Ideology and Disease:

Cholera, Policy and Identity during the Sino-Japanese War

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Abstract

During the Sino-Japanese War the Japanese army medical bureau employed medical protocols based largely on their ideological import. The result was a failed system of testing that prevented the early identification of a cholera epidemic that swept through the warzone. Near the end of the conflict the epidemic also spread to Japan.

Key Terms: cholera, "Asiatic cholera," Meiji Era, ideology, reform, Germ Theory, epidemic, Catarrh, quarantine, medical knowledge, disease and military

During the Meiji Era (1868-1912), Japan underwent dramatic reforms, adapting European political, economic, and social systems that rapidly changed the country into a modern centralized nation state. Specifically, the goal of the Meiji leaders was to transform Japan into an imperialist power in line with Western nations.

In this time of sweeping changes, the Japanese notion of progress was both utilitarian and ideological. Practically speaking, progress as a utilitarian goal translated into the rapid production of industrial goods, forging a modern military, and implementing a national system of compulsory education to offer but a few examples. These initiatives all tied the individual to the state in meaningful ways and created a centralized system of governance based on the populace's mass participation in society. Progress also functioned on an ideological level, often providing an impetus for reform and shaping how reformers conceptualized and implemented programs. Ideologically, through reforms, Japan signaled to Western powers that Japanese society was adapting Western norms, essentially modernizing to be seen as modern. For the Japanese,

progress was not exclusively utilitarian or ideological; in practice, it was both. As Japan emerged as an imperialist state, the officials and bureaucrats in Japan's developing Western institutions determined the relative import of utility and ideology related to each program of reform.

This study addresses the Japanese medical community's treatment of cholera in the Meiji period related to ideological expressions of progress. Japanese medical journals' selective use of terms to describe cholera and the Japanese army medical bureau's policies related to cholera during the Sino-Japanese War offer clear examples of the degree to which Japanese officials stressed progress as ideology, often in lieu of medical efficacy. The intersections and interstices between medicine and institutional policy are key, because policy regularly served as the conveyor of ideology.

During the Meiji period, Japanese practitioners of Western medicine used an array of terms to refer to cholera. They often based their use of specific terms in relation to changes in medical knowledge, as well as institutional policies that associated Japan's medical community with Western medicine. Despite this orientation, Japan's medical institutions did not adopt Western medicine wholesale; rather, they adapted terms and protocols to their evolving needs in a manner that highlighted their drive to modernize.

Cholera had existed for centuries in India's Ganges River Delta region and developed into a pandemic in 1817. This disease was brought to Japan in 1822 by Dutch trading vessels. Throughout the nineteenth century, from 1822 to 1896, Japan suffered through seven different cholera epidemics that took the lives of nearly a half a million people.[1]

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[1] The dates for these epidemics are 1822, 1858, 1862, 1877, 1879, 1886, and 1896. By 1886, Japanese biologist and researcher Kitasato Shibasaburo confirmed the disease was evident in Osaka's water supply year-round, suggesting that cholera had become endemic to Japan by the mid-1880s. For further information refer to *A Brief Review of the Operations of the Home Department in Connection with the Cholera Epidemic of the 19th Year of Meiji, 1886*

"Asiatic cholera" was a prominent Western term for cholera that Japanese physicians seldom used within a Japanese medical context. Even though the Japanese were intent on adapting Western medicine to Japanese society, Japanese medical officials and institutions rejected the term "Asiatic cholera" when referring to cholera in Japan. "Asiatic cholera" was problematic for the Japanese in two ways: first, it painted the disease with a broad geographic brush and implied that all Asian nations were either rife with cholera, or the origins of the disease. Second, Japan's experience with cholera mirrored Europe's, where cholera was understood as a foreign illness, and since Japan was adapting Western social, economic, and political systems, Japanese medical officials were inclined to project a modern identity that distanced the island nation from its Asian neighbors.

The unwillingness of Japan's medical community to embrace "Asiatic cholera" is evident in how Japanese medical journals referred to the disease. In a survey of *Iji shinbun* [The Journal of Medical Affairs] and *Rikugun gun'i gakkai zasshi* [The Journal of the Society of Army Medical Officers] there were no references to "Asiatic cholera" within Japan.[2] In nearly all cases when referencing domestic outbreaks of the disease, or studies done by Japanese researchers, the journals referred to cholera in the three-character *ateji* (虎列剌) pronounced ko-re-ra.[3] In *Rikugun gun'i gakkai zassh,* there were no references to "Asiatic cholera" from 1876 to 1911, its years of

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(Tokyo: The Home Department, 1887), 1-2. Hereafter referred to as *A Brief Review of the Operations of the Home Department* (1887).

[2] For the purposes of this study *Iji shinbun* and *Rikugun gun'i gakkai zasshi* were appropriate periodicals to survey. *Iji shinbun,* a proprietary journal, was published every ten days beginning early in the Meiji period (1878) and enjoyed a wide circulation among Japan's medical institutions, libraries and medical practitioners. *Rikugun gun'i gakkai zasshi* was an institutional journal for the Japanese army published monthly, and was relatively insular in that it addressed medical issues applicable to the military. This journal served as the academic venue for medical officers to present their studies, research and findings.

[3] *Ateji,* used extensively in Japanese in the nineteenth century and earlier, are character clusters that phonetically represent foreign words. In the early twentieth century *katakana,* a type of phonetic syllabary, gradually replaced the use of *ateji* in the written language.

publication. In *Iji shinbun,* from 1878 to 1911, there were only nine articles that used the term "Asiatic cholera." In each of these instances "Asiatic cholera" was a direct translation of research done in Europe and accurately reflected a European researcher's use of the term. For example, Shibuya Shūhei's translation of Robert Koch's article titled, "*Saikin gakujyō no kenkyū ni tsuite*" [Concerning Bacteriological Research] published in *Iji shinbun* in 1890, offers a general overview of Koch's research on microbial pathogens that cause typhus, typhoid fever, diphtheria, tuberculosis and cholera, to which Koch refers as "Asiatic cholera."[4]

In line with this rejection of Asiatic cholera, the Japanese Central Sanitary Bureau reports in the 1870s and 1880s position cholera as an Asian illness that was not Japanese in origin.[5] In 1877 Nagayo Sensai, the Director of the Central Sanitary Bureau, wrote, "Whenever it [cholera] has been observed in Japan in a great epidemic state, it has been introduced into this country either from Java or China."[6] Eight years later, in an 1885 report, Nagayo located the source of cholera as India and clearly objected to viewing cholera as an Asian illness, and in so doing aligned Japan with the West:

> Each new outbreak of cholera in Japan, but renders it more clearly evident that here, as in Western countries, the disease is always imported and traceable to but one and the same origin, in the burning plains of India. [*sic*] Renewed arguments on this point were scarcely needed, were it not that it has been hastily assumed by some, even of late, that cholera is endemic, not only in India, but throughout the greater part of the Far East as well, an assumption for which, we believe, there is no foundation in fact.[7]

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[4] Shibuya Shūhei, "*Saikin gakujyō no kenkyū ni tsuite*" [Concerning Bacteriological Research], *Iji shinbun* [The Journal of Medical Affairs], no. 342, 7 December, 1890, 16-20.
[5] The Central Sanitary Bureau was a part of the Home Ministry.
[6] *Report of the Director of the Central Sanitary Bureau, to H.E. The Minister of the Home Department on Choleraic Diseases in Japan, during the 10th Year of Meiji, 1877* (Tokyo: Central Sanitary Bureau, 1877), I. Hereafter referred to as *Report of the Director of the Central Sanitary Bureau* (1877).
[7] *A Brief Review of the operations of the Home Department in connection with the Cholera Epidemic of the 18th Year of Meiji (1885)*, (Tokyo: Sanitary Bureau, 1885), 2.

In the Meiji period, Japanese medical writings consistently referred to epidemic cholera in a manner that denied a specific geographic locus, all the while asserting cholera's continental origins. The *ateji* for cholera was a geographically null term that provided both the conceptual and linguistic flexibility to associate the disease with specific countries on the mainland. This linguistic cudgel allowed the Japanese to draw epidemiological distinctions between themselves and Asia. This was essential to the Japanese preference to ideologically align themselves with the West as an advanced nation, while conceptually distancing themselves from Asia.[8]

During the Sino-Japanese War (1894-1895), the Japanese army medical bureau entered the conflict confident their modern system of Western scientific medicine would shield its forces from the ravages of continental illnesses.[9] With regard to cholera the army medical bureau required medical officers to identify the disease through a microscopic examination of the patient's bodily fluids. This meant that physicians in the field were expected to isolate the cholera vibrio in a patient's blood, urine, fecal matter, or vomit before determining the individual had contracted cholera. This was problematic in a number of ways. First, this diagnostic technique was relatively new, with Germ Theory only having been confirmed in the 1880s, which meant that many medical officers were not well acquainted with microscopes and microscopic examinations. Second, field grade medical officers serving at battalion aid stations and regimental field hospitals were often inundated with sick and wounded and constantly on the move as the army advanced. Even if they were trained in cholera bacteriological examinations,

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[8] In *Japan's Orient: Rendering Pasts into History*, Stefan Tanaka presents this conundrum by positioning China, and Asia by association, as Japan's past, and a modern Japan as Japan's future. Here Tanaka examines the epistemological underpinnings of a group of *Tōyō* [Oriental] scholars who sought to anchor Japan's historical narrative within the folds of a reconceptualization of China as *shina,* a premodern term that stripped China of its historical authority. For a full discussion of the relationship between *Tōyō* and *shina* see Stefan Tanaka, *Japan's Orient: Rendering Pasts into History* (Berkeley: University of California Press, 1993), 1-28.

[9] Western scientific medicine refers to the system of medical inquiry based on hypothesis and proofs tested in a laboratory to rationally confirm a disease or a treatment.

medical officers at this level seldom had the time to do so for all patients that presented with enteric illnesses. Lastly, cholera is a rapidly advancing disease that could kill a patient in a day or two. Most of the hospitals where such precise laboratory examinations could take place were at more permanent line of communication facilities in Korea, or large army reserve hospitals in Japan. Many soldiers with cholera expired before they reached a hospital that could perform the requisite examination.

The problems associated with testing for cholera in the field were evident in the army medical bureau's official history of the Sino-Japanese War. For those cases where cholera was suspected in a patient, but never confirmed, the army medical bureau classified the patient as contracting a form of gastro-intestinal catarrh.[10] In their *post mortem* of the cholera outbreak the authors of the report implied the actual number of cases of cholera could be much higher than the army listed. "The difficulty is that since a bacteriological examination was not done in each case, we cannot call all of the [catarrh] cases cholera until it is clear we know the pathogenic agent. Whether this is the real number of cholera cases for this campaign, or whether that number will increase, and whether the deaths from acute gastrointestinal catarrh will suddenly change…we do not know."[11]

Early in January of 1895, Japanese soldiers and laborers in Southern Manchuria began to fall ill with severe gastro-intestinal illness. On January 6, Commander Nakamura of the Army

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[10] Catarrh is a disease category that refers to any illness that presents with a buildup of mucus or discharges caused by severe inflammation of any soft tissue or membrane. This is a sixteenth-century medical term that gradually fell out of favor because it referenced a set of symptoms rather than a specific disease.

[11] *Meiji 27-28 nen'eki rikugun eisei jikō: dai 3 kan densenbyō oyobi kakke, dai 3 hen koreri, dai 1 shō kanja sōkei oyobi ryūkō no jōkyō, sono 1 kanja sōkei* [A Record of Army Medicine during the Campaign of 1894-1895: Book Three: Infectious Contagious Illnesses and Beriberi, Volume Three: Cholera, Chapter One: General Patient Statistics and Epidemic Conditions, Part One: Patient Statistics] (Tokyo: The Medical Department of the Ministry of the Army), 1-2. Hereafter referred to as *Meiji 27-28 nen'eki rikugun eisei jiseki*. Officially, the army claimed slightly more than 5,000 troops perished from cholera, while nearly three times that number died from all forms of gastro-intestinal catarrh.

Reserve Hospital in Kokura, Japan, cabled Mori Rintarō, the Commander of the Japanese Second Army's line of communication medical department at Liushutun in the Liaodong Peninsula, Manchuria. Nakamura reported that a soldier on board the *Tateyama maru* carrying sick and wounded from Manchuria to Kokura died from vomiting and diarrhea a day after arriving in Japan. The medic who had cared for the sick man died of similar symptoms a day later.[12] Throughout January and February, instances of acute gastro-intestinal cases continued to pepper medical reports from the field. Most of these telegrams referred to small groups of military personnel falling ill in specific units and on transports. By March, reports from the warzone outlined a growing epidemic with entire units incapacitated by widespread cases of vomiting and diarrhea.[13] From the end of March to July the epidemic was in full swing with reports of hundreds and thousands of troops in specific units presenting with a severe enteric illness. By the end of March more than 400 troops from the Second Division were sick, and on April 10th, 1895, the Imperial Guard and the Fourth Divisions arrived in Southern Manchuria and within a month more than 1,300 troops in these units were stricken with the disease.[14]

The failure of an adequate testing regimen that could rapidly and efficiently determine the nature of the outbreak delayed the army medical bureau's response to the epidemic. In April, the army medical bureau informed the Home Ministry that quarantine stations had to be established to prevent the spread of cholera to Japan. The Home Ministry made clear it was ill-prepared to deal with the quarantine project, so it fell to the army to establish a system of

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[12] *Meiji 27-28 nen'eki jinchū, chū 2, Daihonei yasen eisei chōkanbu* [Campaign Diary during the Sino-Japanese War, vol. II: The Department of the Director-General of Field Hygiene of the Imperial Headquarters] (Tokyo: The Ministry of the Army, 1896), 823. Hereafter referred to as *Meiji 27-28 nen'eki jinchū*.
[13] For specific reports refer to *Meiji 27-28 neneki jinchū* 1,018-1,116. By the first week of March reports from the field noted that the Second Division suffered from 226 cases of vomiting and diarrhea.
[14] *Meiji 27-28 nen'eki rikugun eisei jiseki*, 8-9.

screening and disinfecting more than 250,000 returning troops. The army's quarantine program was not operational until the end of June, because it took a few months to construct the facilities and purchase the quarantine equipment.[15] From April to June, sick and wounded troops continued to return to Japan for medical care. By the time the stations were operational, cholera outbreaks were already evident throughout Japan. In 1895, more than 40,000 Japanese died of cholera.[16]

In summation, the Japanese medical community's rejection of "Asiatic cholera" formed the basis for a Japanese medical identity as aligned with the West and distinct from Asia. This ideological position situated China as a cholera nation and should have made the Japanese army medical bureau more sensitive to a cholera epidemic emanating from battlefields in China. However, the leadership of the army medical bureau placed their faith in Western scientific medicine, because it ideologically served as a marker of Japan's modernity, and practically they viewed bacteriological examinations as a definitive way to confirm cases of cholera. Progress as utility and ideology failed in the face of nature's epidemiological onslaught. The cholera vibrio spread throughout the ranks of the Japanese army regardless of their perceived level of modernity, and practically the army medical bureau's testing policy obscured the epidemic in its early stages, delaying the army's response to the outbreak.

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[15] Yamamoto Shun'ichi, *Nihon korerashi* [The History of Cholera in Japan], (Tokyo: Tokyo Daigaku Shuppansha, 1982), 8-9.

[16] Yamamoto, 96. The total dead from the outbreak of cholera during the Sino-Japanese War remains unclear. As many as 30,000 soldiers may have perished from cholera during the war; this includes all who died from cholera as well as various forms of gastro-intestinal catarrh. Japanese sources are incomplete regarding Manchurian, Chinese and Taiwanese deaths from cholera in the war zone. Anecdotal evidence in Japanese sources points to tens of thousands of civilians perishing from the disease as it ravaged the warzone spread there by troops from both sides and exacerbated by the privations and dislocations of war.