Introduction

Medicine as a Form of "Ordinary Shopping"

IN A SURVEY PUBLISHED IN THE *Yonsei Medical Journal* in 1960, Dr. Jae-Mo Yang (1920–), affiliated with the university and the adjoining Severance Hospital, outlined the steps taken in South Korea toward the refurbishment of the nation's health system since the close of World War II (1945–1960).[1] According to Dr. Yang, a great deal of work remained to be done, and what he found particularly troubling was not so much a problem of material lack as, instead, a series of inadequate measures adopted in addressing large-scale problems. Specifically, he characterized the administrative approach to that date as haphazard in its execution, involving not a long-term view with careful measures taken to reflect local circumstances but instead a number of "temporary and emergency ones."[2] Moreover, the outlook brought with it an almost deliberate denial of the local, with "imported foreign systems . . . followed blindly."[3] Dr. Yang had previously written on the problems of health care specific to Cheju-do, a small island situated off the southeast coast; his latest effort referred to a series of interviews conducted within the city limits of Seoul, with many of these framing remarks holding for the nation by extension.

Seeking to account for the diverse attitudes of his interview subjects, Dr. Yang emphasized the medical pluralism of his South Korean setting, with frequent intersection between the practices of Western-trained doctors and those of herb doctors and healers.[4] He noted that injections were not limited to the doctor's office and were frequently given out at sites such as pharmacies or even at the personal clinics maintained by traditional herb doctors. When pressed, many patients could not distinguish between a hospital per

se and a doctor's clinic, nor did they seem to be concerned about the need to maintain any such distinction. Summarizing the collective behavior of his patient cohort, Dr. Yang would conclude that "the attitude toward choosing healers is not distinct from that of ordinary shopping," despite the possible consequences for the patients' health.[5] From Yang's perspective, South Korea needed not only to make significant material improvements to its health system but also to instruct patients about its proper use and, moreover, to justify why such use might be to their advantage.

Less than a decade removed from the experience of the Korean War (1950–1953), South Koreans found medicine—here referring specifically to Western medicine—largely unfamiliar, despite its growing availability. For Dr. Yang, moreover, the conspicuous presence of medical pluralism was not a positive and resulted in categorical confusion, requiring a great deal of sorting out. Based on Dr. Yang's observations, the present work begins with two framing questions: Under what conditions or circumstances is it appropriate to intervene in the body, and how would these conditions come to be redefined in an emerging postcolonial nation founded specifically on the basis of strident anti-Communist ideals?

Reframing Science, Technology, and Medicine in the Cold War: Mobilizing Biomedicine as Technical Aid

On January 20, 1949, U.S. President Harry Truman delivered his inaugural address, a speech that would subsequently be labeled the "Point Four Speech," with this designation referring to a list of aims outlined by Truman with respect to America's goals for sharing its technical expertise. More specifically, President Truman would emphasize the need for a "bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of underdeveloped areas."[6] With this idealistic language, Truman would explicitly link U.S. diplomacy with America's emerging status as a global power in knowledge production, mobilizing the American academy, along with industry, to contribute toward reshaping the ideals and material practices of a world recovering from the war and just beginning to find its way in the heated ideological climate of the early Cold War. The ambitions contained within Truman's language would soon take the form of the Mutual Security Agency (MSA), overseeing a program that would assume control over lingering elements of the Marshall Plan, and one that would rapidly shift the emphasis from postwar recovery to strengthening

networks of friendship with partner nations through new forms of scientific and diplomatic exchange.

From 1945 to the outbreak of the Korean War in June 1950, the United States and South Korea had already begun to engage in this new brand of technical exchange, although primarily at the level of ensuring the security and viability of the new nation. Economic exchange, administered through the Economic Cooperation Administration (ECA), provided much-needed support to the government of ROK (Republic of Korea) President Syngman Rhee, assisting with critical infrastructural priorities and basic necessities, rather than offering extensive training programs or opportunities for further education.[7] The loss of electrical power in May 1948, with North Korea effectively denying access to its power grid, would be regarded as among these critical priorities, resulting in the provision of power barges based along the southern coast as a temporary measure, along with a great deal of contingency planning.[8] Similarly, the purchase of fertilizer from the northern zone would also become a problem, meaning that import of these supplies would become the only realistic solution for the time being.[9] In both cases, the emphasis of the exchange lay almost exclusively on the material end, the physical object, with little thought given to the possibility of encouraging initiative or manufacture on the part of South Korea.

The Korean War would bring dramatic change to this relationship and, even more powerfully, for the nature and scope of any future relationship of technical exchange, emphasizing medicine in particular. If South Korea had figured minimally in American foreign policy prior to 1945, it went from a temporary problem area, an uncomfortable postwar occupation (1945–1948) marked by mutual confusion, to a major priority. Within a decade, "Freedom's Frontier"—here referring to South Korea's proximity to the Communist world, adjacent to North Korea, China, and the Soviet Union—would be one of the new labels introduced to present the nation to the world as a showcase of "free world" practice, a model of what was possible with assistance.[10] The diverse forms of American and international aid made available to South Korea would begin as early as late 1950, when it appeared that victory was imminent, with the combined forces of American and United Nations (UN) armies driving north toward the Yalu River. The humanitarian face of this scenario made for an appealing sell, offering to potential donors the possibility of contributing to the reconstruction of a nation unified through a brief conflict.

The human face of the war, presented both during and following the conflict, brought the nation of South Korea into American homes for the first time on a regular basis, with standard images underscoring the difficulties faced by refugees, along with related problems that lay ahead for the lengthy process of rebuilding.[11] In the majority of these accounts, historical context was lacking, and the basic necessities required for subsistence tended to be associated with the contingencies of wartime. Not surprisingly, medical and relief work formed a significant portion of the aid packages that would be sent to South Korea, even during the war, with mobile surgical units providing assistance to UN forces.[12] The relationship between conflict and surgical innovation is well established in the history of medicine, with the exigencies of battlefield surgery frequently requiring improvisation to save a patient's life or to at least make an effort in circumstances where conventional techniques would have proven insufficient.[13] Here then was an opportunity to rebuild a "Korean" medicine and, equally, a chance to learn by working with wounded patients.

Making a "South Korean" Medicine?

If South Korea found that many of its activities were framed by the broad contours of emerging American hegemony and its related ideological project directed against Communism, the new nation nonetheless would take the initiative in remaking its own forms of practice, particularly in education and knowledge-making institutions. Eager to begin anew after thirty-five years of colonialism (1910–1945), as well as an unexpected and deeply problematic period of occupation (1945–1948), South Korea would place a heavy emphasis on access to education, with higher education representing a largely unexplored and experimental forum.[14] For medicine specifically, the factors shaping the conditions for pedagogy were complex, with at least three major sources of tradition contributing to the emergence of newer, hybrid forms of practice. Traditional medicine, or *hanŭihak*, had originated in Chinese practice, with Koreans indigenizing the collecting of plants and herbs for medicinal purposes, making this cumulative body of knowledge effectively Korean by increments over the course of the seventeenth through nineteenth centuries.[15]

At the same time, Western biomedicine (*sŏyang ŭihak*) offered an appealing alternative with its message of intervention and cure, marking a contrast with the overall health and program of maintenance associated with *hanŭihak*. In the Korean context, this medicine derived primarily from two

distinct sources: Protestant missionaries who arrived in the late nineteenth century and the Japanese colonial authorities, who brought it as part of their package of enforced modernization, similar to the measures introduced in Japan as part of the Meiji restoration.[16] Although the first of these two sources resulted in a generally positive reception, leading to the construction of hospitals and related facilities, the forms of medical practice brought by the Japanese created a climate of deep ambivalence and unease, especially in the form of policing and quarantine measures.[17] Eager to bring medical modernity to their colony, the Japanese would seek to suppress the legacy of traditional practice, restricting its impact first by eliminating the exam system for court physicians and then by requiring practitioners to be licensed with the colonial authority.[18]

In its basic outlines, the story to be tracked here will follow this narrative, addressing the issue of overlapping forms of medical practice in transition as South Korean doctors, nurses, and practitioners negotiated a move from late-nineteenth-century German models of academic medicine—mediated here through the lens of Japanese colonialism—to some approximation of American and international models of biomedicine in the first two to three decades of independence (1948–1975). Although the South Korean life sciences would not develop until very recently (post-1980), I make deliberate use of the terms *medicine* and *biomedicine* interchangeably, tracking the broad patterns of change from the German research tradition to an independent South Korean research practice.

Within these narrative lines, there would be numerous moments of continuity, as well as rupture, with colonial precedents in the making of a postcolonial medicine by South Korean actors. While recognizing the continuity, my emphasis will rest equally on the side of rupture, a story of the consolidation of new opportunities and professional growth on the part of South Korean biomedical practitioners, resulting in a far more lucrative and culturally powerful form of practice by the late twentieth century. In brief, South Korean practitioners frequently picked up from where Japanese colonial officials had left off and from these diverse elements made a hybrid practice of their own.

If the end result may appear familiar, comprising the elite private clinics of southeastern Seoul, devoted primarily to the aesthetic needs of a wealthy clientele, along with hospital facilities including those of Seoul National University, Severance, and Ajou, the journey to reach this point will prove anything but familiar. In 1945, it was still uncommon for a Korean to visit

a doctor trained in Western biomedicine, and indeed this would remain the case for some time, due to the scarcity of Western medical education during much of the preceding period. Encounters with biomedicine, moreover, were fraught with tension, as these experiences tended to carry extremely negative associations from the colonial period, typically involving quarantine or some form of restriction, with much of the enforcement for public health linked to the police bureau.[19] Biomedicine, in short, was very different from the progressive force brought by missionaries and tended to be linked to images of conjoined power and policing, whether that of the colonizer or even of the American occupying forces who arrived in 1945, providing yet another source of ambivalence.

The major task here will be to explain how and why South Koreans would come to make a medicine of their own, with the degree of physical intervention—including common practices such as the physical examination, injection, surgery, and autopsy—tolerated increasingly by the most recent two to three decades (1980 through the present), so much so that the nation has now come to be associated with the practice of plastic and aesthetic surgery. If sites such as Brazil and Thailand surpass South Korea in the number of procedures performed, the ROK has nonetheless earned for itself the nickname "the Republic of Plastic Surgery," and ambitious efforts on the part of the South Korean cosmetics industry, along with the promotion of medical tourism, have begun to affect neighboring parts of Northeast Asia. I will argue that these developments are far from coincidental and intersect closely with the historical development of medical expertise on the part of South Korean practitioners, spreading to the population through a series of aggressive public health campaigns in the 1960s and 1970s, when medicine began to leave the hospital site and the clinic, making its way to nearby urban and rural areas through both public outreach and nation building.

If the experience of visiting a medical facility or clinic was one fraught with tension in 1945, and still very much atypical, the encounter with the South Korean state in the form of family planning (*kajok kyehoek*) would become a familiar encounter by the late 1960s, with clinics available in most urban areas and with mobile vans and mother's clubs reaching to many parts of the rural countryside. Through these resources, the average individual could obtain information about birth control, and South Korean women were encouraged to submit their bodies to a wide range of reproductive technologies. Men were also included within the scheme; they were educated about the

use of birth control and, in many cases, encouraged to undergo a vasectomy, assuming that they had already fathered children. Although these efforts were largely state directed, the campaigns cannot be dismissed as entirely top down, as South Koreans, especially women, made the campaigns very much their own, actively shaping distribution of the state's resources as well as the contributions deriving from international partners.

By effectively taking over the family planning program through their eager participation, South Korean women were able to pursue their own agendas and also participated in creating new forms of state-sanctioned nationalism. And if the majority of adults met the state through its family planning programs, children would not be left out, as the public schools served as one of the primary mechanisms for distributing public health care, in this case focusing on the presence of intestinal parasites beginning in the late 1960s. The antiparasite campaigns (*kisaengch'ung pangmyŏl*) used these schoolchildren as part of a nationwide survey beginning in 1969, recognizing that environmental conditions—especially the frequent use of "night soil" as a source of fertilizer, along with lack of access to sources of clean water—had brought parasites into the lives of the majority of South Koreans. This development would be treated not only as an endemic health problem but also as a matter of national pride, an index of comparative development at a time when the nation was undergoing rapid change.

As part of these campaigns, schoolchildren were required to donate a stool sample twice a year, creating the familiar ritual of a queue in front of the teacher's desk, with each child holding a small specimen bag to hand in. As with family planning, not everyone was comfortable with this activity, and there remain numerous accounts of those who would skip school out of embarrassment or of children who submitted a pet's sample, typically that of a dog or cat, in lieu of their own. Historicizing this activity is difficult, as these accounts remain apocryphal, yet we should see the refusal to submit a sample not simply as resistance to the state but equally as reluctance to permit access to one's body. In other words, the changes that came with an aggressive public health were incremental, and not everyone embraced these changes eagerly, even as the ROK state sought to tie both campaigns to an emerging nationalism, fostering a sense of personal responsibility.

Along with the changes to attitudes about the body and gradual acceptance of new forms of intervention would come corresponding changes to the professionalization expected of South Korean health workers. Traditional

practitioners would create their own forms of medical pedagogy, based at institutions such as Kyunghee University (1965), bringing a hybrid form of practice into being. Because this reconfigured "traditional" practice would not regain prestige until sometime in the early 1980s, concurrent with rapid economic growth, medical doctors increasingly shifted their training to some approximation of international models by interacting frequently with their foreign colleagues at conferences and by making their proceedings available in other languages, typically English. Moreover, doctors would become less autocratic, sharing their responsibilities with a larger number of support personnel. At the most basic level, South Korean doctors would become increasingly clinically oriented, more "hands on," as they grew more specialized in the forms of care they could offer and as their patient base became much more diverse.

Along with the state's enthusiasm for promoting public health, the medical industry in South Korea would change dramatically with the origins of a national health insurance scheme (1977) and with the subsequent arrival of democratization (1987). The presence of cosmetic/aesthetic surgery in South Korea predates both of these developments and, equally, has numerous precedents in neighboring East Asian countries, with Japan figuring prominently as a source of models, practices, and aesthetic norms. The turn to the aesthetic therefore has less to do with social pathology, as some popular accounts would have it, than with the historical intersection of new professional norms; the increasing economic power of an elite, highly specialized medical community; and, most importantly, the acceptance of and confidence associated with medical intervention as a means to realize and achieve one's desired self-image. Although the state had previously promoted public health to a reluctant population, South Koreans would ultimately make this medicine their own by the mid- to late 1980s, eagerly embracing the possibilities of personal change and self-fashioning.

Mobilizing the Traffic in Bodies

When the process of medical transformation began in the late 1940s and early 1950s, the application of medicine to individuals took place within a particular context, with the political relationship between the United States and its partner nation shaping the exchange as a call to vote with one's feet. In other words, the ideological contrast with neighboring North Korea would rapidly become one in which the movement of large numbers of refugees was a key

selling point in the propaganda war. Biomedicine therefore represented an aspect of relief work associated specifically with a conscious choice to move to South Korea and carried with it a comforting set of images, caring for and repairing damaged bodies on arrival. This type of imagery would tend to hold true regardless of whether the type of injury was caused by the effects of chronic disease (such as tuberculosis) or by the effects of war. In nearly all cases, biomedicine stood as a symbolic and material means of transformation at a time when movement away from North Korea connoted an escape from communism and its associated material lack.

These patterns of movement did not mean that there was no resistance to the practice of biomedicine, and in fact, as we shall learn, the negotiation nearly always required an incremental set of adjustments. Moreover, the remaking of a South Korean medicine required a corresponding traffic in bodies: the bodies of refugees and patients to be treated, the migration of South Korean elites abroad for access to higher education, and the resettling of displaced populations. Of these three groups, the relationship between the first and the third populations will dominate the chapters here, as the mass application of biomedicine took place at a time when adoption and out-migration from South Korea were at their highest and, more importantly were most visible to the international community. Organizations such as the Holt adoption agency famously brought South Korean children out of the war zone, placing them most typically with white, Christian families based in the United States.[20]

More recently, scholarship has begun to look into the political context of these patterns of adoption placement, examining the ways in which South Korean children tended to be asked to adapt themselves to a limited vision of American life, especially one associated with the cultural rhythms of white, suburban life.[21] Working with adoption, medicine offered a means of repairing these shattered lives, regardless of whether children and refugees could make their way abroad, as in a limited number of cases, or more commonly, make a space for themselves within a recovering nation. As for this second case, the many patients helped by American and international surgical units during and following the Korean War attested to the cultural and material power of biomedicine, especially its power to transform personal circumstances. Moreover, new foundations such as the American-Korean Foundation (AKF), taking advantage of the charged political climate, provided various forms of assistance, perhaps most conspicuously by bringing rehabilitative medicine and replacement limbs to South Korea through the figures of prominent physicians such

as Dr. Howard Rusk, an orthopedic surgeon and advocate of rehabilitative medicine based at New York University.[22]

But the movement of ideas, practices, and images was not unidirectional, and this has to be much more than a story of American ideological and soft power focusing on South Korea during the early stages of the Cold War. In fact, the South Korean government learned quickly how to mobilize many of these same patterns of medical practice, corresponding to the incremental growth of its own community of Western-trained doctors, and members of this group would soon constitute a powerful lobby. In the short term, the ROK government would turn its interest in biomedicine into an ambitious series of public health campaigns, many of these having strong overtones from earlier forms of health practice, and this holds especially true for the intersection with Japanese colonial health practice. For example, the energy devoted to family planning in the mid-1960s bore numerous points of comparison with the practice of two to three decades earlier, as Japan had tried aggressively to promote a modern, progressive vision of "scientific" mothering in its colonies.[23]

The success of the ROK state in building on these continuities, even while repackaging the campaigns in a newer vocabulary, resulted in a form of presentation through which medicine and health would rapidly become national concerns. This is particularly true for the charged period encompassing the second half of the 1960s into the 1970s, corresponding to engagement with the Vietnam War (1965) and the suspension of the constitution by Park Chung Hee (1972). With the national antiparasite campaigns beginning in 1969, it is not difficult to read the desire to eradicate unwanted pests as at least partially informed by ideological concerns. To borrow an analogy from the work of Ruth Rogaski, the desire for a body free of pests, while certainly a desirable goal from the standpoint of public health, would become equally about the construction an ideologically "pure" national polity, seeking a population that would conform to the state's goals.[24]

In the case of both family planning (from 1964 through the early 1980s) and the antiparasite campaigns (from 1969 through the early 1990s), the ROK state would invest heavily in appealing to the nation through biomedicine, creating a comprehensive vision of the family, home, and society. Whether residing in rural or urban circumstances, family planning offered the possibility of greater personal control, limiting the number of children and offering the opportunity for "demographic dividends," economic growth achieved by limiting the size of a birth cohort. As the campaign grew more successful and

the range of technologies provided continued to diversify, additional incentives were provided: Men consenting to a vasectomy could receive early release from their reserve military training (*yebigun*), and families could even gain access to a better apartment—receiving a higher placement within the lottery system—if they could demonstrate compliance.[25] Again, although these campaigns might appear to be top down and paternalistic, circumstances on the ground were far more complex, with individuals sometimes negotiating the system to their own advantage.

The arrival of subsequent forms of expertise, referring here to the development of a marketplace for plastic surgery and related forms of bodily enhancement, is thus entirely consistent with the degree of control offered by the public health campaigns of the Park Chung Hee era. Granted, the structural logic would be very different, with leading medical professionals and specialists constituting a powerful interest group setting the terms of the encounter and with individual clients generally embracing a procedure on their own, rather than having it imposed by the state. Regardless, the logic bears many points of comparison, with the patient achieving a desired end through a surgical procedure and with these aims often involving the intersection of economic and personal goals. In this sense, the public health campaigns that would build a strong state helped shape the context for the subsequent emergence of a medical marketplace involving the possibility of personal choice.

Challenging Developmentalism: The "Late" Arrival of National Health Insurance and Neoliberalism

To continue with this last point, South Korean medicine has been characterized by deferral almost since its inception, with the state mobilizing the comforting image of relief to characterize its relationship to the population. At the same time, the state has frequently acknowledged the limited nature of coverage by medical insurance, extending this privilege to incrementally larger numbers of policyholders (1963, 1977, 1989), reflecting the changing demographics of South Korea, along with the need to cater to the electorate with the transition to democracy in 1987. Commentators have often described this broadening of coverage in terms of a temporal scheme, arguing that the provision of health coverage has been "late" in the South Korean developmental context, with the state failing to respond as rapidly as one might expect. However, this characterization assumes that the provision of medical

insurance is a "natural" development, one inherent to this setting, and corresponding to specific political and institutional changes.[26]

If we denaturalize the transition to medical insurance, it makes sense to recognize that the deferral of coverage has its roots in a lengthy history of ambivalence, with the state mobilizing the image of medical coverage as one of the benefits deriving from its authority but without the economic will to provide full coverage. This should not be surprising, as South Korea was an extremely poor country until very recently, and the provision of social benefits would place the state in a precarious position, politically and financially. What is surprising is the extent to which the state has successfully avoided having to provide this full coverage, even with the political transformation to democracy and the accompanying status as one of the world's most vibrant economies. In effect, South Korea, like the model of a limited number of Western countries, has placed much of its medical burden on the availability of private health care as an alternative, opting to provide only a baseline form of care to the general public.

This complex social negotiation, in which the state and the population debate their respective roles, does not have to invoke a radical critique of capitalism to recognize how much South Korea has adopted the privatization of biomedicine as one of its primary strategies, especially in the last two decades. The recent emphasis on the language of neoliberalism and its adoption by the Lee Myung-Bak state is worth noting here, as this implies that only recently has South Korea begun to incorporate this logic into its dealings with its citizenry. I disagree strongly, arguing specifically that biomedicine carries with it a lengthy history in which the state has granted increasing powers to elite groups of South Korean medical professionals, essentially allowing them to regulate their own affairs. In turn, the state has asked for the cooperation of these professionals and elites in mobilizing its claims about health care, effectively obscuring the extent of the problem and the relative lack of coverage.

As this argument will be covered in greater detail in Chapter 6, the version here is an abbreviated one. In simple terms, South Korean physicians, doctors, and nurses have opted for even greater specialization and technical expertise in recent years, especially since the Asian financial crisis of 1997–1998, and, in turn, have expected a corresponding degree of light clinical regulation from the government. What this means in practical terms is the growth of the private clinic as a form of care, with a growing number of these privately owned clinics and facilities in Seoul as well as in many other regions. If the medical

profession continues to be associated with its traditional image of caregiving and providing relief, it should also be associated with affluence and social power, as the financial benefits have increased within a legal climate that focuses more on public health care.

Ultimately, my interest in approaching the issue of health coverage is not an attempt to provide a prescriptive remedy, nor is it motivated by a fascination with the economics of the South Korean health care system. Rather, I want to emphasize the particular role of specialists and the expertise attributed to these figures as a category, especially within the context of the private hospital, as in the case of the elite clinics of southeastern Seoul, the subject of the final chapter. If the emphasis on the widespread availability of aesthetic treatment in South Korea has attracted much attention, this phenomenon is embedded within a much longer history linked to previous forms of reconstructive medicine in the aftermath of the Korean War, as well as to the professionalization of South Korean medical practitioners. I want to historicize the turn to the aesthetic, arguing that the emphasis on reshaping one's body to reflect certain ideals is actually not new but rather represents a lengthy negotiation in which this power is now granted to the individual, rather than deriving from the state.

The Case Studies: Six Sites

In tracing the major themes that have been laid out here—the incremental transition from German/Japanese academic medicine to American and international models of medicine in an independent, anti-Communist state, the corresponding acceptance of diverse forms of bodily intervention, and the adoption of private models of health care—six individual case studies will provide a narrative framework.

Chapter 1 begins with the period of American military occupation (1945–1948), looking at the various fragments from which a South Korean medical community would be assembled following the close of World War II. *Fragments* is the key word here, as both biomedicine—introduced by missionaries as well as by the Japanese colonial presence—and traditional practice would figure prominently during a period in which no single category of practice dominated. As biomedicine emerged as perhaps most critical to the subsequent construction of an independent South Korea, it is important to recognize the diverse contributing factors, as medicine held deeply ambivalent associations from the colonial period and would continue to do so for

some time. For the majority of Koreans, access to a Western-trained doctor was limited, and the figure of the traditional practitioner was much more significant, like that of Mr. Byung Sang-Hun (1902–1989), the individual whose career is detailed here.

Providing further context for the circumstances under which traditional practice would be challenged, Chapter 2 outlines the arrival of USAMGIK (U.S. Military Government in Korea) and, more specifically, the vast medical infrastructure it would convey. Focusing heavily on disease prevention and redefining the Korean peninsula in terms of a regional occupation, the American military would resort to large-scale interventions, including mass inoculation and frequent spraying of DDT to limit the possibilities of epidemic. While disruptive, this approach toward public health would be credited with limiting the impact of a cholera outbreak in summer 1946 and would prove enormously influential in the creation of subsequent South Korean public health policy. That is, the ROK health system was born out of this perceived crisis, a situation soon exacerbated by the beginning of the Korean War, bringing with it disease and devastation.

Chapter 3, the period of the Korean War and its aftermath (1954–1960) coincides with the growing importance of South Korea as a model for international development, bringing American and international actors to visit Seoul for the reconstruction of a number of biomedical sites. The chapter focuses almost exclusively on one of these sites, Seoul National University Hospital, and the collaborative relationship formed with the University of Minnesota, taking the form of the "Minnesota Project" (1954–1962), but it also recognizes that similar rehabilitative efforts were taking place simultaneously at other sites. These would include Severance Hospital and its new relationship with Yonsei University (1957), as well as the National Medical Center (*kungnip ŭiryowŏn*) (1958–1968), the latter a joint project of three Scandinavian nations, with Norway, Sweden, and Denmark coming together to provide aid in the form of a teaching hospital.[27] In all of these cases, the Korean body as an object of biomedical research would be very much at stake, and it was by no means a comfortable and easy transition as the hospital site continued to generate suspicion.

In Chapter 4, the South Korean state begins to take the initiative with public health, coinciding with the arrival of a new Park Chung Hee state in 1961. Prior to this, the most common health issues in the ROK centered around problems of chronic disease—tuberculosis, leprosy, and parasites—and, while

these concerns would persist, the state could now mobilize around a revised conception of the family and the possibility of changing reproductive behaviors, aggressively promoting a menu of new technologies and birth control devices, targeting both male and female populations. Although the FP (family planning, or *kajok kyehoek*) campaigns proved successful from a strictly quantitative standpoint, with many "acceptors" encountering agents of the state, a closer look reveals that this idealized encounter was often fraught with tension. In particular, by the late 1960s South Korean women had begun to avoid using the Lippes loop due to its side effects, forcing a change to the birth control pill as the preferred option by 1968.

Overlapping with the birth control campaigns, the national antiparasite campaigns (*kisaengch'ung pangmyŏl*) began with a baseline survey in the late 1960s and as of 1969 required the twice-yearly taking of samples from children. In material terms, this meant thousands of children bringing their stool samples to school in specially provided sample bags and the construction of an accompanying infrastructure to process and analyze these samples on a mass scale. As family planning sought to extend the reach of the state at the local level through government, these new campaigns added the public schools as the next target site for attention, making it nearly impossible to avoid the reach of the state during this period. Scholarly commentators have argued that only the style of military discipline associated with the Park Chung Hee state could have made feasible the successful conduct of these two aggressive campaigns, and indeed, as we shall see, the antiparasite campaigns were also concerned with the international sphere, protecting the health of ROK soldiers abroad (as in Vietnam) through the construction of a South Korean version of tropical medicine.

Chapter 6 takes up the issue of the present-day market for aesthetic and plastic surgery, flourishing in many parts of South Korea through a series of private clinics and highly trained specialists. These developments are not entirely new, however, and follow from the historical trajectory of the preceding period, including a heavy reliance on reconstructive surgery in the aftermath of the Korean War, an increasing acceptance of medical intervention as a means to achieve self-transformation, and a medical system designed to protect and encourage the interests of highly specialized forms of practice. Beginning with a longer East Asian tradition, the chapter takes up the practice of blepharoplasty, or double eyelid surgery, tracing its roots from Meiji Japan to a postwar form of emerging practice in many parts of East and Southeast

Asia. The South Korean form of the surgery thus represents a recent transformation of a practice with a lengthy history, and the specific variations introduced can be historicized in relation to the Korean context.

In the end, the story of medicine in South Korea is about much more than simply biomedicine, and after 1965 the story of a refurbished form of traditional practice, or TKM (traditional Korean medicine), remains an equally fascinating line of inquiry. South Korea, like many of its Asian neighbors (including China and Vietnam), maintains a dual system of practice, permitting choice according to one's preferences. Moreover, North Korea would have to be included in such a larger story, with its own version of traditional practice (*Koryŏ ŭihak*), its initial embrace of socialist models of public health, and its present-day reluctance to rely on international assistance despite a conspicuous need. This work will focus primarily on the South Korean case of biomedicine to illustrate that the series of choices made by the South (from 1945 to the present) were as equally ideological as those made by the North, if ultimately far more successful in the eyes of the world, and also to illustrate that the embrace of biomedical culture, while now seemingly "obvious," was frequently a tentative and quite painful one, characterized by deep ambivalence.