

Doctors for Frontier Expansion: Japanese Physicians in Hawaii, 1868–1924

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Abstract This article examines how frontier zone expansion and the migration of Asian professionals reinforced each other in complex and indirect ways. It focuses on Hawaii as a microcosm of transnationalism in medicine, analyzing its role as a host for licensed physicians from Japan, the United States, and other countries from 1868 to 1924. Looking beyond the context of a single East Asian country and East Asia as a region, or the East-West dichotomy, this study places all involved territories within the broader trans-Pacific arena to convey the sense of interconnectivity that human resources brought about between all the involved territories. The confluence of (geo)politics in Japan, East Asia, the Pacific, the United States, and the rest of the world molded intellectual migration in medicine from Japan to Hawaii, migration that served as an economically viable, diplomatically peaceful, and socially benign form of expansion.

Keywords Japan · medicine · physicians · transnationalism · Hawaii · Hokkaido · migration · expansion

1 Introduction

On 4 November 1940, roughly twelve hundred representatives from Japanese communities around the world gathered at the Hibiya Public Hall in Tokyo, commemorating the nation's twenty-six hundredth anniversary. Over the next week, the Ministry of Foreign Affairs and the Department of Overseas Affairs awarded honors to 628 Japanese expatriates for their contributions both in Japan and abroad, namely, in Manchuria, China, South and Southeast Asia, Europe, the Americas, and Africa. This historic,

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symbolically important event marked a high point in Japanese expansion. After introductory remarks by an army general and a representative of the Imperial Rule Assistance Association, Mōri Iga, the head of the delegation from Hawaii, gave an oral report on the status of his Japanese community before the entire audience. Foreign Minister Matsuoka Yōsuke, a central figure in the formation of the Axis Alliance with Nazi Germany and fascist Italy, bestowed commendations on twenty-seven leaders of the Japanese community in Hawaii, including four medical doctors like Mōri ([Yamashita 1941: 60–62, 82, 132–33](#)). Politically, physicians played a key role in Japanese expansion abroad.

The following narrative situates one such case of international migration from Japan, the only Asian colonizer of our modern era, within the historical context of trans-Pacific relations, and therefore beyond the context of the one single country and (East) Asia as a region. It will focus on Hawaii as a microcosm of transnationalism in medicine, analyzing its role as a host for licensed physicians from Japan, the United States, and other countries from 1868 to 1924. To convey the sense of interconnectivity that human resources brought about between all the involved territories, this study addresses the following two questions of historical importance: First, how did the expansion of frontier zones and the migration of professional workers help to shape one another? Second, who were the transnational agents of transformation, and how did they come to be in domestic and foreign lands? In a roundabout way, the confluence of (geo)politics in Japan, East Asia, the Pacific, the United States, and the rest of the world molded intellectual migration in medicine from Japan to Hawaii, migration that served as an economically viable, diplomatically peaceful, and socially benign form of expansion.

The theme of transnationalism and globalism has increasingly occupied recent scholarship in East Asian studies, as well as in science, technology, and society. Aside from some colonial science studies, historians have generally examined goods, services, and other resources flowing across national borders, facilitating the analysis of how different parts of the world have shaped each other, as well as of how these transactions have shaped the world as a whole ([Bray et al. 2015](#); [Kim 2014](#)). Previous studies have examined the content and context of Japan's colonial empire. For instance, [Young 1999](#), [Uchida 2011](#), [Anderson 2014](#), and [Moore 2013](#) emphasize the importance of human resources, such as farmers, traders, teachers, and engineers, in the making of Japan and its imperialism. As [Endoh 2009](#) reminds us, signs of Japanese expansion existed outside of East Asia, namely, in Latin America through government-led migration of manual labor and agricultural expansion—or the process that [Louise Young \(1998\)](#) refers to as “agrarian imperialism” in the context of Manchuria. This article, which reflects these trends in scholarship, is similar in that it, too, examines the context and content of the human resources involved in the expansion of Japan's sphere of influence. In addition, it fills a scholarly void by focusing on the importance of skilled labor in medicine within the trans-Pacific arena. As [Bay 2012](#) and [Padilla 2009](#) note, the profession played a crucial role in advancing Japan's military ambitions in East Asia.

Taking into account chronology, and in the interest of clarity, this social study of medicine first compares Japan's northward expansion into Hokkaido with its eastward expansion into Hawaii, both of which took shape concurrently. The intellectual migration of Japanese physicians to Hawaii can be better understood within the framework of this juxtaposition. This article then moves on to examine the demography and

biographies of the Japanese expatriates in Hawaii, mostly nonelites in the field, with particular attention paid to the case of Doctor Mōri Iga. It draws upon published official records, unpublished papers housed in archives, interviews, memoirs, and local publications in Hawaii and Japan.

2 Migration for Japan's Expansion Northward and Eastward

The opening of Japan's gate to the West in the 1850s inaugurated an era of emigration among well-educated and highly skilled professionals. Prohibited until 1866, travel abroad, if it occurred at all, was rare because the Tokugawa shogunate had maintained very tight control on outflow of domestic human capital. Japan had retained many of its intellectuals in science, technology, and medicine within its borders until the late nineteenth century. At first, the Tokugawa central government promoted top-down efforts to engage in active learning using resources from abroad, primarily through Nagasaki as an intellectual and trade outpost. In later Tokugawa years, however, certain domains launched their own initiatives for technology transfer from abroad. Decades of active knowledge acquisition followed. The samurai warrior class, more educated and literate than other groups, played a pivotal role in the process.¹ From 1863 to 1872, for instance, the Satsuma and Chōshū domains independently sent their selected samurai retainers to the University College of London. These samurai subsequently studied the everyday, nitty-gritty aspects of naval engineering. Their mission was to understand the rise of Great Britain as an imperial technology nation, as it had come to such a point of defeating Qing China in the Opium War a few decades earlier (Kikuchi 2009). Fully funded, these samurai went overseas for a short term, with strings attached. They returned home once they had successfully completed their study abroad mission.

After the Meiji Restoration, the new regime had a different use for the warrior class that had resided at the top of the pyramidal sociopolitical hierarchy. Early on, one of the most important policies by the new regime was the liquidation of the samurai class altogether, placing disproportionately intense pressure on those who had sided with the Tokugawa family. By 1876, members of that class—now stripped of special privileges they had possessed, such as carrying swords—were considered ordinary subjects before the Meiji emperor. Samurai became obsolete with the adoption of military conscription. Meanwhile, the central government launched a series of top-down efforts to build a new Japan by promoting migration to as far north as the frontier land of Hokkaido, especially for jobless samurai and small-scale independent farmers in overpopulated rural villages in the midst of land-tax reform and the Matsukata deflation. As part of this demographic shift, many former samurai among others moved to the vast, underdeveloped hinterland. This move suited the Meiji regime well. Militarily and geostrategically, these former warriors possessed important martial skills and offered a perfect solution to Japan's national security concerns in the face of Russia's rising

¹ Aside from court aristocrats and religious leaders, samurai warriors were not the only literate population in Tokugawa society. Groups of wealthy farmers and merchants, especially in urban areas, read both Japanese and Chinese languages and studied neo-Confucian classics. See the case of Kaitokudō merchant academy of Osaka: Najita 1997 and Wakita 1997.

imperialism. As early as 1792, for instance, Russian army officer and delegate Adam Laxman came to the city of Nemuro in Hokkaido and asked Japan to open up trade. Further pressure mounted after the Crimean War (1853–56), which reoriented Russia's attention and power diplomacy in dealing with the Far East. By the mid-1880s, the military defense and economic development of the Hokkaido became imperative in the Meiji government's pursuit of national security.

One product of the Meiji policy was the development of military-reserve units in Hokkaido, known as Tondenhei ex-legionary. Initially limited to former samurai, the new settlers—about half being former low-ranking samurai by one account—had voluntarily left their local, economically deprived homelands. Upon arriving at the northern frontier for settlement, the farmer-soldiers received the necessary materials for farming (e.g., equipment, seeds, and furniture) in exchange for guard duty and their reclamation of the Hokkaido land. Their colonial settlement, which posed physical and economic challenges to the community, was possible through both government efforts and private enterprise. A case in point involved Hokuetsu Migration Company (formed in 1886). Located on the coast of the East Sea, an area that had lacked any viable industry to sustain the local population, it actively sent ex-samurai to Hokkaido by obtaining investments from thirteen local magnates (mostly landowners with strong ties to a local bank). The company thus provided good positions for many households that had sided with the underdog in the Boshin Civil War of 1868–69. Similarly, local leaders from the Nagoya, Yamaguchi, and Iwate areas opened farming businesses in Hokkaido to support the resettlement of former warriors. Some ex-samurai from the Ishikari and Hidaka regions established companies in Hokkaido for land reclamation, namely, the Kaishin Company and the Sekishin Company, respectfully. Some ventures failed after years of struggle, but private and communal efforts as a whole successfully opened areas for agriculture in the northern frontier of Japan, preparing the path for human migration (Yamamoto 1955: 68–70). From 1899 to 1925, a total of 2,111,291 people settled in Hokkaido, which became the prefecture with the third-largest migrant population after Tokyo and Osaka (Hirai 2002: 20–21).

The development in Hokkaido was concurrent with Japan's efforts to make greater inroads into Hawaii, with some notable difference in scope. For this Hokkaido land project, Japan borrowed a useful model from post-Civil War America, which had experienced the clearing of the Wild West by the 1850s. A key figure for Japan was Horace Capron, American adviser to the Hokkaido Development Commission, which embodied the archetypal essence of the forward-looking Meiji government and Western modernization. Whereas the Hokkaido colonization project was successful due in part to induced migration over the short distance from Honshu island, the island kingdom of Hawaii presented an entirely different picture both politically and geographically. Hawaii was a foreign sovereign territory located about four thousand miles away, and a useful model for Japan to expanding its influence in the Pacific did not exist. Meiji's strategy of colonial empire building in Hokkaido was effective in part because the government granted Japanese citizenship to the local Ainu indigenous population. This assimilation policy, however, was futile in the Pacific.

What proved timely and convenient for Meiji Japan was foreign imperialism, which threatened the sovereignty of the Kingdom of Hawaii (1795–1893) and then of the Republic of Hawaii (1894–98). Both regimes had good reason to welcome Japanese influence. Because Hawaii was located roughly halfway between Japan and the west

coast of North America, rising Meiji imperialism seemed a useful counterweight to the imperialistic power of America that had gone beyond its overland borders. In 1881, King Kalakaua visited the Meiji emperor on his world tour and proposed a marriage between a Japanese prince and a Hawaiian princess. This effort to create an informal alliance failed, but his proposal to support Japanese migrant workers' arrival in Hawaii bore fruit. Subsequent diplomacy pulled Japanese labor to the Pacific region.

Hawaii gradually overtook Hokkaido as the preferred destination for agricultural migration. From 1885 to 1894, a total of 29,984 individuals moved to Hawaii in twenty-six enrollments, all of whom were recruited through regional or local offices located in eighteen prefectures of Japan. As local case studies show, the volume of immigrants to Hokkaido from two main home prefectures, Hiroshima and Yamaguchi, dropped sharply after 1885. Many moved to Hawaii instead (Hirai 2002: 21, 23–24). Prevailing public opinions at the time of this shift in migration began to focus on the importance of opportunities abroad. Until the mid-1880s or so, public discourse favored Hokkaido over Hawaii, treating international migration as a means to increase personal wealth and learn methods of farming. By the early 1890s, public policy makers and influential writers looked overseas for viable solutions to surplus populations in farming communities. Among the Meiji politicians was Enomoto Takeaki, president of the separatist republic of Hokkaido, who was later a leading advocate for Japanese migration to Mexico and the Pacific region. Ōkuma Shigenobu, prime minister of Meiji Japan and founder of Waseda University, advocated peaceful expansion in the form of Japanese citizens opening new businesses abroad. Such views were promoted by scholars and writers. Shiga Shigetaka, a geologist, wrote a book in 1887 on the basis of his experience as a student in Hokkaido and then an observer in Hawaii, encouraging readers to undertake expansion overseas. Hawaii's higher wages seemed more promising to him, and many others, than overpopulated rural communities with few economic opportunities. These ideas reflected Japan's expansionist ambition of the age (Tanno 2015: 86–89).

The labor force from Japan was welcomed in Hawaii's rising sugar industry, which benefited from workers of different ethnicities who toiled hard for meager compensation. The Kingdom had hosted the first Chinese contract laborers in 1852, and then Portuguese (1878) and Germans and Norwegians (1881), but the growing enterprise needed more plantation workers, while laborers brought from Africa, Puerto Rico, and Russia fell short of expectations. The demography of this multinational workforce in Hawaii was further complicated by domestic politics in the contiguous United States. Many plantations owners, for instance, had once considered Chinese laborers a good alternative to the less reliable Portuguese, but the former ended up in short supply, especially after the application of the Chinese Exclusion Act, which prohibited the immigration of Chinese laborers to Hawaii (Hayashi 1909: 21). Japanese laborers had consistently met the growing need in the labor market, coming to form a majority ethnic group around the turn of the twentieth century. By one account, across sugar plantations in 1905, there were a total of 48,229 workers consisting of Europeans, Americans, Portuguese, Puerto Ricans, native Hawaiians, Pacific Islanders, Chinese, Koreans, and Japanese—and the Japanese made up 66 percent (31,735 workers) of the total workforce and 64.2 percent (23,461) of the total farmers (*Hawaii Nihonjin Nenkan* 1917: 129). In 1908, the number of Japanese working in the sugar industry peaked at 32,771 (Yamanaka 1998: 20).

A closer look into the demography and background of early Japanese workers in Hawaii reveals the importance of the visible hands of the Hawaiian and Meiji governments, both helping to mold the flow and volume of international migration. A point to note is the staffing of 29,084 migrants in total from 1885 to 1894, centered overwhelmingly in western Japan, especially in impoverished areas. Their prefectural backgrounds consisted mostly of Hiroshima (38.2 percent), Yamaguchi (35.8 percent), Kumamoto (14.6 percent), and Fukuoka (7.5 percent), with these four making up 96.2 percent (Hirai 2002: 23). Understandably, what mattered most in the selection of indentured laborers was physical health and ability. The application guidelines of 18 March 1880, prepared in Tokyo, clearly “limited migrant workers to obedient, sincere farmers in robust health . . . from age twenty-one to thirty-six”—“pregnant wives were not allowed” to take passage (Doi 1980: 45–46). In Hiroshima, as elsewhere, minimum qualifications for participation became higher in later years because the Hawaiian government, having witnessed a high turnover rate, began to ask for hardy farmers drawn from remote rural villages rather than for nonfarmers from urban areas. Many migrant workers to Hawaii were small-scale tenant farmers living on rental property in Japan, which suggests that they went abroad to pay off their debts. Upon arrival, many provided physical labor in their receiving plantations, with travel and food expenses borrowed in advance on their salary (Hirai 2002: 27).

In the early years, Japanese migration to Hawaii was also shaped by gender. Males dominated in hard labor. Hiroshima, for instance, sent the largest numbers of workers to Hawaii, 972 in total, with 726 males (or 74.7 percent) and 246 females (or 25.3 percent). This gender disparity also reflects the prevalent patriarchy of the time. Given the terms of the labor contract, for instance, married women were not allowed to apply independently. Only males could enter into a contract, and about 20 percent of the total workforce was allotted to their wives. The Japanese workforce in Hawaii predominantly consisted of young, typically unmarried males working on a three-year contractual basis (Hatsukaichichō 1988: 336–37, 341, 344–45, 348).

The Hawaiian and Japanese governments set up other legal arrangements for the next decades to come. The Meiji-Hawaii diplomatic agreements of 1868 and 1886 required that plantation owners provide housing, medical care, and fuel for cooking to contract workers free of charge. This arrangement, applied retroactively to Japanese laborers who had arrived earlier, protected them legally. The Hawaiian government also hired a certain number of immigration inspectors, translators, and Japanese medical practitioners (Ōdō and Shinotō 1985: 21–22, 73).

These physicians provided decent medical care to Japanese plantation workers and their families in Hawaii. Officially hired and paid by the Immigration Bureau, these professionals served local Japanese communities in the archipelago of Hawaii on a daily basis. Some doctors maintained local residence in remote areas, visiting patients on horseback, which was often the most reliable and accessible means of transportation on rough terrain (Yamanaka 1998: 22). Their care, available to Japanese communities across several islands, consisted of consultation and medicine, all free. Laborers often sought ways of malingering, taking advantage of the medical system by requesting free medicine even for mild illnesses. Some doctors responded by beginning to charge two-thirds of the medicine’s cost while still providing medical examinations at no charge. Such affordable medical care contributed to the growth of a family-based Japanese community. After the end of their three-year labor contract in sugar plantations, many

unmarried males returned to Japan, but many others set the foundations of their livelihood in Hawaii, with wives found locally or brought from Japan (Negoro 2003 [1915]: 11, 242). Once their contracts ended, many Japanese laborers moved to urban areas and paid for their own medical expenses, but those who remained in the plantations continued to receive low-cost medical care, all paid by their landlords (Yamanaka 1998: 30).

The accessibility, availability, and affordability of decent medical care by Japanese physicians (all trained in Western medicine) seem to have played a key role in increasing the Japanese population in Hawaii by reducing mortality. The death rate in the community was among the lowest, comparable only to those of Westerners on the islands. In 1927, for instance, the total number of deaths per one thousand people among the Japanese was 8.85, a figure slightly higher than those of Spain (8.41), England, the United States, Russia, and Germany (all at 6.85). Little changed beyond the Japanese population, with other national groups marking higher rates, as seen with the Portuguese (10.83), Chinese (11.81), Filipinos (13.53), Puerto Ricans (15.29), and Hawaiians (31.11) (Nippu jijisha henshūkyoku 2008c [1929]: 54–55). Major illness among Japanese workers in sugar plantations included beriberi (caused by vitamin B₁ deficiency) and infectious diseases. Typhoid in particular proved deadly (Yamanaka 1998: 23). The top five causes of death in 1926 were diarrhea and inflammation of the intestines (for children under two years old); congenital abnormality, debility, and peculiarity; tuberculosis; bronchitis; and heart disease (Nippu jijisha henshūkyoku 2008a [1927]: 41). Along with the relatively low mortality rate, at least for some time, the Japanese community experienced the greatest number of live births of all ethnic groups. In 1926, the Japanese community had 5,594 newborns, which far exceeded the second-largest increase by the Filipinos (1,796) followed by the Portuguese (997) and the interracial infants of the white and indigenous populations (927). The net increase among the Japanese that year was 4,591 (subtracting 407 deaths before the age of one), ethnically the largest addition to the total population in Hawaii (Nippu jijisha henshūkyoku 2008c [1929]: 54–55). Blessed with a high birth rate, low mortality, and workers arriving from Japan, the Japanese community grew massively. In 1884, there were only 116 Japanese individuals (or 0.1 percent of Hawaii's population), but in 1920, this had increased to 109,274 (or 42.7 percent), vastly outnumbering the Chinese (23,507, or 9.2 percent) and all other groups of foreign origins (Ōdō and Shinotō 1985: 19).²

The increase of the Japanese population in Hawaii owes in part to Japanese physicians who settled locally for a long time, sometimes permanently, providing medical care in urban and rural areas of the islands. As the demographic data from several years suggest, the number of physicians originally from Japan rose steadily, peaking circa 1924, the year in which the United States banned Japanese immigration, thus ending the supply of first-generation Japanese medical doctors to the islands. Of all of the sporadic annual figures I have obtained, the data from 1926 are the most useful because they are the closest chronologically to 1924. A point worth noting is the relative importance of medical doctors according to their national origin (Yamanaka 1998: 48). Relatively speaking, the Japanese maintained the second-largest number of physicians (38, or 22 percent, of a total of 174 physicians on the islands) after the Americans (101, 58

² In 1940, there were 28,774 Chinese (or 6.8 percent) and 157,905 Japanese (or 37.3 percent).

percent). These doctors outnumbered the third and fourth largest groups, with fourteen Chinese doctors (8 percent) and seven British (4 percent) (*Nippu jijisha henshūkyoku 2008a [1927]: 44*). A more nuanced picture of doctors' ethnicity and availability could be drawn from data of 1920. Caucasian doctors (101, or 66 percent of the total number of physicians) were amply available to care for working populations of their own ethnicity, but this was not the case for Asian communities. Some groups were better off than others. Japanese, Chinese, Filipino, and Korean communities all had varying degrees of doctor shortages across Hawaii, but given the size of the working population in each group, the shortage of medical practitioners was least acute among the Japanese.³ Medical care was accessible and available in Japanese communities across the islands.

3 The Making of Japanese Physicians Abroad

These physicians were a product of the new Meiji era, which effectively replaced common practices of the pre-1868 regime. The Tokugawa central government had lacked a nationwide medical system in any form. Given the existence of dubious (and often risky) practices by unscrupulous and inexpert individuals, samurai warlords retained their own reliable physicians in their local or central domains. Japan's lack of any coherent, nationwide medical system during the Tokugawa era meant that each domain government, rather than the central one, issued "medical licenses" to any self-proclaimed practitioners, including those with dubious qualifications, if any.

This picture changed drastically when the Meiji government introduced a medical licensing system. Established in 1873, the new mechanism fulfilled its function in accordance with a total of seventy-six articles, one of which set up the licensing system for all practicing physicians. The Ministry of Education administered the medical license exams, first in Tokyo, Osaka, and Kyoto in 1875 and then in other prefectures. Candidates were required to successfully pass these tests covering areas like anatomy, physiology, and pathology (*Kōseishō Imukyoku 1976: 64*). All of the licensed medical practitioners were thereby defined as state-sanctioned experts; they had successfully met specific high standards by passing a set of demanding exams. This top-down effort standardized the qualifications and quality standards for all physicians in the country for the first time in history. In so doing, the Meiji regime aligned the system with Western medicine, steering it away from Chinese medicine, which had dominated much of the field before that point.

In adhering to Western medicine, the Meiji government searched for a suitable model country. Historically, under the national seclusion policy (1639–1854), Western medicine in Japan was synonymous with Dutch medicine, which became discredited at

³ To calculate the availability of medical doctors for the working population of their own nationality, the deviation value was computed per ethnic group. The higher the value above one, the greater the availability of physicians for each community. A value below one denotes a dearth of doctors; put simply, the smaller the number, the worse off the ethnic group. The value of the white population as a whole (excluding people of Hawaiian or Portuguese descent, 0.57 and 0.10, respectfully) was 5.97, which surpassed the second-highest value, the Japanese (0.76). Other groups include those from China (0.23), Korea (0), and the Philippines (0). See *Yamanaka 1998: 52–54*.

the demise of the Tokugawa regime. The most viable alternatives came from Germany and Great Britain, the former style having been more firmly established in Japan than the latter, given its ties to Dutch learning. Eventually, the Meiji government adopted the German model for both the education and research systems, a choice that has been explored by many historians (see, e.g., Kim 2014).

An important point to note is that, at least initially, the Meiji regime leaned toward British medicine, which carried indirect, yet long-term, consequences in a roundabout way. The utility of British medicine for the war effort was clear in the eyes of some experts in the field. The Boshin Civil War of 1868–69 revealed the unquestionable superiority of British combat medicine over Chinese medicine, as well as over its Dutch counterpart, which lacked substantive experience in battlefield medicine. Also, Great Britain was the leader in field surgery and preventive medicine by that time.⁴ In Japan, a key figure in the transformation of medicine was William Willis (1837–94), a British physician who served as the medical advisor to the Meiji government and received a prestigious monetary award from the emperor. British medicine, as embodied in Willis's practice, was handed down from generation to generation at a hospital in the Satsuma domain. In the early 1870s, Takaki Kanehiro, a naval physician, learned medical science from the British doctor. After his subsequent study abroad in London, he founded what would later become Jikei University, a major production center for navy physicians (Kira 2006: 758–62; Nakayama 2008: 698–700). This private medical college in Tokyo carried on the tradition of British medicine that focused on the clinical treatment of patients rather than on laboratory research. It nurtured English-speaking Japanese alumni who, as it turned out, were well suited to go abroad as licensed physicians for local Japanese expatriates.

Hawaii became the first host in the world to such a growing Japanese medical community abroad. The first Japanese physician to set foot in the territory, Yoshida Kōsai, arrived in 1885 at the age of twenty-one, working either for a private transportation company or for the Immigration Bureau, or possibly both. Whatever the case may be, he was one of the “government physicians.” He earned a handsome annual salary of \$628, or four times more than a typical Japanese sugar plantation worker, along with eight European or American doctors. Having been “employed by the Board on the Island of Maui,” he resigned after two years of service and left the islands with his wife and child.⁵ The number of first-generation immigrant doctors increased thereafter. From 1886 to 1924, a total of ninety-one physicians had moved from Japan and obtained a license in Hawaii, and forty of these had opened a medical practice in

⁴ Readily available examples include Scottish physician James Lind, who contributed to the prevention and cure of scurvy in the mid-eighteenth century. A few decades later, Edward Jenner, an English pioneer in immunology, developed the world's first smallpox vaccine. Joseph Lister from Scotland transformed surgical practice in 1867 by introducing the principles of antiseptics into the field.

⁵ “Yoshida, Kosai” in *Japanese Passenger Manifests Index*, Hawaii State Archives (hereafter HSA), <https://digitalcollections.hawaii.gov/greenstone3/sites/localsite/collect/index/toj/index/assoc/HASHc49a/878bbf9d.dir/doc.pdf>. Different sources point to different beginnings for the employment that led to Yoshida's life in Hawaii. By one account, he was trained at the Tokyo Medical School and arrived first as a contract laborer. He was later put to work as a physician, given his medical training. See Kimura 1989: 106 and Yamanaka 1998: 47. Presumably Yoshida earned \$1,256 in two years, given that the total two-year salary paid to this group of nine physicians during 1884–86 was \$11,304. The quotations in the text are from Board of Health 1886: 22, HSA.

Honolulu (Yamanaka 1998: 49). After the Immigration Act of 1924, some apparently returned to their homeland. According to one report, in 1927 there were thirty-seven registered medical practitioners of Japanese descent residing in Hawaii (Nippu jijisha *henshūkyoku* 2008b [1928]: 58).

During the period under study, certain locations in Hawaii drew in a sufficient number of Japanese physicians to form a critical mass. One result was the first Japanese medical society in Hawaii, the Association of Japanese Physicians. It was formed in Honolulu on the island of Oahu, an urban area that hosted Japanese workers who had completed their labor contracts in the sugar industry. In the formative stages of the association, a team of four doctors gathered at the private residence of each member, seeking advancement in medical knowledge and business communication (Morita 1919: 646). Doctors in other locations followed suit. In 1914, four Japanese physicians formed the core of a medical association on the island of Maui. They held a monthly meeting to deepen mutual friendship and exchanged medical opinions for further study. An international medical association was established on the island of Kauai the following year, consisting of three Japanese physicians, as well as American and German doctors. They met every three months, cultivating a rapport that formed the basis of collaborative measures for tuberculosis prevention, such as the creation of isolation hospitals (Morita 1915: 510).

This growth of the Japanese medical community owed much to the international flavor of medical licensing in Hawaii; that is, those with a medical license obtained from abroad could legally practice medicine on the islands without further exams. At the center of the administration was the Board of Health. Created on 8 May 1851, during the era of the sovereign Kingdom of Hawaii (1795–1893), the board began its operation as part of the Ministry of the Interior (1851–76) until it began to independently serve as the policy-making authority for public health measures in Hawaii during the Republic of Hawaii (1894–98) and the Territory of Hawaii (1898–1959).⁶ The Board of Health worked closely with the Immigration Bureau in supplying foreign doctors in Hawaii. The physicians hired by the Immigration Bureau obtained their medical license from the Board of Health after they submitted their foreign medical diploma (Morita 1919: 645). No one was officially allowed to practice medicine in Hawaii without a valid license obtained from the organization.⁷

This scene changed somewhat in the 1890s as a fierce debate about the procedure sent out a shockwave across international medical communities in Hawaii. Apparently, at the heart of the matter was a growing concern in the Board of Health about how to maintain quality standards among medical practitioners of foreign origin. From 1896, the revised process required that all candidates for a Hawaiian medical license, regardless of their nationality, complete rigorous written exams administered over a few days and that the candidates obtain references from two local licensed doctors. This change was applied retroactively. Current medical practitioners of foreign origin were also now required to pass these exams in whichever the language they preferred, English or the Hawaiian language. The Board of Health disallowed foreign language interpretation during the exams. This reform mattered a great deal to the Japanese medical

⁶ Hawaii State Archives, Hawaii State Archives Government Record Inventories, vol. 16 (1997: 3), Department of Health, Division History, Board of Health, HSA.

⁷ Hawaii State Archives, Hawaii State Archives Government Record Inventories, vol. 16 (1997: 3), Department of Health, Division History, Board of Health, HSA.

community, causing, as a reputable physician of the time wrote, “a stir in government and among people.” Local Japanese newspapers denounced the administrative change. The Japanese consul intervened. Faced with mounting criticism, the Board of Health allowed foreign language interpretation during the exams (Morita 1919: 646; Hayashi 1909: 30–31).

After these hiccups in medical license administration, the number of first-generation Japanese physicians grew in size, as shown in demographic data from that time. As of 1917, a total of 138 medical practitioners (excluding dentists and veterinarians) had arrived from various countries, together forming a multinational medical community—with the Japanese, at 32 percent, the second-largest national group in this community. The majority, seventy-two Americans (52 percent), was followed by forty-four Japanese, eleven British, four Germans, four Chinese, one Portuguese, one Korean, and one Norwegian (*Hawaii Nihonjin Nenkan* 1919: 149). From the 1920s, the labor market became more complex with the coming of the Japanese American physicians from the second generation who had completed their education in the continental United States.⁸

4 Biography of Japanese Physicians in Hawaii

For our study of international migration by first-generation Japanese physicians, a demographic report from 1912 deserves a closer look because it contains much detailed information. The report lists the names of twenty-nine physicians. Cross-referencing this with other sources of the time reveals some important characteristics of twenty-three of these medical doctors, including each physician’s birth year, birthplace, family background, academic credentials, the year of license registration in Hawaii, and reason(s) for relocation from Japan.⁹ An examination of their biographical data points to five important characteristics that marked the first waves of exodus among professionals in medicine.

The first notable point is the prominence of ex-samurai. At least 30 percent of the Japanese expatriates on the list were identifiably of samurai descent, all being of middle to lower ranks. These physicians were remarkably diverse in terms of their prefectural background, marking a stark contrast with the 96.2 percent of agricultural laborers who migrated from the western parts of Japan, namely, Hiroshima, Yamaguchi, Kumamoto, and Fukuoka. The fact that these ex-samurai doctors came from all over Japan points to the widespread impact of the Meiji Restoration, which completely liquidated the warrior class across the entire country. This policy prompted many members of this class to make life transitions both occupationally and geographically as far as to Hawaii.

As for the second important characteristic, these ex-samurai doctors were both by-products and producers of the expansion of Japan’s two frontiers, one in Hokkaido and the other in the Pacific. Particularly telling for our purpose are two specific cases drawn from the 1912 list. Takeda Kazushige and Mori Tokisada, both former samurai, used

⁸ The first among them was Hoshino Mitsuharu, who began serving in 1920 (Okiihiro 2002: 112).

⁹ The source also lists the names of dentists, veterinarians, and pharmacists from Japan. This study, however, focuses exclusively on physicians.

their family wealth to change their life course by the end of 1872, during the age of frontier expansion. Soon after the Meiji Restoration, jobless young samurai Takeda studied British English and then medicine in Hiroshima prefecture, where he subsequently served as a hygienist. His field study proved useful for the then Hokkaido development; as a medical doctor for the Tondenhei headquarters, he played a role in smallpox vaccination in the Nemuro area. His experience in bacteriology soon formed the basis of his medical practice abroad, in the Honokaa district of the Hawaiian island (Shimada 1912: 69–71). A somewhat similar pattern could be seen in Mori's life. His family, along with about four hundred other ex-samurai, moved to Hokkaido after a great famine hit his Miyagi prefecture. With his medical school degree, he soon contributed to the Hokkaido development as the director of public hospitals. He gained experience in hospital management and in a Red Cross relief squad in China during the Sino-Japanese War (1894–95), both of which formed the basis for his pursuit of a second career in Hawaii as an esteemed physician (Shimada 1912: 9–12). These physicians and settlers aided in expansion both within and outside of Japan.

These two doctors and the rest from the 1912 list point to a third common characteristic, age and gender, among the first generation of intellectuals who departed Japan. They were all males born between 1857 and 1879, with ages ranging from thirty-three to fifty-five as of 1912, almost all in prime working age. Only a few were in their twenties upon arrival. This relatively older age group reflects how time-consuming it was for the physicians to complete their education in Japan and subsequent training in Hawaii. Hawaii did not prevent Japanese females from becoming licensed physicians; in fact, at least one female doctor obtained a medical license in Hawaii but then left the islands.¹⁰ Males dominated the medical scene in Hawaii and the contiguous United States before 1924 and even for a time thereafter.

The fourth important feature of the first-generation Japanese physicians in Hawaii was their rather modest educational background. By no means elite, at least academically, few had graduated from top universities in the field. With very few exceptions, almost all were the products of second-rate medical colleges in regions that focused on clinical practice in treating ordinary patients rather than on more prestigious laboratory research. One may understand this point more fully in the context of the Germanization of medicine that was taking place at that time in Japan. Beginning in 1869, nearly all significant Meiji higher education in medicine adopted the German institutional model, as famously epitomized by Tokyo University and the Japanese Imperial Army. Soon, less prestigious medical colleges across the country followed suit. As Hoi-eun Kim (2014: 60) shows, Japanese students who had failed to enter prestigious medical programs in Japan often tried their luck abroad. Elite students typically studied in Germany for various short periods of time, some with a government scholarship, but a clear majority of private students—65 percent of 14,686 from 1881 to 1905—studied in the United States, where they could work and study. The West Coast seems to have been an optimum destination for many self-financed students. Five Japanese physicians on the 1912 list were such students, all with a medical degree from Cooper Medical College in San Francisco.

¹⁰ “Ōhashi Ryufu sensei no goryakureki,” Sakaideshiritsu Ōhashi Kinen Toshokan, Kagawa; and “Yoshihara, Dr. Ryu” and “Yoshihara, Dr. Ryuko,” Hawaii State Archives, Department of Health, Physician's Licensing Records: Register of Licenses, Physicians, Licensed (Retired), 1890s–1930s, HSA.

The fifth important characteristic of the first wave of Japanese intellectual migration was common across all first-generation immigrants: strong ties to their home country. All of them retained a curious mix of permanent settlement in Hawaii and very frequent, or almost routine, visits to Japan. In certain cases, these expatriates stayed in Japan for as long as a few years. Among the physicians on the 1912 list, only two returned to Japan for good; both left Hawaii after a few decades, loaded with honors. One of them, Uemura Futao, finished a medical program at the age of twenty-five and opened up a private practice in Kumamoto, Japan. After moving to Hawaii four years later, he eventually achieved greatness, becoming the manager of a hospital in Honolulu until he, at the age of fifty-three, returned home to Kumamoto with his family (Sogawa 1927: 201; Shimada 1912: 76–77). Uchida Jūkichi followed a similar path. Upon completing his medical program in Tokyo at the age of twenty-three, he went overseas. In Honolulu, he was running a hospital by the time he reached the age of fifty-five. He then handed over the property to his adopted child and returned to Japan, where he worked at the Kitasato Institute with his long time colleague, the world-famous bacteriologist Kitasato Shibasaburō (Sogawa 1927: 202). These two physicians in Hawaii maintained close ties with their medical communities in Japan for three decades, presumably via personal networks, correspondence, and sea voyages across the Pacific.

5 Japanese Physicians at Work: Mōri Iga as a Case Study

The five notable characteristics of Japanese physicians in Hawaii, articulated in the preceding section, reinforced one another in the making of the intellectual migration. This point is illustrated by the career path of the Japanese doctor Mōri Iga (1864–1951), probably the most prominent leader of the Japanese medical community in Hawaii before 1945. His background epitomized the confluence of the five factors in play, altogether shaping the context and content of intellectual migration in complex and subtle ways. Mōri linked Hawaii and Japan as well as frontier expansion and physicians through his social class, his gender and age, his education, and Japan's ambitions in East Asia. Notable in his representative case is the concurrent expansion of Japanese and American influence across the waters. These expanding frontier zones in the Pacific set the tone for the first waves of Japanese expatriates in medicine.

Mōri Iga's story begins with his birth as the second son of a samurai family on 11 February 1864, four years before the Meiji Restoration. His biological father, Oguri Yūma, was a middle-ranking samurai; in the Tokugawa era, he belonged to a Daijōji subfief that had formed part of the Kaga domain in the Honshu island facing the East Sea.¹¹ It was a "prominent family of Ishikawa prefecture," to use the words of the navy registry, with six sons and several daughters, including Iga's younger sibling Oguri Kōsaburō (1868–1944), an admiral of the Japanese navy.¹² In 1875, at the age of eleven,

¹¹ "Mōri Iga koseki tōhon," in Dr. Victor Mori Family Papers (pre-1700 to 2003), box 1, folder 3, Resource Center Archival Collection at Japanese Cultural Center of Hawaii (hereafter JCCH); and "Oguri Yūma" in *Ishikawaken-shi dai 2-hen hanchijidai vol. 1* 石川県史第2編 藩治時代(上) (1928).

¹² "Oguri Yūma koseki tōhon" in Dr. Victor Mori Family Papers, box 1, folder 3; and "Imukyoku todoke Mōri Igajirō hoka 9mei seito mōshituke," *Kaigunshō kōbunbikō*, Honsho kōbun Meiji 15-nen, vol. 2, Japan Center for Asian Historical Records (hereafter JCAHR).

Iga was adopted into the Mōri family, which lacked an heir. Both the Oguri and the Mōri families were of the samurai class, and neither had the family lineage of physicians. Iga's biological and adopted fathers had known each other as samurai servants guarding their Maeda domain warlord.¹³ The practice of adoption likely alleviated the Oguri family's financial hardship during the early years of the Meiji Restoration. Now, as head of the eighth generation of the Mōri family, Iga inherited 150 koku (today's equivalent of 3,750,000 yen or roughly \$37,500), which apparently financed his later travels.¹⁴ On the basis of historical studies of Meiji science and technology, one might expect that Iga also inherited the tradition of the Bushido Code, or the idealized, constructed ethos for the samurai class that emphasized the importance of serving others even through the relentless pursuit of self-cultivation and self-denial.¹⁵ The lasting impact of the bushido teachings, if there was any, seems to have been far weaker than the tangible financial assets and network of social contacts (especially within the navy) that he inherited. His frequent visits to Nagasaki through his network cultivated his interest in the navy and medicine, both of which set the tone for his later career.

Like many others who formed the first wave of intellectual migration from Japan, Mōri Iga had a somewhat modest educational background. He was by no means an elite in the field of medicine. Top students pursued their studies, some with scholarships from the government, at imperial universities that followed the traditions of German medicine, but Iga did not. He studied at Jikei University, a private medical college established in 1881 for the production of navy physicians that followed the British style of medicine. Mōri was not the best student in class; he was a student of above-average standing. For instance, he ranked high on a midterm exam in 1885 (3,164 points) that covered the subjects of internal medicine, surgery, gynecology, clinical lecture, and foreign language. His academic performance improved somewhat after that, scoring the highest in class in clinical lecture and foreign language. His total score on the summer exam of that same year (3,521 points) was the second best in his class, with the second highest score in surgery and the highest in foreign language.¹⁶ The curriculum at Jikei University firmly prepared Mōri to follow the traditions of British medicine after his graduation in September 1887.¹⁷ He applied for a naval commission and then moved on to study combat medicine at London University as a navy cadet.¹⁸ Later, in 1898, he enrolled at the University of Glasgow for one year, where he studied

¹³ "Mōri" in Dr. Victor Mori Family Papers, box 1, folder 3; and Mōri Motojirō, Interview by Masao Ōta and Chiyo Yanagida, 3 November 1996, Honolulu, transcript 2, Dr. Victor Mori Family Papers, box 1, folder 5.

¹⁴ "Mōri" in Dr. Victor Mori Family Papers, box 1, folder 3.

¹⁵ The use of culture in making sense of history of East Asian science and technology has generated heated discussions in scholarship. In the context of modern Japan, for instance, *Morris Low* (2005) examines "the samurai science," whereby Japanese science after the Meiji Restoration derived from the cultural, social, or ethical traits of the samurai class dedicated to selfless public service. For a critical review, see *Ito* 2017.

¹⁶ "Jūgatsu Itsuka Gun'i gakusha seito no daichūshiken seisekihyō," *Kaigunshō kōbunbikō*, Meiji 18-nen, vol. 19, JCAHR.

¹⁷ "Mori, Dr. Iga," physician's licensing records (retired) 1890s–1930s, HSA.

¹⁸ "Dr. Victor Motojirō Mori," in Dr. Victor Mori Family Papers, box 1, folder 17; and "Where did the Daishoji Mori's come from?" in Dr. Victor Mori Family Papers, box 1, folder 5; and *University of Glasgow* (2013), "The University of Glasgow Story: Iga Mori," 25 July, <http://www.universitystory.gla.ac.uk/biography/?id=WH25153&type=P>.

pathology and bacteriology (University of Glasgow 2013). These medical fields proved useful in clinical practice of treating patients at home and abroad. In a way, those who opted to pursue the British style seem to have gained a better chance of migrating internationally, especially to the English-speaking world such as the United States. Graduates from Jikei University like Mōri, a decidedly a minority group in the medical world of Meiji Japan, found a niche later in Hawaii.

Whereas Japanese students commonly stayed in Germany to study medicine, the country was not a common destination for long-term settlement. In retrospect, Germany did not provide an optimum environment for Japanese medical experts to migrate and stay permanently. By 1912, an increasingly large number of students, some with scholarships from the Ministry of Education, chose to study in Germany, at least in part to take advantage of the reputation associated with German medicine. With few possible exceptions, all of them returned after completing their studies abroad. One reason had to do with a changing political climate in Germany. Foreign medical students began to experience a surge in xenophobia, which reached a high point circa 1920. Upon its defeat in World War I, the German government ordered 534 Japanese, mostly students, to evacuate to neutral Switzerland. Some were even arrested and then interned for knowing “too much” about German science and technology (Kim 2014: 149–50). The devastated domestic economy, with high unemployment rates, rejected foreign medical experts who sought employment and permanent residence.

Mōri’s studies abroad, which emphasized the importance of clinical treatment, reflected the imperial ambitions of the Japanese navy as much as America’s expansion into the Pacific. From 1889, he attended the Cooper Medical College (then located in San Francisco). Established in 1858 and later absorbed into Stanford Medical School, it was the first of its kind on the West Coast. At the end of America’s continental expansion westward by the mid-nineteenth century, alumni of this medical school crossed the waters, some settling in Hawaii and occupying important positions in and out of the Board of Health. In support of Mōri’s application to this medical school, his navy commander wrote a letter seeking approval from the Minister of the Navy, requesting that Mōri, as “a self-financed student, go to the United States for further study in medicine for the next five years.” The Department of the Navy approved it promptly. With that support, Mōri became “a navy student” and was “exempt from [military service of] a navy cadet.”¹⁹ His credentials as a licensed physician in Japan enabled him to join the medical program as a junior (Ōsawa 1925: 263). He became one of about ten Japanese alumni of the institution from 1883 to 1920, including at least four who, like Mōri, had moved to Hawaii for a postgraduate career.²⁰ With

¹⁹ “Kaigun seito Mōri Iga Sekijūjisha ni kameishi shōhei no kyūgo ni jyūji no ken,” *Kaigunshō kōbunbikō*, *Kōbunzasshū Meiji 27-nen*, vol. 7: Tosho, imueisei, jinjiō, JCAHR.

²⁰ The alumni directories of the Cooper Medical College from 1891 and 1920 list the full names of all graduates, including ten Japanese last names. The first names of these ten suggest that two were of the second generation, born in the United States, although they could have been Japanese citizens who had adopted American first names. See Stanford Alumni Association, *Stanford Alumni 1891-1955* (1956), vol. 2, 945-951; Stanford, CA (<http://elane.stanford.edu/medalum/cooper.txt>, accessed 16 February 2016) for the time period from 1883 to 1912 and Stanford Alumni Association, *Stanford Alumni 1891-1920*: Stanford, CA (http://distantcousin.com/Yearbooks/CA/Stanford/1891_1920/Medical.html, accessed 16 February 2016) for 1891 to 1920.

his training at Jikei University and then at the Cooper Medical College, he wrote clinical records in English.²¹

At the prime age of twenty-six, Mōri first came to Hawaii for financial gain. Studying abroad at his own expense was costly; his savings paid only for his first fourteen months. In August 1890, he arrived in the Kingdom of Hawaii as a physician hired by the Bureau of Immigration. Whatever his ten-month earnings at the sugar plantation may have been, they were enough for him to resume and complete his remaining studies in six months at the Cooper Medical College (Ōsawa 1925: 265). With the medical degree and then the navy's approval, he returned to Hawaii the following year, this time to study leprosy on the island of Molokai, where patients had remained sequestered.²² His experience on the West Coast and then in Hawaii transformed him into a transnational physician with a curious mix of international flavors: he was a Japanese citizen whose handwriting was a script he had learned in England; he spoke American English; and he remained "in perm[anent] residence" in Hawaii.²³

Mōri's credentials in medicine were useful to advance the needs of various parties. For one, he proved to be ideal for the military's imperial expansion in Asia. His status as a navy student mandated that he follow directions from the navy's office at every important step of his career, be it in Japan, Hawaii, or elsewhere. In September 1894, the navy sent him to the Sino-Japanese War immediately after his return from Hawaii to Japan. He became a head surgeon for the First Corps of the Japanese Red Cross, which was working on the frontlines of the Japanese empire in East Asia, treating wounded soldiers in locations like Pyeongyang in Korea and Dalian in China. Mōri's nine months of medical service abroad earned him two awards, one of which—Sixth Class Order of the Sacred Treasurer—made him the first of only three Hawaii residents decorated by the Japanese government before the Japanese-American War 1941 (Yamashita 1941: 176–77). His work was beneficial to the military and the Japanese community in Hawaii. Earlier on, eleven leaders of the community had raised \$8,000 for the war and written to the president of the Japanese Red Cross, expressing their "burning desire" to be part of the ongoing war from abroad, calling Mōri "the representative of the subjects of the Emperor in Hawaii."²⁴ What sustained the link between Hawaii, China/Korea, and Japan in the age of imperialism was Mōri's frequent voyages. From 1907 to 1911, for instance, he resettled in Japan while concurrently managing hospitals in Tokyo and Hawaii. With each sea voyage taking about two weeks, he went back and forth between the two locations three times in 1910 alone.²⁵ His role as a transnational physician linked East Asia and the Pacific region, signifying the international expansion of Japan's influence from the late nineteenth century to the early twentieth century.

²¹ Victor Mōri (grandson of Iga Mōri), email message to the author, 1 November 2017.

²² "Kaigun seito Mōri Iga Sekijūjisha ni kameishi shōhei no kyūgo ni jyūji no ken," *Kaigunshō kōbunbikō*, *Kōbunzasshū Meiji 27-nen*, vol. 7: Toshō, imueisei, jinjiō, JCAHR; Victor Mori, "Iga Mori," in *Time Capsule for My Grandchildren* (2003), 2, JCAHR; and Mōri 1930.

²³ "Where did the Daishoji Mori's come from?," Dr. Victor Mori Family Papers, box 1, folder 5. The quotation is from Passport of Japan no. 054994 Mori Iga, Dr. Victor Mori Family Papers, box 1, folder 5.

²⁴ "Kaigun seito Mōri Iga Sekijūjisha ni kameishi shōhei no kyūgo ni jyūji no ken," *Kaigunshō kōbunbikō*, *Kōbunzasshū Meiji 27-nen*, vol. 7: Toshō, imueisei, jinjiō, JCAHR.

²⁵ Passport of Japan no. 054994 Mori Iga, Dr. Victor Mori Family Papers, box 1, folder 5; and "Mōri Iga no ryakureki," Dr. Victor Mori Family Papers, box 1, folder 5.

6 Conclusion

This article has examined how frontier zone expansion and the migration of physicians reinforced each other in complex and indirect ways. Looking beyond the context of a single East Asian country and East Asia as a region, or the East-West dichotomy, this study has placed all involved territories within the broader trans-Pacific arena to convey the sense of interconnectivity between them. The context and content of the experiences of the Japanese expatriates during the time under study merit our attention because these individuals played key roles across the geographic territories involved. These well-educated, highly skilled, licensed professionals helped maintain the healthy growth of Japanese communities in frontier zones, thereby contributing to Japan's expansion, especially to the Pacific theater.

The departure of Japanese medical doctors for Hawaii may be understood more fully within larger patterns of international migration after 1868. Thus, this study first analyzed the mechanism of migration as a means of Japan's expansion northward and eastward. Shortly after its formation, the Meiji regime created a favorable setting for agricultural migration into Hokkaido. Hawaii, with its rising sugar industry, gradually overtook the northern frontier as the preferred destination for migration among manual labor—with the visible hands of the Hawaiian and Meiji governments molding the flow and volume of the international migration. The making of the first generation of Japanese physicians abroad was set within this context. The newly formed medical license system in the Meiji era signaled the beginning of the migration of medical doctors—all trained in Western medicine—to the Pacific. Hawaii reaped the gains. Territorialized by the United States, Hawaii remained neither subdued nor thoroughly imperialized by Japan, but it became the first host in the world to a growing Japanese medical community abroad. Here, the early Japanese physicians, having settled locally, played a pivotal role in maintaining the physical health of Japanese agricultural communities, sustaining an economically sound, diplomatically viable, and socially acceptable form of expansion.

The demography and biographies of Japanese expatriates in Hawaii present a curious mixture of domestic and international tensions during the time under study—as manifested in certain characteristics. First, a good portion of the Japanese physicians who settled abroad were of samurai descent, all of middle to lower rank, which points to their migration as a repercussion of the Meiji Restoration. Moreover, these physicians, as well as the others who migrated, tended to be physically healthy adult males with a modest educational background. They also maintained strong ties to their home country. These characteristics reinforced one another in the making of the international migration of Japanese medical doctors. When compared to agricultural laborers, these professionals were more different than similar. The doctors also tended to be older than the manual laborers. Though they were less diverse in terms of gender, they came from a much broader range of prefectures. More important, the physicians played a more visible and active role in the professional and geopolitical connection between their host and home countries.

The making of the Japanese physicians in Hawaii reflected an increasingly tense international context from 1868 to 1924 and beyond—as encapsulated in the life story of Mōri, an ex-samurai with a background in British medicine. As it turned out, his studies in Japan and in the English-speaking world abroad, which emphasized the importance of clinical treatment, were optimal for practicing medicine in Hawaii. Mōri's career mirrored America's expansion into the Pacific region just as much as

it did Japan's naval expansion. Through his ex-samurai lineage, his gender and age, his educational and professional background, he embodied the Japanese government's ambition abroad. His role in linking Hawaii and Japan as a transnational physician underscored the ongoing interconnection between expansion and physicians: each shaped the other indirectly.

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