

Japanese Medical Education Reforms during the Allied Forces Occupancy; Roles Played by the Public Health and Welfare Section of the Supreme Commander for the Allied Powers

Shigemasa IKEDA¹⁾, Satoru SUGITA²⁾ and Seiji TANAKA³⁾

¹⁾ Professor emeritus, Department of Anesthesiology and Critical Care, St. Louis University School of Medicine, St. Louis, Missouri, USA

²⁾ Professor, School of Nursing, Faculty of Medicine, Oita University

³⁾ Assistant Professor, School of Education, Niigata University

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Abstract: The health and welfare of the Japanese people were of a lower standard compared to other developed countries at the end of the World War II in 1945. Crawford F. Sams, Chief, the Public Health and Welfare Section of the Supreme Commander for the Allied Powers thought that medical care in a war-torn country could be improved not by building new hospitals and providing more medical equipment, but through professional education and training. He founded the Council on Medical Education to reform the Japanese medical education. The Council shaped Japanese medical education by establishing the standards for medical school education and initiating internship and a national medical licensure examination.

In the early 1950s, the Unitarian Service Committee Medical Mission was invited to teach to medical school professors and students American medicine. This medical mission was also a contribution of the Public Health and Welfare Section to Japanese medical education.

This article explores how Public Health and Welfare Section played vital roles in transforming Japanese medical education and postgraduate training during the occupation.

Key words: Occupied Japan, Supreme Commander for the Allied Powers, Medical Education, Internship, Medical License

Soon after the occupation of Japan by Allied Forces in the summer of 1945, the Public Health and Welfare Section (PH&W) of the Supreme Commander for the Allied Powers (SCAP) investigated health conditions in the country. This revealed that the health and welfare of the Japanese people were of a lower standard than that of many other developed countries.¹⁾ Crawford F. Sams, Chief, the PH&W of the SCAP from October 1945 to July 1951 was convinced that medical care in a war-torn country could be improved not by building new hospitals and providing more medical equipment, but through professional education and training.

Sams, a physician himself, became concerned with the quality and methods of medical education and the lack of structured postgraduate medical education. After careful consideration of all the phases of the problem, he founded the Council on Medical Education (Council) to reform the Japanese medical education.²⁾ The Unitarian Service Committee (USC) Medical Mission in 1950 and 1951 was another PH&W's contribution to Japanese postgraduate medical education. One of the most important and successful

reforms during the occupancy was changes in Japanese medical education.

In order to explore the PH&W's roles in transforming Japanese medical education and postgraduate training during the occupation, we reviewed publications from the PH&W, in addition to documents archived at Hoover Institution, Andover-Harvard Theological Library and articles published in peer reviewed English journals, and report how the PH&W intended and accomplished the transformation. Knowledge of how Japanese medical education and postgraduate training were reformed during occupancy is essential to understanding not only immediate postwar, but also current Japanese medical education.

Though a summary of history of post WWII medical education in Japan was recently published as a book chapter³⁾, we intend to identify gaps in our knowledge how the PH&W intended to reform Japanese medical education during occupation, especially for non-Japanese readers of this journal.

Japanese Medical Care System and Medical Education in 1945

During the first three months of the Allied Forces occupation, the PH&W investigated the Japanese healthcare system and found several serious deficiencies. The interruption of vaccination programs and other public health interventions during the war had detrimental effects on overall public health. The population's poor nutritional state increased susceptibility to tuberculosis, dysentery, typhoid, typhus and smallpox. Parasite infections were rapidly spreading.¹⁾ Japanese medical schools had problems. In addition to severe physical damage to school buildings, quality of education at many schools was questionable. In 1945, there were eighteen university medical schools in Japan. Admission to these schools required education at a primary school for six years, four to five years at a secondary school, and three years at a Koto Gakko (高等学校), which was equivalent to a liberal arts college in the United States (US). Upon completion of four years of medical education, a license to practice medicine was automatically issued without any qualifying examination or additional clinical training. Concurrently, there existed another type of medical school, called Igaku Senmon Gakko (医学専門学校) whose students were accepted directly from secondary school. Most of the first year students were 17 years old. The school was called at the PH&W as the second class medical school or technical medical college. These schools had limited clinical and educational facilities and, in many cases, were not affiliated with a hospital for clinical teaching. Graduates from Igaku Senmon Gakko were also automatically licensed to practice medicine without any qualifying examination after completion of a four year medical education. Ten such schools were in operation prior to 1938. During the war, medical education was geared to wartime requirements, and the number of such schools had increased to 51 during the war. Many of these schools were 'diploma mills' producing physicians of inferior educational and clinical qualifications. There was no structured postgraduate medical education. As a result of these problems, the quality of medical care was compromised.

Sams, a native of East St. Louis, Illinois, graduated fourth in his class from Washington University School of Medicine in St. Louis in 1929. He was a career Army physician with extensive experience in public health and disease control. At the SCAP, he was responsible for preventive medicine, medical care, welfare, and social security. As a late 1920's medical school graduate, he was familiar with the Flexner Report.⁴⁾ We are not able to say if Sams intended to play a Flexner's role in the immediate postwar Japan, however, he certainly knew that it took a decade to implement new medical educational system in the US, and that reforming postwar Japanese medical education would be a difficult, time-consuming task.

The Council on Medical Education

Japanese medical education had been firmly established modeling the German system. German medical education stressed didactic lectures, book-learning and memorization, but neglected bed-side teaching. Japanese physician had more detailed medical knowledge, but because of inadequate clinical clerkship, he was less adept in applying his knowledge in clinical practice. Sams believed that rigid adherence of Japanese medicine to German medical tradition might be disadvantageous, and would hamper modernization of Japanese medical education. He also believed that American medicine was felt to be the world's most progressive at the time, and Japanese medical education could be reformed by following the American model.⁵⁾

Sams initially planned to delegate oversight of medical education programs to the Japan Medical Association (JMA). However, he realized that the JMA, whose members were primarily physicians in private practice, had not played any major role in medical education. Any other medical societies had had no voice in establishing their own standards of education.¹⁾ There was no Japanese agency to undertake the re-organization of the medical educational system, therefore, it was necessary to newly form an organization to reform the medical educational system. In January 1946, Sams invited seven Japanese academic physicians to a meeting to discuss medical education.⁶⁾ He also invited representatives from the Ministry of Education, the Ministry of Health and Welfare, and the JMA. This Council was officially organized under the auspices of the SCAP on February 11, 1946⁷⁾, composed of academic physicians of both national and private medical schools, representatives from the JMA, Ministries of Education, Health and Social Welfare, officers from the PH&W, and Civil Information and Education (CI&E), another section of the SCAP, which oversaw Japanese education.^{8,9)} Dr. Yoshio Kusama (草間良男), then Professor of Public Health at Keio University (慶應義塾大学) and a 1920 graduate of Stanford University School of Medicine was nominated as Chairman of the Council.¹⁰⁾ Major Sylvan Moolten, Laboratory Consultant, and Colonel Harry Johnson, Chief of Medical Service Division, served as advisory members. Colonel Johnson, a Sams' trusted aide, was chosen to implement the reforms. The purpose of the Council was to study weaknesses of the Japanese medical educational system and make recommendations to the Ministry of Education with a goal of establishing basic standards for a medical curriculum, postgraduate education, and license to practice medicine.¹¹⁾

Sams encouraged thorough implementation of medical education reforms modeled after the US system, and told the Council members:

“I think that this group has one of the most important tasks of any group in Japan. If you can carry out the program I have in mind it will advance the practice of medicine and benefit Japanese people far greater than anything else this section can do in Japan.” He continued, “Japanese medicine blindly followed the German system of medical education. Leadership in medicine today lies in the US. That is where the greater progress had been made and is being made today. To get to the specific problem of change of education requirements in Japan, it can be done in one of two ways. You can do it by law, that is, establish standards of licensure for the practice of medicine, the standards being set so high as to prohibit the practice of medicine by poorly trained doctors. The other method is to voluntarily attempt to raise the standards of the medical schools without any resource to law. Either one

will work alone, but I think the best method is that which we use in America, where we combine both methods to establish the standards for all of Japan. When you have arrived at this set of standards, which should be incorporated in an ordinance, I want you to bring it to me. I will see that it is placed in effect through your Ministry.”¹²⁾

The Council meetings were held twenty-one times from February 27, 1946 to April 12, 1947. Two additional meetings were reported to be held in 1950, but we were not able to find either the meeting minutes or attendees' name at each meeting.¹³⁾

In order to establish a long range medical education policy, the Council had six agendas regarding post-graduate education: 1) improved pre-medical education 2) higher standards for admission to medical school 3) improved medical curriculum 4) national medical licensure examination 5) establishment of an internship and 6) development of post-graduate medical education.⁹⁾ In August 1946, the Council formally presented its agendas to the Ministry of Education. The PH&W understood that the Council's recommendations would be accepted by the Ministry and put into effect. However, the Council's medical education reform encountered another hurdle. A different organization named the Japan Education Reform Council (JERC) headed by Yoshishige Abe (安倍能成) was founded under the auspices of the Japanese Cabinet in August 10, 1946. The JERC tried to gain control over all education from primary school to university in order to preserve the traditional Japanese education.

A new educational system called '6-3-3-4 Education' was adopted in 1947. In this system, six years of elementary school were followed by three years of junior high school, three years of senior high school, and four years of college. Under the new system, all Koto Gakko, providing students with a liberal arts education before entering professional schools, were to become 4-year colleges. Under this new educational system, the JERC advocated direct admission to medical school from high school without a pre-medical liberal arts education, and rejected other professional opinions regarding standards for education and training. The JERC's decision was understandable since only one member among thirty-eight committee members was a physician. Conversely, the Council members who were predominantly physicians strongly believed that standards of professional education and training, such as medicine should be established by experts in their respective fields. The JERC was reluctant to accept the Council's recommendation on medical education.

The Council's problems became further complicated with the CI&E's relation with JERC and Ministry of Education. The CI&E was a SCAP section which oversaw Japanese education. Relationship between the JERC and the CI&E was similar to that of the PH&W to the Council. When the Council was established, the initial agreement between the PH&W and the CI&E was that medical education and allied professional fields were handled by the PH&W and the Council, and that the CI&E was primarily interested in the field of general education rather than professional school education.¹⁴⁾ A CI&E officer became a charter member of the Council, who later became the CI&E Director. The CI&E continued to send its officer to the Council meetings.

Even though Sams mentioned that anything proposed by the CI&E had never conflicted with a PH&W policy, in reality all educational problems came through different channels – the Council, JERC, PH&W, CI&E and Ministries of Education. Every agency had its own interest in education problems. There were a lot of confusion, misunderstanding and inadequate communication among them. One of major differ-

ences in interest was premedical education. Another hotly debated topic was the quality of medical education at Senmon Gakko. All of them agreed with a 4 years medical education. The Council strongly insisted medical students need liberal arts education at a college level school before starting medical education, which did not fit the 6-3-3-4 system.¹⁵⁾

To end the dilemma, dialogues between the JERC and the Council were initiated. The Council invited the JERC chairman and vice chairman to its regular meeting several times, and the physician member of the JERC later served as a Council subcommittee member. The JERC also invited Kusama and other Council members to its regular meeting. The Council also held a series of joint conferences with the JERC, CI&E, PH&W and Ministry of Education. Inasmuch as the program for medical education reform by Council had not been carried out by the Ministry of Education as a result of resistance from JERC, it was recommended that instructions be issued to the Ministry of Education stating the objectives to be reached by the institutions concerned with medical education, in order that professional groups had a voice in determining their own professional education standards.

In the end, the Ministry of Education adopted the Council's recommendations on medical school education. By 1951, the Council had improved medical school education, established an internship and national medical licensure examination, and opened the door for continuous medical education for practicing physicians.

Medical Education

There were several obstacles that the Council had to overcome in reforming Japanese medical education. Medical education in Japan had traditionally emphasized the didactic lectures. Japanese physicians had a detailed knowledge, but were less adept in applying knowledge to clinical practice. In university hospitals, faculty accomplishment was judged not by teaching and caring for patients, but by research productivity. In other words, a "publish or perish" culture outstripped teaching. Professors viewed teaching as less important activity. Major Moolten, an advisory member, was critical of research-oriented Japanese professors. He said that research was much emphasized over practical clinical teaching at a medical school, and that research had even been carried out for enhancing personal and institutional prestige. He concluded his comment by saying that reorganization of a new medical program was hampered by decades of traditional didactic teaching.¹⁶⁾

Dr. Yoshihiro Takaki (高木喜寛), a Council member, was an 1899 graduate of St. Thomas's Hospital Medical School in England and a professor at Jikei University School of Medicine (東京慈恵会医科大学). He favored a close relation between professors and students, and advocated medical school faculty appointments by merit, not by seniority, and said of the relationship between professors and students:

"The unapproachable and tyrannical attitude of the professors should be corrected. Selection of the faculty through seniority rather than for ability or fitness should be discontinued."¹⁷⁾

a) Premedical liberal arts education

One of major differences in interest between the Council and the JERC was premedical education. In April 1947 the Council members discussed whether senior high school graduates in the new educational

system were well prepared for medical education. Most realized that three years of education at a senior high school was not sufficient for medical study. A question asked at a meeting was how long should premedical education at college be.

General Sams[#] believed that premedical education should promote the attainment of personal maturity for all future physicians, and that such a requirement would guarantee the training of first rate physicians. He thought only a liberal arts education could produce such physicians. His comments regarding premedical education at the meeting were not palatable to most Japanese;

“I do not understand why your professional people are children when they start out. Because it is not just confined to medicine, but to nursing, dentistry or veterinary, graduates of your schools are just children, when they are turned loose to practice medicine. So, I would like to emphasize that there is never any hurry to have a man graduate from a profession, such as medicine, nursing or any other allied fields dealing in human life. The Council was set up to advise the Ministry of Education and the Ministry of Health and Welfare as to what they thought was the proper requirements for the education of a doctor. The decision must be yours as to whether you are willing to take second or third place or whether you, as Japanese, will have as good doctors as anywhere else in the world. We do not believe that you should have second or third in anything. We feel that Japan is entitled to the best.”

He firmly believed that Japan deserved to have the best of her own physicians. Later, Sams stressed again that pre-medical education should be broad, covering not only subjects in the natural sciences required for medical education, but also instruction in the social sciences and humanities, so that physicians in the future would have a sufficient cultural and educational background to cope with problems outside the technical fields of medicine.¹⁸⁾

On the other hand the JERC advocated direct admission to medical school from high school without a premedical liberal arts education, which did not fit in the 6-3-3-4 system.

In April 1947, the Council decided that the prerequisite for admittance to medical school should be three or more college years, with study of subjects essential for medicine.¹⁹⁾ However, financial considerations were crucial for all Japanese at that time, whether for education, politics, or commercial enterprise. Considering the financial burden on students that an extension of mandatory three years pre-medical education would entail, the Council compromised by requiring that all medical school applicants have a minimum of two years of pre-medical education, including a foreign language, mathematics, other pre-medical sciences, and humanities. Dr. Kohsaku Kakinuma (柿沼昊作), a Tokyo University professor, who was the only physician member of the JERC and also served as a Council member seemed to play a role to persuade both the Council and the JERC members to accept a minimum of two years of pre-medical education. This two-year stipulation of university training was finally written into law in June 1949.²⁰⁾

b) University Medical School

Under the new educational system, all 51 Igaku Senmon Gakko schools were to become university level medical schools. The Council recognized the need to evaluate their educational standards. Inspectors appointed by the Ministry of Education reviewed all schools to determine if they complied with the

requirements of the new university medical school curriculum, clinical facilities, and faculty qualifications. Of the 51 schools, 45 met the requirements; six schools failed and closed.²¹⁾ The Council also recommended changing the focus of education; such as 1) increasing teaching at patients' bedside in hospitals 2) decreasing purely didactic lectures at the classroom 3) accepting no more than 80 students/year at all medical schools. Under the new medical curriculum, 45% of the required hours were to be devoted to the teaching of pre-clinical subjects, with an emphasis on practical laboratory work. The remainder was assigned to clinical teaching and lectures.¹⁶⁾ By 1951, all schools were accredited and became university medical schools, admitting students with at least two years of pre-medical education.

c) Unitarian Service Committee Medical Mission

The USC, headquartered in Boston sent 30 medical missions to European, Middle Eastern, Asian and South American countries from 1945 to 1956.²²⁾ This medical mission's primary purpose was to teach the latest developments in American medicine to physicians in war-torn countries. Sams who was concerned with the quality of medical education and the lack of structured postgraduate education invited the USC Medical Mission to Japan in 1950 and 1951 for the rehabilitation of medical education.²⁾ Though the medical mission did not receive extensive news coverage and unknown even to many physicians, the mission played a crucial role in important part of introducing undergraduate teaching and postgraduate clinical training at American medical schools and a new medical specialty, such as anesthesiology.²³⁾

The 1950 mission consisted of 12 professors in biochemistry, pharmacology, bacteriology, physiology, internal medicine, surgery, pathology, radiology, anesthesiology, and pediatrics. Two meetings were held in Tokyo and the Osaka/Kyoto area and 460 professors from all Japanese medical schools attended the meeting. The mission devoted to lectures in each specialty to bring the Japanese up to date on new medical developments. The Japanese professors were especially impressed with demonstrations of American teaching methods, such as the joint sessions between anesthesiology and physiology, surgery, pediatrics and pharmacology. Interdisciplinary cooperative sessions helped the Japanese with limitations of their own rigid departmental and caste system for many years.²⁴⁾

The 1951 second mission was able to concentrate more effectively on problems of education method. The mission members visited twelve medical schools for two weeks and made contact with more than 7,000 teachers and students. American professors were able to observe Japanese teaching methods and provide on-the-spot advice and assistance to the Japanese professors.²⁵⁾ The mission also recommended that medical schools concentrate on clinical training of physicians instead of research, and students should spend more time to get clinical experience in hospital wards.²⁶⁾

Regardless of its intended purposes, the missions were a great success. Certainly, Japanese medical education was poised for change at that time after several years of isolation. However, it would seem fair to suggest that the mission stimulated development and shaped it through lectures, demonstrations, and the exchange of people and ideas.

Internship

Internship training was not necessarily a unique innovation of the Council. In 1942, the Medical School Investigation Committee, established by the Japanese Ministry of Health and Welfare, had recommended

a full year of clinical training for medical school graduates before granting medical license. However, during the war, military authorities desperately needed physicians and did not favor an additional year of education.¹⁶⁾

Before internship was established, most medical school graduates joined a department of their choice at their alma mater and became an assistant. There was no formal postgraduate clinical training program. These new physicians were assigned research projects by their professors and spent many hours in the laboratory, sacrificing their immediate postgraduate clinical training. Typically, after three to five years of such an experience, a research degree of *Igaku Hakushi* (医学博士) – equivalent to a Ph.D. degree – was awarded.²⁷⁾ The Council did not consider such the degree a substitute for clinical training.

In March 1946, the Council unanimously recommended one-year internship for medical school graduates, and in 1948 internship became mandatory for admission to the National Medical Licensure Examination. Internship was beneficial to Japanese medicine in several ways. The number of patients required for interns' training exceeded inpatient populations in many university hospitals, necessitating the distribution of interns to non-university hospitals all around the country, in many cases far from the interns' alma mater. This helped eliminate the citadel influence of academic cliques. Moreover, assignment of interns from multiple schools to a single hospital brought about a beneficial exchange of knowledge, improving standards of care and enhancing teaching innovation.

In its infancy, internship was far from perfect and interns encountered many problems. Many hospitals approved for internship training were perceived as superior to non-teaching hospitals. But in reality, physicians responsible for internship training had never experienced internship themselves and were understandably poorly prepared to contribute to the education of young physicians. Even years after internship was established, staff physicians in many hospitals devoted little time to the education and supervision of interns. Interns without a medical license - many of them unpaid – were not allowed to care for patients without a staff physician's direct supervision. Interns themselves had a problem. Some spent many hours for studying National Medical Licensure Examination. Still many interns appreciated the new clinical training system. In 1949, two interns wrote to Sams, expressing their gratitude for his efforts to improve postgraduate medical education and lead Japan through the chaotic postwar period.²⁸⁾ One of the USC medical mission's recommendations was to offer internship to Japanese medical school graduates at US Military Hospitals based in Japan. This did not begin until 1953, however, and the benefits of the program were limited, although it was one contribution to Japanese medical education by the SCAP.

In 1949, Sams wrote that only time will determine whether the intern system has a place in Japanese medical education.¹⁾ Internship had a stormy course for many years. A Sams' concern became reality and internship was terminated in 1968. Internship was one reform that could not be sustained.

Licensure Examination

The national medical licensure examination became a requirement for all medical school graduates in 1946, and immediately revealed problems in medical education.²⁹⁾ The examination conducted in November 1948 revealed a high failure rate, primarily due to weakness in pre-clinical studies. Analysis of the average examination score showed anatomy to be the weakest pre-clinical subject, with a passing rate of only 40%, indicating that anatomy was poorly taught at many schools. The passing rate in obstetrics and

gynecology was 52.6%, suggesting that obstetrics and gynecology also received only cursory attention. Analysis of the examination results led to beneficial revisions of the medical curriculum, and eventually improved the standard of care for practicing physicians.³⁰⁾ Despite the disappointing examination results, the responses from medical students were rather positive. A group of students at the University of Tokyo wrote that the national examination would establish a minimum standard of knowledge necessary for a physician. They hoped that the examination method and standardized minimum scores would soon be published to benefit their training.

The licensure examination was given in Japanese, but provisions were made for translation of the questions into English. Qualified applicants from foreign countries desiring to practice medicine in Japan could take the examination in October and April of each year. Colonel Harry Johnson was one of the foreign physicians who passed the examination, and he practiced medicine in Yokohama after his retirement from military service.³¹⁾

Specialty Training

When internship became mandatory for medical school graduates in 1948, Sams thought the next step to improve postgraduate training of Japanese physicians was the establishment of residency programs and specialty board certification. Though the system he thought was similar to that in the US, he did not suggest duplication of the US system.³²⁾ He knew that medical specialists in the US provided high quality care, but he did not believe that every physician had to have three to five years of additional training to become a specialist. He personally did not see a significant difference between specialists and general practitioners in the military medical service. He also believed that eighty-five percent of medical care could be handled by well-qualified general practitioners.²⁾ In Japan the specialty board was not established until anesthesiology instituted board certification in 1963.²³⁾

Medical References

Isolated from the rest of the scientific world since 1939 and without international exchange of medical textbooks, journals and research data, Japanese medical libraries lacked up-to-date scientific texts and medical literature. The great gulf in medical knowledge and technology, especially in new specialties such as anesthesiology and neurosurgery caused the stagnation of normal educational development in Japan. During the early postwar occupation, the great need for modern medical literature was recognized. However, since Japanese currency was not permitted as a medium of exchange outside Japan, subscriptions to foreign medical journals and publications were impossible.

In 1946, while Japanese physicians did not have access to the latest medical journals, Sams told Japanese to ignore copyright issues, and encouraged to translate articles published in American journals. Several Japanese physicians translated the latest medical information in American journals kept in a viewing room at the PH&W and reported it in newly published Japanese medical journals. After two years of effort, in conjunction with the CI & E, Japanese publishing companies were finally given republication rights to some American medical textbooks and journals, resulting in the publication of 350 to 400 selected textbooks. A considerable number of individuals and organizations in the US, especially former members

of the Occupation Forces, began to send books and journals to Japan as gifts.

In June 1948, more medical journals became available to Japanese physicians after international postal regulations were revised to permit Americans and other nationals to mail books and journals, as well as subscriptions directly to Japan. The monthly Japanese edition of the *Journal of the American Medical Association* was also published with permission from the American Medical Association starting August 1948. Demand for the journals, however, still far exceeded their availability. The situation was also partially alleviated by loans and donations from the Army Medical Library in Washington DC, which shipped duplicate medical journals to Japan, some fairly current. The journals were turned over to the Japan Medical Library Association, an organization established by medical school library representatives to promote the interchange of literature on a loan basis.⁵⁾ In July 1948, the Army Medical Library sent a representative to Japan, who completed plans for the restoration of international exchange of medical literature.³²⁾

The USC medical missions' another contribution was that many books were donated to several medical schools. In her letter to publishing companies, Dorothy Snaverly (Assistant Director, USC) wrote that Japanese professors' salaries hardly cover their own living expenses and the personal possession of medical textbooks was a luxury. Many publishing companies responded to her request and donated books.

One of the 1950 mission members, Dr. Paul Schaefer, a professor of surgery at University of Kansas noticed that some deficiencies in Japanese medicine were in part due to the lack of contemporary medical literatures. He sent letters to 50 surgeons in the United States, England, and Scandinavian countries asking them to send him reprints of their articles. He distributed thirty-five volumes of the bound reprints to academic surgical departments throughout Japan.²³⁾

The PH&W's roles to current Japanese Medicine

A nation's healthcare system is strongly interrelated with other areas of national interest including economic stability and political development. In early post WWII Japan, successful medical education reform and subsequent improvements in the healthcare system were a major factor in the transition from a war-torn country to a successfully rehabilitated nation. The catalysts for this success were the vigorous efforts of the SCPAP, and the willingness of Japanese to adopt its recommendations. In this article, we reported how the PH&W played an important role in successfully transforming Japanese medical education during the occupation.

The Council could be considered to be a Gen. Sams' brainchild. Its Japanese members consisted of forward-looking educators whose innovations were far-reaching. You may say that the Council used the PH&W's authority to adapt existing US medical systems to Japanese realities, although some of its reforms were perceived as criticism of the pre-war Japanese medical education system and were not appreciated at the time. Regardless of its intended purpose, all but one of the reforms could be sustained and medical education reform was one of the most successful accomplishments of the SCAP's work during the occupation.

We believe that the Council not only reformed immediate post World War II medical education in Japan, but also shaped current Japanese medicine. The Allied Forces occupation of Japan ended officially in 1952, yet an impact of the post-war medical reform has since been felt. Unlike many physicians in the

prewar period who studied in European countries, many Japanese physicians who traveled to the US for further clinical training and research career at the US institutions. This could have been an evidence of long lasting impact of the reform on the present day Japanese physicians and medicine.

Conclusion

This article elaborated roles played by the PH&W and the Council to transform Japanese medicine. The Council established minimum standards for medical education and instituted a national medical licensure examination and internship. The USC Medical Mission invited by the PH&W introduced the up-to-date American medical education to Japanese professors and students. The medical education reform could be interpreted as one of the SCAP's policies of an orderly transition from a war-torn country to a democratic country. Regardless of its intended purpose, criticisms and even a failure, medical education reform was one of the most successful accomplishments during the occupancy.

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Notes

promoted to Brigadier General on 26 April 1948.

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