

Transforming Medical Paradigms in 1950s Taiwan

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Abstract During the early Cold War period, medical reconstruction accelerated in Taiwan with the valuable support of the American medical profession. A common interpretation of this medical reconstruction focused on either the Japanese colonial legacy or the American heritage from China. Both arguments, however, oversimplify the complications inherent in transforming Japanese colonial medicine to meet American criteria of medical service in early Cold War Taiwan. This article explores the confrontation and conflict that made controversial the transition from Japanese colonial medicine to American standard medicine. This review of the history of the changing medical care system in Taiwan identifies a gap between the end of formal colonialism and an invisible colonialism. A new form of colonial medicine in Taiwan unveiled the current global configuration of power and culture during the Cold War in East Asia that was both similar to and different from the historical or imperial-colonial paradigm. Finally, the article touches on some thoughts on new forms of colonial medicine during the Cold War in East Asia.

Keywords Taiwan · medical profession · transforming paradigm · subimperialism · invisible empire

Scholarship on Taiwan history generally considers the year 1949 as either the beginning or the end of an era. This perspective is also applied to the understanding of the medical profession and practices in Taiwan. While the Japanese medical profession was most commonly associated with its colonial influence in Taiwan from 1895 to 1945, medicine in post-WWII Taiwan soon adopted certain aspects of American medicine from the time of the retreat of the Republic of China to Taiwan in 1949, resulting in the creation of a hybrid model of medical service in contemporary Taiwan. Under this system, the professional criteria of Japanese colonial medicine guided generations of medical practitioners in the colonial period and later, who, to some scholars, became

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the legacy to post-WWII Taiwanese medicine.¹ During the postwar period, especially after the relocation of the Nationalist government to Taiwan, American standard medicine and public health ideas were introduced by American transnational philanthropic organizations and aid agencies. Such a process caused conflicts and negotiations within medical circles, which continue even in contemporary Taiwan. This article explores the confrontation and conflict that made the transition from Japanese colonial medicine to American standard medicine controversial but achievable.

Ann Laura Stoler, Carole McGranahan, and Peter Perdue asked in the introduction to their 2007 *Imperial Formations* how one could study European and non-European forms of empire in the same analytical frame. In a similar vein, their question calls for a more nuanced understanding of colonialism without colonies, adding another dimension to thinking about imperialism and colonialism. During the past several decades, new discourses of decolonialism and postcolonialism have arisen. Their arguments have demonstrated a definite effort to turn away from the old school of colonialism and focus more on the social and cultural questions. Moreover, the multifarious networks of economic, scientific, and political actors, as well as institutional constellations, cultural formations, political strategies, commercial interests, capital flows, and knowledge production, in fact were able to generate a new form of colonization. This is an invisible element beyond what conventional imperialism can explain. In addition, the concept of subimperialism developed by Kuan-Hsing Chen and others indicates that Taiwan is not yet decolonized, deimperialized, or what they describe as “de-cold warred.” Their interpretation of subimperialism links global capitalism, a new form of imperialism, with debates of decolonization in Taiwan, a state in East Asia and the point of this article. Chen states clearly that “stratified construction of global capitalism is neocolonial imperialism.” (Chen and Wang 2000: 15–16) The features of old colonization are succeeded by subimperialism or neocolonial imperialism via political and economic dominance rather than military force (Chen and Wang 2000). In his 2010 book *Asia as Method: Toward Deimperialization*, Chen further suggests “multiply[ing] frames of reference in our subjectivity and worldview” to understand the unique colonial histories and cultures of Asian societies while acknowledging the West as constitutive of Asian subjectivity (223), bringing the case study of Taiwan to a much broader framework of understanding Asia during the Cold War period. As that schema is similar to the argument by Stoler, McGranahan, and Perdue (2007), Taiwan could remain subordinate or an unviable colony to the United States and Japan. In short, these latest theories bring a ray of light to interpret the conflicts during the transformation from Japanese colonial medicine to the American criteria of medical care in postwar Taiwan and probably will be useful to understand other East Asian countries during the same period. It is worth noting that, in English, the term *medical profession* usually refers to both health care workers and medical institutions, while the term *professionalism* refers to high quality in terms of meeting “ethical standards and criteria of a profession.” However, the definition and development of professionalism in Taiwanese history was vague, and commonly both terms were used interchangeably. In the following discussion, the term *profession*

¹ For discussion of the Japanese-German medical system in the Japanese Empire prior to World War II, see Liu 2009.

could include doctors, other health care workers, and medical institutions, while *professionalism* concerns the quality or ethics of the medical or public health systems.

1 Medicine in Colonial Taiwan and “Semicolonial” China

During the early Cold War period, medical reconstruction accelerated in Taiwan, with the valuable support of American professionalism. Some doctors usually treated American medicine as a vital means to improve medical care in Taiwan from the outrageous Japanese models (see, e.g., [Huang 2007](#)). Others tend to see Japanese colonial medicine as the essential root of modern medicine and its postwar development in Taiwan.² Both arguments, however, overlook several factors that separately developed in colonial Taiwan and mainland China prior to 1945 and simplify the complications inherent in transforming Japanese colonial medicine to meet the American criteria of medical service in early Cold War Taiwan. Furthermore, the concept of “semi-colonization” may be more suitable for interpreting the transformation of colonial medicine to the post-WWII medical profession in Taiwan. There has been discussion that prior to 1949 China was a “colony” or “semicolony” ([Zarrow 2005: 36](#)). As Taiwan was fully occupied by the Japanese Empire, the concept “semicolony” may illuminate the multiple imperial powers in China and Taiwan during the 1950s.³

1.1 Clinicians in Colonial Taiwan: The Agent of Imperial Schemes

Medicine has been perceived as an elite profession in Taiwan ever since colonial days. However, medical education in colonial Taiwan was essentially vocational from the beginning. The Japanese system was divided between the elite education of university graduates and vocational training for college students, which together made up a comprehensive process supporting the whole range of medical services, both research based (university) and clinically based (college). Vocational education to train clinicians as local forces assisting the medical service had long operated in colonial Taiwan from 1895 to 1945, when Dr. Yamaguchi Shuko proposed to establish the Native Doctor Training Institute (Dojin Ishi Yōseisho) in Taiwan in 1897. What began as an intensive training program in first aid expanded to become a formal medical school for Taiwanese clinicians in 1902, and it retained that educational goal until it formed part of the Japanese imperial university system in 1936. Japanese medical practice is most commonly associated with German influences. However, colonial medicine in Taiwan additionally adopted several aspects of British tropical medicine, creating a true hybrid. In the beginning, the colonial government showed concern about how to balance medical needs and a centralized sanitary administration, especially the best way to resolve the shortage of medical practitioners ([Takaki 1911: 45–58](#)). As the recruitment of public doctors from Japan failed, after 1897 two categories of medical

² This is the mainstream view in Taiwanese history of medicine and is very influential. See [Chu 2009](#).

³ There has been a great deal of discussion of China prior to 1949 as a “colony” or “semicolony.” As Taiwan was fully occupied by the Japanese Empire, I prefer to choose *semicolony* to show the multiple imperial powers in China. For the details and discussion of China as colony or semicolony, see [Zarrow 2005: 36](#).

practitioners were produced through intensive government medical courses in colonial Taiwan. One was the *keisatsu i* (medical police), a system learned from German Medizinpolizei.⁴ The other was the *genji i* or *otsushôishi* (limited-practice doctors in certain areas), a modification of the Indian medical services under the British Empire.⁵ The colonial government promoted former first-aid helpers to be doctors with practice restrictions in villages and townships that lacked modern medical resources (*Taiwan Historica* 1954: 33–39). Both *genji i* and medical police were merely tools to enforce medical and public health policies and were provided through the colonizers' benevolence, without concern for professional ethics or values.⁶ The establishment of vocational medical education in Taiwan allowed private Taiwanese physicians to share administrative power with governmental medical personnel, all of whom represented the power of the colonial government. To them, medicine was the key to opening the doors to medical welfare and modernity for an uncivilized Taiwanese society, as well as for showing Japanese colonial philanthropy.⁷ Such self-identity brought Taiwanese doctors unique status as clinicians to their patients and to their society.

Emphasizing clinician training, medical education in colonial Taiwan soon expanded in the first quarter of the twentieth century. During the whole colonial period, most medical practitioners in Taiwan were graduates either of vocational high schools or medical colleges of clinical practice. Before 1942, less than 5 percent of medical professionals had received university or higher-level training (*Weishengshu* 1995: 104–9). The number of public hospitals never exceeded 35, while the number of private dispensaries, usually owned by Taiwanese clinicians, grew to 263 by 1940 (*Taiwansheng xingzheng zhanguan gongshu* 2016: Table 484). By the end of the 1930s, more than 90 percent of doctors in Taiwan practiced Western medicine, while only 2 percent treated their patients using traditional remedies (*Liu* 2009: 154–55). As the practice of traditional medicine came under great legal pressure, training local clinicians in Western medicine was meant to bring medical service to Taiwanese society without questioning the colonial justification of civilization and modernization. Medical education in colonial Taiwan aimed to train sufficient clinicians, not physicians in hospitals and laboratories, to meet the medical needs of local society.

Private clinicians and their dispensaries symbolized the benevolence of the Japanese Empire toward colonial Taiwan and placed Taiwanese clinicians atop the social pyramid in the colony (*Liu* 2004). By contrast, Japanese physicians still constituted the majority of doctors in public hospitals and various sectors of the government (*Liu* 2004: 305). Most of the time, Taiwanese doctors, often working alone in private

⁴ *Keisatsu i* was in fact a police officer with limited training in medicine. Although the original mission of German Medizinpolizei was disease isolation, quarantine regulation, and registration of births and deaths, the Japanese allowed *keisatsu i* in Taiwan to practice therapeutic work in certain areas, especially in aboriginal areas. For an introduction to German Medizinpolizei, see *Pickstone* 1996.

⁵ For more information about the Indian Medical Service, see *Harrison* 1994.

⁶ It was very common for many countries to try to organize low-cost medical practitioners and provide a substantial level of medical care at the beginning of medical reform. For example, in China, the Rockefeller Foundation supported the Peking Union Medical College's effort to train many "rural medical helpers" in the 1920s. This effort may have been one source for the "barefoot doctor" system in China after the 1950s. There is no evidence to show that the *genji i* system in colonial Taiwan had any influence on developments in China, however, before World War II, when there was a public health trend for states to expand low-cost medical care into the countryside.

⁷ An excellent example of this argument is *Lo* 2002.

clinics, were the experts who made all decisions, supposedly in the best interests of their patients, who were passive and had little or no say in the decision-making process (Liu 2013: 172). As a result, Taiwanese clinicians in local societies played multiple roles. Not only did they offer medical service in their own private clinics, but they were very often also mentors, role models, and opinion leaders in the neighborhood. While clinicians in colonial Taiwan were the main health care providers, their social role was in promoting modernization in the neighborhood they served. The sphere of their service would extend no farther than a half-day trip by bicycle or motorcycle from the dispensary. During his clinician career in a small town in southern Taiwan, Dr. Wu Xin-jung maintained such a lifestyle for more than thirty years (Wu and Zhang 2007–8). In many ways, Taiwanese clinicians expressed feelings of superiority toward their neighborhood by showing the advantage of medicine, a tool of Japanese colonialization, without the power to touch any medical care policy or resource distribution in the colonial government. To use the Taiwanese clinicians as an arm of colonization in local society, a training program for home visits (*onshinkagu* in Japanese) was started in medical schools in the 1910s. The course not only trained physicians on how to equip themselves for home visits but also detailed the information they should collect for treatments to be provided and for reports to be furnished to the local sanitary police.

According to the *onshinkagu* textbook to train Taiwanese clinicians, the main mission of a doctor's home visits should be the patient's health, but in fact the author suggested the clinician's duty was more to record patients' social and economic data and their family conditions (Seiichi 1936: 47). The record of a doctor's home visit could look like a patient's socioeconomic data set rather than a medical profile. In addition to providing medical care to the people in the neighborhood, the clinician was also a family friend who was always on call. Their clinical waiting rooms sometimes served multiple functions, such as a public arena for political discussion or negotiation of family feuds, and even hosted temporary markets outside (Nianhuang Zhong 2000: 25–26). By doing so, local clinicians commonly enjoyed a high social status, perhaps as an opinion leader in the community. Due to monopolization of medical equipment and medicine by the Japanese, Taiwanese clinicians constantly faced the embarrassment of supply shortages and had to rely on trust and respect from their neighborhood. Therefore, Taiwanese clinicians could not always guarantee therapeutic results for their patients while the monopoly remained. Also, without professional credentials, they were looked down on as technicians in a colonial scheme of health improvement by their Japanese colleagues. However, they were treated as social elites and symbols of modernization and civilization in Taiwanese society. To sum up, Taiwanese clinicians in the colonial period were simply a social elite with white coats.⁸ Their private life and professional practice obviously could not be separated from the surrounding neighborhood and colonial atmosphere.

⁸ The chancellor of Taihoku Medical College, Takagi Tomoe, stated: "One must learn to be a respectable human being before one can become a doctor. Without an integrated personality, one cannot fulfill the duty of a good doctor" (quoted in Lai 1979: 267). This clearly showed the feature of medical training of Taiwanese.

1.2 Physicians in China: The Coordinators of Foreign Aid

Compared to strong colonization in Taiwan, with its centralized but discriminatory system of medical care, mainland China was much more chaotic due to long-term domestic conflicts and a weak central government. Beginning under the auspices of missionary medicine in late Qing China, private foreign aid in medicine was the keystone to the development of modern medicine there. Among aid givers, the Rockefeller Foundation eventually became a magnificent symbol of foreign medical aid to China, especially during the Republican era (1912–49), via its biggest investment, the Peking Union Medical College (PUMC). PUMC and its alumni became the cradle of American efforts to transform medical professionals in 1930s China.

The Rockefeller Foundation was established in 1913 in the United States, with John D. Rockefeller Jr. as its president. Its stated aim was to “promote the well-being of mankind throughout the world” (Rockefeller Foundation 2003: 1). The foundation’s trustees agreed that the work of the foundation was not to provide charity or relief but instead to offer “the means or the occasion for evoking from the community its own recognition of the need to be met, its own will to meet that need, and its own resources, both material and spiritual, wherewith to meet it” (Rockefeller Foundation 2015). If they were to choose between “objects which are of an immediately remedial or alleviatory nature, such as asylums for the orphan, blind or cripples, and those which go to the root of individual or social ill-being and misery, the latter objects are preferred—not that the former are unworthy, but because the latter are more far-reaching in their effects” (Bloomberg 2015). The Rockefeller family already had launched a program that met these criteria beyond North America. One month after the foundation was established, the International Health Board (IHB) was created. Soon thereafter, the China Medical Board (CMB) was established to oversee programs in China.⁹ A strategy was soon developed for a mass attack on hookworm infection, which eventually led to projects in fifty-two countries and twenty-nine islands. Virtually all of the IHB staff started their careers in hookworm projects—John Grant in Puerto Rico and Santo Domingo, Lewis Hackett in Central America and Brazil, Victor Heiser in Ceylon, India, and Australia, and Wilbur Sawyer in Australia (*Science* 1921). Among these, Grant later served as the essential channel of the Rockefeller Foundation’s contributions to China.¹⁰ It has been well noted that in mainland China the PUMC and the CMB, both funded by the Rockefeller Foundation, were major actors in transforming medical and public health systems from the first decade of the twentieth century.

Besides investment in medical education in China, the Rockefeller Foundation also coordinated with major foreign aid groups on public health works in China. By the 1930s, for example, Selskar Gunn of the League of Nations Health Organization (LNHO) had a meeting with Rockefeller trustees, officers, and directors and urged satisfying the “full needs of the community rather than an isolated need such as public health,” a request to support LNHO director Ludwik Rajchman’s rural health project

⁹ Paul Reinsch to Wallace Buttrick, 1 December 1915, box 1, series 1, RG 4, Rockefeller Foundation Archives, Rockefeller Archive Center, North Tarrytown, NY; Heald and Kaplan 1978: 6.

¹⁰ For a brief description of Grant’s works in China, see Bu and Fee 2008.

in China.¹¹ The Commission on Rural Revival and the Collaboration of the Population was obviously the “keystone” to promote Rajchman’s project to promote rural hygiene in China.¹² The Rockefeller Foundation’s multidisciplinary China Program (1935) later departed from its preset goals to join the Rajchman project. US aid agencies remained content with backing Chinese efforts that were “60% efficient rather than Western ones that were 100%.”¹³ Under the coordination of the Commission on Rural Revival, the Collaboration of the Population, and foreign institutions such as LNHO and Rockefeller Foundation, attention was drawn to clumsy, fragile experiments of the sort designed by the Mass Education Movement at its demonstration center in Tinghsien (Ding-xian), Hopei (Hebei) Province. An instant hit, as noted by Gunn, now vice president of the Rockefeller Foundation, this “‘village self-government organization’ sparked unequaled enthusiasm among talented Chinese students and foreign experts” (Thomson 1969: 128). Why are people greatly enthusiastic about what appears to be a faulty project, as Gunn admitted? The multiple roles of being financial investor, social engineer, and agent of international health that the Rockefeller Foundation played in China should explain such enthusiasm among young Chinese reformers.

Based on all the efforts to improve medical care in China, the Rockefeller Foundation played roles from health promoter to financial investor to the major engineer of medical modernization in China. According to historian Yip Ka-che (1995), the American-oriented medical care system in China, as well as the technical approaches of the Rockefeller Foundation, was adopted by most health officials of the Nationalist government during the 1930s as a part of the public health modernization scheme. However, there were many barriers to the ambitious scheme that Americans and the Nationalist government proposed. Yip shows that the agricultural economy was a significant hindrance to the project, since industrialization was a key factor in the development of the American public health system. To American experts on medical care, sufficient medical supplies and comprehensive medical facilities are two major players in high-quality medical service (Yip 1982). All of these could materialize on the basis of a prosperous economy with strong industrial production, including strong pharmaceutical and chemical sectors. In addition, for most historians of modern China, the military conflict between Japan and China during the period was a major factor delaying the modernization efforts.

While the socioeconomic obstacles were a chronic issue, military invasion also soon complicated matters. The Japanese conquest of Manchuria in 1931 was only the first step in what became a much larger campaign to expand Japanese influence in northern China, a campaign that resulted in full-scale war between Japan and China in 1937. During the invasion of the North China plain by Japanese troops, the Chinese government was unable to provide sufficient medical care by itself, and PUMC doctors played an important role in caring for both military personnel and the civilians

¹¹ “S. M. Gunn [28–30 October 1930],” quoted in Ninkovich 1984. Gunn was also a key promoter of the rural reconstruction project in northern China between 1935 and 1937. For his career, see Litsios 2005.

¹² Rajchman had a broader vision to internationalize rural hygiene and promoted it as a part of a rural reconstruction scheme in China during the 1930s. For a brief discussion of Rajchman’s ideas, see Packard 2016: 66–71.

¹³ “J. B. Grant [1922],” quoted in Bullock 1980: 141.

caught up in the conflict.¹⁴ Initially, assistance provided by American funding had been, in part, to run medical training programs such as those created in Beijing (1906), Jinan (1909), and Chengdu and Changsha (1914).¹⁵ However, assistance provided by American funding was not just for the day-to-day running of the medical schools; it also took the form of assistance in the wartime period. By 1937, despite friction between the different organizations—the PUMC, the Nationalist government, and the International Committee of the Red Cross—the implementation of an emergency health care system and the establishment of a medical corps became the top priorities of both the Red Cross Society of the Republic of China and the National Health Department in Nanjing, conditional on the reliability of resources from the United States (Zhang 2001).

As the war progressed, Japanese forces progressively took control of Shanghai; the capital, Nanjing; and Wuhan, forcing the Chinese central government to relocate to Chongqing, in Sichuan, southwestern China, which was far from the reach of Western medicine. Records from the time show 8,900 registered physicians, 2,740 pharmacies and dispensaries, 3,700 midwives, and 575 nurses in the entire country (Watt 1992: 3). In remote southwestern areas, the core of the limited medical resources was the well-trained medical practitioners and public health workers who had retreated with the government. These professionals were greatly supported by the Nationalist government's medical modernization scheme in the 1930s. Dr. Liu Rui-heng (Dr. J. Heng Liu), the former chancellor of the PUMC and a Harvard medical school alumnus, played a key role in promoting this modernization project by adopting American standards.¹⁶ One of Liu's main tasks was to replace the dominant German configuration of Chinese military medicine with American standards. Since its defeat during the first Sino-Japanese War in 1895, in addition to ceding Taiwan to Japan, China also attempted to copy Japanese Westernization, including its German-like military medicine curricula. However, due to the heated conflicts between China and Japan, it would have been very ironic to keep a Japan-inspired German system to train Chinese military surgeons. The model of American medicine was an option for the Republican authorities. Liu's mission to reform medical training in the military was later taken over by Dr. Robert Lim, a Singaporean Chinese and also a PUMC professor. Their cooperation resulted in the creation of a reservoir of modern medical resources within the military, as well as the maintenance of links with American supporters (Wu 1995: 12–29). This connection was very important when the Nationalist government retreated to Chongqing and relied heavily on military personnel to keep modern public health systems running.

The effort to continue the medical training program and local health reforms in Southwest China was intended not to immediately reduce the health crisis in China during the war but to maintain the capability for postwar reconstruction. Major

¹⁴ “Dr. Robert Lim outlines medical relief work,” *Daily Bulletin*, no. 66, 21 June 1941, China Information Committee, folder “National Red Cross Society of China, Robert K.S. Lim,” box 22, series II: permanent file, American Bureau for Medical Aid to China, Rare Book and Manuscript Library, Columbia University, New York.

¹⁵ On the medical schools in the first decades of the twentieth century, see Lucas 1982: 69–70 and *Dakongbao* 1933.

¹⁶ For Liu's career, see Liu 1989.

Mendelson of the US Army visited the Emergency Medical Service Training School in Guizhou in 1942 and declared that the technical short-term emergency training was managed effectively, showing good results in the prevention and mass treatment of disease.¹⁷ Progress in sanitary training was achieved in two ways: the enrollment of local helpers for public health services, and establishment of several nursing schools for young women. The purpose was to increase the numbers of trained medical personnel who could support the military in times of war and work in their local communities during peacetime (*Emergency Medical Service Training School 1944: 16–17*). Moreover, American officers were attached to these units, if available. Some of the best Chinese officers and staff were sent to America for advanced training with the US Army. After returning home, they were charged with training as many instructors as possible, military and civilian, who would be sent to the front and to unoccupied areas (*Emergency Medical Service Training School 1944: 17*). This strategy was clearly not only for the specific medical demands of wartime but also for the peacetime that would eventually follow.

During the wartime period, China was in fact only a small part of the entire American war effort in the Far East and the Pacific in the early 1940s, yet American military aid, including medical supplies to the desperate Chinese military, was very important (*Stone 1969: 74*). Most of the Chinese population struggled with insufficient medical care and supplies and suffered high risk of death and poor quality of health care (*Wan 1947*). Only staff and their families of those institutions that could coordinate American military actions, such as the Army Institute of Nutrition (*Anonymous 1944*), might take a share of medical aid. Its administrators were able to seize power in the Nationalist government. It is clear that the Chinese government could not carry on the mission of improving medical care to Chinese unless foreign aid was sufficient. The Chinese who could coordinate with American medical care support either had training in the West, including the United States, or had connections with funding organizations in America. For physicians like Lim and Liu, their status was firmly established based on their connections to the American medical aid that sustained China's military capability, rather than their links to power from central authorities or the trust of local society. As noted above, both proved essential to secure Taiwanese clinicians' status in the colonial period.

2 Colonial Medicine without Colonies in the Cold War Era

Undoubtedly, the United States was the only superpower dispensing international medical aid in the early Cold War period. After the end of World War II, James A. Crabtree, deputy surgeon general of the US Public Health Service from 1946 to 1948, promoted the idea of building a new organization for international health (*Williams 1951: 487*), a mission that had been initiated by the League of Nations before the war. World War II had severely curtailed the international cooperation-based disease control efforts carried out by the Health Section of the League of Nations in Geneva,

¹⁷ "G. Correspondence," CMB Inc. archive, series CMB, box 122, folder 886, Rockefeller Foundation Archives.

a European city trapped in the debris of war damage. A proposal by Brazil and China to establish an international health organization at the 1945 San Francisco Conference was soon recognized by the US Public Health Service (Williams 1947). American organizations, including Johns Hopkins University, the Rockefeller Foundation, and the American Medical Association, recommended specifically that the US government include nongovernmental charity resources in the early formation of a new international organization that would be closely linked to the United Nations (World Health Organization 1958: 38–40). With abundant American resources from both governmental and private organizations, the World Health Organization (WHO) represented a multilateral approach to international public health, also mobilizing the cooperation of many nations in pursuing common goals (Williams 1951: 821–24). American medical aid was once again sent to China, including Taiwan, prior to 1949, but this time under the names of the United Nations and WHO, aid that was benevolent but also political and strategic. Public health and medical reform in China were seen as part of the broader American model of the professionalization of medicine in an East Asian ally after World War II.

China would maintain the bonus of enjoying foreign aid only as long as it was an ally of the United States, a relationship that was broken in 1949. When the first World Health Assembly Conference passed the charter to establish the WHO in 1948, the Nationalist government in China had already lost diplomatic support from the US government, along with all forms of aid. After the failure of negotiations by General George C. Marshall in China, President Truman announced in August 1949 the withdrawal of all support from China and blamed the decision on corruption in the Nationalist government. The damage to the Nationalist government was tremendous, causing its retreat to Taiwan.¹⁸ Following this change of US diplomatic policy toward China, the CMB also stopped its aid to China and prepared to withdraw its staff from Taiwan.¹⁹ The withdrawal of American organizations further suffocated the early reconstruction of the public health infrastructure in Taiwan.

At the end of World War II, Taiwan was returned to China and soon became integrated into China's administrative structure. As far as health matters were concerned, the island not only underwent changes in the organization of health agencies but also was very much affected by the spread of diseases from the mainland.²⁰ Various communicable diseases that had been under control in the colonial period (1895–1945) reappeared and caused high mortality among the infected.²¹ The ensuing panic and turmoil helped to trigger riots in 1947 (Zhang 1988). In 1945, the Taiwanese government had reorganized the Japanese hygienic model by removing public health activities from the police department and placing them in a new Bureau of Sanitation (Weishengju) (Su 2004: 185). The change did not, however, create a

¹⁸ Although the letter from the Rockefeller Foundation to the CMB did not point out the causality between Truman's announcement and the withdrawal of personnel, it did quote from Truman's announcement to illustrate the Sino-American relations. For cases, see "Letter from Chester I. Barnard to John D. Rockefeller 12, Sept., 1950," Rockefeller Foundation, RG 2-1950, series 200: US, box 478, folder 3207, Rockefeller Foundation Archives.

¹⁹ "Letter from Dr. Balfour to Dr. Strobe, 25, Feb., 1949," Rockefeller Foundation, RG 1, series 601, box 44, folder 361, Rockefeller Foundation Archives.

²⁰ For a case study of epidemics in early post-WWII Taiwan, see Chen 2000.

²¹ For a general description, see Zhang 1998: 364–65.

radical overhaul of the medical care system in Taiwan. One scholar has claimed that public health in early postwar Taiwan was merely a system that “put out fires” and not a reliable system to handle medical needs (Chen 2000: 101–5). Undoubtedly, postwar Taiwan urgently needed new health resources and administrative skills to fill the vacuum caused by the withdrawal of the Japanese in August 1945.

In 1946, a Rockefeller Foundation evaluation of sanitary conditions in Taiwan revealed both “modern” and “medieval” aspects of Japanese colonial sanitation.²² Although some of these projects were unrealistic under the devastating postwar conditions, several institutes were established with American support. For example, the Malaria Research Institute, founded in 1936 with support from both the Rockefeller Foundation and the CMB, moved from Yunnan to Nanjing with the Rockefeller Foundation’s support in 1947. Levels of malaria on the newly liberated island of Taiwan were much lower than on mainland China in 1947, and the island did not receive supplies of DDT.²³ Mainland China received the majority of American donations of medical resources until late 1947, when the provincial government in Taipei started to receive aid from the United States.²⁴ Undoubtedly, changes of government, economic depression, movements of people, shortages of medication, and the neglect of the public health infrastructure all contributed to the resurgence of infectious diseases in Taiwan between 1946 and 1947.

Following the retreat of the Nationalist government to Taiwan in 1949, controlling epidemics was not the only motive for the Nationalist government to follow the American scheme of public health. During the first half of the 1950s, the Nationalist government in Taiwan was eager to regain the support of the United States to block possible invasion from mainland China. Maintaining philanthropic work such as epidemic control and medical improvement in Taiwan was a strategy to continue the cooperation between Nationalist Taiwan and the United States in the post-WWII era. The outbreak of the Korean War in 1950, with Russia and China supporting North Korea and the United States supporting South Korea, intensified the Cold War and brought American medical aid back to Taiwan. American sources of medical aid in the 1950s and 1960s included public agencies such as the Economic Cooperation Administration, private foundations such as the Rockefeller Foundation, the Population Council, the American Bureau for Medical Aid to China, and the Supreme Commander for the Allied Powers in Tokyo, and universities such as Princeton and the University of Michigan. Foreign assistance brought new forms of medical treatment and also introduced very different strategies in the identification of disease and public health problems (Yang 2008).

The malaria eradication campaign is commonly portrayed as a success story of improving public health in post-WWII Taiwan based on the use of American medicine. The campaign was also part of a global effort to combat this deadly disease using DDT indoor residual spraying; however, as Randall Packard (2007) has demonstrated, despite the critical role of biomedicine, the result of the campaign depended to a

²² “Annual Report 1949,” pp. 3–5, China Medical Board, RG 5, International Health Board/Department (hereafter IHB/D), series 3, box 217, folder 600, Rockefeller Foundation Archives.

²³ Robert Briggs Watson, “Annual Report of Activities, 1946,” and J. H. Paul, “A Report on the Year’s Activities for Year 1946,” IHB/D, RG 5, series 3, box 217, folder 600, Rockefeller Foundation Archives.

²⁴ “Annual Report 1949,” p. 3.

significant extent on the social and political conditions prevalent in individual countries. Moreover, in *Disease, Colonialism, and the State* (2009) Yip shows the great diversity in antimalaria efforts in East Asia and highlights the importance of qualified personnel. In Cold War East Asia, the global DDT campaign was badly needed by Taiwan to demonstrate its alliance.

The DDT program was launched in 1951. The first objective of the 1951 agreement between the Nationalist government in Taiwan and the WHO was “the control of malaria and eventually the eradication of this disease on the whole island of Taiwan, with modern methods at the lowest feasible cost” (Taiwan Provincial Malaria Research Institute 1952). The project aimed to control malaria and other insect-borne diseases and to improve the health of the population, agricultural production, and the general economy. The eradication program was preceded by two years of scientific study into the effectiveness of indoor residual DDT spraying when applied to walls made of different materials, field research into mosquito habitats, and cost-effectiveness studies of the various eradication procedures (Watson and Liang 1950; Watson, Paul, and Liang 1950). Generous financial and technical support from the United States helped ensure the success of the program, which benefited almost every aspect of life in Taiwan. During the 1950s, the DDT program in Taiwan not only laid a foundation to combine resources from Taiwan’s colonial past and mainland China but also significantly boosted Taiwanese confidence in American public health practices. With the growing confidence in American medicine, more reforms were on the way. Two American experts, Van Hoge and Ross Porter, produced an evaluation of public hospitals in Taiwan in 1952 that recommended a radical makeover of the whole system.²⁵ To further promote the American model of public health, the Nationalist government launched a five-year Integrated Health Project in 1959 to train Taiwanese medical professionals in the “integration of curative and preventive medical service”—a radical change from colonial medical training to a much broader public health approach.²⁶ In addition, American experts pointed to the general weakness of environmental sanitation in postwar Taiwan as a result of the Japanese colonial policy of focusing mainly on urban sanitation. Working with the Sino-American Joint Commission on Rural Reconstruction,²⁷ American aid agencies subsidized the establishment of the Provincial Institute of Environmental Sanitation, which went on to create many rural health stations in 1955.²⁸ The “rural health station,” an organization that had been launched in the 1910s by John B. Grant of PUMC, was maintained during the 1940s in wartime China and was then extended island-wide in Taiwan. In addition to setting up the rural health stations, the institute also trained nurses and

²⁵ “Counterpart Budget—PH CY-1953,” 30 March 1953, and “CY-53 Counterpart Allocation,” 9 June 1953, CIECD36-11-003-001, Institute of Modern History, Academia Sinica, Taiwan.

²⁶ “Application for Local Currency AID Funds—Project #84-55-514,” 29 December 1959, CIECD36-11-003-046, Institute of Modern History.

²⁷ The Sino-American Joint Commission on Rural Reconstruction was established in 1948 in mainland China and then moved to Taiwan, where its work has been widely credited with laying the agricultural basis in the 1950s and 1960s for Taiwan’s economic, social, and technical development. For its brief history, see Yager 1988.

²⁸ “Taiwan sheng zhengfu weisheng chuzhi meiyun huihan” (Letter from Taiwanese Provincial Health Department to CUSA), 5 April 1957, and “Project Agreement Between ICA and CUSA,” 6 March 1958, CIECD36-11-003-067, Institute of Modern History.

technicians who would work in them. The training unit was under American supervision.²⁹ It is worth noting that many rural public health projects in Taiwan originated from the Joint Commission on Rural Reconstruction's original plans and experience in mainland China.

From 1952 onward, the authorities in Taiwan began formulating long-term plans for improvements based on previous Rockefeller Foundation proposals, but any implementation of the plans would depend to a large extent on the cooperation of local governments and medical professionals in Taiwan. Following the outbreak of the Korean War, the US Foreign Operations Administration sent Emile E. Palmquist and Kaarlo W. Nasi to review Taiwan's medical and public health conditions.³⁰ Their report later served as the basis for the USAID Health Program in Taiwan, aimed at maintaining economic stability and military power in Taiwan. The report stressed that the target institute with which an ambitious program of rehabilitation and technical support would be affiliated should be selected carefully (Yang 2008: 108). Moreover, when Dr. Edger Hull, medical consultant to the Mutual Security Agency mission to China, expressed his strong concerns about the quality of the National Defense Medical Center public health program,³¹ the dean of pathology at the Medical College of National Taiwan University (NTU) also started the "Americanization" of its new medical curriculum (Yeh 1989: 56). The reform showed signs of transforming the former Japanese colonial medicine to American medical professionalism.

In 1951, two American public health experts, Dr. Magnus I. Gregersen and Dr. George H. Humphreys of Columbia University, evaluated the medical school at NTU. Although their proposal for medical school reform was too expensive to be implemented, their visit brought to the Rockefeller Foundation's attention and later provided some support to the school (Watt 1992: 174–77). In late 1951, the former dean of the Public Health Department of PUMC, John Grant, was invited by Liu Rui-heng to help the conversion of the Tropical Institute at NTU into a Department of Public Health, which was later established with the Rockefeller Foundation's full support. The successful creation of nursing and public health departments laid the foundation for long-term cooperation between NTU and various American aid organizations (Taida Yixueyuan 1998: 16; Du 2008: 27, 29). In 1955, US Naval Medical Research Unit no. 2 (NAMRU-2) decided to relocate to the NTU-affiliated hospital in Taipei. Affiliation with an advanced research institute that was also a significant symbol of American medicine in the Far East vastly enhanced NTU's prestige in the eastern Pacific Rim region (Xie 2008). With this decision, American medicine was overwhelmingly accepted by Taiwanese health officials and educators, and the strategic relationship between the two countries was furthered, as the USAID Health Program expected. Under these conditions, American medical models and pro-

²⁹ "Project Proposal and Approval Summary (#84-52-291)," 8 January 1957, CIECD36-11-003-067; "Report of Sanitarian Training Program," 1 November 1957, and "Taiwansheng huanjing weisheng shiyenso zhi J. I. Connolly han" (Letter from Taiwan Provincial Institute of Environmental Sanitation to J. I. Connolly), 6 June 1958, CIECD36-11-003-067, Institute of Modern History.

³⁰ "Zhinaizhengbu Taiwan shengzhengfuhangao" (Draft: letter from CUSA to the Ministry of Internal Affairs and Taiwan Provincial Government), 16 September 1954, CIECD36-11-003-001, Institute of Modern History.

³¹ "Lu Zhider zhi mei yuanhui han" (Letter from Lu Zhider to CUSA), 7 August 1958, CIECD36-11-003-104, Institute of Modern History.

fessional practices eventually guided public health reform in Taiwan between 1952 and the 1960s, creating new methods of epidemic control and new professional standards for the postwar generation.

The year 1951 witnessed many key events affecting medical circles in Taiwan: the outbreak of war in Korean peninsula, the withdrawal of the Supreme Commander for the Allied Powers in Tokyo, and most important for our topic, the establishment of the WHO Regional Office for the Western Pacific in Manila, the Philippines (WHO Western Pacific Region 2016). How did these developments affect Taiwan? During his trip to Asia in 1953, political observer James Reston (1953) reported: “America’s contribution to the safety and sanity of Asia, however, goes well beyond the products of her factories. . . . In Korea, Japan and Formosa (Taiwan), dependence on America is so great as to be almost pathetic. I had long talks with Syngman Rhee, Premier Yoshida of Japan and Chiang Kai-shek. Each in his own way had criticisms to make of American policy and all were asking [for] more.” Reston’s description may have merely revealed the general feeling about American medical aid to East Asia.

Despite great similarity on the surface, the continuity of American medical aid from pre-WWII to postwar contexts should not be exaggerated. Due to the new crisis of the Cold War in East Asia, the expansion of state-governed international institutions alongside America’s emergence as a global superpower transformed state relations in profound ways (Anheier and Hammack 2010: 222). This shift was evident following the creation in 1948 of the WHO, in 1950 of the National Science Foundation, and in 1951 of the National Institutes of Health. All three organizations were chartered to take on roles in research, field building, and infrastructural development in which the Rockefeller and Carnegie foundations had earlier been prominent players. In 1951, only three years after the creation of the WHO, Rockefeller shut down its own prestigious International Health Division.³² This major source of private charity in medical aid to China in the 1920s and 1930s totally transferred its function to the state, starting in the 1950s. This shifting balance of authority and influence away from foundations was reinforced by developments outside the United States: decolonization, the growing authority of “new states” in East Asia previously under European control (Anheier and Hammack 2010: 215), and the increasing prominence of state-led international institutions. In general, driven by the growing centrality of the Cold War as an organizing principle of US foreign policy, the engagement of international foundations during the prewar period in various fields, such as public health, health education, and medical science, was reframed in the postwar era as expressions of the global struggle against communism. In 1950s Taiwan, major US medical aid was dealt with in both diplomatic and medical aspects by the Nationalist government in Taiwan

³² After World War II, Dwight Macdonald (1956: 48) writes, the US government increased its research budget from \$90 million to \$2.1 billion: “Some \$150,000,000 of the total goes to universities for government-sponsored projects; trivial though this sum is in comparison to what the government is spending directly, it is more than all the foundations combined contribute to university research. The Department of Commerce now undertakes the national-debt surveys that were initiated by Edward A. Filene’s Twentieth Century Fund as well as much of the statistical work on national income that was originally done by the Rockefeller-financed National Bureau of Economic Research; the General Education Board’s farm and home programs have long since become part of the Department of Agriculture’s extension services; and the Point Four program dispatches American experts and techniques to backward countries on a scale that no foundation can begin to match.”

(Siggers 1954). American medical aid to Taiwan was obviously a form of humanitarian aid, as well as a military strategy.

Beneath the success of improving public health and medical care, the conflicts between two groups of medical professionals (Japanese Taiwanese vs. American Chinese) were intensifying. In 1947, the chief deputy of the Bureau of Sanitation criticized Taiwanese medical caretakers as having received less qualified training under the Japanese educational system (Jing 1947). The pre-1945 vocational and clinician training curricula were soon under attack (Huang 2008: 202). The resistance and unrest in response to closing the clinician training program at NTU lasted until 1950 (Zhang 2013: 29). During this period, most Japanese-trained faculty and students recruited in the 1940s were on tenterhooks (Xie 2012). Historian Zhang Xiu-rong (2013: 51–53) noticed that the United States in the early 1950s merely watched the personal friction without lifting a finger and even watched as NTU's medical education failed. On the surface, however, she also mentioned that Liu Rui-heng was the invisible hand manipulating American attitudes to transform medical education at NTU (Yeh 1989: 12), the former glory of Japanese colonial medicine. Zhang's assertion can be confirmed by the current dean of pathology at NTU: in his memoir, Yeh Shu (1970: 154) writes: "Besides dean of the medical school and affiliate hospital of NTU . . . Mr. Liu Rui-heng, an outsider, is very influential in affecting the medical reform." Without proper negotiation between the two sides, the Chinese and Taiwanese, the institutional reform in NTU soon became personal.

One of the conflicts that occurred was in changing the status of internships in NTU hospital. Under the colonial system, graduates of medical schools were qualified to practice medicine without any requirement of being an intern or resident doctor in medical facilities. Most graduates worked as interns or resident doctors without salary to gain more training. Therefore, the training hospital usually allowed them to open their own clinics or work outside of hospitals (Yang and Luo 1996: 42–43). It was the same situation in the NTU hospital prior to the 1950s. However, copying from the American system (Anonymous 1933), in post-WWII Taiwan the internship and resident training were required for graduation and before the licensing examination. The resultant meager salaries obviously caused financial difficulties to medical students, especially for those who expected to graduate and practice to earn a living (Zuo 1946). Interns and resident doctors went on strike for months. Historian Zhang Zhiming (2005: 273) believes the conflicts reflected the Nationalist government's underestimation of the difference between the Japanese colonial system and the American requirement in medical education, while Zhang Xiu-rong (2013: 54) blames the friction on a significant gap between the American medical curriculum and the Japanese design of medical training for colonial needs. Whatever the explanation, the strike at NTU hospital implied that grafting the American system from China's experience onto formerly Japan-ruled Taiwan would not be easy and certainly required more delicate arrangement.

During the period of the strike, Dr. Du Congming, the most respected medical professional in the Japanese-ruled period, was the dean of the medical college and superintendent of the hospital at NTU. Du reached the greatest academic achievement in pharmacology and won high status in the colonial government. Most historians believe Du's achievements in medicine and politics boosted the dignity and confidence of the Taiwanese people (Lai 2003). Like contemporary Taiwanese, Du took a

position in favor of sustaining the former Japanese system with adaptation of internships in hospitals (Anonymous 1946), a compromise without support from either Chinese mainlanders or American experts. In 1950, Dr. Xu Bang-xing, graduate of the former Taihoku Medical College in 1934 and current director of the First Surgery Department in NTU, was forced to resign (for details, see Zhang 2013: 62–63) and later opened a private clinic (Guo 2003). In addition to accusations of malpractice, Xu's graduation certificate from Taihoku Medical College was also placed under review and criticized by Fu Sinian, the chancellor of NTU (Tang 1994: 30). Fu also blamed the deterioration of the medical school and NTU hospital on Du's leadership,³³ which was also linked to some features of Japanese medical education (Anonymous 1932). It is clear that the pressure on Du and Xu for medical reform at NTU was designed to replace a generation of Japanese-trained doctors and to establish an American medical system.

In a report circulated in 1953 among the Rockefeller Foundation, CMB, and NTU, Dr. Loucks of the CMB strongly advocated "replacing him [Du] with a more competent mainlander" for better cooperation between Taiwanese and American support.³⁴ Loucks's report was later adopted by B. J. Watson, chair of the CMB, as guidelines on policy to aid Taiwan.³⁵ To secure American resources, especially the cooperation on medical educational reform between NTU and Columbia University (Wei 1962), in 1953 Du was asked by the NTU chancellor to resign (Du 1955: 569). After a generation of Japanese-trained doctors left the NTU, the American scheme of medical reform soon accelerated, beginning with the period that Dr. Xie Bo-sheng (2012: 4), dean of the NTU Medical College (1995–2001), called the "introduction of American medical education." The establishment of NAMRU-2 in 1955 within NTU marked a turning point of medical Americanization, after which the Japanese-trained generation would gradually vanish from Taiwan's medical system.

3 Concluding Remarks

To most medical historians of post-WWII Taiwan, American medical aid and the WHO's assistance in the 1950s and 1960s brought new forms of medical treatment, and they also introduced very different strategies to upgrade the training of the medical profession, which were linked to mainland experience and colonial roots in Taiwan. The results were nothing short of astounding. Controversies continued to erupt during the period of merger in the 1950s. The cases of Du Congming and Xu Bang-xing have sometimes caused fiery debates, even nowadays. Within the context of these debates, the aim of this article is to reveal the complex nature of medical modernization and Americanization in Taiwan during the early 1950s. Similar to the colonial powers in pre-WWII Taiwan, the expansion of state-governed international institutions alongside America's emergence as a global superpower in the post-WWII era actually took

³³ "Fu Sinian huihan" (Fu Sinian's reply), in Zhang 2013: 336.

³⁴ "Report by Dr. Loucks on Visit to Taipeh," p. 5, CMB 100, 1950–55, China Medical Board, RG 1, series 100, box 3, folder 27, Rockefeller Foundation Archives.

³⁵ "Report by International Health Division," IHD 200, 1950–55, RG 1, series 605, box 2, folder 18, Rockefeller Foundation Archives.

advantage of interwar efforts of medical reform that replaced the structure of colonial medicine in 1950s Taiwan. This article demonstrates that the US experience in post-war Taiwan can serve as a model for studying the real impact of the Cold War in medical modernization and the entanglement of American medical aid with international politics and provoke discussion about the nature of American medicine in Cold War Taiwan.

Prior to the Mutual Defense Treaty between the United States and China (1954–79), the government of the Republic of China in Taiwan was a relatively weak ally of the United States and paid little attention to eliminating the Taiwanese colonial legacy in medicine. Medical aid was seen as part of the assistance to stabilize Taiwan's economy and defense capability (Morgner 1967). The US aid to Taiwan in the early stage of the Cold War period was economy-oriented assistance. There were fewer formal institutions of medical aid in East Asia, but there was a good deal of US economic assistance of various kinds to Japan, Taiwan, and South Korea in particular (Wallerstein 2010: 17). After retreating to Taiwan, however, the Republican government had limited choices and little bargaining power if it wished to maintain its affiliation to the United States. In addition, the parallel but isolated development of Japanese colonial medicine in Taiwan from 1895 to 1945 caused much misunderstanding and mistrust between Taiwanese and Chinese medical professionals, creating circumstances that required patience and tolerance. However, under the government of the Republic of China in the early 1950s, Taiwan did not exhibit such characteristics and was eager to improve medicine by winning American aid. As a result, the medical authorities in Taiwan conducted their relationship with US medical aid as much as possible on US terms; the latter was truly an “interested party” and acted accordingly. Generally speaking, the glory of building modern medical care and public health systems in post-WWII Taiwan was achieved at the cost of sacrificing generations of medical professionals who were trained before 1945 and were immensely influenced by Japanese paradigms of colonial medicine. It is also worth noting that, as Taiwanese clinicians practiced medicine on an ethical and social basis, the Republican government under American influence would pay more attention to fundamental rural health needs. This forced the retreat of Taiwanese doctors from hospitals in the cities to practice in the countryside. Such a move may have meant better development of state medical ideas to the Chinese in Taiwan but also felt like oppressive exile to Taiwanese medical elites.

Since the Japanese colonial medicine in Taiwan was the hybrid of German state medicine and British colonial medicine, as mentioned previously, the medical aid to Cold War Taiwan again reveals a sample of a hybrid model of modern medicine in Taiwan. Alternatively, the continuity between colonial medicine and medicine in decolonialized Taiwan obviously existed in various forms. A similar hybridity in Chinese medicine occurred when the Republican government ruled mainland China. Bridie Andrews (2014) and Sean Hsing-lin Lei (2014), coincidentally, give nuanced accounts of foreign-Chinese interactions and demonstrate the coevolution of medical knowledge and practices in the Republican era. Both of their arguments about the constitution of modern Chinese medicine reveal that “Western” and “Chinese” medicines were also hybrid. How the historical roots of hybrid medicine in Republican China affected the conversion of Japanese colonial medicine to American standard medicine in Cold War Taiwan will be an important question for further studies if more

materials appear. Despite the request to do further research on the issue of medical hybridity, it is worth noting that “hybrid” is an essential constant of medical modernization in Taiwan linking its colonial past and Cold War experience.

Reviewing the history of the changing medical care system in Taiwan identifies a gap between the end of formal colonialism (1945) and an invisible colonialism. The argument above also partially confirms the theory of subimperialism by Kuan-Hsing Chen. The problem we now face is how to understand the global configuration of power and culture during the Cold War in East Asia that was both similar to and different from the historical imperial-colonial paradigm. Inspired by Masao Miyoshi's (1993) concerns with transformation and persistence of the colonial practice of displacement and ascendancy in early post-WWII, and with speculative engagements in discourse on interchangeable features of colonialism and neocolonialism, this article, with the cases of transforming paradigms of medical professionalism in postwar Taiwan, argues that colonial practices could be even more active in the early Cold War years under the form of transnational corporatism. This preliminary study attempts to provoke discussion about the nature of American medicine in Taiwan during the 1950s, what constitutes an international relationship in global health, and whether we can consider transnational medical projects in the post-WWII period to be an American version of colonial medicine. While not explicitly colonial, the relationship between the United States and countries like Taiwan during the Cold War was nonetheless more nuanced than their official status as allies would suggest. Prasenjit Duara (2006: 1) contends that empire without colonialism is the “new imperialism” of the twentieth century: “The new imperialists espoused anticolonial ideologies and emphasized cultural or ideological similarities; they made considerable economic investments, even while exploiting these regions, and attended to the modernization of institutions and identities.” In the same vein, the transformation of medical paradigms in Taiwan of the 1950s could imply a new medical aspect of Cold War East Asia to American “colonial medicine.”

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