than KM and KM doctors. Moreover, KM doctors have difficulty in contradicting the biomedical doctors' arguments and bringing around their patients to them, being asked to provide proof that there are no cross-coupled side-effects of KM herbal medicine when taken together with biomedicine, in a 'scientific' or – in other words – 'biomedical' way in which the biomedical doctors can understand and accept, and where the patients have more confidence in the statistical basis of biomedicine in terms of its remedial effects and more accurate judgment for prognosis. Regarding the patients' preferences for biomedicine, such as biomedicine-friendly attitudes and the biomedicine-oriented perception of disease, DK2 and DB3 explain the situation in a broad sense within the frame of the general knowledge system in South Korea in the modern era as follows.

*The way of biomedical explanation is not different from the general way of explanations in different fields in South Korea at present, sharing with a kind of universal language and common explanations. As people come to see us (KM doctors) with such a biomedical knowledge, we would look unprofessional to them if we don't know and use biomedical terms and explanations. (DK2, KM doctor, professor of division of longevity and biofunctional medicine)*

*When we explain a phenomenon, we should express with the language of the day. KM cannot express their concepts and principles with modern words. Concepts like Eum (Yin) and Yang, how should we explain such concepts? What did the people of that time want to express with the concepts Eum and Yang? Why don't any KM*

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appear between KM and biomedical doctors in the process of the WKCT.

*doctors answer this question with modern words? (DB3, neurology)*

Both of them recognize that biomedical explanations about health and illness can be more widely accepted to the public than explanations about KM because biomedical terms and explanations are closer to the current general knowledge system in the modern South Korean society. In this connection, DK2 acknowledges that biomedicine is the mainstream medicine today in South Korea, while DB3 argues that the terms and concepts of KM do not relate to modern scientific words that people can easily understand and commonly use. After all, this results in patients' more familiar attitudes concerning biomedical explanations, promoting biomedical doctors' more advantageous position than KM doctors in the process of the WKCT in clinical practices, as described above.

Such a finding with regard to patients' role in the process of the WKCT corresponds to the result of survey research on the South Korean medical consumers' attitudes concerning KM (Yeong-ho Jeong et al. 2008),<sup>239</sup> as described below in table V.8. Regarding the question of when to visit KM clinics/hospitals for medical treatments (question 1), 47 percent of the respondents answered that they choose KM as the second choice after first seeing a biomedical doctor and if they do not get better with biomedical care, while only seven percent of them visit KM hospitals as their first choice for their medical care. Moreover, 21.8 percent of the respondents showed a very skeptical view about KM, stating that even when their health problems are not solved with biomedical care, they would not take KM therapies. Corresponding to the result of the first question, 44.9 percent of the respondents answered the question concerning the role of KM in the South Korean medical system (question 2) that it plays a secondary role in supplementing biomedical care, while only 24 percent of the respondents acknowledged that KM serves an equally important role as biomedicine. Ultimately, the majority of patients' preferences for biomedicine over KM described in this chapter underpin the result of Jeong's survey research, namely that even those patients in the WKCT hospitals who chose to visit such hospitals expecting KM and biomedical doctors'

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<sup>239</sup> This study was conducted from 18 July 2007 to 21 September for the 866 interview-based households nationwide in South Korea as the second pilot study to implement data for 'Korea Health Panel,' an annual research project conducted since 2008 by the Korea Institute for Health and Social Affairs (a national research institute under the Prime Minister's office) and the NHIS for the suggestion and establishment of national health policy. From: Official website of Korea Health Panel, retrieved 27 May 2016 from <https://www.khp.re.kr:444/>.

collaborative treatments assign biomedical diagnosis and treatments superiority over KM despite their particular expectations about KM in the cases of certain diseases. Accordingly, such an attitude emerges in the process of the WKCT with advantageous positions of biomedical doctors over KM doctors.

Table V.8 Health Care Consumers' Attitudes towards KM (Yeong-ho Jeong et al. 2008: 140)

Question 1: When do you usually visit KM hospitals/clinics?	%
- I go to see a KM doctor when the problem is not solved with biomedicine, after firstly visiting biomedical doctors.	47.0
- Even in the case the problem is not solved with biomedicine, I do not visit KM doctors.	21.8
- As an adjuvant treatment for biomedical care.	14.7
- When the disease outbreaks, I firstly visit KM.	7.6
- Other	6.6
- No response	2.3
Question 2: What do you think of the role of KM?	%
- It plays an ancillary role for biomedical care for the certain cases of medical problems which biomedicine alone cannot cure completely.	44.9
- It provides with an equally important role as biomedicine.	24.0
- It provides only with restorative.	20.6
- It provides with main medical care, preceding biomedicine.	4.0
- Other	1.7
- No response	4.7

This chapter has examined patients' role in the process of the WKCT, especially concerning physicians' decisions to initiate WKCT requests. In the cases of biomedical doctors' WKCT requests for KM treatments, their patients' expectations about additional KM treatments in these hospitals prompt them to request the WKCT more frequently to improve their patients' treatment satisfaction as a kind of patient management tool, regardless of their recognition of the real curative effect of KM treatments. However, it was more dominantly observed that patients' general preferences for biomedical diagnoses and treatments over KM have an effect on KM doctors' more frequent WKCT requests to the biomedical sector than what the KM doctors actually believe is necessary in terms of biomedical help. Such biomedicine-friendly

attitudes among patients are deeply related to the fact that biomedical terms and principles have more persuasive power to the public in modern South Korean society than KM, based upon traditional notions of health and illness. Consequently, the patients' such attitudes have an effect on the power relations between KM and biomedical doctors in the daily clinical process of the WKCT in hospital settings. In the next chapter, I will examine the role of hospital administrators in each hospital in the process of the WKCT, as another external factor affecting the physicians' decision for the WKCT.

#### **2.4.2 The Role of Hospital Administrators in Promoting the WKCT**

During the fieldwork, it was observed that all four hospitals claim to stand for the WKCT through the public relations for their hospital marketing, while they also tried to promote the process of the WKCT internally within their hospitals in various ways, supporting their physicians' actions for the WKCT and recommending the WKCT to the patients. Such tasks are mainly conducted by the hospital administration department, mostly under the supervision of hospital owners or hospital directors in each hospital. In the process of promoting the WKCT within their hospital, hospital administrators particularly make an effort to persuade biomedical doctors to accommodate the WKCT, as the biomedical doctors often adopt more negative attitudes towards the WKCT than KM doctors in many cases. In this chapter, we will take a closer look at the role of hospital administrators – including hospital directors and owners – mainly based upon the interviews with hospital administrators (AA1, BA1, CA1, DA1), including how and to what extent they support and promote the WKCT and are involved with the physicians in charge of the WKCT process in their hospitals. First, various forms and activities of hospital administrators to promote the WKCT will be introduced in each hospital. Subsequently, it will be examined how and to what extent their efforts influence the process of the WKCT.

Concerning hospital administrators' promoting activities for the WKCT observed in the fieldwork, first – as mentioned in Chapter V.2.3.2 'Communication outside of the WKCT process – it is observed in all four hospitals that the department of hospital administration or hospital directors arrange occasions for KM and biomedical doctors to meet with each other in various ways, through organizing congregated dinners ('A,' 'B' and 'C' hospital), and

making common areas within the hospital where both KM and biomedical doctors share a space ('D' hospital, where the KM and biomedical sectors are separated with different neighboring buildings). This aims to provide KM and biomedical doctors with more opportunities to engage private communication, expecting that such a relationship will have a positive influence on the process of the WKCT. Second, there is a case whereby the department of hospital administration organizes monthly regular meetings for all KM and biomedical doctors together to request cooperation for the WKCT. Indeed, this was observed in two medium-scale hospitals ('A' and 'C' hospital), where it is supposedly easier to convene a meeting for all the physicians working in the hospital, compared to the large hospitals ('B'- and 'D' hospital). According to AA1, there is a monthly meeting of the steering committee hosted by the department of hospital administration in 'A' hospital. In this meeting, the head of the medical treatment department<sup>240</sup> (AK1, KM doctor), the head of the training unit<sup>241</sup> (AK2, KM doctor), the director of the biomedical practice (AB1, biomedical doctor) and the head of the hospital administration department (AA1) have a conference with administrative issues related to patients' care, including those in the process of the WKCT. In the case of 'C' hospital, CA1 mentions that there is a monthly staff meeting that all the physicians attend, hosted by the department of hospital administration. In this meeting, CA1 (head of hospital administration department) usually explains the financial issues of the hospital, including the analysis of health insurance fees in the preceding months. She also mentions that she often asks during the sessions for understanding among the physicians – especially the biomedical doctors – for more frequent WKCT requests in certain cases of patients to achieve greater financial profit regarding hospital management. Third, in the case of 'B' hospital, a separate project unit called 'WKCT Center' was launched by the department of hospital administration in 2007, comprising hospital administrators and physicians to support and promote the WKCT within the hospital. Finally, in the case of 'D' hospital, there is a short-term overseas training program organized by the hospital administration departments in the KM and biomedical sector<sup>242</sup> for KM and biomedical doctors visiting cooperative hospitals where traditional and biomedical doctors work together, such as in China or Taiwan. According to DA1, he devised this program during his time as the director of the biomedical sector of 'D'

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<sup>240</sup> One who is in charge of the affairs in clinical departments, occupying the highest position among physicians under the director and assistant director of the hospital.

<sup>241</sup> Attending physician who is in charge of the education of training doctors.

<sup>242</sup> In 'D' hospital, KM and biomedical sector have their own administration department in each sector.

hospital. He suggested this program to biomedical doctors who he believed are presumably 'less hostile' to working with KM doctors for the WKCT, sending them to those hospitals abroad for about a week with KM doctors whose specialty corresponds with that of biomedical doctors participating in this program. He mentions that this program aims to make the participant physicians build personal relationships for cooperative work in clinical settings in the future, as well as collaborating on cooperative research.

As listed above, various actions of hospital administrators are conducted to promote the WKCT, varying in different ways in each hospital depending on its circumstances. Despite such differences, there are several common features across different clinical settings regarding the role of hospital administrators in promoting the WKCT. First, although all four hospitals try to promote and support the WKCT through the efforts of the hospital administrators, their influence has limits in that the full authority for the definitive decisions in terms of initiating WKCT requests are in the hands of the physicians who are mainly in charge of the patient management. Accordingly, hospital administrators' roles are limited to supporting the physicians' actions in the process of the WKCT. Another common feature concerning the role of the hospital administrators observed in all four hospitals is that their main focus in promoting the WKCT is to induce biomedical doctors to be more cooperative to the WKCT. As examined in the previous chapters, biomedical doctors consider the WKCT with KM doctors as an optional choice, while KM doctors actively make requests of the WKCT for biomedical inspections and treatments, often with their own needs in many cases. For this reason, hospital administrators try to make the biomedical doctors more interested in and cooperative to the WKCT process in various ways, while providing more chances to learn about KM knowledge and engage in contact with KM doctors.

A good example of the hospital administrators' efforts for the WKCT having a limited influence can be observed in the case of 'WKCT Center' in 'B' hospital, as an advisory organization to promote and support the WKCT process. It was established in 2007 by the department of hospital administration upon the imitative of BK3, who was the hospital director of the KM sector at the time. It comprises an executive director and a vice director,<sup>243</sup>

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<sup>243</sup> The positions of executive director and vice director are chaired by one KM doctor and one biomedical doctor in rotation every two years. BK3 served as the first executive director for the first two years, while BK1

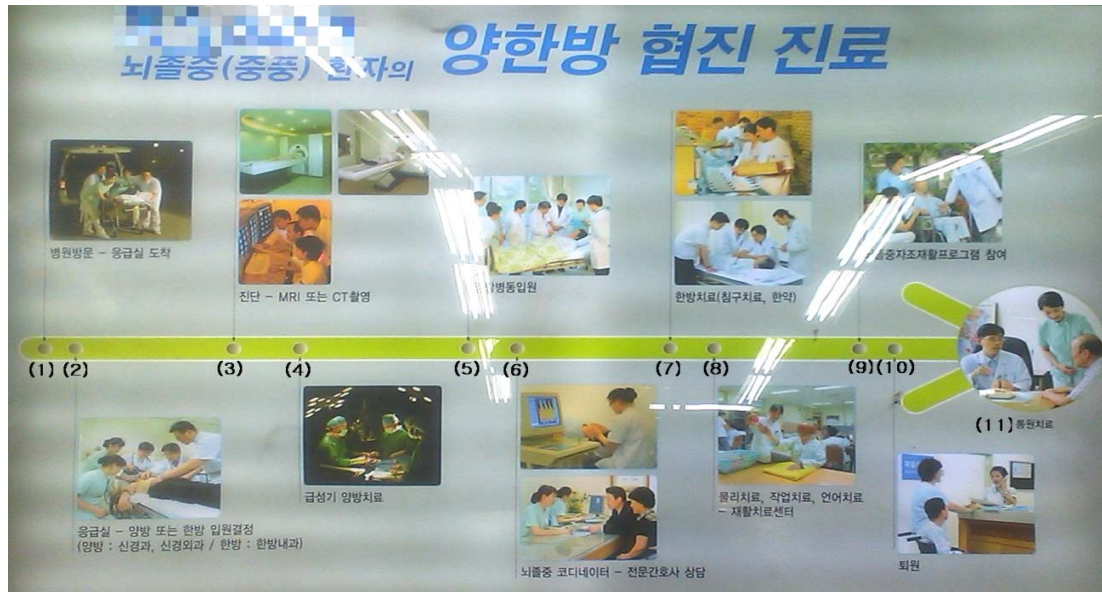


with a WKCT coordinator concurrently working in the department of hospital administration. BK3 and BA1 state that WKCT Center was established to systemize the process of the WKCT, to induce patients to receive the WKCT and ask for physicians – mostly biomedical doctors – to be more interested in the WKCT. With this purpose in mind, WKCT Center hosted regular joint conferences in which both KM and biomedical doctors participated, as well as supporting cooperative research projects among them. According to BA1, the joint conferences were held every two weeks for about eight months in 2007 and 2008, usually dealing with general principles of KM and concrete biomedical treatment methods in certain specific diseases. WKCT Center also formulated proposals concerning WKCT processes that can be applied to certain diseases such as CVA, facial nerve palsy (Bell’s palsy), cancer and orthopedic pain management, based upon previous experiences of the WKCT in ‘B’ hospital. Such knowledge had been informally accumulated without any regularized instructions, with the intention to apply it as general clinical practice guidelines for the WKCT in the future. In obedience with such proposals, the WKCT coordinator – also working as a hospital administrator – has recommended hospitalized patients for additional treatments through the WKCT process, while the WKCT directors (physicians) have tried to promote these models to the physicians for more frequent WKCT requests, as well as utilizing these models when advertising the hospital to the public, as shown in the figure V.6. In terms of administrative support, an integrated EMR was newly introduced by WKCT Center to ensure that both KM and biomedical doctors can easily access all information on patient management from both sides. In addition, an incentive payment program for the WKCT was launched by WKCT Center as a promotion policy for the WKCT, whereby physicians who send and receive their patients for the WKCT are paid extra for each such case.

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worked as the second vice director for the next two years and BA1 as a WKCT coordinator for four years from the beginning until 2010.

Figure V.6 A Billboard Advertisement for the WKCT in ‘B’ hospital<sup>244</sup>



Despite the existence of WKCT Center engaging such efforts to promote the WKCT within the hospital, the majority of interviewees in ‘B’ hospital did not provide positive responses about its influence on the process of the WKCT in clinical situations. Regarding joint research projects between KM and biomedical doctors, BA1 mentions that it was difficult to secure biomedical doctors’ involvement with cooperative research work with KM doctors because they complained that they were fully occupied with their own clinical work within their wards, whereas the majority of KM doctors were willing to participate in the research projects as they needed to produce research work as professors in the KM school in the hospital.<sup>245</sup> As a result, only a single research project – in which BK3 participated as the lead author – on the effect of the WKCT in the case of patients with facial nerve palsy had been conducted under the support of WKCT Center in the four years since its establishment.

<sup>244</sup> This photo was taken in a subway station nearest to ‘B’ hospital in May 2011 (modified from the original photo with numbering). It describes the process of CVA patients’ treatments through the WKCT from hospitalization to discharge and outpatient treatment: (1) hospitalization to the emergency room, (2) emergency room: decision for KM or biomedical ward (biomedicine: Neurology, Neurosurgery, KM: KM internal medicine), (3) diagnosis: MRI or CT scan, (4) biomedical treatments in the acute phase, (5) transfer to a general ward, (6) counseling with WKCT coordinators, (7) KM treatments (acupuncture and herbal medication), (8) physical therapy, occupational therapy, speech therapy in rehabilitation center, (9) participation in rehabilitation program within hospital, (10) discharge from the hospital, (11) outpatient treatment.

<sup>245</sup> In ‘B’ hospital – a university hospital with a KM school without biomedical school – biomedical doctors are generally less interested in medical research projects, compared with the situation in ‘D’ hospital, with both a KM and biomedical school.

Concerning the clinical situation, BK3 – the first executive director who advocated the establishment of WKCT Center in the front line – offers an even more skeptical response to the effect of WKCT Center, arguing that it merely ‘reorganized’ and ‘stipulated’ previous ways without any further steps forward concerning the quality of the process and participants’ communication. He proceeds to reveal that it failed to induce the biomedical doctors in becoming more interested in KM treatments, which he believes is crucial for the success of the WKCT for patient management at the clinical level. BK1 – who was the vice director of WKCT Center – also agrees that it remains a difficult task for him to make biomedical doctors interested in KM treatments and cooperative towards the WKCT. Indeed, he states that any kind of efforts among the hospital administration department and KM doctors through WKCT Center have no effect whatsoever, while expressing his regret for the new executive director’s (biomedical doctor) lack of interest in his job in WKCT Center.

Regarding the influence of WKCT Center on the physicians’ decisions for the WKCT in clinical practices, DB1 and BB2 respond that they concern themselves about what WKCT Center suggests. However, they also emphasize their own right to decide treatments for each individual patient. Let us consider the following quotations concerning their perceived role of WKCT Center.

*(Question: I heard about WKCT Center in ‘B’ hospital. Do you think that it had an effect on physicians’ decisions for the WKCT when you worked there?)*

*Of course there is an invisible ever-present recommendation for the WKCT by WKCT Center to us (biomedical doctors). I mean, hospital administrators expect that we let our patients receive the WKCT as many times as possible. So, we are in need of satisfying what they expect from us, and actually we often do as they expect.*

*(Question: For instance, in certain cases with your patients, when to send your patients to receive acupuncture, or whether or not to allow them for the WKCT...?)*

*(Interrupting in the middle of the interviewer’s asking) Oh, that is totally my own decision. You know, following clinical guidelines may often interfere with choosing the optimal treatments for each patient. For hospital administrators, it will be desirable for us to follow the medical guidelines, but from a clinician’s perspective, such medical guidelines often stand in the way of choosing the best for each patient.*

*(DB1, neurology)*

*(Question: Is there anything that WKCT Center has a direct effect on when you are involved in the WKCT process with patients?)*

*When it comes to clinical situations, we (biomedical doctors) can't revert everything to the guideline as WKCT Center suggests. Not the directors of the center, but individual physicians are in charge of management for our patients. I have full authority for the medical decisions for my patients as their attending physician. If I want to make a request of the WKCT for my patients, I do. But, no one in WKCT Center may ask me to make the request for certain individual patients.*

*(BB2, neurosurgery)*

*(Question: Do you know what WKCT Center does for the WKCT at present?)*

*I don't know what they are doing now. I really don't know... (BB2, neurosurgery)*

According to DB1 (biomedical doctor, neurologist in 'D' hospital, previously worked in 'B' hospital for one year), the majority of the biomedical doctors are influenced by the policy of WKCT Center in terms of promoting the WKCT, prompting them to consider more frequent WKCT requests for their patients. However, he emphasizes that it is always the physician who makes decisions for their patients under any circumstances, while he limits the role of WKCT Center. Likewise, BB2 is also emphatic about the authority of the physicians in charge of the patients in terms of initiating the WKCT process, adopting a skeptical perspective concerning the influence of WKCT Center on physicians' clinical decisions. In this regard, BB2 provides a negative response to the question of what WKCT Center does to promote the WKCT at present. Indeed, this corresponds with the answers of BK1 and BA1 concerning the decreasing activities of WKCT Center two years after its establishment. Let us consider the statements below.

*In the beginning (of the establishment of WKCT Center), we often used to have joint conferences and tried many other things, aiming to narrow the differences of the view (between KM and biomedical doctors). We (KM doctors) used to give lectures on the general principles of KM to biomedical doctors and they came to us to lecture biomedical treatments for certain diseases. But it didn't last long. After*

*two years (2009), a biomedical doctor accepted the position of the executive director, and I became vice director. Since then...you know... the executive director doesn't seem very eager about this job to promote the WKCT. It was so difficult for me as a KM doctor to convince biomedical doctors to step forward for the higher level of the cooperative treatment together with us, partly because they are already so busy with their own patients, and also because the guidelines for the WKCT do not have any binding force as long as they maintain prejudice or ignorance about KM. We failed to change their uncooperative attitudes through the activities of the center. And now..., there are no more serious activities to promote the WKCT in this center. (BK1, KM internal medicine)*

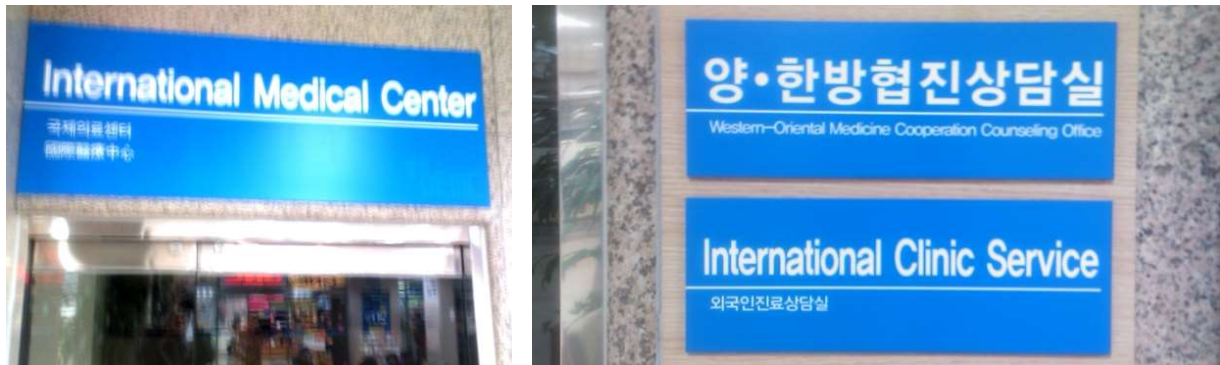
*(Question: As a WKCT coordinator, did you work to suggest the WKCT for both physicians and patients?)*

*The main task for me as a coordinator for the WKCT was to explain and suggest the WKCT to patients, but in the first two years (2007-2008) I was also busy making general models of the WKCT processes, arranging joint conferences, developing incentive payments and an online integrated medical information program. For such tasks, I often met with physicians. After those things settled down up to a point, there was nothing more left to work with physicians. Joint conferences have been no longer held either, since two years ago. Since then, I have spent most of the time working as a hospital coordinator meeting patients to suggest the WKCT until I quit the job last year (BA1, former hospital coordinator of WKCT Center, nurse).*

As described in the statements above, as BK3 (KM doctor) handed over his position of executive director of WKCT Center to a biomedical doctor in 2009, a marked drop seems evident in various activities to promote the WKCT in the center; for instance, joint conference – which had lasted for two years – have now stopped, while there have been no meaningful further cooperative relationships between KM and biomedical doctors in clinical practices compared with before the center's establishment. In this regard, WKCT Center seems to have remained virtually nominal since 2009, without any further programs to promote the WKCT aimed at physicians, aside from the coordinator's consultation to hospitalized patients to explain and recommend the WKCT. To summarize, while the

example of WKCT Center in ‘B’ hospital illustrates hospital administrators’ efforts to promote the WKCT in various ways, it also clearly demonstrates that their influences on actual processes of the WKCT in clinical practices are clearly limited given that the physicians involved with the process of the WKCT have full authority for clinical decisions for their patients’ treatments.

Figure V.7 WKCT Center of ‘B’ Hospital<sup>246</sup>



This chapter has examined the role of hospital administrators in promoting the WKCT. Despite the different ways regarding the situations in each hospital, hospital administrators in all four hospitals engage in various efforts to support the process of the WKCT to both the patients and physicians, while considering the WKCT as an important feature for the public relations of their hospitals. Although their efforts have a positive effect on more frequent WKCT requests, there are apparent limitations of their influence on physicians’ decisions for the WKCT, as illustrated in the situation in ‘B’ hospital with the case of WKCT Center, whereby the physicians in charge of the patients have the full authority for medical decisions in the process of the WKCT. This implies that it is very difficult for hospital administrators – including general directors or hospital owners – to induce biomedical doctors who are not interested in KM and the WKCT to work more willingly with KM doctors for further steps of the WKCT in clinical settings. In the next chapter, legal regulations, government policy and the NHI policy on the WKCT will be examined as further external factors in the interviews with physicians found to influence the KM and biomedical doctors’ clinical decisions in the

<sup>246</sup> These pictures were taken on 10 March 2011. In 2011, WKCT Center (Western-Oriental Medicine Cooperation Counseling Office) was sharing the office with the International Clinic Service, existing under one umbrella as the International Medical Center on the first floor of the main building of ‘B’ hospital. When I visited ‘B’ hospital for interviews, the office was closed with the lights off (illustrated in the left picture) in the daytime during working hours (3:30 pm on Thursday).

process of the WKCT.

### **2.4.3 Influences of Legal Regulations, Government Policy and National Health Insurance (NHI) Policy on the WKCT**

As the concept of the WKCT originates in the South Korean medical system, where the traditional sector of medical practice is professionalized with an equal status as the biomedical sector – both as medical doctors – while each part may not intrude on the area of the other side, legal regulations on KM and biomedical doctors' authority and the range of their cooperative work play essential roles in framing the existence of the WKCT in clinical practices. Moreover, the physicians and administrators who I interviewed often indicated legal regulations and NHI policy related to issues in the process of the WKCT. In this chapter, I will examine how and to what extent external legal and administrative regulations – such as South Korean government's medical policy for promoting the WKCT, the MSA and its enforcement ordinances, as well as NHI policy – have an effect on the physicians' decisions for the WKCT, based upon the previously-described situations in four hospitals. This part first demonstrates promoting or impeding factors that influence the WKCT process among these regulations. Subsequently, it attempts to ascertain how such factors influence the relationship between KM and biomedical doctors in the process of the WKCT.

As mentioned in Chapter IV.1.4 'Modernization of Korean medicine and the establishment of a dual medical system in the postcolonial period,' the establishment of the MSA in 1951 created a distinctive dualized medical system acknowledging traditional practitioners' legal status as KM doctors equally respected as biomedical doctors. Nonetheless, their domains are separated from each other, which provided a basic milieu for the existence of the WKCT, whereby two different kinds of medical doctors send and receive their patients for extra inspections and therapies. In particular, since the revision of the MSA and its implementing ordinances allowed the WKCT within one single medical corporation in 2009, more frequent WKCT requests have been reported within a single WKCT hospital, while the number of the WKCT hospitals has also increased nationwide (M. Sohn & W. Lee, 2010: 16-17). Furthermore, the medical policy of the South Korean government is another important external factor for the process of the WKCT. As mentioned in Chapter IV.3.2, 'History and development of the WKCT,' the government started to consider the WKCT as the first step

towards integrating the medical system in the 1990s. Based upon DK3's recollection during the interview, the issue of cooperation between KM and biomedicine was first raised as an agenda of the government in a health care reform deliberation committee in 1994, when the government at the time – a so-called 'Civilian Government' (*Munmin Jeongbu*)<sup>247</sup> – had searched for reform plans in various fields of social policy since seizing power in 1993. Following long discussions for over a decade, the government strengthened a financial support for cooperative research and activities in clinical practices related to the WKCT in the 2000s. 'D' hospital can be considered one of the main beneficiaries of this policy as the only state university hospital with both a KM and biomedical school in South Korea. The aforementioned symposium on the WKCT and joint research projects of KM and biomedical doctors in 'D' hospital were also conducted with financial support from the South Korean government through the Ministry of Health and Welfare.<sup>248</sup> In addition, DA1's (former executive director of 'D' hospital) arrangements for KM and biomedical doctors' joint meetings can be understood in line with this policy. Moreover, DK1 and DB2's cooperative activities for joint research projects also result from this circumstance. In sum, the South Korean government's policy to promote the WKCT has a positive effect on more frequent joint research and clinical requests for the WKCT to some degree, especially in national hospitals like 'D' hospital, while medial law plays a role as a basic guideline for the process of the WKCT in clinical practices.

Aside from such an influence of the MSA and the government's policy on the WKCT process, the majority of interviewees indicate the importance of the NHI policy, namely insurance payments for the WKCT and the classification of the diseases for insurance claims. Regarding the issue of payment of NHI to hospitals for the medical expenses of the WKCT, most of the WKCT's healthcare costs are charged separately by the KM and biomedical sectors, because a 'medical consultation fee' – in which the WKCT costs can be categorized – is only allowed to be claimed to the NHIS once a month per patient. However, as already

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<sup>247</sup> After the period of military regime and presidency of former military men from 1961 to 1992, the new government was launched in 1993 by President Young-sam Kim, politician and former pro-democracy activist during the 1970s and 1980s. He named his government as 'a civilian government' (*Munmin Jeongbu*), which has been widely used to call his incumbency by the South Korean media until now. From: "Kim Young-sam Government," (*Kim Young-sam Jeongbu*), Doosan Encyclopedia, retrieved 27 May 2016 from [https://www.doopedia.co.kr/doopedia/master/master.do?\\_method=view&MAS\\_IDX=101013000868122](https://www.doopedia.co.kr/doopedia/master/master.do?_method=view&MAS_IDX=101013000868122).

<sup>248</sup> It was introduced in Chapter V.2.3.2 'Ways of communication outside of the WKCT process' (pp. 179-181).



explained in Chapter IV.3.3 ‘Legal regulations on the WKCT,’ in case a patient is treated by the biomedical and KM department for an identical disease in one day, only one of these treatments is fully paid by the NHIS, whereas the patient is liable to pay the remaining costs. Concerning the reason behind this policy, the hospital administrators who I interviewed (AA1, BA1, and CA1) indicate that the NHIS is concerned about the financial burden through the WKCT in case both of the treatments from the KM and biomedical sector are fully paid. Moreover, this reflects another reason potentially against its policy on the standardization of the treatment to cover both therapies undertaken by KM and biomedicine through the WKCT, given that the WKCT is still conducted in a smaller numbers of hospitals nationwide where both KM and biomedical doctors work in a single hospital. This implies that the WKCT therapies in which both KM and biomedical doctors are simultaneously involved for patients with certain diseases is not fully admitted as essential by the state. The hospital administrators in all four hospitals mention that such a NHI policy pre-screens the potential of the WKCT while having a negative effect on more frequent WKCT requests in their hospitals. Regarding this issue, it is worthwhile considering AA1’s statement below.

*(Question: What do you think of the influence of the NHI policy on the WKCT process in clinical practices in your hospital?)*

*In every respect, the quality of the medical service declines (due to the limited coverage of payment for the WKCT by the NHIS). Under the current regulation, when a patient in a biomedical ward of internal medicine receives an additional biomedical orthopedic inspection or therapy for the identical disease in the department of orthopedics (a biomedical ward) within the same day, for instance, it is allowed to claim the treatment costs for both therapies separately to the NHIS. However, if he or she receives additional KM therapy with biomedical treatments simultaneously within the same day, the NHIS pays only one of them. If NHIS covered the costs both of them, we could achieve more advanced WKCT, but... under the current policy of NHI, the WKCT is regarded as not essential but rather additional or superfluous... In this situation, we can’t expect to move forward for the better quality of the WKCT. (AA1, hospital administrator)*

*Because of the guideline of the NHIS..., we arrange that a patient receives either*

*therapies every other day. I mean... biomedical therapy for one day, and KM therapy on the next day by turns, or the patient receives both therapies on the same day and we charge the additional cost directly to the patient at a lower charge. It's a kind of expedient, but... I think this kind of problem of payment system is the greatest obstacle making it difficult to conduct the WKCT in clinical practices. (CA1, hospital administrator, nurse)*

AA1 comments that NHI policy on the WKCT has a negative effect on both the frequency and the quality of the WKCT, given that it does not fully cover the expenses of the WKCT. In this situation, CA1 proposes two possible ways to deal with such problems with financial burdens on the patients, namely by alternating KM and biomedical therapies every other day or in case the patients want to receive both therapies every single day, charging additional medical expenses to the patients at a lower rate than full fees. This means that as long as the NHIS does not pay both KM and biomedical treatments within the process of the WKCT, there will be a limit of the expected curative influence of the WKCT, or the WKCT hospitals cannot expect major earnings through the WKCT. In this context, CA1 answers that the WKCT is not a profitable item in terms of hospital management, which is the main reason why 'C' hospitals withdrew from the WKCT, closing the KM sector one month after the fieldwork was conducted in 2011. A more important aspect relevant to the relationship between KM and biomedicine in this issue is that KM treatment is often in an inferior situation compared to biomedicine when it is necessary to choose either KM or biomedical treatment due to such a problem of medical costs originating from the NHI policy. BK1 and CA1 comment on this issue as follows.

*When there are KM and biomedical departments in a single hospital and if a patient receives both KM and biomedical therapies for an identical disease on the same day, one of the two therapies is not insured by the NHI. This is always a stumbling block to us (KM doctors). It is always a problem... When we tell biomedical doctors to do the WKCT with us, they always pounce on it. You know, no matter how willing we are to cooperate with them, it is hard to induce them to take part in the WKCT due to this problem. (BK1, KM internal medicine, vice director of WKCT Center)*

*Since three or four years ago, there has been more strict control on over-treatment by the NHIS, as the NHIS encountered financial difficulties. For example, if a patient receives physical therapy (belonging to biomedicine) and KM therapy on the same day, the NHIS cutbacks the payment for the KM therapy. Another example is..., as a rule, hospitalization in KM wards is supposed to be paid by the NHI, but if we hospitalize any patients to the KM ward, we are asked not to hospitalize them to the KM ward from the NHIS in reality: people there say that KM therapies are sufficient with outpatient treatment, and it is not necessary to hospitalize the patients in a ward. We previously used to hospitalize patients to the KM ward if they prefer KM treatment, but from May last year (2009) until now (June 2011) there have been only four cases hospitalized to the KM ward out of thousands of inpatients, although I received calls of complaints from the NHIS for three cases out of four. For this reason, we have been hospitalizing all the inpatients to biomedical wards since then, whether the patients want KM or biomedical wards. (CA1, hospital administrator, nurse)*

BK1's statement above implies the influence of NHI policy on the relationship between KM and biomedical doctors. In conditions where most of the biomedical doctors believe that biomedical treatments precede KM, considering KM treatments as adjuvant therapy, BK1 describes clinical situations in which such a policy of the NHIS has a negative effect on biomedical doctors' assent to KM treatments through the WKCT for their patients. On the other hand, CA1 tells us a more interesting story about the differing attitudes of the NHIS on KM and biomedicine in the process of an insurance claim to the NHIS. According to her statement above, when a patient has received both KM and biomedical treatments on the same day for an identical disease, the NHIS tends to refuse to pay the costs of KM treatments, but not biomedical treatments. In addition, it poses a problem in terms of hospitalizing inpatients in the KM ward, while accepting hospitalization in biomedical wards for patients with the same degree of severity in identical diseases. As a result, CA1 reveals that she has been under pressure to make newly hospitalized inpatients choose the biomedical ward, even in case they favor being hospitalized in the KM ward. The situation in 'C' hospital does not represent a general phenomenon compared to other hospitals such as 'A' hospital, where there is an only KM ward for inpatients, as well as 'B' hospital, where there are large KM wards

with over 100 beds. However, we can infer from the case of ‘C’ hospital that at least in the case of the medium-scale biomedicine-oriented WKCT hospital with a smaller number of KM doctors than biomedical doctors, the policy of the NHIS has an effect on reinforcing the dominating position of biomedicine over KM.

Another important factor related to the issue of NHI policy having an effect on the WKCT concerns the disease codes used to claim the payment to the NHIS. As introduced in the first section of Chapter V.2.2.1 ‘KM doctors’ WKCT request to biomedical doctors,’ ‘1) Biomedical inspection to confirm diagnosis,’ KM doctors have widely been using integrated disease codes introduced by Statistics Korea (national statistical office of South Korea) when claiming insurance payments to the NHIS. AK1 mentions that he needs a biomedical inspection such as CT scanning to verify his patients’ neck pain as ‘spinal disc herniation on cervical spine’ as categorized in the newly integrated guideline of the disease codes, rather than categorizing it as a KM term, ‘*Gyeong-chu-tong*’ (neck pain). AK4 also categorizes her patients’ disease as a biomedical term ‘Bell’s palsy,’ not ‘*Wa-sa-pung*’ or ‘*Gu-an-wa-sa.*’ As briefly introduced on page 152, the most important change of the Sixth Revision of the Korean Standard Classification of Diseases (KCD-6) is that KCD-6 officially absorbed KM disease codes, which had been sorted in a separate classification scheme as an independent supplement of KCD.<sup>249</sup> Statistics Korea states two main reasons for this integration of disease codes: first, “to produce whole general statistical data nationwide, covering both biomedicine and KM to understand the health situation in South Korea more properly”; and second, “to join the efforts of WHO, which tries to integrate the concepts of diseases within various types of traditional indigenous medicine into its international classification of diseases.”<sup>250</sup> Following this new system, KM doctors have been adopting integrated disease codes based upon biomedical terms for their patient management to claim medical payment

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<sup>249</sup> From: A Press Release of Korea Statistics on 5 Jul. 2010, retrieved 27 May 2016 from [http://kostat.go.kr/portal/korea/kor\\_nw/2/14/1/index.board?bmode=read&aSeq=71629](http://kostat.go.kr/portal/korea/kor_nw/2/14/1/index.board?bmode=read&aSeq=71629); Seung-won Choi (2010).

<sup>250</sup> From: Kye-lang Kwon (2009), “Answers on Civil Complaints,” Homepage of Statistics Korea. Answered on 30 Jul. 2009, retrieved 27 May 2016 from

[http://kostat.go.kr/portal/korea/kor\\_cc/2/2/1/7/index.board?bmode=read&aSeq=65809&pageNo=16&rowNum=10&amSeq=&sTarget=&sTxt](http://kostat.go.kr/portal/korea/kor_cc/2/2/1/7/index.board?bmode=read&aSeq=65809&pageNo=16&rowNum=10&amSeq=&sTarget=&sTxt). This implies that such efforts of WHO (2002) for the integration of TM/CAM into the national medical system in each country – as illustrated in Chapter II.1.2.1 ‘Three types of health care systems by WHO (2002)’ – could result in reinforcing the situations of biomedical dominance over TM/CAM in the national level. It also corresponds with Young’s argument (1994) on the orthodox medicine’s reinforcement of power in the process of integration, as introduced in Chapter II.1.2.2 ‘Models of health care pluralism by Young (1994).’

to the NHIS, in a situation where only small numbers of KM disease codes have remained in KCD-6, classified within “the codes for special purposes (U00-U99).”<sup>251</sup> KM doctors’ usage of new diseases codes mainly based upon biomedical concepts has led to biomedical inspection being an essential process for KM doctors’ patient management, regardless of their own clinical need. In this situation, the result of biomedical inspection is adduced as a diagnostic proof to claim the medical cost to the NHIS. In this situation, KM doctors are becoming increasingly dependent on biomedical doctors’ authority of biomedical inspection through the process of the WKCT.

In this chapter, we have explored the effects of legal regulations, government policy and the regulations of the NHIS on the WKCT process and participating physicians’ decisions. As a distinctive phenomenon of the dualized South Korean medical system in which both KM and biomedical clinicians are equally respected as medical doctors and each of them has an exclusive boundary of medical authority based upon the MSA, the WKCT has been influenced by the changes of the MSA and the state policy in clinical settings. As the South Korean government has tried to integrate such a dualized medical system since adopting a medical integration policy of KM and biomedicine, it has supported the WKCT in research and practice while considering the WKCT as the first step towards the integration of the South Korean medical system. Such an effort by the government to promote the WKCT has been notably observed in ‘D’ hospital – a national university hospital – encouraging cooperative research with financial support and attracting more frequent contact between KM and biomedical doctors by means of hospital administrators’ efforts. Despite not being very huge in size, this has a meaningful positive influence on the WKCT process in clinical practices in ‘D’ hospital. By contrast, the policy of the NHIS has a rather negative effect on the process of the WKCT in a more direct way than government policy. Due to NHI policy on the WKCT covering only a part of medical expenses in the process of the WKCT on the same day in the case of an identical disease, this has a negative effect on more frequent WKCT requests. In a situation where biomedical treatments are widely considered more essential for patient treatment than KM, NHI policy makes fewer WKCT requests for additional KM

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<sup>251</sup> From: “Korean Standard Classification of Diseases,” Homepage of Statistics Korea, retrieved 27 May 2016 from.

[http://kssc.kostat.go.kr/ksscNew\\_web/kssc/common/ClassificationContent.do?gubun=1&strCategoryNameCode=004&categoryMenu=007&addGubun=no](http://kssc.kostat.go.kr/ksscNew_web/kssc/common/ClassificationContent.do?gubun=1&strCategoryNameCode=004&categoryMenu=007&addGubun=no).

treatments through the process of the WKCT. On the other hand, the NHIS' adoption of the newly integrated disease code system of KM and biomedicine – developed by Statistics Korea for processing insurance costs – has prompted KM doctors to send their patients to the biomedical sector for biomedical inspections as an essential routine, to present the patients diagnostic information to the NHIS to claim the medical costs, under circumstances where most newly integrated disease codes are based upon biomedical terms and concepts. In sum, the policy of the NHIS influences the WKCT process through encouraging fewer KM therapy requests and more biomedical diagnosis requests in clinical settings in each hospital. Accordingly, such a policy consolidates the 'asymmetric' situation concerning KM and biomedical doctors in the process of the WKCT.

In the next chapter, I will summarize the findings of the fieldwork concerning the general process of the WKCT in four hospitals. Subsequently, I will rearrange the factors of the unbalanced situation between KM and biomedical doctors as examined thus far, systemizing it with the concept of asymmetry discovered and developed during the process of analyzing the fieldwork and connecting this concept with the debates on biomedical dominance within the situations of medical pluralism in medical systems.

### **3. Summary and Analysis: Multi-layered Biomedical Dominance in the Process of the WKCT**

In Chapter V.2, we have sorted through the actual meaning and the process of the WKCT in clinical settings, and the relationship between KM and biomedical doctors in this process, together with examining external factors that influence their working relationship. As the closing chapter of Part V. ‘Case study,’ this chapter first summarizes the findings of the fieldwork, concerning the actual meaning of the WKCT in clinical practices, concrete processes of the WKCT and the backgrounds of physicians’ decisions, ways of contact and communication between KM and biomedical doctors and external factors that influence the WKCT process and physicians’ decisions. Subsequently, KM doctors’ biomedical knowledge will be examined as the core element of connecting KM and biomedical doctors in the process of the WKCT, before examining the South Korean case within the existing debates on biomedical dominance over traditional or alternative medicine in the situations of medical pluralism, utilizing the concept of ‘asymmetry’ that I discovered in the coding process of the fieldwork.

#### **3.1 Summary of Fieldwork Findings (Chapter V.2)**

In Chapter V.2.1 ‘Actual meaning of the WKCT in clinical practice,’ we explored the working definition of the WKCT in view of the physicians’ actual work in WKCT hospitals. Contrary to public expectations literally originating from the word ‘cooperative treatment’ – implying that KM and biomedical doctors thoroughly discuss clinical management for certain identical patients face-to-face with each other at one place in hospitals – the WKCT in clinical settings is understood as sending their own patients to their counterparts for short time for additional diagnoses or treatments, mostly without any direct face-to-face contact and discussion for patient management between KM and biomedical doctors, while the patients’ main attending physician – either a KM or biomedical doctors – is not changed in this process. In this sense, according to definitions suggested in Table IV.6 (Barron & White, 2009; M. Sohn & W. Lee, 2010), the WKCT is a kind of clinical consultation or referral rather than co-management. Such a situation in the process of the WKCT can be categorized as “collaboration and combination,” as proposed by Young (1994: 64).

In Chapter V.2.2 ‘Process of the WKCT,’ we examined various reasons for physicians’ decisions for WKCT requests in four hospitals with two categories: KM doctors’ WKCT requests to biomedical doctors and biomedical doctors’ WKCT requests to KM doctors. First, in the case of KM doctors’ requests to biomedical doctors, there are several situations commonly observed in four hospitals in which KM doctors often make WKCT requests: 1) biomedical inspection to confirm their patients’ biomedical diagnosis, routinely conducted when the patients are hospitalized; 2) biomedical medication for acute patient care and intense pain control; and 3) uptake of medical technicians who are under the supervision of biomedical doctors, such as physical therapists. In the case of biomedical doctors’ WKCT requests to KM doctors, the following situations were often mentioned as the reasons for their sending patients to the KM sector: 1) relief of symptoms and pain control for non-fatal yet intractable chronic diseases such as facial nerve palsy, muscular skeletal pains and chronic prostatitis; 2) additional treatments for irreversible diseases in the chronic phase, such as CVA patient management; and 3) patient management for incurable or end-state diseases such as terminal cancer. Concerning these differences between the two cases, there are several conspicuous features. First, concerning WKCT requests for diagnostic inspections, WKCT requests for biomedical inspection are considered a kind of essential routine for KM doctors’ patients when they are hospitalized as inpatients, whereas there are no such WKCT requests that biomedical doctors make to KM doctors exclusively for KM diagnosis for their patients in biomedical wards. Accordingly, all the WKCT requests by biomedical doctors to KM doctors are requests for additional KM therapies rather than KM diagnoses. KM diagnoses for biomedical doctors’ patients through WKCT requests are conducted before KM doctors apply additional KM therapies for biomedical doctors’ patients, without notifying them to biomedical doctors. Second, concerning WKCT requests for additional therapies, KM doctors tend to make WKCT requests to biomedical doctors predominantly for acute patient management, while biomedical doctors mostly request additional KM therapies for chronic patient management after their patients’ conditions are stabilized from the acute phase. Finally, in line with the second issue, KM doctors usually ‘ask for’ the WKCT to biomedical doctors because they are in need of biomedical help for their patients in many cases, based upon their own therapeutic decisions after comparing the effects of KM and biomedicine in certain situation of patients’ conditions, as well as their patients’ demands on biomedical treatments. By contrast, biomedical doctors usually ‘allow’ their patients to receive KM



therapies through the WKCT because their patients, hospital administrators or even KM doctors in contact with them expect or ask for such therapies far more often than biomedical doctors' own needs for KM therapies. That is, biomedical doctors' medical actions through WKCT requests are often considered 'essential' by KM doctors, whereas KM doctors' additional therapies are rather considered 'optional' by biomedical doctors. This implies that KM doctors are more dependent on the WKCT with biomedical doctors for their patients' management compared with biomedical doctors.

Chapter V.2.3 'Ways of communication between KM and biomedical doctors in WKCT hospitals' illustrated various ways in which physicians contact and communicate within and outside of the WKCT process. As examined in Chapter V.2.3.1, most contacts between KM and biomedical doctors occur either when they make requests to their counterparts for additional medical actions or when they receive the results of medical actions through the WKCT process. Accordingly, they rarely intervene in their counterparts' medical actions once they entrust such actions in the hands of their counterparts. In terms of ways of communication in this process, the physicians occasionally contact each other directly through phone calls, internet messenger programs or e-mails to make WKCT requests and receive or notify the results of the inspections or treatments. However, it is much more common that they make contact indirectly through nurses in wards, training doctors working under their supervision or patients directly involved with the WKCT. In this sense, communication between KM and biomedical doctors in the process of the WKCT is very restrictive regarding their low frequency and indirect ways of communication. This corresponds with the findings of Kye-hyun Kim (2004) and Sohn and Lee (2010) that the frequency and the degree of contact and communication between KM and biomedical doctors are profoundly limited in the process of the WKCT, as introduced in Chapter II.2.1. Concerning the means of their communication, it was observed that biomedical information is exclusively used when they exchange information regarding the patients' conditions and medical actions, in a situation where most of the biomedical doctors do not have any concrete KM knowledge. KM doctors – who have biomedical knowledge through their education in the KM schools, in which biomedical subjects are taught to the same extent as KM – consistently absorb and improve their biomedical knowledge while they participate in the process of the WKCT in clinical practices. On the other hand, biomedical doctors merely

have to utilize their biomedical knowledge to work with KM doctors. Even when the biomedical doctors decide whether to allow their patients' additional treatments through the WKCT, they tend to interpret KM therapies such as herbal medication and acupuncture within the frame of biomedical principles; for instance, they understand acupuncture therapy as a nerve-stimulating therapy. In this respect, to biomedical doctors the WKCT is a process in which they provide KM doctors with biomedical help and allow their patients to receive additional non-biomedical treatments. In Chapter V.2.3.2, physicians' communication outside of the WKCT process was examined, including joint conferences and collaborative research projects, as well as private meetings during or after working hours. Such occasions can have an effect on the WKCT process by enabling more frequent WKCT requests through better understanding of their counterparts' therapies and closer acquaintance with each other. However, such effects have clear limitations in terms of the content and intensity of the mutual communication between physicians within the actual clinical process of the WKCT.

In Chapter V.2.4 'External factors related to the process of the WKCT,' external factors that exert an influence on their decisions in the WKCT process were introduced, such as the patients who are involved with the WKCT, hospital administrators and legal regulations and NHI policy related to the WKCT. First, regarding the role of patients, as shown in Chapter V.2.4.1, most physicians working in WKCT hospitals take account of their patients' general expectations concerning WKCT therapies, aside from 'D' hospital, where the KM sector was newly established, having an effect on the physicians' more frequent WKCT requests. This is similar to the findings of Sohn and Lee (*ibid.*) that the demands of patients have a crucial effect on physicians' decisions in the process of the WKCT, as mentioned in Chapter II.2.1. Although the patients' expectations for the WKCT also manifest themselves in their preferences for KM therapies for certain diseases such as CVA, facial nerve palsy and chronic orthopedic pains, majority of KM doctors indicate that most of their patients' biomedicine-oriented views on health and illness force them to be dependent on biomedical diagnoses and therapies, aside from their own clinical needs for biomedical help. In addition, they argue that it is better for them to communicate with their patients with biomedical terms and explanations, which their patients understand far easier than their explanations based upon KM principles. In this context, they concede that biomedicine is settled as the mainstream medicine in current South Korean society. In accordance with this phenomenon, most of both

KM and biomedical doctors who I interviewed agree that the majority of patients tend to follow biomedical doctors' advice in case of lacking consensus between KM and biomedical doctors in the process of the WKCT. Such a preference for biomedicine over KM among patients is also observed in the findings of Jongyoung Kim's research (2005), as mentioned in Chapter II.2.2. In sum, aside from considerable preference for KM therapies for certain diseases, the patients' preferences for biomedical explanations of diseases based upon their biomedicine-oriented view on health and illness has a crucial influence on the physicians' decisions in the process of the WKCT and their 'asymmetrical' relationship between KM and biomedical doctors in the process of the WKCT in clinical practices.

Chapter V.2.4.2 covered the examination of hospital administrators' efforts and their influences on the process of the WKCT. Hospital administrators generate publicity while the WKCT is centered in an important P.R. exercise for their hospital. On the other hand, they also try to support the WKCT process within their hospitals, supporting physicians involved with the WKCT through hosting joint conferences and research, persuading more frequent WKCT requests to the physicians during steering committee sessions and arranging private meetings between KM and biomedical doctors. Despite different concrete ways of promotion originating from differing sizes, ratios of KM/biomedical doctors and ownership structures in each hospital, such efforts for the promotion of the WKCT were observed overall in all four hospitals. However, as illustrated in the case of WKCT Center in 'B' hospital, their efforts on the physicians' decisions in the process of the WKCT have clear limitations under the clinical circumstances, whereby the physicians have ultimate authority in making medical decisions for their patients. In particular, such limitations are predominantly observed when the hospital administrators try to induce biomedical doctors – most of whom are lukewarm to the WKCT – to arouse their interest in taking part in the process of the WKCT. Therefore, the findings of this study, mainly focusing on the actual clinical process of the WKCT, suggest that the result of previous research conducted by Sohn and Lee (2010) – namely that hospital owners' affirmative attitudes to the WKCT have a significant influence on KM and biomedical doctors taking part in the WKCT process – should only be acknowledged restrictively.

Finally, in Chapter V.2.4.3 we examined the influences of legal regulations, government policy and NHI reimbursement policy related to the WKCT. Since the South Korean

government shed new light on the WKCT – a kind of distinctive by-product of the dualized South Korean medical system in which modern biomedical and traditional medical sectors are strictly divided by the MSA – as the first step for the integration of the medical system between KM and biomedicine, various measures were presented to support the WKCT in terms of academic research and clinical practices during the 2000s. Especially the revision of the MSA in 2009 – which officially allowed both KM and biomedical doctors to work in the same hospital cooperations – invigorated the establishment of the WKCT hospitals, which had been previously conducted unofficially between independent KM and biomedical hospital cooperations on paper. Together with this, the South Korean government has supported cooperative academic research in which both KM and biomedical doctors participate, as well as promoting the WKCT in clinical settings in national hospitals. The positive influences of such government efforts on the WKCT are particularly prominently observed in ‘D’ hospital, a national university hospital with both KM and biomedical schools. By contrast, regarding the NHI policy concerning the reimbursement of the costs of the WKCT treatments, the WKCT is considered as a kind of unstandardized over-treatment by the NHIS, given that it does not cover all the costs of medical treatments during the process of the WKCT in case KM and biomedical treatments are conducted within the same day for certain patients’ identical diseases. Such a policy has a negative effect on the frequency of the WKCT requests and the depth of cooperation between KM and biomedical doctors in clinical practices in reality. In this process, KM treatments undergo a more negative influence due to this policy than biomedical treatments, given that KM therapies are widely considered more optional or less essential than biomedical treatments by patients and biomedical doctors. Moreover, in a situation where the NHIS adopted newly integrated disease codes developed by Statistics Korea – in line with WHO policy aiming for the integration of biomedicine and TM/CAM – KM doctors are under more pressure to consider biomedicine as an essential process for their patient management because most disease codes are integrated to biomedical terminology, which reinforces KM doctors’ dependence on biomedical inspections in clinical practices.

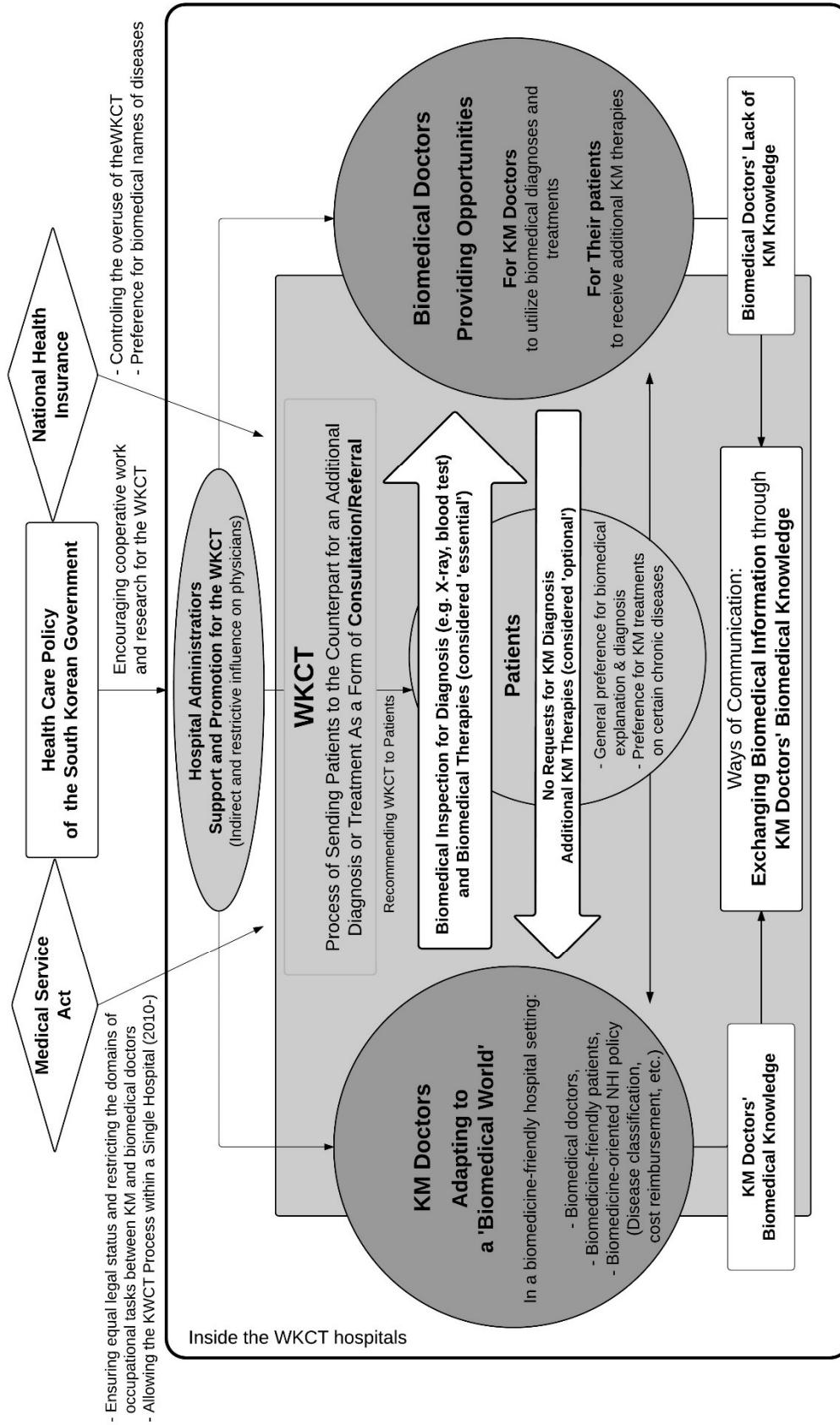
To summarize, the WKCT in clinical practice is a process in which KM and biomedical doctors working in the same or neighboring hospitals send their patients to their counterparts for additional medical inspections or therapies and receive the results of their counterparts’

medical actions. In the process of the WKCT, they communicate with each other mostly in indirect and restricted ways without actively intervening their counterparts' medical actions. In this process, they exclusively exchange biomedical information based upon biomedical terminology. Accordingly, the WKCT between KM and biomedical doctors who have different views on health and illness is practicable through the medium of KM doctors' biomedical knowledge. In this process, KM doctors are constantly situated to review and develop their biomedical knowledge to interpret biomedical information and communicate with biomedical doctors, whereas the biomedical doctors do not have to learn any concrete KM knowledge to take part in the process of the WKCT. On the other hand, biomedical help for acute patient management and biomedical inspections is considered indispensable to KM doctors, whereas additional KM therapies are perceived as additional or supplementary to most biomedical doctors, acceding to their own patients' demands or expectations, or hospital administrators' suggestions for the WKCT. In this regard, KM doctors depend more predominantly on the WKCT than biomedical doctors. Regarding external factors influencing physicians' decisions in the process of the WKCT, patients, hospital administrators and legal regulations and policies of the government and the NHIS were found in the fieldwork. Amongst them, patients particularly have an important effect on the physicians' decisions for WKCT requests, whereby their preferences for biomedical explanations based upon a biomedicine-oriented view together with the newly integrated disease codes adopted by the NHIS reinforces KM doctors' dependence on biomedical inspections through the WKCT. In comparison, the efforts to promote the WKCT conducted by hospital administrators within each hospital and governmental policy in line with its medical integration policy have rather limited effects on the WKCT in clinical practices, whereby the clinicians directly involved with the patient management have ultimate authority for the medical decisions for their patients.

In conclusion, the WKCT is a process in which the advantageous position and superiority of biomedicine and biomedical doctors over traditional medicine and KM doctors comes into view in its process despite KM and biomedical doctors' equal status as medical doctors within the South Korean medical system. In other words, when both medical doctors work in the same places, contacting each other for patient management, they experience such superiority of biomedicine and biomedical doctors, which is not clearly to be observed when

they work separately outside of the WKCT hospitals. Concerning the main findings of this study, a schematized summary is illustrated in Figure V.8 on the next page. In the next chapter, I will explain the situations concerning KM and biomedical doctors in WKCT hospitals within the frame of the debates on biomedical dominance in the concept of medical pluralism, after I briefly review the aspect of KM doctors' biomedical knowledge, the core element of connecting KM and biomedical doctors in the process of the WKCT.

Figure V.8 Relationship between KM and Biomedical Doctors in the Process of the WKCT



### **3.2 KM Doctors' Biomedical Knowledge as the Core Element Connecting KM and Biomedical Doctors in the Process of the WKCT**

As examined in previous chapters, KM doctors' biomedical knowledge enables KM and biomedical doctors to connect with each other in the process of the WKCT, under the circumstances whereby biomedical doctors are not interested in or do not have any concrete knowledge on KM. In this process, KM doctors working in WKCT hospitals – in comparison with KM doctors working in private KM clinics without biomedical doctors – are consistently situated to recall and develop their biomedical knowledge, while explaining their patients' medical conditions to the biomedical doctors or receiving information about biomedical doctors' patients in the daily process of the WKCT, particularly for inpatient management at the hospital-level medical institutions. Such different perspectives on their counterpart's medical knowledge – together with the fact that there is a gap between KM doctors' biomedical knowledge with their needs for biomedical actions and the absence of their prescriptive authority for biomedicine – have important implications for the power relations between KM and biomedical doctors, reflecting the main topic of this study. Before analyzing this in the next chapter, I will briefly review the issue of KM doctors' biomedical knowledge, including their experience in KM schools and WKCT hospitals, as well as KM and biomedical doctors' evaluations concerning KM doctors' biomedical knowledge, aiming to answer the research question: 'what is the coupling media between KM and biomedical doctors in the process of the WKCT?'

KM doctors' first experience of learning biomedical knowledge traces back to the first year of their two-year pre-medical courses in KM schools, encompassing basic biomedical subjects such as "biochemistry, anatomy, (biomedical-) physiology, pathology, pharmacology and radiology" (Geun-chun Yoo et al. 2004: 33), followed by clinical subjects of biomedicine in four-year regular courses, often taught in parallel with KM within a single subject (ibid. 34). DKS1 and DKS2 – college seniors of the KM school in 'D' hospital – mention that about 40 percent of all subjects that they learn belong to biomedical subjects,<sup>252</sup> the contents of which

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<sup>252</sup> Concerning the ratio of biomedical subjects taught in KM schools, there are significantly differing results among interviewees in the fieldwork – as well as news articles – between KM doctors or KM doctor-friendly journalists and biomedical doctors or biomedical doctor-friendly journalists. The majority of KM doctors, students and KM professors tend to estimate the ratio of biomedical subjects taught in KM schools at 35 to 50



are included in the state examination for KM doctors. They mention that the biomedical subjects are taught in parallel with KM subjects in each semester from the first to the last semester. In this process, DKS1 and DKS2, together with AK3 and BK4 – trainee KM doctors (residents) – agree that they have been taught to learn and accumulate these two different kinds of medical knowledge simultaneously and separately without integrating them. Regarding this issue of the learning process in KM schools, one of the most notable aspects found in the interviews with KM doctors is that the majority of them answered that it was more difficult to embrace KM principles than biomedical principles when learning in their KM school days. Let us take a look at DKS1, AK3 and BK4's statements below.

*(Question: While you learned both KM and biomedical subjects at the same time in KM schools, was there anything that collided or was difficult to accept between KM and biomedicine?)*

*Some of us (KM students), particularly those who are interested in logical, or theoretical parts, seem to be concerned about how to accept KM principles... As for them, biomedical principles seem to be better to understand than KM. (DKS1, senior student, 'D' university school of KM)*

*(Question: Did you have any internal conflict while you learned both biomedicine and KM at the same time during your school days?)*

*Well, their knowledge systems are so different... When I began with learning KM at KM school, I used to think 'should I know both different kinds of medical knowledge that cannot be mutually understand?' I mean, one cannot be understood with the principle of the other... In the first semester, one of my professors who taught us a KM subject often told us (KM students) during the lectures that in order*

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percent (e.g. Interview with DKS1, DKS2; Yoon-kyeong Kim, 2013), which is lower than biomedical doctors' or biomedical doctor-friendly journalists' estimations. For instance, DB3 estimates it at 60 percent, while Eun-young Kim (2015) even estimates 70 percent, with both of them severely criticizing the poor quality of biomedical lectures in KM schools during their respective interview and article. Such a phenomenon seems to result from the different viewpoints concerning how to classify certain subjects into the category of KM or biomedical subjects. As an example, Eun-young Kim (ibid.) categorizes all the applied clinical subjects taught in parallel with KM and biomedicine to the category of biomedical subjects, which KM doctors would categorize as KM subjects or at least integrated or common subjects of KM and biomedicine. Considering such different perspectives on balance, I estimate that at least 40 percent and at most 60 percent of subjects taught in KM schools can be categorized as biomedical subjects.

*to learn KM therapies we should 'throw out' previous ways of thinking that we had learned until high school... (AK3, resident, KM rehabilitation)*

*Until high school, we used to learn various subjects mostly based on natural scientific principles. So, it was much easier for us to accept biomedical principles than KM... While learning at KM school, we didn't have any resistance against learning biomedical subjects at all. The difficult thing was... to learn totally different medical principles at the same time without any mutual coupling of them. (BK4, resident, KM internal medicine)*

Most of the KM trainee doctors and students whom I interviewed admit that it was easier to absorb biomedical knowledge than KM, recalling their educational experiences before entering the KM schools. Instead, they faced difficulty in accepting KM principles in the beginning and learning both KM and biomedicine separately without any internal integrating process of different kinds of knowledge. This implies that biomedical principles used to be more familiar forms of knowledge even for KM students and doctors. Accordingly, it reflects the superiority of biomedical knowledge, being more syntonious with the modernized South Korean knowledge system than KM. On the other hand, any possible questions concerning the content collision or hybridity of biomedical and traditional medical knowledge do not mainly take place within the relations between KM and biomedical doctors, but rather within the area of KM in the process of KM doctors' educational and professional experience, as Jongyoung Kim (2005) argued.

KM students' learning experience of biomedical knowledge at KM school continues in a more concrete clinical situation while working as KM doctors in clinical practices. Such a clinical experience with biomedicine prominently appears in hospital-level medical institutions mostly working with biomedical doctors, in comparison with cases encountered in private KM clinics working without biomedical doctors.<sup>253</sup> As already examined, KM

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<sup>253</sup> As a matter of fact, only about 15 percent of KM doctors work in hospital-level medical institutions (from: Ministry of Health and Welfare, 2012a). As for the rate of KM trainee doctors, about 30 percent of new licensors of KM doctors newly work as KM trainee doctors (interns, estimated based upon data from Ministry of Health and Welfare, 2012a, 2012b). It presents a sharp contrast with the situation of biomedical doctors, whereby most of graduates of biomedical school who have newly passed the national exam work as interns in

doctors working in WKCT hospitals are in a situation where they constantly experience, recall, develop and need biomedical knowledge and therapies while working with biomedical doctors in the process of the WKCT for their patient management. Concerning the characteristic of the WKCT hospitals as a place for medical actions – in comparison with KM clinics being exclusively managed by KM doctors – it is useful to quote from AK3 and BK4, two KM residents.

*(Question: You said that it is necessary for you to have as much biomedical knowledge as possible while you work here in 'A' hospital. If you worked at KM clinic only with KM doctors, do you think that you would think differently about the necessity of biomedical knowledge compared with now?)*

*I haven't had any experience in working at local private KM clinics yet, but when I meet my old classmates working there, many of them also say that without biomedical explanation they would not gain trust from their patients, particularly from younger patients. Even if I had chosen to work at private KM clinic after graduating from college, I would try to acquire biomedical knowledge as much as possible.*

*(Question: Do you know any KM doctors working at KM clinics who have negative views on KM doctors' learning biomedicine?)*

*Of course, there are some of them I have personally met, as well as on the internet. Their logic is... No matter how we understand disease with biomedical knowledge, we as KM doctors are supposed to treat the patients with the principles of KM, after all. In this situation, they criticize that there would be no major difference, whether we know biomedicine or not. If anything, **the more we talk to our patients with biomedical terms, the more they would like to receive biomedical treatments.** For this, there are some KM doctors who are skeptical about us utilizing biomedical knowledge. (AK3, resident, KM rehabilitation)*

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that year, in a situation where there are higher quotas in terms of places for interns (3,877 places nationwide) than the actual number of the graduates who passed the national exam (3,095, from: Ministry of Health and Welfare, 2012a; Ki-won Kim, 2011). The KM graduates who are not trained as trainee doctors work as general KM physicians in private KM clinics or hospitals. This implies that hospital-level medical institutions – in comparison with private clinics – are still not the main place where the majority of KM doctors work as practitioners, while the experiences of KM doctors working with biomedical doctors in hospitals do not represent the general situations of all KM doctors.

*(Question: Do you see any difference of viewpoints concerning KM doctors' utilizing biomedical knowledge among KM doctors within and outside of the WKCT hospitals?)*

*Once we enter the WKCT hospitals as KM trainee doctors, there are numerous chances to come into contact with biomedical things inside, but those who do not have experience of trainee doctors have less chance to enter into contact with such things. After the lapse of time, when I meet my old classmates who have been working at private KM clinics, I see a lot of differences between them and myself in terms of our interests in or knowledge of biomedicine. As an example, when I look back my own case (he had worked in a KM clinic as general KM physician before entering 'B' hospital as trainee KM doctor), the experience here as a trainee doctor changed me a lot. When it comes to diagnostic imaging for orthopedic diseases, there is no major difference between those who work at KM clinics and hospitals. But, there are more different things observed in internal medical parts, such as using electrocardiograms, blood tests, hormone examinations... In the local clinic, there used to be more cases where I directly applied KM diagnoses and treatments without such biomedical inspections, but here ('B' hospital) we routinely check out such things through referral to the biomedical sector, in parallel with our own KM ways of diagnosis... Another example is... as for some patients having a history of liver problems, we constantly check out how the liver somatic index changes during the KM medication. While we take lessons from the professors (KM attending doctors) and senior trainee doctors about patient management, we also learn how to utilize biomedical help through the WKCT. In this process, we also learn how biomedical doctors give treatments to patients in such cases. In this way... (BK4, resident, KM internal medicine)*

AK3 and BK4 show slight different perspectives concerning KM doctors' needs for biomedical actions/knowledge between the situation in private KM clinics working without biomedical doctors and in hospital-level medical institutions working with biomedical doctors. AK3 expects no fundamental differences between working with or without biomedical doctors in terms of his interest in and needs for biomedical knowledge. However, borrowing another KM doctor's words – *“the more we talk to our patients with biomedical*

*terms, the more they would like to receive biomedical treatments*” – he conveys other colleagues’ apprehension that KM doctors’ continuous application of biomedical knowledge in WKCT hospitals may reinforce their dependence on biomedicine and biomedical doctors in a situation where KM doctors do not possess the authority of biomedical diagnoses and treatments. In comparison with AK3, BK4 – who had previously worked in a private KM clinic for one year – states based upon his own experience that there are distinct differences between working at clinic- and hospital-level KM medical organizations. He recalls that while working at a private KM clinic he did not so actively apply biomedical inspections as in ‘B’ hospital, aside from the usage of X-rays. By contrast, in ‘B’ hospital, he routinely utilizes various biomedical inspections for patient management through the WKCT process in parallel with KM therapies. In this process, he explains that he is steadily in need of utilizing and developing his own biomedical knowledge while working at the WKCT hospital, particularly for inpatient management, which marks a fundamental difference compared to working at the KM clinic. Accordingly, their statements imply that hospital-level organizations – which are mainly in charge of inpatient management while working with biomedical doctors in most cases – create a circumstance under which biomedical knowledge is embodied in KM doctors’ medical decisions.

Another interesting aspect related to KM doctors’ biomedical knowledge that I found during the interview is that they frequently use biomedicine-oriented terms when they explain their work and the situations in WKCT hospitals, seemingly resulting from the situation of the WKCT hospitals where they have to communicate with their biomedical colleagues. Accordingly, they not only employ biomedical terms of diseases, diagnoses and treatments, but they also use specific terms related to patient management in hospitals that are believed to be originally developed by biomedical doctors. For instance, during the interviews they often mentioned diseases or symptoms in English such as “*back pain*,” “*neck pain*,” “*CVA infarction*,” “*sprain*” or “*Bell’s palsy*” without translating them into Korean, as well as describing diagnostic results, e.g. “through *MRI*, *narrow findings* between *L4* and *L5*<sup>254</sup> with *disc herniation* were observed” (AK1). Likewise, concerning the ways of patient management, they often use English expressions without translating them into Korean, such as “*injection for pain control*” (AK1), “writing *SOAP notes* or *progress notes*” (AK3),

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<sup>254</sup> The fourth and fifth vertebrae of the lumbar area (lower back).

“admission order” (AK1), “ABR” (absolute bed rest, CK1), or “SLR test” (straight leg raise test, AK2) as well as English expressions often used in hospital settings such as “notifying to the supervisor” and “making an order” (BK2), “chronic,” “acute,” “routine,” and “care.” Such expressions by KM doctors originate from biomedical doctors’ colloquial usage developed within a circumstance in hospital settings. In this instance, this hints at the internalization process of the biomedical knowledge into KM doctors while they adapt themselves to such a biomedicine-friendly circumstance of the hospital setting.

Concerning the issue of KM doctors’ biomedical knowledge as the key element connecting KM and biomedical doctors’ communication in the process of the WKCT, it is useful to consider the KM and biomedical doctors’ (self-) evaluation regarding the level of KM doctors’ biomedical knowledge. First, in the case of KM doctors’ self-evaluation concerning their biomedical knowledge, most of the KM doctors showed pride in their high level, particularly concerned with their specialties, such as KM gynecologists regarding their biomedical knowledge about gynecological disease (CK1) and KM acupuncturists in terms of their ability to read and interpret biomedical imaging for orthopedic and neurosurgical diseases (AK1). The majority of them evaluate their biomedical knowledge as being equally high as their biomedical counterparts who exchange biomedical information with them, accumulated through their clinical experience of the WKCT in clinical practices together with their educational experience at KM schools. Many of them were confident in stating that they have more knowledge at least in their own area than other biomedical doctors who majored in other fields. As an example of KM doctors’ self-confidence concerning their biomedical knowledge on their fields, let us consider CK1’s statement below.

*In order to confirm the diagnoses of my (KM doctor) patients with “Jung-pung,” in KM terms, CVA in biomedical terms, it is necessary to read an MRI or CT scan... Based on my 15-year experience in this hospital, I am sure that I have much more clinical experience with deciphering such images than any other biomedical internal medicine doctors, or orthopedic specialists in this hospital. I can diagnose them by myself (through reading such images alone without biomedical doctors’ help). In uncertain cases, I consult neurosurgery doctors about such cases; for instance, ‘is this part (on the images) problematic?,’ ‘should this be “acute,” or*

*“old” (chronic)?’ On this basis, I compare their prognosis with mine. When it comes to a theoretical prognosis, the (biomedical) neurosurgeons must be more aware of it than me. Anyway, I inquire to the biomedical doctors and integrate it with my own opinion. Then, I explain it more lucidly to the patients or their family members taking care of them. (CK1, KM gynecology)*

Grounded upon her long-term experience of the WKCT in ‘C’ hospital, CK1 showed confidence and pride in her biomedical knowledge without recoiling from her biomedical counterparts in the process of the WKCT. Regarding more concrete and detailed prognosis, she states that she often consults the biomedical doctors. However, even in such cases, she tries to utilize her biomedical knowledge actively while comparing it with the biomedical doctors’ clinical findings and integrating it with her own view based upon her biomedical knowledge. Such a confidence in her own biomedical knowledge is mainly based upon her clinical working experience in WKCT hospitals. Regarding this connection between KM doctors’ high self-evaluation concerning their own biomedical knowledge and their working experience in clinical settings of the WKCT hospitals, it is worth considering the statements of two KM trainee doctors (AK3 and BK4) who have recently gained such a working experience in ‘A’ and ‘B’ hospital.

*Personally I think..., I am not sure of the cases of KM doctors who do not have any experience working at hospital-level organizations, but at least for KM doctors who experienced interns and residents in training hospitals, we acquire a lot of biomedical knowledge while working here. As we have been learning how biomedical treatments (through the WKCT process) are applied to our patients, we can explain every detail of biomedical doctors’ treatments to our patients, to say nothing of understanding the biomedical doctors’ explanation on the patients’ conditions and the biomedical doctors’ therapies. (AK3, resident, KM rehabilitation)*

*As we are KM doctors, we don’t know every single detail of the pharmacological mechanism of (biomedical) medication, but at least what we (KM trainee doctors) are doing as a routine is investigating the mechanism of all the (biomedical) drugs that our patients take (through the WKCT process with biomedical doctors). This is*

*the main task of (KM) interns. They are supposed to record it in detail, making reference to online information on (biomedical) drugs on the internet or... there is also an online program developed by our hospital ('B' hospital) on the information about the ingredients of medication. In such ways, we are prepared to discuss biomedical doctors' prescriptions if needed. (BK4, resident, KM internal medicine)*

Both AK3 and BK4 indicate that KM doctors with the experience of training at hospital-level organizations have above a certain level of biomedical knowledge through their daily tasks for patient management confronting with the process of the WKCT with biomedical doctors. This results from KM doctors' experiences in WKCT hospitals, where they need to develop biomedical knowledge in the process of the WKCT, thus becoming confident with their biomedical knowledge. However, at the same time, it also implies that it makes them realize the gap between their lack of biomedical authorities and their necessity for biomedical actions, which strengthens their dependency on biomedical doctors' help through the WKCT.

In contrast to KM doctors' concurrent high opinion concerning the level of their biomedical knowledge, it was discordant how biomedical doctors would evaluate KM doctors' biomedical knowledge. Regarding this issue, let us compare the respective statements of CK1 and BK3.

*(Question: What do you think of your counterparts' (biomedical doctors) evaluation of KM doctors' biomedical knowledge?)*

*Well, as far as I feel, biomedical doctors in this hospital ('C' hospital) will acknowledge that I am widely informed about biomedical knowledge, I believe. But they will not highly appreciate biomedical knowledge of KM doctors in general, especially those who do not work at WKCT hospitals, I guess. (CK1, KM gynecology)*

*I think it is up to the individual, but I don't think they would highly appreciate our (KM doctors') level of biomedical knowledge. I guess they would think we know more than general physicians (biomedical doctors) when it comes to our major fields. I think they consider that we are as good as them, at least, but not more than*



*that... (BK3, former president of 'B' hospital)*

CK1 – who has confidence in her biomedical knowledge based on her long-term clinical experience in 'C' hospital – answered that her biomedical colleagues would highly estimate her biomedical knowledge. By contrast, BK3 – former president of 'B' hospital who has wider contacts with biomedical doctors – shows a rather negative opinion about biomedical doctors' evaluations concerning the level of KM doctors' biomedical knowledge. Based upon his administrative experience with biomedical doctors, he estimates that the majority of them would acknowledge the KM doctors' biomedical knowledge at best as being equal to general physicians or training doctors. Overall, slightly more KM doctors who I interviewed hold the same view as CK1, although a significant number also hold a similarly negative view as BK3.

By contrast, biomedical doctors evaluate the level of KM doctors' biomedical knowledge rather more negatively than KM doctors' expectations. Concerning their viewpoints on KM doctors' biomedical knowledge, let us look at several statements below.

*(Question: What do you think of the level of KM doctors' biomedical knowledge?)*

*Personally I rate their biomedical knowledge considerably high, at least in the cases of professors at the KM school in this hospital. (DA1, former director of the biomedical sector of 'D' hospital, professor of anesthesiology and medical ethics at 'D' university biomedical school, biomedical doctor)*

*(Question: Based upon your own experience in WKCT hospitals, how do you evaluate the level of your KM colleagues' biomedical knowledge?)*

*I would like you not to record this part... (I turned off the voice recorder and handwrote his answer.) I doubt if they really have profound understanding of biomedical knowledge as they believe. Several times I have experienced that they say that they know and understand what I have explained to them in biomedical terms. But later on, they ask similar things again; I feel... they haven't understood what I previously explained. I don't think their level of biomedical knowledge is that high, rather superficial... (AB1, internal medicine)*

*As KM doctors have also learned (bio-) medical terms and basic (biomedical) pathology, they roughly understand biomedical explanation, up to a fashion. But their main task is to apply KM therapies. As they are not allowed to apply any biomedical treatments directly, there must be a clear limitation on the understanding of biomedicine in depth. (DB1, neurology)*

*Their (KM doctors') biomedical knowledge is rather superficial. Not as good as those who major in biomedicine. With whom can they be compared...?*

*(Question: What about biomedical students, trainee doctors or medical technicians like physical therapists?)*

*I guess higher than medical technicians. Probably comparable to the certain grades of biomedical students, that much... I think (DB2, rehabilitation medicine).*

*(Question: I heard KM students also learn biomedical subjects at KM school...)*

*Yes, they do, about 60 percent are biomedical subjects. But all they learn is just at a student level, based on medical text books. It still lacks much in terms of applying it to patients in clinical practice.*

*(Question: So, do you think that the level of their biomedical knowledge is not particularly high?)*

*Not at all, they have only superficial knowledge on biomedicine.*

*(Question: Probably comparable with biomedical students' level?)*

*No, even worse than them. Seniors at (bio-) medical school can manage patients in practice to some degree after a one-year practicum, but KM doctors can't. They only have book learning. (DB3, neurology)*

Aside from DA1 – former director of the biomedical sector at 'D' hospital, who took the lead in establishing the KM hospital and KM school in 'D' hospital – most of the interviewees rate their counterparts' level of biomedical knowledge not as high as KM doctors' own evaluations, varying from those who rate their level as being equivalent to the levels of general physicians or biomedical trainee doctors to those who rate it even lower than biomedical students with experience of practicum. They indicate two aspects as the reasons for their under-appreciation of KM doctors' biomedical knowledge. First, they criticize the

quality of biomedical education at KM schools, stating that biomedical subjects taught there are not as thorough as at biomedical schools in terms of the length and profundity. Second – and more importantly – the biomedical doctors indicate that the KM doctors do not have a right to make a direct clinical decision for biomedical therapies on their own; rather, they are always dependent on biomedical doctors' medical actions for biomedical diagnoses or therapies in the situation where KM doctors do not have the authority of biomedical treatments in the dualized South Korean medical system. From this aspect, they argue that KM doctors' biomedical knowledge cannot be highly evaluated in terms of 'clinical' competence. Of course, the biomedical doctors' such negative view about the level of KM doctors' biomedical knowledge should be understood in the context of current conflict between KM and biomedical doctors, as summarized in Chapter IV.4.2.3. Nevertheless, regardless of whether the level of KM doctors' biomedical knowledge is high or not in reality, the fact that KM doctors have biomedical knowledge does not prompt them to maintain the lead over or equalize with biomedical doctors in the process of the WKCT in terms of their power relationship: if anything, it reinforces biomedical doctors' relational superiority over KM doctors, as long as the KM doctors are in need of biomedical actions and dependent on biomedical doctors' medical authority for biomedical care. In this process, to the biomedical doctors the WKCT is merely a kind of 'dispensation' for KM doctors in that they provide KM doctors with biomedical care and instruct biomedical knowledge to KM doctors who need such medical actions, as long as they are not interested in or respect KM therapies. Meanwhile, they confirm the superiority of biomedicine and themselves as individuals over KM and KM doctors.

As the core element connecting KM and biomedical doctors in the process of the WKCT in clinical practices, this chapter has reviewed several aspects concerning KM doctors' biomedical knowledge, including the learning experience of KM doctors' biomedical knowledge in KM schools and WKCT hospitals, as well as their own evaluations concerning their biomedical knowledge compared with their biomedical counterparts' rather critical view of it. Based upon their previous learning experience of biomedicine in KM schools, KM doctors in WKCT hospitals steadily develop and utilize biomedical knowledge for patient management to communicate with biomedical doctors and their patients. Under this circumstance in clinical practice, most of the KM doctors who I interviewed showed

confidence in utilizing biomedical knowledge in the process of the WKCT, such as understanding biomedical doctors' medical explanations and explaining their patients' status to the biomedical doctors and the patients. In line with their such confidence, it was also observed during the interview that they often naturally use biomedical terms and colloquial hospital expressions describing various tasks for patient management within the context of hospital settings, originally developed by biomedical doctors. However, in the situation where they do not have medical authority to directly prescribe biomedical inspection and medication without help from biomedical doctors, the more they accumulate biomedical knowledge the more they tend to become dependent on biomedical doctors through the WKCT process as a result. Put simply, KM doctors' ability to utilize biomedical knowledge enabling the communication between KM and biomedical doctors ironically results in reinforcing the superiority of biomedicine and biomedical doctors in clinical settings. The next chapter will finally discuss the dominance of biomedicine and biomedical doctors over KM therapies and KM doctors observed in the process of the WKCT. It will be discussed within the context of the pre-existing debates on biomedical dominance over traditional medicine in situations of medical pluralism worldwide, while considering the specific feature of the South Korean medical system.

### **3.3 KM Doctors Adapting to a 'Biomedical World': Multi-layered Biomedical Dominance in the Process of the WKCT in Hospital Settings**

Part V examined the actual meaning and process of the WKCT as well as the relationship between KM and biomedical doctors in this process in the clinical settings of four different WKCT hospitals in Busan. In the process of the WKCT – namely the process of sending their patients to their counterpart for additional diagnoses and treatments – ‘asymmetrical relations’<sup>255</sup> between KM and biomedical doctors regarding the frequency of the WKCT requests to their counterparts, interest in and dependence upon their counterpart's medical

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<sup>255</sup> The notion of an ‘asymmetrical relation’ inductively emerged in the coding process, while connecting and reorganizing open codes in the process of analyzing the interviews. Subsequently, I found that the term ‘symmetry/asymmetry’ was already used in various articles on medical sociology and anthropology to describe the relationship between biomedicine and indigenous medicine (e.g. the “asymmetrical relationship” between KM and biomedical doctors, Hyo-je Cho, 2000: 123, 132; “asymmetrical conversations/structure/relations” between biomedicine and indigenous medicine, Naraindas et al. 2014: 6, 9, 11), as well as between CAM practitioners and clients (“symmetries of power,” Sointu, 2012: 111-113), along the same lines as what I coded.

actions, as well as through external factors such as the relations with patients and the process of medical insurance claim were commonly observed in all four hospitals, regardless of the different sizes and styles of hospital settings. In this final chapter of Part V, I will review such asymmetrical aspects discovered during the analysis of the interviews, while connecting them with the debates of biomedical dominance in situations of medical pluralism, taking account of critical medical anthropologists' arguments in particular. In addition, KM doctors' way of 'adaptation' in WKCT hospitals will be also discussed, being labeled as 'adapting to a biomedical world' in the course of data analysis.<sup>256</sup> Concerning this issue, the notion of the "hospital as the primary locus of biomedicine" raised by Baer et al. (2003: 344) will be reviewed in consideration of the South Korean situations in the WKCT hospitals.

Despite different scales (large: 'B'- and 'D' hospital, medium: 'A'- and 'C' hospital) and styles of hospital settings (biomedical doctor-oriented: 'A'- and 'B' hospital, KM-oriented: 'C'- and 'D' hospital), significant differences were commonly observed concerning the frequency of the WKCT requests, dependence on their counterparts' medical actions through the WKCT and interest in the WKCT process and their counterpart's medical knowledge between KM and biomedical doctors involved with the WKCT process in each hospital. More precisely, KM doctors more frequently make requests of the WKCT for additional biomedical diagnoses or treatments to biomedical doctors, showing more dependence on biomedical actions and more interest in biomedical knowledge and collaborative work with their counterparts compared with biomedical doctors. In this process, KM doctors are exposed to steadily learning and reviewing biomedical knowledge to communicate with biomedical doctors and their patients, as well as to verify their patients' illness with biomedical terms to NHIS for medical insurance claims. Meanwhile, they tend to depend on biomedical doctors' clinical help for patient management in the WKCT hospitals. By contrast, the biomedical doctors involved with the WKCT process steadily confirm the superiority of biomedicine over KM and their status over KM doctors, while providing such medical actions and knowledge with KM doctors more frequently than they receive additional

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<sup>256</sup> The term 'adaptation' in this study merely describes a situation for KM doctors who work in a biomedicine-friendly circumstance. I applied this term in the coding process after the fieldwork to emphasize the KM doctors' 'disadvantageous' situation in WKCT hospital settings compared with that of biomedical doctors, which is conceptually unlinked with the notion of "biocultural adaptation" widely used by biocultural anthropologists to describe a 'successful' interaction between human and cultural environment in the process of "evolution" (e.g. Alland, 1990; Relethford, 1990; Willey, 1992).

medical help from KM doctors.

The emergence of such an asymmetrical relation between KM and biomedical doctors in the clinical process for patient management can be explained within the debates on biomedical dominance over indigenous traditional medicine. In hospital-level organizational settings – mainly in charge of inpatient management – biomedical diagnoses and therapies are widely considered as essential, not only by biomedical doctors but also by patients and even a majority of KM doctors. Meanwhile, KM therapies are more often considered as ‘ancillary’ or ‘residual,’ making up for what biomedicine is lacking, i.e. when biomedicine cannot completely cure in the case of terminal diseases or is not interested, as is mostly the case with chronic, irreversible or non-fatal diseases. This situation results in unequal power relations between the KM and biomedical doctors who are respectively in charge of each sector, despite their legal status being guaranteed as equal as medical doctors. Such a phenomenon becomes visible when they work together in a certain place, while it is less evident when they work separately in their own place in biomedical/KM hospitals/clinics, which comprise the vast majority of medical institutions in the current South Korean medical system. Accordingly, WKCT hospitals are places where biomedical dominance – shadowed by the South Korean dual medical system – manifests itself in the clinical process for patient management. At the same time, such a biomedical dominance is steadily reinforced in the process of the WKCT.<sup>257</sup> On the other hand, ironically, an asymmetric situation between KM and biomedical doctors in terms of their counterparts’ medical knowledge – KM doctors have both KM and biomedical knowledge whereas biomedical doctors only have biomedical knowledge – has an influence on biomedical doctors’ superiority over KM doctors in a situation where biomedical doctors exclusively retain clinical authority for the application of biomedical actions.

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<sup>257</sup> Such a dominative position of biomedical doctors over KM doctors seems to be revealed more realistically with the difference in pay levels between them in WKCT hospitals. Although no statistical information on the average salaries of KM and biomedical doctors working in WKCT hospitals is officially disclosed to the public, purportedly the average salaries of KM doctors tend to be lower than those of biomedical doctors working in the same hospital. According to what I heard during the fieldwork, in a case of convalescent hospital where both KM and biomedical doctors work together for the WKCT, the average salaries of KM doctors are set about 20 percent point lower than those of biomedical doctors. While this may simply reflect the difference of average income between KM and biomedical doctors on the whole, as shown in the table IV.4, it may also reflect the differing significance of the roles in WKCT hospitals between KM and biomedical doctors, as shown in this study.

If we reconsider the circumstance of the WKCT hospitals from the position of KM doctors, the WKCT is a kind of KM doctors' adapting process in a biomedicine-friendly space, featuring: 1) biomedical doctors, who exclusively use biomedical terms without an interest in KM; 2) patients, who prefer biomedical explanations for their diseases, as well as showing more trust in biomedical rather than KM diagnoses and treatments in most cases;<sup>258</sup> 3) the clinical settings of the hospital-level organization mainly for large numbers of inpatients in need of standardized en-bloc patient management; and 4) the NHI system, asking for 'biomedically' defined diagnoses and charging the WKCT as a kind of 'unstandardized overtreatment.' Such a situation was not fundamentally different between KM- ('A'- and 'C' hospital) and biomedicine-oriented hospitals ('C'- and 'D' hospital), aside from there being slightly more frequent and earlier medical interventions by KM doctors observed in the cases of acute diseases in KM-oriented hospitals than biomedicine-oriented hospitals. Despite the South Korean government's policy and the efforts of hospital administrators in each hospital to promote the WKCT in clinical practices – mostly aiming for biomedical doctors' increased interest in KM and cooperative attitudes towards the WKCT – the majority of biomedical doctors in all four WKCT hospitals do not show much interest in KM and the WKCT process, while rather reluctantly acceding to the WKCT requested by KM doctors or their patients. By contrast, aside from their own interest in biomedical treatments, KM doctors are steadily in a situation in WKCT hospitals where they have to 'polish' their biomedical knowledge to communicate with biomedical doctors and their patients through biomedical terms, as well as verifying their patients' diseases with biomedical principles through the WKCT process for biomedical inspections. Accordingly, they have to adapt themselves to 'biomedicine-friendly' hospital settings. As a result, they become dependent on biomedical doctors' medical actions under circumstances in which they do not have a medical authority for biomedical actions, which formulates an unequal power relation between KM and biomedical doctors in the process of the WKCT despite their equal legal status as medical doctors.

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<sup>258</sup> However, the patients' preference for biomedical treatments found in the interviews with the physicians in WKCT hospitals should not be misunderstood as a general attitude of the public given that it only reflects the opinions of patients who are hospitalized in the hospital-level medical institutions with relatively more serious diseases than outpatients in the clinic-level medical institutions or non-patients who have more interest in health promotion or disease prevention, and thus who could have more positive attitudes on KM, which is widely believed to be more competitive with chronic diseases and recovery or restoration of general physical conditions than biomedicine. In this sense, such a preference should be restrictively understood as a phenomenon within the circumstance of hospital-level medical institutions.

Let us compare the situations in WKCT hospitals in South Korea with other examples studied by medical anthropologists with the notion of biomedical dominance in medical pluralism. In the case of the WKCT hospitals, KM and biomedical doctors – as equally acknowledged as medical doctors – share their patients through the WKCT process. This differs from the majority of fieldwork findings in research on biomedical dominance in the third world (e.g. Janzen, 1978; Crandon-Malamud, 1991; Brodwin, 1996) outside East Asian Countries as well as Western countries such as Australia and the U.S. (e.g. Willis, 1989; Baer, 2001), given that most of them indicate as evidence of biomedical dominance/hegemony either the superior legal and socio-cultural status of biomedical doctors over traditional practitioners or different socio-economic classes – including gender and ethnicity – of patients who visit biomedical and indigenous practices; namely, lower classes have less access to biomedical care than upper classes. Instead, the case in the WKCT hospitals is rather analogous with the cases in Chinese hospitals, where TCM and biomedical doctors work together in the same place for identical patients (e.g. Henderson and Cohen, 1984; Schneider, 2000). In line with Chinese situations, the findings of this study also support Baer et al.’s argument based upon such findings in Chinese hospitals, stating that “medical pluralism in complex societies is characterized by a pattern in which biomedicine exerts dominance over alternative medical systems, whether they are professionalized or not” (Baer et al. 2003: 352). However, in contrast to the Chinese cases with more direct state intervention in the actual clinical settings over the medical practitioners’ own decisions – possibly reflecting its socialist regime – biomedical dominance in the WKCT hospitals in South Korea manifests in the actual clinical process within the circumstance of hospital itself with less active intervention of the state, while the physicians’ medical autonomy for clinical decisions and the administrative autonomy of hospitals are presumably more assured than in Chinese cases. This implies that the South Korean case provides an ideal circumstance where biomedical dominance originating from biomedical knowledge manifests itself with less influence from other external factors, particularly the direct instructions of the state.

This study has examined the power relations between KM and biomedical doctors in the process of the WKCT in clinical settings regarding the concept of biomedical dominance in situations of medical pluralism. KM and biomedical doctors are situated in a steady asymmetrical relation in terms of the frequency of the WKCT requests, dependency on the



WKCT process and their counterparts' medical actions. Such an aspect of asymmetry in the process of the WKCT reflects the unequal power relations between biomedicine/biomedical doctors and KM/KM doctors, which is 'shadowy' when they are separated but becomes visible in the course of clinical practices when they work together for patient management in WKCT hospitals. This situation in South Korea is an interesting example in which biomedical dominance manifests itself in the clinical process, albeit not through the explicit superior status of biomedical doctors over traditional practitioners or through medical clients' different socio-economic classes between biomedicine and indigenous traditional medicine; rather, the South Korean case in the WKCT hospitals shows that biomedicine exerts its superiority over traditional medicine in the process of clinical practices for patient management by its own bootstraps, even in a situation where the traditional medical sector is highly professionalized with traditional practitioners' equal legal status with biomedical practitioners and their medical territories being guaranteed by the state.



## **VI. Closing Remarks, Research Limitations and Future Research Perspectives**

Founded upon the basic interest in the relationship between biomedicine and traditional indigenous medicine in the situations of medical pluralism worldwide, this study has examined how the relationship between KM/KM doctors and biomedicine/biomedical doctors is formulated in the clinical settings in South Korea when they work together for patient management in the name of the WKCT, as well as illustrating its actual process in various hospital settings. Through the fieldwork research based upon qualitative interviews with KM and biomedical doctors in four WKCT hospitals in Busan, this study has attempted to ascertain what the actual process of the WKCT looks like in clinical practices, how KM and biomedical doctors communicate with each other and extent to which the external factors such as patients, hospital administrators, government policy and national health insurance system influence the relationship between KM and biomedical doctors in the process of the WKCT, aiming to determine the power relations between KM and biomedical doctors in the clinical process of the WKCT. Under the South Korean medical system in which the traditional medical sector has been highly professionalized and traditional practitioners have legally achieved an equal status with biomedical doctors, KM and biomedical doctors take charge of mutually exclusive medical territories within the KM and biomedical sectors. However, when they work together in the same place, being involved in collaborative patient management in the name of the WKCT, previously unseen biomedical dominance comes into view in the clinical process of the WKCT in the ‘biomedicine-friendly’ circumstance of hospital settings in various ways, regardless of the size and style of each hospital. Under this circumstance, KM doctors are in a situation where they steadily have to develop and utilize biomedical knowledge while they are dependent on biomedical doctors’ biomedical actions. Such dependency on biomedical knowledge and medical actions among KM doctors results in an unequal power relationship between KM and biomedical doctors in WKCT hospitals. In this sense, the WKCT hospital is a place where biomedical dominance presents itself while both KM and biomedical doctors are involved with patient managements in the same place through the process of the WKCT. As a contribution to the existing debates on biomedical dominance in medical pluralism, the findings of this study provide an interesting empirical

example of how biomedical dominance manifests itself over traditional forms of medicine in the daily process of patient management within the professional medical sector, in a situation where the explicit dominance of biomedicine – in terms of the practitioners’ legal status and the matters of social classes of medical consumers – is to be observed less than any other possible cases thus far. However, such findings cannot be generalized as encompassing the whole South Korean medical system, given that the vast majority of KM and biomedical doctors still work in separate places, unlike in WKCT hospitals. Furthermore, this study has clear limitations originating from the research methods based upon qualitative interviews, including the selection of fieldwork places and interviewees, as well as from the conceptual and theoretical perspectives. In the final part of this study, I will introduce various aspects of research limitations and the future perspectives for further studies on the issues of the South Korean situation of medical pluralism as closing remarks of this study.

Concerning the limitations of this study in terms of research design based upon qualitative methods for inductive empirical research, first there is a basic limitation of the qualitative interview method compared with the participant observation method in terms of the validity of data. All the processes of the WKCT I described are the results of reconstitution derived from interviews reflecting the viewpoints of interviewees, rather than reflecting what I actually observed in the process of patient management in the hospital settings. I chose the qualitative interview method because it was difficult to gain access to actual scenes of patient management in hospitals owing to ‘medical confidentiality.’ Moreover, I considered that it would not be a useful method to follow every single flow of patient management of the WKCT from the beginning to the end, as I realized from the pilot research that KM and biomedical doctors do not meet directly with each other in the process of the WKCT with active communication, but rather simply send their patients to their counterpart and receive the results of the diagnostic inspections or therapies. In this situation, I decided that it would be more efficient to hear from the physicians involved with the WKCT in as many different scales and styles of hospitals as possible to analyze their attitudes concerning the WKCT as well as reconstructing the actual process of the WKCT in each hospital. Nevertheless, the weak points of the qualitative interview method remain relevant, such as questions concerning the truth of interviewees’ statements and the bias of the interviewer’s interpretation, although I repeatedly cross-checked the answers on the same questions to KM

and biomedical doctors as well as hospital administrators working in the same hospital to minimize such weak points of the qualitative interview method.

Regarding the limitations related to the conceptual framework of this study, there is a lack of connection between the findings of this study concerning the KM and biomedical doctors' relationship and the basic theoretical premise of biomedical dominance raised by the critical medical anthropologists, whereby inequality in a certain medical system reflects the reality of "inequalities of the wider society" at the state level society (Singer & Baer, 2007: 121). As this study has discovered the importance of biomedical knowledge as the key element having a crucial influence on power relations between KM and biomedical doctors in the clinical practices, further research should be directed at determining how such power relations within the hospital settings - originating from the power of biomedical knowledge - are connected with the issues of inequality in a broader range of the current South Korean social structure. In this regard, it will be useful to adopt theoretical perspectives concerning the debates on power-knowledge relations in future research – such as the Foucauldian approach – to examine the South Korean case more systemically regarding biomedical dominance in situations of medical pluralism. Apart from that, in case we are more interested in the relations between KM and biomedical 'knowledge' rather than between KM and biomedical 'practitioners,' it will be worthwhile for future research to examine the clinical decisions of the holders of both KM and biomedical doctor's licenses in their practices.<sup>259</sup>

Aside from this issue, regarding the selection of interviewees, most of them were KM or biomedical doctors (including two KM senior students who experienced medical care training at 'D' hospital with four hospital administrators in each hospital) involved within the clinical process or collaborative research work of the WKCT. However, patients who actually receive the medical inspections or treatments in the process of the WKCT were omitted from the list of the interviewees. This decision was consciously made because I attempted to concentrate

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<sup>259</sup> As of August 2014, it was reported that there were 247 license holders of both KM and biomedical doctor nationwide (Eun-taek Choi, 2014), who graduated from both KM and biomedical school and passed the state examinations for biomedical doctors and KM doctors. In accordance with the regulations of the MSA, it had not been allowed for them to apply KM and biomedical inspections or treatments simultaneously in their practices until 2009; rather, they had to select to identify themselves as either KM or biomedical doctors in the sense of clinical practices. However, with the revision of the MSA in 2009, they have been allowed to practice both KM and biomedical therapies simultaneously in their clinics since 2010 (Yun-bok Lee, 2009).

on the main focus of this study, namely the relationship between KM and biomedical doctors. Nevertheless, considering that the vast majority of the interviewees indicated that their patients have an important influence on their decisions for the WKCT requests while playing an active role regarding the communication between the physicians and their clinical decisions, it would have been useful to hear the patients' voices directly through interviewing them, rather than reconstituting their viewpoints through the physicians' voices. In future research on the WKCT, it will be necessary to analyze the WKCT process encompassing the perspectives of patients who actually receive the therapies through the WKCT to further explore the relationship between KM/KM doctors and biomedicine/biomedical doctors in more of a stereoscopic way. Together with the lack of giving consideration to the patients' own voices in the fieldwork, there is a certain wistfulness to the fact that the role of the state was not fully examined with further details in this study. As Young (1994) and Last (1996) indicate, the state plays a crucial role in the formulation of the medical system in each country. Furthermore, critical medical anthropologists (e.g. Baer et al. 2003; Singer, 2004; Baer, 2011) particularly emphasize the role of the state as the principal agent formulating the biomedical dominance over other forms of medicine in the situations of medical pluralism. As examined in Chapter V.2.4.3, this study also illustrated how the legal regulations and government policy have an effect on the physicians' decisions in the clinical process of the WKCT. However, such a role of the state was rather restrictively discussed, merely relying on the statements of the physicians and hospital administrators in the hospital settings. Clearly more research is needed in future research to illuminate the role of the state on power relations between KM and biomedical doctors in the clinical settings, while devoting attention to the decision-making process of administrative officials involved in medical policy or health insurance policy.

Concerning the process of fieldwork analysis, the lack of interest in the possible difference within each group of KM and biomedical doctors leaves much to be desired. I noticed during the fieldwork that there could be a significant difference in biomedical doctors' attitudes on KM and the WKCT depending on their specialties. However, it was difficult to generalize their viewpoints merely based upon the results of the interviews.<sup>260</sup> This is partly because I

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<sup>260</sup> For instance, AB1 (internal medicine) and DA1 (hospital administrator, anesthesiology) answered that physicians of internal medicine and pediatrics tend to have more negative views on KM therapies while

did not fully cover various physicians with different specialties in the process of snowball sampling in each hospital in sufficient number to analyze their attitudes regarding their specialties. Furthermore, it could also be because I mainly paid attention to the differing attitudes ‘between’ KM and biomedical doctors to find the way of biomedical dominance over traditional indigenous medicine, without seriously considering the difference ‘within’ each group of KM and biomedical doctors. In this regard, it is necessary for future research to examine whether there are any internal differences within the groups of KM and biomedical doctors – e.g. regarding their medical specialties, places of work (small private clinics or larger-scale hospitals) ages and gender, etc. – to analyze their multidimensional relations in more elaborate way.

Regarding the scope of the research, as briefly mentioned in Chapter II.3, this study exclusively focused on the relationship between KM and biomedical doctors working in the WKCT hospitals to examine their working relations in clinical settings more clearly when they are mutually involved with certain patient managements both as medical doctors in the same place. However, considering that a large majority of KM and biomedical doctors work without their counterparts under the influence of the MSA – which strictly divided areas of KM and biomedical doctors in principle until the 2000s<sup>261</sup> – there is a clear limitation that

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indicating the side effects of herbal medication, whereas orthopedic surgeons and neurosurgeons are more generous to KM and the WKCT than the physicians because KM therapies can supplement their biomedical treatments without colliding into each other. However, BB1, a neurosurgeon, argued that he has personally experienced more cases in which neurologists or rehabilitation physicians are more interested in the contents of KM treatments than the surgeons, while he indicated the conceptual commonality of the traditional principle of acupuncture with the meridian system and the biomedical principle of IMS and motor points in muscles. Unlike BB1’s expectation, DA1, a rehabilitation specialist, complained about a situation in which his affirmative attitude towards collaborative work with KM doctors was severely criticized by other rehabilitation specialists who he said are more hostile to such cooperative work with KM doctors than any other biomedical specialists, because KM doctors and the rehabilitation physicians are in competition with each other while both of them mostly conduct non-operative therapies on identical diseases, such as CVA and musculoskeletal pain. What is worse, DB3, a neurologist, showed the most hostile manner against KM therapies among all of the biomedical doctors who I interviewed, while blaming KM as being unscientific. To summarize, it implies that orthopedic surgeons and neurosurgeons could be more cooperative with KM doctors through the WKCT regarding ‘division of labor,’ while neurologists and rehabilitation physicians could be more interested in the therapeutic contents and principles of KM. Meanwhile, physicians of internal medicine and pediatrics could be more skeptical of KM therapies, particularly of herbal medication. Nevertheless, I could not discover any coherent general phenomenon on biomedical doctors’ differing attitudes towards KM depending on their medical specialties during the fieldwork.

<sup>261</sup> For further details on the change of the MSA regarding the regulations on the WKCT, see Chapter IV.4.3.3

the findings of this study cannot be generalized as describing the full situation in terms of the relationship between biomedicine and KM within the South Korean medical system. On the other hand, we should also give consideration to the existence of the traditional folk medical sector – where non-licensed traditional folk medical healers or CAM therapists are in conflict with or collaboratively work with KM and biomedical doctors – to adopt a more comprehensive view of the South Korean medical system from the perspective of the relationship between biomedicine and traditional indigenous medicine in situations of medical pluralism. In this regard, it will be useful for future research to analyze multi-dimensional relationships among biomedical doctors, KM doctors and non-licensed traditional therapists, which will provide more wide-ranging and deeper insights into the issues of medical pluralism in South Korea.

In addition, we should also consider that the fieldwork of this study was conducted within hospital-level medical institutions. This study discovered that the characteristics of hospitals – mainly in charge of a large number of inpatient managements, the majority of whom are in acute or serious phases – have a crucial influence on the power relationship between KM/KM doctors and biomedicine/biomedical doctors in the process of the WKCT. In this regard, it will be useful to examine the process of the WKCT in clinic-level medical institutions, mostly in charge of outpatient management dealing with more chronic or less serious patients than in hospital-level medical institutions. Although there have been remarkably few cases of the WKCT in the clinic-level medical institutions thus far,<sup>262</sup> it will be worth examining the WKCT process in smaller scale clinic-level medical institutions in future research. It may show differing relationships between KM and biomedical doctors compared with the situations in hospital-level medical institutions observed in this study. Concerning this issue, I would like to emphasize again that the findings of this study – the situation of biomedical dominance over KM in WKCT hospitals – should not be understood as a general phenomenon representing the entirety of the South Korean medical system. The fact that the traditional medical sector has developed as a form of professional medicine ranking with the

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‘Legal regulations on the WKCT.’

<sup>262</sup> According to the revision of the MSA in 2009, it is allowed to hire biomedical doctors and KM doctors in identical hospital-level and general hospital-level medical institutions (Article 43 of the MSA). In this regard, the WKCT ‘within’ a single clinic-level medical institution is not possible. However, it is possible for KM and biomedical doctors to conduct the WKCT ‘between’ neighboring KM and biomedical clinics.



biomedical sector in South Korea despite such a biomedical dominance in the hospital-level organizations implies that KM as a professionalized traditional medicine definitely has strength and constant demands over biomedical therapies widely acknowledged by the general public in the modernized (or ‘Westernized’) current South Korean society, which should not be overlooked despite the findings of this study.

Finally, the current unstable changing situations related to the circumstance of the WKCT process – namely the debates around authorizing KM doctors to apply biomedical/modern diagnostic instruments such as X-rays and ultrasonography, which have exclusively belonged to biomedical areas – should be followed with intense interest.<sup>263</sup> As illustrated in the first section of Chapter V.2.2.1, KM doctors’ WKCT requests to biomedical doctors for biomedical inspection comprises a large portion of KM doctors’ WKCT requests, while being considered as a routine for patient management in WKCT hospitals. However, if KM doctors are allowed to apply such instruments by the South Korean government despite biomedical doctors’ strong opposition, it will have a fundamental effect on the power relationship between KM and biomedical doctors in the process of the WKCT. Accordingly, I anticipate that KM doctors’ dependence on biomedical doctors’ medical authority for using modern/biomedical inspections in the WKCT hospitals will become reduced. It would prompt less asymmetrical relations between KM and biomedical doctors in the WKCT hospitals. However, KM doctors’ free usage of such instruments could paradoxically prompt KM doctors’ increased dependence upon biomedical knowledge. In this sense, as long as biomedical doctors still have an exclusive right for biomedical ‘treatments,’ biomedical doctors’ superior position over KM doctors may remain unchanged or even be reinforced in the long term. Together with the long-term discussions concerning the integration of the dualized South Korean medical system, we need continually monitor the changing situations concerning this issue in the context of power relations between KM/KM doctors and biomedicine/biomedical doctors in situations of South Korean medical pluralism. It reminds us of Stollberg’s perspective (2013: 150) on the changing characteristic of medical pluralism in the socio-historical context: “medical pluralism is not a stable phenomenon, neither historically nor in our times.”

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<sup>263</sup> Further details on this issue are introduced in Chapter IV.2.3 ‘Issues of KM doctors’ usage of biomedical/modern diagnostic equipment.’



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In Hyo Park