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A Social History of Seoul National University Hospital: The National Health Insurance, Three-Minute Consultation, and the Convoluted Legacy of American Aid for a Postcolonial Medical Institution in South Korea

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ABSTRACT: The author traces the evolution of Seoul National University Hospital (SNUH) and its predecessors, focusing on their transformation from the 1960s to the 1980s. Starting as an impoverished governmental hospital of a postcolonial country, it grew into a major South Korean biomedical corporation with many faculty members with American training, a new main building with the latest technologies, and a larger independent budget supported by the National Health Insurance (NHI). However, this evolution accompanied multiple issues stemming from overcrowding, which resulted in short and skimpy consultations, a poor environment, staff exploitation, and various minor crimes. Yet the crowds in the hospital assisted young doctors' training and some faculty members' research. The author explains this complexity by analyzing the American aid's legacy alongside the NHI's roles. This explains the limitations to the U.S. attempt to shape Korea's medicine amid its state-driven industrialization and health insurance evolution under a military dictatorship, which partly reflected the colonial heritage.

KEYWORDS: Seoul National University Hospital, South Korea, National Health Insurance, three-minute consultation, industrialization, military dictatorship, medical research

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Seoul National University Hospital (Sŏul Taehakkyo Pyŏngwŏn, SNUH) is South Korea's flagship medical center affiliated with the nation's most prominent institution of higher education, Seoul National University (SNU). As its attending physicians are faculty members of Seoul National University College of Medicine (SNUCM), most Koreans believe that SNUH is the best hospital in the country. Indeed, it has been pioneering novel therapies and biomedical research. It has facilitated the growth of medicine in the country by exporting its alumni and professors to other health care institutions. Recognizing this significance, many foreign and domestic agencies supported SNUH through fellowships, grants, and donations.

This paper traces SNUH's history by focusing on its most crucial years, the decades from the 1960s to the 1980s.[1] Emerging from its colonial predecessor affiliated with Keijō Imperial University during Japanese Rule (1910–1945), Seoul National University College of Medicine–affiliated Hospital (Sŏul Taehakkyo Ŭigwa Taehak Pusok Pyŏngwŏn, SNUCMH) struggled hard until the mid-1970s owing to its limited budget, dated facilities, and patient care by family members and others without expertise. In this context, the American aid amid the Cold War and the Koreans trained in the United States during the economic growth under military dictatorship facilitated SNUCMH's transformation into SNUH, a novel medical corporation with its new main building and a larger budget funded by the National Health Insurance (NHI). The problem was that this process accompanied other issues that were hard to manage, including

[1] SNUH's history has not been a focal point of research. The few works to examine it include SNUH's official publications, including those written by Kim Sangtae. See Seoul National University Hospital History Publishing Committee (SNUHHPC), *Kkum, ilsang, ch'uŏk*, 2 vols. (Seoul: SNUH, 2015); *Sŏul Taehakkyo Pyŏngwŏn sa saryojip* (Seoul: SNUH, 2015). Other historians have investigated some portions of SNUH's past. See Han Chin'gyu and Yi T'ŭkku, "Han'guk pyŏngwŏn kŏnch'uk ŭi paljŏn kwajŏng e kwanhan yŏn'gu (1)," *Han'guk Ŭiryo Pokchi Sisŏl Hakhoe chi* 11 (2005): 55–67; Junho Jung, "Constructing Changes: Seoul National University Hospital and China Medical Board Support, 1967–1978," *Rockefeller Arch. Center Res. Rep.* (2022); John P. DiMoia, *Reconstructing Bodies: Biomedicine, Health, and Nation-Building in South Korea since 1945* (Stanford, Calif.: Stanford University Press, 2013), 72–106.

overcrowding, short and skimpy consultations, exhausted staff, poor environment, and various minor crimes. SNUH did become a modern hospital, but its developmental trail differed from the highway toward a "world-class general hospital," imagined by its staff and sponsors.[2] Its significance in Korea was "absolute," but this entailed "many contradictions and disorder."[3]

These problems started from a desire to reprise American hospitals' evolution on Korean soil. As described by Charles E. Rosenberg, Morris J. Vogel, and David Rosner, American hospitals, with increasing reliance on paying patients, underwent a historical shift from institutions for the poor to biomedical centers intertwined with educational and research imperatives.[4] Jeanne Kisacky and others also depicted their architectural transformation from pavilion-type establishments to structurally complex modern edifices in the twentieth century.[5] The Americans and SNU's doctors educated in the United States attempted to replicate these changes for SNUH but saw a key institutional factor that they never expected in America, the NHI. The insurance scheme, partly a legacy of the colonial rule, substantially increased the numbers of patients who did pay their own fees but engendered multiple problems. The perceived duration of patient consultation became shorter, eliciting some journalists and patients to coin a new pejorative term, "three-minute consultation" (*sam pun chillyo*). Excessive patients attracted minor crimes such as pickpocketing in the buildings and worsened the problems of

[2] "Ch'anggansa," *Sŏul Taehakkyo Pyŏngwŏn po* (hereafter *STPP*), April 30, 1979.
[3] "Panghwanghanŭn hwanja," *STPP*, November 15, 1988.
[4] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: Johns Hopkins University Press, 1987); Morris J. Vogel, *The Invention of the Modern Hospital: Boston, 1870–1930* (Chicago: University of Chicago Press, 1980); David Rosner, *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885–1915* (Princeton, N.J.: Princeton University Press, 1982).
[5] Jeanne Kisacky, *Rise of the Modern Hospital: An Architectural History of Health and Healing, 1870–1940* (Pittsburgh: University of Pittsburgh Press, 2017). See also Annmarie Adams, *Medicine by Design: The Architect and the Modern Hospital, 1893–1943* (Minneapolis: University of Minnesota Press, 2008); Stephen Verderber and David Fine, *Healthcare Architecture in an Era of Radical Transformation* (New Haven, Conn.: Yale University Press, 2000).

patient care by families, which generated bad odors, garbage, and possible risks of infection in the novel building that did not allow natural ventilation. The attempts to imitate American hospitals resulted in something different.

These features were not unique in SNUH. Overcrowding, poor environment, and family members' care of patients were common in many Western hospitals in Asia, as Michelle Campbell Renshaw, Alice Street, and Sara Honarmand Ebrahimi have shown. European and American missionaries and colonialists could not replicate their own countries' hospital architecture and systems in Iran, India, and China, as they had to consider locals' emotions and cultural preferences.[6] The meaning of "paying patients" was also different; paying just a small amount of fees for admission and consultation, most people in the patient crowds in Chinese hospitals did not need to be members of the middle class like those in Western voluntary hospitals.[7] The Chinese paying patients after the mid-twentieth century increasingly relied on state health insurance schemes, which generated overcrowding and other problems in large hospitals.[8]

What nevertheless makes SNUH's story still worth tracing is the specific way that the American hegemony during the Cold War was tweaked in the Korean situations with a colonial heritage. Unlike Asian hospitals investigated by Renshaw and Ebrahimi, SNUH was not a missionary institution. There was no religious need for evangelizing patients and their family

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[6] Sara Honarmand Ebrahimi, *Emotion, Mission, and Architecture: Building Hospitals in Persia and British India, 1865–1914* (Edinburgh: University of Edinburgh Press, 2023); Michelle Campbell Renshaw, *Accommodating the Chinese: The American Hospital in China, 1880–1920* (New York: Routledge, 2005); Alice Street, *Biomedicine in an Unstable Place: Infrastructure and Personhood in a Papua New Guinean Hospital* (Durham, N.C.: Duke University Press, 2014).

[7] Renshaw, *Accommodating the Chinese* (n. 6), 120–37.

[8] Michelle Campbell Renshaw, "The Evolution of the Hospital in Twentieth-Century China," in *Medical Transitions in Twentieth-Century China*, ed. Bridie Andrews and Mary Brown Bullock (Bloomington: Indiana University Press), 317–35.

members during their stays in the hospital. Although SNUH had a colonial origin, just like Papua New Guinea's Madang Hospital scrutinized by Street, South Korea's politics in the Cold War and its state-driven industrialization during the military dictatorship—which also incorporated what Koreans learned during the colonial period—made it very different. Like Madang, SNUH was a hospital with multiple issues, but it did not become a hospital where most patients in the public wards were abandoned except for some whose bodies were studied by foreign experts.[9] The biomedical projects pursued in SNUH were dissimilar to their counterparts in Madang, owing to its reliance on NHI patients and clinical relevance pursued by Korean doctors. Indeed, the use of paying patients under national health insurance in biomedical research may be hard to find in other hospitals of the world.

In this paper I argue that Americans and their Korean disciples' drive for the hospital's transformation during Korea's industrialization under the military dictatorship engendered many contradictory problems, due primarily to the NHI as a Japan-inspired institution, which nevertheless assisted in some doctors' successful research and resident education. The considerably expanded crowds after launching the insurance increased the staff's workload and made consultation skimpy, also bringing about multiple side effects including minor crimes, families' continuing care of patients, and worsened hospital environments, which were supposed to disappear in the new building that ended the legacy of the pavilion-type architecture. The American ideal of the hospital did not exactly replicate itself in Korea. However, these very problems were useful in training young doctors and conducting biomedical research for some SNUH faculty members. Narrating this story, I highlight ironies by illustrating unexpected consequences of an effort to build a modern hospital based on American models. Populated not only by patients and medical staff but also by blood sellers, pickpockets, and herb drug peddlers,

[9] Street, *Biomedicine in an Unstable Place* (n. 6), 194–222.

SNUH represented a twisted history of technology transfer and desire for better health care at an institution where the Koreans in their postcolonial era appropriated American ideas.

Colonialism, Poverty, and the Cold War

SNUH's colonial predecessor was Keijō Imperial University Hospital. Tracing its origin from Taehan Ŭiwŏn (Great Korean Clinic) built by the Japanese in 1908 (figure 1), the hospital was a showcase of the Japanese Empire's medical modernity and the most prominent teaching hospital in colonial Korea.[10] The Japanese faculty taught modern biomedicine to students, the majority of whom were also Japanese, except for a small number of Koreans. While wealthy Japanese were treated in this hospital for a fee, most indigent Koreans who could not pay had to be charity patients (*siryo hwanja*) and allow their bodies to be used for medical education and autopsy. These patients were often treated in an amphitheater where students observed what Japanese professors did.[11]

[10] Sin Tongwŏn, *Han'guk kŭndae pogŏn ŭiryosa* (Seoul: Hanul, 1997), 338–63; Pak Yunje, *Han'guk kŭndae ŭihak ŭi kiwŏn* (Seoul: Hyean, 2005), 185–97; Hwang Sangik, *Kŭndae ŭiryo ŭi p'unggyŏng* (Seoul: P'urŭn yŏksa, 2013), 735–50.

[11] SNUHHPC, *Kkum, ilsang, ch'uŏk*, vol. 1 (n. 1), 24.

Figure 1. The clocktower of Taehan Ŭiwŏn in 1908. Courtesy of the Institute for the History and Culture of Medicine at Seoul National University Hospital.

But the hospital was not modern enough in some respects. Its architecture adopted the pavilion style focused on ventilation, based on the archaic theory that miasma, or "bad air," caused illness. As Kisacky and Annmarie Adams have shown, this theory was reflected in most pavilion-type hospitals in the West built during the nineteenth century and remained popular until the 1930s, long after miasma theory was discredited.[12] It is thus no wonder that Keijō Imperial University Hospital, an institution designed by the Japanese aiming at rapid Westernization, used the pavilion style and stressed ventilation through large windows.[13] However, to an American, the hospital looked unsatisfactory not only in ventilation but also in other functions. When William Carter, associate director of the Rockefeller Foundation's Division of Medical Sciences, inspected the hospital and the medical school after the dean's funding application, he found that

[12] Kisacky, *Rise of the Modern Hospital* (n. 5), 35–77, 81–98; Adams, *Medicine by Design* (n. 5), 9–31.
[13] Yi Kyuch'ŏl, "Taehan Ŭiwŏn pon'gwan ŭi kŏnch'uk kwajŏng kwa kŏnch'uk kyehoekchŏk t'ŭksŏng," *Ŭisahak* 25 (2016): 1–40; Jung, "Constructing Changes" (n. 1), 5; "T'ŭksu pŏbinhwa ihu ŭi Sŏul Taehakkyo Pyŏngwŏn," *STPP*, October 15, 1988.

it was "the most disorderly, dismal, dirty, and foul smelling" among all teaching hospitals in the Japanese Empire.[14] Its bad odor meant that it was not well ventilated. To Carter, there was also an "artificial and unnatural division" between morbid anatomy and pathology in the medical school, although they needed to collaborate closely. The wards of the hospital were not warm enough in winter, due to its inadequate heating infrastructure. Further, the nurses, whose work quality looked "hopeless" to him, were also severely abused as if they belonged to a "servant class." After his short visit in 1927, he decided to reject dean's application.

After Japan's defeat in the Second World War, Keijō University's faculty members returned to Japan, enabling Koreans to take over what remained in their school located in the peninsula's southern half, a U.S.-occupied territory. At that time, the U.S. Army Military Government in Korea realized the strategic significance of this school as a leading institution of higher education in southern Korea facing the communists in the north. The Americans then started a process to establish SNU by merging Keijō (now called Kyŏngsŏng) University with various other schools, including Kyŏngsŏng Medical College. Keijō University's Medical School would then become SNUCM, while the hospital affiliated with it should start anew as SNUCM-affiliated Hospital. To the Americans, the medical college and hospital should guide the growth of the nation's medicine, which must "meet the minimum requirements of the [American Medical Association]."[15]

The new university's medical college and hospital soon experienced a major hardship, which accompanied some opportunities. After Syngman Rhee became the first South Korean

[14] William Carter to Richard Pearce, December 6, 1927, box 1, folder 1, series 613A, Rockefeller Foundation Records, Rockefeller Archive Center, Sleepy Hollow, N.Y. For more details on this decision, see Hyung Wook Park, "China Medical Board and Modern Medicine in Seoul," *Rockefeller Arch. Center Res. Rep.* (2023).

[15] "Aims and Objectives of Medical Education" (January 28, 1948), *Taehak ch'angsŏl mit Kuktaean e kwanhan kirok*, SNU Library.

president with the Americans' support, North Korea's Kim Il Sung invaded the south in 1950. Although the retreat from Seoul was a critical ordeal for most SNUCM and SNUCMH members, it enabled them to interact with the United Nations (UN) doctors. As Justin Barr described, American surgeons during the Korean War developed important technologies of blood vessel repair, reducing amputation cases.[16] Many Korean medical professionals, including the SNUCMH faculty, learned from the Americans, who shared their newly developing skills. Koreans also had an opportunity to work with European physicians and surgeons. This experience exposed Koreans to novel medical knowledge and skills, especially those in anesthesiology, surgery, and neurology.[17]

However, after the 1953 armistice, the SNUCM and SNUCMH staff could not find an adequate venue to practice what they learned because their facilities were heavily damaged during the war. The hospital lacked staff, order, and facilities, as a nurse recollected after the war: "SNUCMH was like a squalid slum [*pinmin'gul*]. If a man was hospitalized, all his family members came to his ward and lived there. They cooked and even did the laundry in the hospital. It was such a mess. As the hospital had virtually nothing, patients had to search for medicines and bandages by themselves."[18] While the eighth SNUCMH superintendent Han Simsŏk had suspected that patients' care by their family members was "Korea's tradition," this practice was probably a default mode of care for all.[19] While it declined in the United States and many European countries with their hospitals' medicalization, it continued in many institutions of the world for various political, cultural, and religious reasons.[20] Koreans' reason for patient families'

[16] Justin Barr, *Of Life and Limb* (Rochester, N.Y.: University of Rochester Press, 2019), 106–36.
[17] SNUHHPC, *Kkum, ilsang, ch'uŏk*, vol. 1 (n. 1), 179–80.
[18] "Anae imjongdo mot han kŭmnamŭi yŏbyŏngdong," *Chosŏn ilbo*, June 3, 1973.
[19] "Sae pyŏngwŏn e parranda," *STPP*, December 1, 1979.
[20] Graham Mooney and Jonathan Reinarz, eds., *Permeable Walls: Historical Perspectives on Hospital and Asylum Visiting* (Leiden: Brill, 2009); Ella Ayalon and Nurit Kirsh, "Doctors and Parents in Children's

care in SNUCMH was related to the war's destruction—the hospital's shortage of medical supplies and supporting staff, including nurses and laundry services.[21] With few facilities and employees in SNUCMH, patients' families had to do all their jobs. In this indigent institution, physicians were similarly impoverished. A doctor painfully recollected that the faculty salary was equivalent to soybeans in an eighteen-liter-bag (*mal*) right after the war.[22]

To Americans assisting the postwar restoration of its East Asian protégé facing communist threats, a more serious issue was the low-level proficiency of its doctors and nurses, especially those at SNUCMH. Despite the short-term training conferred by UN doctors, their original education at Keijō University looked deficient, especially during the Pacific War when the length of training was substantially curtailed. At the university's medical school, the lecture content was from German medical textbooks, which the Japanese had long used but not updated since the late 1930s due to the war. Hence, Koreans did not know of several recent developments, including antibiotics.[23] Furthermore, there was no standard for graduate clinical training. In each medical division in the hospital, young doctors were trained in the ways that the lead faculty member determined for himself.[24]

This situation prompted some Americans and Europeans to intervene, especially through its support for SNUCM and SNUCMH. The United Nations Korean Reconstruction Agency, the American Korean Foundation, the Scandinavian Medical Center, and the German Academic Exchange Service were particularly significant in reconstructing medical infrastructure after the

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Wards," *Soc. Hist. Med.* 36 (2023): 263–83; Ebrahimi, *Emotion, Mission, and Architecture* (n. 6), 114–41; Renshaw, *Accommodating the Chinese* (n. 6), 172–73.

[21] Chu Kŭnwŏn, *Hamch'unwŏn ŭi hoesang* (Seoul: Hyomunsa, 1983),72, 293–95.

[22] "Ŭihak pansegiŭi hoego," *STPP*, May 15, 1988.

[23] Han Simsŏk, *Kwanak ŭl parabomyŏ* (Seoul: Iljogak, 1981), 77.

[24] Yi Wangjun, "Minesot'a P'ŭrojekt'ŭ ka han'guk ŭihak kyoyuk e mich'in yŏnghyang" (Ph.D. diss., SNU, 2006), 270.

war. With them, some SNUCM faculty, including Kwŏn Ihyŏk and Yi Munho, had an early opportunity for overseas training.[25]

More important was the International Cooperation Administration (ICA) of the U.S. federal government that launched what Koreans called the "Minnesota Project." This retrained SNU faculty members in medicine, engineering, and agriculture at the University of Minnesota from 1954 to 1961.[26] Ending a few months prior to Major General Park Chung Hee's military coup that established his dictatorial regime for the next eighteen years, this project benefited a total of seventy-seven health care professionals at SNU, including sixty-two doctors and nine nurses.[27] Among them, twenty-two finished their master's and three earned their Ph.D. degrees. Yi Howang stood out amid these people for his discovery of hantavirus and developing the first vaccine.[28] Others learned new skills through their clinical participation. Yi Yŏnggyun was probably the most remarkable among them with his open-heart surgery that he learned from C. Walton Lillehei. During the same period, eleven faculty members in Minnesota came to Seoul to assist in reforming medical education and practice.

The ICA left multiple legacies. In 1958, the Minnesota advisor Edmund B. Flink made a crucial contribution to establishing the internship and residency programs.[29] The "medical grand rounds," where professors, residents, and interns could join and discuss recent cases, were also introduced after the Minnesota Project. Simultaneously, the Minnesota doctors and their Korean

[25] Yi Munho, *Ŭihak sarang 60 nyŏn* (Seoul: Chungang, 2001), 49–51.
[26] Ock Joo Kim and Sang Ik Hwang, "The Minnesota Project," *Ŭisahak* 9 (2000): 112–23; Yi, "Minesot'a" (n. 24); DiMoia, *Reconstructing Bodies* (n. 1), 72–106.
[27] Neal L. Gault Jr., *Observations and Comments on the Seoul National University College of Medicine, Attached Hospital, School of Nursing, and School of Public Health* (Minneapolis: University of Minnesota, 1961).
[28] Kim Kŭnbae, "Net'ŭwŏk'ŭe kŏllyŏdŭn pairŏsŭ," *Han'guk Kwahaksa Hakhoe chi* 27 (2005): 1–25; Sin Miyŏng, "Han'guk esŏ kukchejŏk yŏn'guja ro sŏngjanghagi," *Ŭisahak* 26 (2017): 95–114.
[29] Yi, "Minesot'a" (n. 24), 139–41.

disciples built several new hospital facilities, including the canteen, laundry, and nurse dormitory, while upgrading its water supply and heating systems.[30]

However, SNUCMH did not become an ideal hospital that the America-trained Koreans expected. Above all, the substantial wear and tear over the past years entailed considerable risks. Its aged pipes occasionally failed to supply water, and heating was often disrupted.[31] A politician claimed that the hospital's management was a "total mess."[32] Further, SNUCMH could not afford the costs of maintenance and upgrading. This issue brought about a disaster in 1973, when half of the outpatient clinic was destroyed owing to a sudden blaze. The cause turned out to be the lack of heating in the hospital, which led some administrative staff members to use personal electric stoves that they forgot to switch off before leaving their office.[33]

The hospital even lacked an appropriate system of acquiring healthy blood for transfusion. When there was no proper arrangement for blood donation, SNUCMH heavily relied on "blood sellers" (*maehyŏlja*), the indigent people peddling their own blood for the hospital's use. The problem was not only the quality of blood from these people—many of whom seemingly carried hepatitis B and other diseases—but also several thugs who exploited their situation.[34] Called *Tetppangjok* (ironclad gangs), they claimed a large proportion of the money each seller earned from their blood sales, after allowing them to cut in line in the hospital.[35] Since SNUCMH could purchase blood only from the first thirty or fewer people per day, those

[30] Han, *Kwanak* (n. 23), 181–85; Yi, "Minesot'a" (n. 24), 126–29.
[31] "Sudomul an nawasŏ," *Kyŏnghyang sinmun*, December 25, 1973.
[32] *Kukhoe Mun'gyo kongbo wiwŏnhoe hoeŭirok* (hereafter *KMKWH*), 67th, vol. 8 (November 6, 1968): 3.
[33] "Chŏn'gi nallo k'yŏ noŭn ch'ae t'oegŭn," *Tonga ilbo*, January 29, 1973.
[34] Many Korean doctors worried about their infection due to their "unhygienic lifestyle." See Hyung Wook Park, "Bodies and Viruses: Biomedicalizing Hepatitis B in Shaping South Korea's Nationhood," *Seoul J. Kor. Stud.* 32 (2019): 173–209.
[35] "Kanan tŭngch'inŭn hŭphyŏlgwi," *Chosŏn ilbo*, March 12, 1961. The word *Tetppangjok* seems to be a partial Japanese pronunciation of *ch'ŏlp'anjok*.

with later queueing numbers could ask *Tetppangjok* to move them to an earlier place in line. Anybody who complained, including those whose numbers were pushed back, was physically abused.

There were other problems: some essential medical supplies were occasionally lacking, including rubbing alcohol.[36] According to Francis Fellers from Harvard, several latest diagnostic machines—which had been purchased with the ICA funding—remained unused, probably because the doctors did not know how to manage them.[37] Worse, a few staff members illegally sold off medical facilities in good condition after scrapping them as "junk."[38] Moreover, the inpatient wards were frequently infested with mosquitoes that entered through the pavilion-type buildings' large windows.[39] Without air conditioning, these windows were insufficient to cool down the surgeons who often sweat in front of patients they operated on during the summer. The outpatient clinic was equally problematic: as there was neither an appointment nor a referral system, many patients came to the clinic even before the dawn and stood in a long queue, which accompanied occasional violent disputes owing to some who pushed in.[40] After the clinic opened in the morning, it was still hard to maintain order because patients and their family members often spit or extinguished cigarette butts on the floor while waiting for their turn.[41]

Even for SNUCM graduates, the hospital might not have been the most attractive place. In a 1972 statistical record, about a quarter of SNUCM alumni practiced overseas, mostly in America.[42] They passed the certification test of the Educational Commission for Foreign Medical

[36] "Sodogyong alk'ol 4 kaewŏl tchae p'umgwi," *Kyŏnghyang sinmun*, February 13, 1973.
[37] "Report to China Medical Board on Visiting Professorship," 1967, box 13, folder 69, series 2, accession 2014: 022, SG1, China Medical Board Records, Rockefeller Archiver Center (hereafter CMB).
[38] *KMKWH*, 67th, vol. 8 (November 6, 1968): 3.
[39] "Mogi kŭksŏng," *Tonga ilbo*, June 18, 1973.
[40] "Chigwŏn tŭl kan inhwa," *STPP*, October 15, 1988.
[41] "Wisaengjŏgimyŏ ch'ŏnggyŏrhan pyŏngwŏn," *STPP*, August 10, 1990.
[42] "Illyŏk such'ul tŭngŭro ppaeatkinŭn kungnae ŭiryo son'gil," *Tonga ilbo*, May 16, 1972.

Graduates of the United States and became interns and residents in American hospitals. For some Koreans, this "achievement" demonstrated how successful SNUCM students were in acquiring medical knowledge and mastering English.[43] For others, it just reflected the increased demand for foreign medical manpower in America during the Vietnam War (1955–1975).[44] As the United States needed more doctors amid the war, it relaxed its immigration requirements for overseas medical professionals. For these professionals from SNUCM, their own teaching hospital, with its miserable condition, had to be shunned in favor of better alternatives in America.

Even this inadequate institution was unavailable for many patients who could not afford the cost. In the 1960s and 1970s, South Korea suffered high inflation, ranging from 10 to 30 percent per year. Therefore, SNUCMH precipitously increased its fees for consultation, admission, and surgery. Since there were no fixed rules for doing this, the price changes looked arbitrary, and the hospital was deemed very expensive to most patients.[45] Nevertheless, there were lots of patients seeking treatment at SNUCMH, although they did not have enough money. According to a government report, the hospital allowed its outpatients to have consultation and treatment before paying because the cashier was located far away from physician offices and treatment rooms. Although SNUCMH wanted to reduce patients' discomfort in moving across a long distance, some exploited this situation by running away after seeing their doctors and nurses.[46] Therefore, the hospital could not collect a sizeable sum of money, which amounted to 40 million won in 1971.[47]

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[43] Han, *Kwanak* (n. 23), 235.
[44] Yi, "Minesot'a" (n. 24), 186–95.
[45] "Oeryo suga chemŏttaero," *Kyŏnghyang sinmun*, December 15, 1975; *KMKWH*, 66th, vol. 5 (June 18, 1968): 5.
[46] "Sŏul Taehakkyo mit Ŭigwa Taehak Pusok Pyŏngwŏn kamsa kyŏlgwa," 1965, BA0017830, Nara Repository, National Archives of Korea (hereafter NR).
[47] "Hakcha nŭn issŏdo sŭsŭng ŭn ŏpta," *Kyŏnghyang sinmun*, November 16, 1971.

Admittedly, SNUCMH tried multiple means to stop this problem, although some of them were questionable. For example, in 1964, a few staff members were investigated by police because they detained a patient's daughter as a "mortgage," after the patient's sudden departure from the ward without payment.[48] Of course, there was a gentler method, which was just to send a letter to the patients. However, many of them simply ignored the notice, prompting the government to demand stronger measures.[49] One of these measures was to reject patients if they would not pay before consultation. But several media reports of a few indigent patients who died after being denied access to hospitals led the government to make doctors' treatment of emergency cases compulsory even if the patients could not pay. This order produced an unexpected outcome: many patients with mild symptoms entered the SNUCMH's emergency room and disingenuously claimed that their illnesses demanded urgent attention.[50]

Poverty affected SNUCMH's staff, too. Most significantly, interns and residents at SNUCMH struggled. In 1960, the hospital's interns publicly criticized their dismal salary and poor food in SNUCMH's canteen. They then started a "hunger strike" by refusing to eat.[51] This unusual form of protest in the wake of the April Student Revolution—which ended Rhee's regime—brought about immediate public attention and increased their income, but the hospital failed to keep their salary levels in line with the persistent inflation in the 1960s and 1970s. SNUCMH's young doctors-in-training repeatedly staged strikes during the two decades.[52]

If SNUCMH's interns and residents, who were mostly men, could expect better lives after finishing this ordeal, its nurses, the majority of whom were women, could expect no change. They were exploited at minimum salaries in the crowded hospital. They were not even

[48] "Ipwŏnbi mot naen ŏmŏni taesin," *Tonga ilbo*, February 8, 1964.
[49] "Sŏul Taehakkyo mit Ŭigwa Tehak Pusok Pyŏngwŏn silji kamsa kyŏlgwa," 1974, BA0066584, NR.
[50] "Katcha ŭnggŭp hwanja swaedo," *Chosŏn ilbo*, August 15, 1972.
[51] Paek Man'gi, "Sigyet'ap ŭi yŏksa," *STPP*, September 10, 1990.
[52] For example, see "Taehak pyŏngwŏn suryŏnŭi chillyo kŏbu," *Kyŏnghyang sinmun*, December 21, 1974.

college graduates before their school was reconfigured from the "Nursing High School" to the "Department of Nursing" within SNUCM in 1959.[53] Even after this shift, their department was a subordinate organization within the doctors' college, where nurses were trained to be subservient to doctors. They were thus not very different from their predecessors who were likened to a "servant class" during Japanese Rule. Worse was that the patient numbers in the hospital were far greater than what staff could realistically accommodate. A nurse had to deal with from 2,100 to 2,800 patients per year in the 1960s (table 1). Hiring more nurses in the mid-1970s lowered their workload, but it would increase again thereafter.

[53] It was only in 1992 that nurses had their own college within SNU.

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	1962	1964	1966	1969	1976	1978	1980	1982	1984	1987	1989
Outpatients	145,895	159,744	137,849	174,302	206,766	266,707	534,953	741,351	741,586	877,246	938,466
Inpatients	89,010	112,571	135,733	151,915	145,310	146,643	320,257	384,541	386,630	468,885	494,765
Total patients	234,905	272,315	273,582	326,217	352,076	413,350	855,210	1,125,892	1,128,216	1,346,131	1,433,231
Faculty		67	72	78	87	123	155	179	188	227	233
Nurses		118	125	119	208	414	658	520	519	705	711
Residents and interns		174	179	183	466	379	528	580	523	610	669
Patients per faculty		4,064.4	3,799.8	4,182.3	3,736.5	3,360.6	5,517.5	6,289.9	6,001.1	5,930.1	6,151.2
Patients per nurse		2,307.8	2,188.7	2,741.3	1,692.7	998.4	1,299.7	2,165.2	2,173.8	1,909.4	2,015.8
Patients per resident/intern		1,565.0	1,528.4	1,782.6	755.5	1,090.6	1,619.7	1,941.2	2,157.2	2,206.8	2,142.3
Outpatients per faculty		2,384.2	1,914.6	2,234.6	2,376.6	2,168.3	3,451.3	4,141.6	3,944.6	3,864.5	4,027.8

Table 1. Tabulation of the numbers of patients, faculty, nurses, and interns/residents as well as the patient counts for each group of professionals in SNUCMH and SNUH from 1962 to 1989. *Source*: Figures from Sŏul Taehakkyo Ŭigwa Taehak Pusok Pyŏngwŏn yŏnbo (SNUCMH Annual Reports, 1964–77) and Sŏul Taehakkyo Pyŏngwŏn yŏnbo (SNUH Annual Reports, 1978–89).

Hence, when the young doctors staged a strike, none could prevent nurses from choosing the same action. In 1970, after the interns' strike ended, SNUCMH nurses started their own strike, demanding higher salaries and paid menstruation leave.[54] However, nurses were less aggressive; they accepted the government's lukewarm measure and thereafter refrained from public protest. They just bore the brunt of high workloads and low salaries. Consequently,

[54] "It'ŭl mane p'aŏp kkŭnna," *Chosŏn ilbo*, September 27, 1970.

without enough nursing workforce, the care of patients by family members continued.[55] Moreover, SNUCMH had to acknowledge the "caretakers" (*kanbyŏngin*), the lay workers without any training, hired just for patients' care by their families.[56]

At SNUCMH, even the professors of medicine could not enjoy comfortable lives. "Since most of them visited America through the ICA funding," a urologist recollected, "they wore suits like American gentlemen."[57] However, few could avoid poverty with their salaries. Even after the introduction of "special consultation" (*t'ŭkchin*) in 1962 to collect more cash from patients who wanted better treatment by designated faculty, it failed to be an exclusive financial resource for the professors who offered that consultation because its income was used to pay for other staff's services as well.[58] Under these circumstances, many faculty members opened their own clinics where they consulted private patients after regular hours at SNUCMH. As all these doctors were public workers, this practice was illegal according to Korean law. A worried politician thus stated that the doctors "smuggled" their patients from SNUCMH to their private clinics, worsening its financial condition.[59] This frowned-upon practice died hard. Even Park's military government could not end it immediately, when a large proportion of SNUCMH faculty had their own clinics and many of them resisted the governmental order.[60] In 1975, the government had to punish these noncompliant professors.[61]

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[55] See Neal L. Gault Jr., "Korea: A New Venture in International Medical Education," Minnesota Medical Foundation Day Address, September 25, 1961, 82; "Report to China Medical Board" (n. 37).
[56] SNU, *Chegyujŏngjip* (Seoul: SNU Press, 1962), 163. For the predecessors, see SNUHHPC, *Sŏul Taehakkyo Pyŏngwŏn sa saryojip* (n. 1), 179.
[57] Chu, *Hamch'unwŏn* (n. 21), 362.
[58] "Sŏul Kyŏngbuk Ŭidae suryŏnŭidŭl chŏnmyŏn p'aŏp," *Tonga ilbo*, December 21, 1974; Han, *Kwanak* (n. 23), 189.
[59] *KMKWH*, 98th, vol. 16 (December 7, 1977): 12.
[60] "Kukkongnip pyŏngwŏn ŭisa ijung kaeŏp sŏnghaeng," *Tonga ilbo*, November 27, 1973; Gault, *Observations and Comments* (n. 27), 66.
[61] "Mun'gyobu kyŏmjik kyosu chaeimmyŏng an hae," *Tonga ilbo*, November 3, 1975.

However, the doctors' workload was not as high as that of nurses, as many doctors "arrive late in the morning for their duties" and "leave early to attend to their private patients," making nurses and residents care for all patients.[62] In truth, the very fact that many of these professors had their private patients meant that they were at least not exhausted during their regular hours. Admittedly, the absolute numbers of SNUCMH patients were not small. The average number of outpatients that a professor had to treat per annum was over 2,000 in the 1960s and 1970s (table 1). But SNUCMH's rapid increase in medical fees amid inflation restricted uncontrolled increase of patient count.[63] Hence, the doctors had time to practice what they called "students' preliminary consultation" (*haksaeng yejinje*).[64] For this, medical students diagnosed patients first and brought their opinions to their professors, who then consulted the patients by themselves in front of the students to tell if they had been right or wrong. This time-consuming practice would not have been possible if there had been too many patients. It implied that the average patient count per day in SNUCMH was not excessive, or at least less than, what the professors would later have to endure.

Americans Designing a Modern Hospital

The SNUCMH professors were indeed privileged to enjoy continuous opportunities. When the China Medical Board (CMB), a Rockefeller-endowed philanthropic organization, stopped its support for China after the 1949 communist triumph, it began to sponsor medical institutions in other Asian countries, including SNUCM and SNUCMH. Unlike the Rockefeller Foundation, which had refused to patronize Keijō University, the CMB was quite favorable to SNUCM from

[62] Gault, *Observations and Comments* (n. 27), 66.
[63] "Munt'ŏk nop'ajin chonghap pyŏngwŏn," *Maeil kyŏngje*, January 16, 1975.
[64] "Siron," *STPP*, October 15, 1988; Yi Puyŏng, "Taehak pyŏngwŏn ŭi haksaeng kyoyuk," *STPP*, January 15, 1985.

the 1950s, when it began to assist the purchase of medical journals. In 1963, the CMB started a more systematic program for SNU. Just like the ICA, the CMB underwrote SNUCMH's renovation of medical facilities and the construction of buildings. Yet more important was the fellowships for overseas training from 1963 to 1973, which benefited thirty-five doctors, who soon joined those trained in Minnesota in forming the hospital's decision-making group.[65] These fellowships also played pivotal roles in major biomedical innovations, including Kim Chŏngnyong's development of a hepatitis B vaccine, Kim Chinbok's novel treatment for gastric cancer, and Kim Sut'ae's liver transplantation. After 1973, the CMB changed its policy by establishing a long-term endowment fund to which both the board and SNUCM contributed.[66] This grant became a continuous resource for SNU's medical staff. By March 1980, the CMB had spent a total of $2,763,000 for SNUCM and its hospital.[67]

Unlike the ICA, the CMB provided funding for specific research projects as well. It initially appropriated $10,000 for SNUCM in 1963 to assist with "the purchase of supplies and equipment needed in the four research projects" in virology, nephrology, biochemistry, and internal medicine.[68] Thereafter, the CMB continued its funding for research, including some using the hospital's patients.[69] By 1973, the board had spent $255,339 to support seventy-two projects conducted at SNUCM and SNUCMH.[70]

[65] I count only the names identified in my research at the Rockefeller Archive Center. For the number of nurses and public health researchers, see Yi, "Minesot'a" (n. 24), 161–63; Sin Miyŏng, "1950–70 nyŏndae Ch'ainamedik'ŏlbodŭ ŭi Han'guk chiwŏn'gwa t'ŭkching," *Ŭisahak* 32 (2023): 387–422.
[66] "Endowment Fund for Medical Research," December 10, 1976, box 12, folder 55, RG2, accession 2014:022, SG1, CMB.
[67] "Table 1," undated, box 13, folder 57, RG2, accession 2014:022, SG1, CMB.
[68] Connell to Rha, December 12, 1963, box 15, folder 93, RG2, accession 2014:022, SG1, CMB.
[69] Hahn Yongchol, "Application for Grant," box 15, folder 95, RG2, accession 2014:022, SG1, CMB.
[70] "Table 1: The Top 10 Departments," box 15, folder 107, RG2, accession 2014:022, SG1, CMB.

Another difference was that the CMB sponsored the design of the hospital's main building, which would forge the architectural basis of its future transformations. Indeed, Han Simsŏk and other U.S.-trained SNUCM professors wanted to renovate the old hospital throughout the 1960s. Their initial idea was to repair its aged facilities and increase its bed count, but they soon realized that it was better to establish an entirely new building filled with far more beds, updated machines, and increased manpower.[71] The buildings and their facilities were not only hopelessly old but also the symbols of Korea's humiliation under Japan. At this point, the CMB stepped in to promise its support for this idea by hiring Whiting Associates International, an American architectural firm. With the cooperation of SNU architect Yi Kwangno, the Whiting firm designed the new main building following a popular trend in American hospital construction, a thin alphabet-shaped skyscraper.[72] Significantly, Han's suggestion to President Park led this project to become part of the "SNU General Plan," which aimed to renovate the nation's flagship university.[73]

But the Park government did not have sufficient funds to support the project; hence the largest portion of the money also came from Americans. The government's initial estimated budget was just 1.3 billion won, yet Park's administrators did not consider inflation as a factor. Moreover, the construction was delayed for many unanticipated incidents, such as workforce shortages and the contractors' sudden bankruptcy, which further increased the cost.[74] The final

[71] *KMKWH*, 66th, vol. 5 (June 18, 1968): 5; Chu, *Hamch'unwŏn* (n. 21), 413; Han, *Kwanak* (n. 23), 190–208.
[72] Kisacky, *Rise of the Modern Hospital* (n. 5), 248–95. SNUH looked like two juxtaposed Ys.
[73] "Mi EXIM 5562 Sŏul Taehakkyo Pyŏngwŏn sisŏl ch'agwan kwan'gyech'ŏl," 1976, BA0146850, NR: 230.
[74] "Status of Planning and Construction," July 18, 1973, RG2, accession 2014:022, SG1, CMB.

amount, when the construction ended in 1978, was 37.5 billion won.[75] The only way to respond to this vastly increased cost was to borrow a large sum of money, especially from the United States. By 1976, SNUH had borrowed $32 million from the Export-Import Bank of the United States and other creditors.[76]

This major architectural overhaul necessitated a new organization, which similarly originated from Americans. Minnesota advisor Glenn Mitchell pointed out that SNUCMH was too "slow and inefficient." Important hospital posts were filled by governmental employees without expertise because it was unlawful to hire relevant specialists from outside of the government. The superintendent did not have enough power because he had to report to SNUCM dean and SNU president in the governmental hierarchy. Further, he was "bound by a general financial law which is practically unworkable for a hospital."[77] Another advisor, Neal L. Gault Jr., agreed: instead of the government treasury, SNUCMH itself must "keep and utilize its income from patient care." SNUCMH did not even have a board of trustees like U.S. hospitals.[78] Being criticized by these Americans, the Korean government ultimately decided to refashion the new hospital as a special corporate body (*t'ŭksu pŏpin*) under the superintendent's direct guidance. Significantly, this institution was meant to have independent financing, which included decreasing amounts of governmental subsidies (table 3). The new institution came to be called Seoul National University Hospital (SNUH).

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[75] Sin Yŏngsu, "T'ŭksu pŏpinhwa ihu ŭi Sŏul Taehakkyo Pyŏngwŏn," in *Sŏul Taehakkyo Pyŏngwŏn pŏpinhwa sipchunyŏn kinyŏm haksul taehoe nonmunjip* (Seoul: SNU Press, 1988), 3–16; "Ŭihak pansegi ŭi hoego," *STPP*, August 15, 1988.

[76] "Mi EXIM 5562 Sŏul Taehakkyo Pyŏngwŏn sisŏl ch'agwan kwan'gyech'ŏl," 1976, BA0146905, NR: 93.

[77] Glenn Mitchell, "Report on the Seoul National University Hospital" (November 6, 1958), box 65, folder 24, Various Reports on SNU, ICA Records, University of Minnesota Archives.

[78] Gault, *Observations and Comments* (n. 27), 53.

The new hospital seemed to represent a high modernity in Korea's health care (figure 2). Boasted as "the largest in Asia," it had 1,056 beds for inpatients as well as clinical spaces for more than 2,000 outpatients.[79] Moreover, its fully air-conditioned wards, operating rooms, and physician offices differed from those in the pavilion-type old buildings that reflected the outdated obsession with natural ventilation. After most of these old buildings were demolished except the central clock tower that became a medical museum, the new building embodied not only the ideal of modern architecture but also the latest scientific medicine. In this high-rise edifice, elevators would efficiently transport doctors, nurses, and patients to each floor, in contrast to the old low-rise buildings where the few elevators served only seriously ill patients. The elevators' size was designed rather small, with an expectation that the new hospital would be a place for only patients and medical staff rather than patients' families and caretakers, just like the "hospitals in advanced economies" like the United States.[80] Within the new building, the operating rooms were connected with closed-circuit video cameras that broadcast surgical procedures to external audiences, including medical students who would learn in classrooms instead of sitting on amphitheaters in the old buildings that had limited visibility.[81] The novel construct was also stocked with many pieces of the latest medical technologies, including a linear accelerator for radiotherapy, a computerized tomography scanner for organ imaging, and an oximeter for measuring blood gas concentrations.[82] Furthermore, the top two floors of the building were reserved for research laboratories.

[79] "Ch'anggansa" (n. 2).
[80] "Sigyet'ap," *STPP*, July 15, 1986.
[81] "Susulbu," *STPP*, January 15, 1981; "Seoul National University Teaching Hospital Architectural Program," March 1967, box 13, folder 63, series 2, accession 2014:022, SG1, CMB. See Kisacky, *Rise of the Modern Hospital* (n. 5), 325–26.
[82] "CLINAC-18," *STPP*, April 30, 1979.

Figure 2. The main building of Seoul National University Hospital, 1986. From DET0042033-016-PG-1986-0603-016, Nara Repository, National Archives of Korea, Sungnam, South Korea.

SNUH also pioneered the promotion of blood donation as a regular practice, following most American hospitals' practice. In 1980, pathologist Kim Sangin and SNUH's managing faculty asked all staff to pledge personal blood donation. When a particular blood type was necessary in the hospital, workers with compatible blood would donate theirs, contributing to a successful transfusion and operation.[83] Outside of the hospital, it also pursued an active public campaign for blood donation rather than sales. Although blood sales did not immediately stop, they were actively condemned as a backward practice.

SNUH differed from its predecessor in administrative aspects as well. Like American hospitals, it began to take patient appointments, although walk-ins were still allowed.[84] This new policy obviated long queues of outpatients that started early in the morning and occasionally entailed violence. Underlying this policy was the plan to make SNUH a tertiary health care institution in the forthcoming referral system.[85] SNUH sought to be the "final hospital" for patients who had visited their primary and secondary clinics but could not find proper care.[86] As

[83] "Hŏnhyŏl yeyak che silsi," *STPP*, March 15, 1980.
[84] "Yeyak chedo," *STPP*, April 30, 1979.
[85] "Idal put'ŏ ŭiroe chillyo che silsi," *STPP*, November 1, 1979.
[86] "Sŏul Taehakkyo Pyŏngwŏn e parranda," *STPP*, October 15, 1984.

these clinics referred their cases to SNUH, its top medical staff would be the last hope for patients suffering from rare and complex conditions. A new hospital-wide computer system would support this task by digitally storing and managing each patient's clinical history, test results, and prescriptions.[87]

Incorporation would bring another important change. It promised better payments for its doctors through a "rationalization of management," which would enable it to "hold capable medical professionals."[88] Indeed, the faculty salary continued to increase by large proportions every year, while inflation subsided.[89] In the mid-1980s, doctors began to say that their salary became much better than what it used to be.[90]

Amid all these changes, the legacy of the past—both as a governmental hospital and as a symbol of Japanese Colonial Rule—did not disappear, just like the old pavilion remaining in front of the new building. Obviously, incorporation was not privatization. Above all, SNUH had to be managed by the board of trustees comprising top government officials—the Vice-Ministers of Culture and Education, Health and Social Affairs, and Economic Planning.[91] Whereas American hospitals' evolution made trustees subservient to physicians, SNUH's trustees were superior to the faculty, who were still government employees as professors of SNU, a public school.[92] Moreover, SNUH's finances became even more governmental after incorporation because they had to be controlled by the NHI, which Americans did not have.

In 1977, Park Chung Hee and his administrators launched the insurance. Just as Park—a former Japanese military officer—often looked toward Japan rather than America for ideas of

[87] "K'ŏmp'yut'ŏ," *STPP*, July 31, 1979.
[88] *KMKWH*, 98th, vol. 5 (December 7, 1977): 7.
[89] For example, see "81 nyŏndo kyŏlsansŏ sŭngin," *STPP*, March 15, 1982.
[90] Chu, *Hamch'unwŏn* (n. 21), 361.
[91] Sŏul Taehakkyo Pyŏngwŏn sŏlch'ibŏp, 1977, DA0067271, NR: 213.
[92] Rosner, *Once Charitable Enterprise* (n. 4), 105–21.

modernity, his officials referred to their former colonial master for ideas regarding health insurance.[93] Based on the Japanese precedent that had started in 1922 and was updated in 1961, the Park administration tried to enact a law in 1963, but it failed owing to the lack of financial resources in an indigent country.[94] In the 1970s, the government revised the law in response to social changes. The government's state-driven industrialization, which also followed Japan's strategy of "developmental state," produced a large number of skilled workers with an overall increase in the nation's wealth.[95] The workers' demand for better welfare and the industries' preference for lower corporate responsibility, amid the weakening political support after the 1972 Yushin Constitution—which made Park the permanent ruler—led the government to offer something attractive that could win Koreans' hearts.[96] The revised act offered the first effective NHI for all corporations with more than five hundred employees. In a few years, the insurance came to cover public workers, teachers, professors, and military officers as well. Under this new social welfare system, SNUH was expected to prosper. Yet this institution brought about many unanticipated changes as well.

The NHI, Crowds, and Three-Minute Consultation

Above all, the NHI critically elevated patient counts (table 1). The NHI's eligibility requirement was relaxed further by the administration of Chun Doo Hwan, another military dictator who seized the power through his bloody coup in 1979 after Park's assassination. As Chun wanted to

[93] Pak Chŏngho, *Kukka wa ŭiryo pohŏm* (Seoul: Sinjŏng, 2008), 60–86.
[94] William Steslicke, "Development of Health Insurance Policy in Japan," *J. Health Polit. Policy Law* 7 (1982): 197–226.
[95] Chalmers Johnson, *MITI and the Japanese Miracle* (Stanford, Calif.: Stanford University Press, 1982); Jung-en Woo, *Race to the Swift* (New York: Columbia University Press, 1991).
[96] Chŏn Kwangsŏk, "1976 nyŏn ŭiryo pohŏm pŏp," *Sahoe pojang pŏp hak* 7 (2018): 79–118; "Kŏn'gang pohŏm pŏp ŭi hyŏngsŏng kwa paljŏn, kŭrigo kwaje," *Ŭiryo pŏphak* 20 (2019): 3–45.

ease Koreans' anger by widening the coverage, more patients with NHI cards visited the hospital. To these patients, SNUH was the place to find the best doctors, who were faculty members in the nation's top university.[97] Furthermore, with their card, they could enjoy affordable copayment.[98] Its amount was not larger than what they would pay to their local clinics because the insured patients' fees were under a strict governmental control that banned each health care provider's arbitrary hike. But the fees for uninsured patients kept rising.[99] Therefore, SNUH's outpatient clinic was always extremely crowded with more than 12,000 patients and visitors per day (figure 3).[100] As most inpatients came from this outpatient crowd, the beds for hospitalized cases were also nearly full. Unlike SNUCMH, SNUH became a cheap hospital.

Figure 3. Patient crowds lining up for registration under the NHI. *STPP*, September 15, 1983. Courtesy of the Public Relations Office of Seoul National University Hospital.

[97] "Chillyo punsŏk," *STPP*, August 15, 1984.
[98] "Hyŏnjang rip'ot'ŭ," *STPP*, February 15, 1981.
[99] "Sŏuldae Pyŏngwŏn ŭiryo suga insang," *Tonga ilbo*, February 7, 1979.
[100] "Oerae hwan'gyŏng," *STPP*, October 15, 1986.

Consequently, SNUH doctors' workload further grew, although their number persistently increased from 67 in 1964 to 233 in 1989 (table 1). The number of daily inpatients per faculty also escalated from 4.57 in 1976 to 5.88 in 1986, and the average outpatient per professor similarly increased from 7.89 to 11.07.[101] Hence the number of outpatients each faculty had to consult in a year elevated from 1,914.6 in 1966 to 4,027.8 in 1989 (table 1). The internal medicine department saw a more dramatic increase, as it jumped from 5.7 to 13 around these years. Amid this surge, an average SNUH physician consulted about 100 to 150 patients per day, whenever they worked at the outpatient clinic (figure 4). An external observer noted that an SNUH doctor looked "dog-tired" (*p'agimch'i ka toeŏ*) after finishing his endless consultations.[102]

Figure 4. "Busy, busy." *STPP*, May 15, 1988. Courtesy of the Public Relations Office of Seoul National University Hospital.

[101] Sŏ Chŏngdon, "T'ŭksu pŏpinhwa ihu ŭi Sŏul Taehakkyo Pyŏngwŏn," *STPP*, October 15, 1988.
[102] "Kin anmok ŭi sŏlgye p'iryo," *STPP*, October 15, 1987. Most American physicians treated 10 to 20 patients per day in 2012. See "How Many Patients Should Your Doctor See Each Day?," *Washington Post*, May 22, 2014.

This high workload sacrificed an important part of their job as health care providers: enough time with patients. That most doctors spent no more than several minutes per patient led Koreans to call the practice "three-minute consultation."[103] In front of swarming patient crowds, students' preliminary consultation could not continue.[104] Instead of this time-consuming practice, SNUH doctors chose to make a quick diagnosis and prescription after skimming through patients' signs, symptoms, and test results. Appearing in the mass media for the first time in 1979, this notorious term symbolized the skimpy health care in major hospitals like SNUH.[105]

This made most patients unhappy. Since referral letters from primary care providers were used for prioritized queuing, but not required for a visit, many patients just walked in, and waited for their turn for many hours (figure 5). Compared with this long waiting, their time for seeing a doctor was very short. Some doctors did not even allow patients to ask questions. Afterward, they were sent to a diagnostic unit where they were tested through X-ray, urinalysis, or blood inspection. Finishing all these procedures, they waited for another several hours in front of physician offices before being called. When they could finally meet the doctor, the end was not near, however. Acquiring their prescription, they had to wait again at SNUH's internal pharmacy, which dispensed cheap medicines but was very slow. Patients would then realize that they spent their whole day mostly in waiting.[106] Even more worrisome was the possibility of a mistake. Many patients wondered if their doctors could correctly diagnose their illnesses through such

[103] "Pulssin sidae ragonŭn hajiman," *STPP*, September 15, 1980; "Taehak pyŏngwŏn esŏ saenggangnanŭn kŏt," *STPP*, April 15, 1985.
[104] "Siron" (n. 64); Yi, "Taehak pyŏngwŏn ŭi haksaeng kyoyuk" (n. 64).
[105] "Ŭiryo pohŏm," *Chosŏn ilbo*, July 1, 1979.
[106] "Hwanja ŭi sori," *STPP*, September 15, 1987.

brief consultations. Occasional media reports of actual misdiagnosis at SNUH deepened this concern.[107]

Figure 5. Patients falling asleep during a long wait for their turn. *STPP*, November 15, 1988. Courtesy of the Public Relations Office of Seoul National University Hospital.

Why, then, did SNUH take so many patients? If the hospital had the best doctors, could it then try to be an institution for a small number of affluent patients? In truth, SNUH was also known for its care of wealthy people, including major politicians and rich businessmen. However, such patients could not be the main source of its income. Above all, it was a "special corporate body" managed by governmental trustees. Even though it was legally an independent corporation, it could not avoid its obligation to Korea's general public.

But this role was not the same as that of "charity hospitals" in America. In truth, SNUH and its predecessors did care for charity patients—called the "government-supported charity patients" (*kwanbi hwanja*) in the time of SNUCMH and the "medical protection patients" (*ŭiryo*

[107] "Chonghap pyŏngwŏn chonghap chindan handa," *Kyŏnghyang sinmun*, March 26, 1984; "Sŏuldae Pyŏngwŏn ojin susul 14% sŏn," *Tonga ilbo*, November 9, 1984.

poho hwanja) at SNUH under the Medical Protection Scheme (Ŭiryo Poho Chedo) established in 1978—but the proportion of these "free" patients remained small and gradually decreased (table 2).[108]

	1966	1969	1976	1978	1980	1982	1984	1987	1989
Total inpatients	135,733	151,915	145,310	146,643	320,257	384,541	386,630	468,885	494,765
Charity patients (*kwanbi* or *ŭiryo poho hwanja*)	18,281	14,776	9,013	6,601	9,417	31,657	21,336	28,697	17,655
Proportion	13.5%	9.7%	6.2%	4.5%	2.9%	8.2%	5.5%	6.12%	3.6%
Patients for academic work (*hakkuyong hwanja*)					6,926	3,938	1,521	1,184	796
Proportion					2.2%	1.02%	0.39%	0.25%	0.16%
Insured patients					150,759	227,448	255,291	340,753	430,076
Proportion					47.1%	59.1%	66.0%	72.7%	86.9%

Table 2. Tabulation of the numbers and proportions of different kinds of patients in the SNUCMH and SNUH inpatient populations from 1966 to 1989. *Source*: Figures from SNUCMH and SNUH Annual Reports.

SNUH's main customers were "paying patients," but they differed from their counterparts in for-profit or voluntary hospitals in the United States. As many historians have discussed, prestigious physicians in these hospitals were the central attraction for paying patients, whose medical fees in turn became the financial resources for hiring more reputable practitioners and buying expensive facilities.[109] This positive feedback cycle induced increasing proportions of the

[108] Chŏn, "1976 nyŏn" (n. 96), 104–6.

[109] Rosenberg, *Care of Strangers* (n. 4), 237–61; Vogel, *Invention of the Modern Hospital* (n. 4), 97–119, 135; Rosner, *Once Charitable Enterprise* (n. 4), 94–121; Joel D. Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: Johns Hopkins University Press, 1995), 114–28.

middle class to visit hospitals, which thereby became more affluent and technology-intensive. Neal Gault implied this model in 1960: while "at least half of the beds in attached hospital should be free beds for non-paying patients," "the faculties should have the privilege of private practices" for the affluent, the fees from whom should enable the "hospital to defray the cost of providing physical facilities and equipment."[110] The Whiting firm also considered this when it separated the private rooms for "paying patients" from the wards for "four, six, and eight patients."[111] Better facilities, including personal closets, were provided for "private and semiprivate patients," whose payments would contribute to the hospital's budget. Yet the nature of paying patients and the rooms they occupied differed at Seoul. While most patients at SNUH paid their fees (table 2), they were far from affluent. These patients, staying in wards, used their NHI cards to reduce the cost.[112] It is true that these "paying" patients also came to SNUH due to its eminent doctors. However, each of these patients contributed very little to the hospital's finance.

This issue was owing to the NHI's inherent limitations. As the legal scholar Chŏn Kwangsŏk mentioned, it aimed at a "low-level equality of welfare," because it never offered a comprehensive coverage of services, and relied on meagre amounts of money as both premium and copayment from less-than-affluent citizens in a developing country. Hence, its compensation for physicians and clinics were also less than a half of what they would expect from the uninsured.[113] This often threatened the livelihood of physicians in small private clinics that could

[110] Neal L. Gault Jr., "Needed Changes in Medical Education," *Taehan Ŭihak Hyŏphoe chi* 3 (1960): 17.
[111] Whiting Associates International, "Seoul National University Teaching Hospital Architectural Program," March 1967, box 13, folder 63, series 2, accession 2014:022, SG1, CMB.
[112] *KMKWH*, 123rd, vol. 3 (October 17, 1984): 79.
[113] Chŏn, "Kŏn'gang Pohŏm" (n. 96), 21.

not reject the insurance cards by law.[114] These practitioners saw their income diminishing from what it used to be when many SNUCMH doctors illegally maintained private practices; now SNUH's salaried doctors did not share the same financial insecurity, as they worried about neither income nor patient number in their flagship medical corporation. The problem was that even this major corporation did not make much money.

SNUH consistently suffered from financial deficits. Unlike SNUCMH, SNUH was a corporation that should make profits, which unfortunately stayed elusive (table 3). In its newly introduced business accounting, SNUH's costs, including those from depreciation, usually far exceeded earnings, which could not increase much owing to the NHI's restricted compensations and the small amounts of patient copayments. Moreover, SNUH started with a major debt because of the foreign loan for the main building construction. Although the Korean government partly subsidized the down payment, SNUH was mainly responsible.[115] Of course, few anticipated that its debt and deficit would lead to its financial failure. Since it was the nation's flagship hospital, its bankruptcy was unimaginable. In reality, the overall cash flow, comprising incomes and expenses, always showed positive balances, due partly to the government subsidy and others' donations (table 3). The point was thus to do business as usual and minimize deficits at the lowest possible level.

[114] Kim Pyŏnggŭk, "Pohŏm suga chŏngch'aek ŭi kaesŏn panghyang," *Taehan Ŭihak Hyŏphoe chi* 26 (1983): 281–82.
[115] *KMKWH*, 119th, vol. 2 (November 7, 1983): 86.

	Government subsidy (proportions among gross income)	Gross income (including government subsidy)	Total expenses and losses	Balance (gross income – total expenses and losses)	Gross earnings	Total costs	Net profit (gross earnings – total costs)
1964		104,710,000	140,013,000	–35,303,000			
1967		344,851,000	314,198,000	30,653,000			
1970		1,412,520,000	1,269,938,000	142,582,000			
1973		1,928,888,000	1,888,388,000	40,500,000			
1975		4,960,557,000	3,189,997,000	1,770,560,000			
1977		12,963,587,000	10,719,541,000	2,244,046,000			
1979					14,673,314,000	16,490,361,000	–1,817,047,000
1981	7,448,000,000 (19.1%)	38,910,000,000	36,069,000,000	2,841,000,000	33,326,424,000	33,449,797,000	–123,373,000
1983	4,573,577,000 (9.4%)	48,478,000,000	41,243,000,000	7,235,000,000	39,675,678,000	40,860,784,000	–1,185,106,000
1985	3,714,000,000 (6.2%)	59,686,000,000	48,911,000,000	10,775,000,000	46,524,805,000	46,143,403,000	381,402,000
1987	3,197,000,000 (4.3%)	74,940,000,000	63,842,000,000	11,098,000,000	62,343,083,000	64,841,473,000	–2,498,390,000
1989	2,390,000,000 (2.5%)	97,296,000,000	81,287,000,000	16,009,000,000	85,719,005,000	89,743,795,000	–3,754,789,000

Table 3. Tabulation of the financial state of SNUCMH and SNUH from 1963 to 1989. *Note*: Before the 1978 incorporation, there was neither governmental subsidies nor earnings/costs because SNUCMH was a governmental institution. The unit is South Korean won. All numbers below 1,000 were rounded off. Source: Figures from SNUCMH and SNUH Annual Reports.

To do so, SNUH's superintendents employed multiple means. According to Yi Yŏnggyun, SNUH's staff in the 1980s struggled to save consumables and energy to "improve the business."[116] While Yi recollected that this effort was successful owing to the staff's "spirit of

[116] *KMKWH*, 123rd, vol. 3 (October 17, 1984): 79.

saving," it indicated the hospital's financial difficulties. But a more important means to "improve the business" was to treat as many patients as possible. The surge of patients was not just because of the NHI's impact or the hospital's prestige. SNUH itself needed enough patients to sustain its finances as a corporation. Although each of them paid just a small sum of money, the grand total of their small bits, if their numbers were large enough, would increase SNUH's income. Its demand for more patients explained some of its members' concerns over the referral system: if it would ever be strictly enforced, it could incur "problems in income" to the hospital.[117] It was rather good for them to accept all patients without discrimination, even though their conditions were not challenging enough to be treated in a tertiary health care institution. For this reason, additional beds were pushed into the wards, making them even more crowded. Furthermore, the student laboratories attached to each clinic, which had been designed for clinical instruction, were also cleared out for extra ward spaces.[118]

In this hospital, nursing was cheap labor. As SNUH needed more patients for monetary reasons, each nurse had to endure long shifts, which often continued for more than eleven hours into the late night.[119] A nurse residing in a ward usually looked after more than fifteen patients and was involved in various other jobs, such as transferring calls, managing drinking water for patients, calling engineers to repair broken machines, and guiding visitors to the correct locations.[120] After all these works, an exhausted nurse claimed that somebody should "save them from toil and poverty!"[121] Probably the best response was to increase the nursing budget to a much greater extent and hire an adequate number of them, but this was not feasible. Except for a short period from 1976 to 1979, when the hospital substantially increased its number of nurses

[117] "Han'guk ŭiryo ŭi hyŏnjuso (1)," *STPP*, September 15, 1986.
[118] Kim Yongil, "T'ŭksu pŏpinhwa ihu ŭi Sŏul Taehakkyo Pyŏngwŏn," *STPP*, October 15, 1988.
[119] "Kanhowŏn kwa pamgŭnmu," *STPP*, April 15, 1986.
[120] "Kanho hyŏnjang," *STPP*, November 15, 1987.
[121] "Ŏttŏn hant'an," *STPP*, February 15, 1989.

amid its incorporation, the average yearly patient count per nurse remained around 2,000 (table 1). Although the nurse number increased over time, it was never enough to cover the patient numbers that also increased persistently.

Consequently, the practice of outsourcing many duties of patients' care to their family members and caretakers not only continued in the 1980s but even intensified. Indeed, the aforementioned hike in the nurse count was for implementing a "full-time nursing scheme" (*chŏnim kanhoje*) that aimed to use only nurses in patient care, excluding all without a license.[122] However, the hospital staff soon realized that patients in their wards still needed extra care in addition to that offered by nurses, who were usually very busy in various drudgeries.[123] Although the staff neither requested nor paid for services of patients' family members and caretakers, they remained an indispensable part of the hospital's function. Therefore, SNUH's population density increased even further.

Around 1986, these issues revived the old problem of bad air, which appeared to have disappeared after demolishing the pavilion-style buildings. The large crowd in its wards, comprising patients, family members, caretakers, and visitors, left not only a substantial amount of trash but also an unpleasant odor, mostly from the foods they brought to the hospital. In the fully air-conditioned and hermetically sealed wards, many visitors ate *kimchi* and other smelly Korean side dishes (*banch'an*). It was hard to remove that odor because the windows barely opened. The very system that denied the old idea ironically revived it in different ways. An observer also noted the following:

> As I mentioned earlier, Koreans have warm hearts [*chŏng*]. Hence, they cannot pass over if any of their acquaintances are hospitalized. Occasionally, some neighborhood aunties [*tongne ajumŏni*], workplace colleagues, relatives, or friends visit the patients in the hospital. These people are never alone and come in herds [*muri rŭl chiŏsŏ*]. . . . Suppose

[122] "Chŏnim kanhoje silsi, Sŏuldae Pyŏngwŏ," *Chosŏn ilbo*, February 2, 1979.
[123] "Ŏttŏn hant'an" (n. 121).

> that they all stay in a ward for six patients. The room will be too full for doctors and nurses to step in.[124]

This ward differed from its American counterparts where, as Rosenberg dubbed, "care of strangers" took place.[125] In SNUH, patients' family members and caretakers often slept near the sick on rollaway beds for their twenty-four-hour care. Some stayed up all night in hallways, although it was not allowed. Along with odor, these people's perennial stay implied a higher risk of infection.

The outpatient clinic had even more serious problems. The patients in this overcrowded place often found themselves surrounded by people selling unauthorized herbal medicines (*hanyak*) and dietary supplements.[126] The sheer number of people in the clinic made it an ideal place to sell things. Despite persistent crackdowns, however, it was hard to drive out these peddlers: an SNUCM professor's public critique of one of these products prompted a group of sellers to detain him for more than twelve hours to threaten him to retract his remarks.[127] In addition, some people came to the outpatient clinic simply because it was warm in winter and cool in summer.[128] The new building's air conditioning provided the city's poor with necessary heating and cooling in harsh weather. Hence, SNUH's outpatient clinic looked to some like a "flea market" (*tottegi sijang*), which was vulnerable to various petty crimes.[129] Significantly, its elevators, which were always full, assisted pickpockets in grabbing wallets and cash from tightly packed people.[130] A 1983 police statement indicated that these pickpockets were organized,

[124] "Hwanja kanho e mich'inŭn yŏnghyang," *STPP*, October 15, 1986.
[125] Rosenberg, *Care of Strangers* (n. 4).
[126] "Toesara nan hanyak yugaekkun," *Chosŏn ilbo*, February 18, 1981.
[127] "Hakcha ŭi yŏn'gu kyŏlgwa," *STPP*, November 15, 1988.
[128] "Hamch'un manp'yŏng," *STPP*, August 15, 1983; August 15, 1988.
[129] "Kaewŏn 3 chunyŏn ŭl maja," *STPP*, October 15, 1981.
[130] "Sigyet'ap," *STPP*, July 15, 1986.

comprising at least three groups responsible for multiple reported cases each month.[131] The small size of the elevators that had been justified with a hope to exclude anybody other than patients and medical staff turned out to be unrealistic and brought forth unanticipated side effects.

The Use of the Crowd

Ironically, this overcrowded hospital was good for intern and resident education. Admittedly, SNUH was challenging for them, as they had to care for increasing numbers of patients. While the patient count per doctor-in-training was 755.5 in 1976, it became 2,142.3 in 1989 (table 1). Being allowed to return home only on a few days a week and being abused verbally by some professors, the young doctors mostly stayed in the night-duty rooms, which were poorly furnished and infested with cockroaches and other insects.[132] Although SNUH increased their salaries after incorporation—which effectively stopped their public protests—they had to do all sorts of drudgeries that "doctors are not supposed to do."[133] Yet the sick crowd in the hospital became abundant "clinical materials" for them with a variety of conditions, ranging from the common cold and appendicitis to leukemia, hepatoma, kidney failure, and AIDS. A senior resident remarked, "SNUH is superior to other hospitals in facilities, patient count, and diversity of patients."[134] It was a place where the student doctors observed "all the diseases recorded in textbooks."[135]

The crowd in SNUH was also useful in medical research, which, according to its early superintendents educated in the United States, was the key priority. Kwŏn Ihyŏk claimed that

[131] "Naesa chonggyŏlch'ŏl," 1983, CA0320455, NR.
[132] "Mae ch'ŏnjin in ŭisa," *STPP*, July 15, 1988.
[133] "Songnyŏn chwadam," *STPP*, December 15, 1986.
[134] "Suryŏn kwajŏng ŭl mach'imyŏ," *STPP*, March 15, 1983.
[135] Kim Yongil, "T'ŭksu pŏpinhwa ihu ŭi Sŏul Taehakkyo Pyŏngwŏn: kyoyuk ch'ŭngmyŏn," in *Sŏul Taehakkyo Pyŏngwŏn* (n. 75), 31.

SNUH must "play the role of the center of healthcare through research."[136] Hong Ch'angŭi also argued that the burdens of patient care and financial deficits should not discourage research.[137] Some faculty even asserted that they must promote "medical sciences" (*ŭihak*), not "medical care" (*ŭiryo*).[138] Research was also the way to enhance SNUH's international stature to the levels of the Mayo Clinic or Massachusetts General Hospital, whose scientific achievements were highly regarded by America-trained doctors.[139] To follow the footsteps of these American models, they needed patients as well as mice or rabbits.

Human subject research was not new in the hospital. As I mentioned, charity patients were used in medical research since the time of Taehan Ŭiwŏn. SNUCMH's "government-supported charity patients" were utilized in "academic research or education."[140] Papers published in the *Seoul Journal of Medicine*—the official periodical for SNUCM members—illustrate that many doctors indeed used their patients, who probably included these charity patients, in various clinical studies. After 1978, when these people came to be called "medical protection patients," they were no longer eligible for research, and a new category, "patients for academic work" (*hakkuyong hwanja*), was crafted as a replacement. Although not patients, blood sellers were also utilized in a clinical trial in the 1970s by Kim Chŏngnyong to develop a hepatitis B vaccine.

In a country under military dictatorship with little respect for human rights, the doctors conducting these studies did not seem to ask if their patients wanted to participate, although many of the researchers were educated in America, where the concept of "informed consent" had

[136] "Che 3 tae Hong Ch'angŭi wŏnjang ch'wiim," *STPP*, August 15, 1980.
[137] "Kaewŏn 3 chunyŏn kinyŏmsa," *STPP*, October 15, 1981.
[138] "Pyŏngwŏn ŭi ŏje wa onŭl," *STPP*, September 15, 1980.
[139] "Miguk Meiyo K'ŭllinik," *STPP*, February 15, 1989; "Oeguk pyŏngwŏn sullye," *STPP*, June 15, 1985.
[140] SNU, *Chegyujŏngjip* (n. 56), 150.

developed from the 1900s through the long debates spurred by multiple abusive experiments.[141] I found few papers from the 1960s to the 1980s mentioning that the patients agreed to participate after understanding their doctors' work. Kim Chŏngnyong was one of the few who wrote how he acquired the consent of his subjects, but even he stressed their monetary gain and patriotism rather than any risk: Kim asked blood sellers to participate in the trial if they wanted five thousand won and hoped to prevent hepatitis, their motherland's major problem (*kungminbyŏng*).[142] Consent was not a significant matter even for the "patients for academic work." In the National Assembly, politicians attacked SNUH regarding these patients, not because of the absence of consent but due to the excessive amount of public funds used for them.[143] Journalists also challenged SNUH for using these patients, due not to the lack of research ethics but to some employees who arranged for their relatives to be treated for free in this category despite their lack of eligibility.[144] In general, Korean doctors discussed medical ethics from the 1960s in their professional journals but never talked about subjects' consent in research. There was not even a single case of debate on the ethical use of patients in medical science.

SNUH's doctors continued to be uninterested in patients' consent, when they used an even larger pool of subjects coming to the hospital with their insurance cards, after charity patients and blood sellers decreased. Indeed, the proportion of government-supported charity

[141] See Susan E. Lederer, *Subjected to Science: Human Experimentation in America before the Second World War* (Baltimore: Johns Hopkins University Press, 1995); Harry M. Marks, *The Progress of Experiment: Science and Therapeutic Reform in the United States, 1900–1990* (Cambridge: Cambridge University Press, 1997); Steven Epstein, *Inclusion: The Politics of Difference in Medical Research* (Chicago: University of Chicago Press, 2007); Sydney A. Halpern, *Dangerous Medicine: The Story behind Human Experiments with Hepatitis* (New Haven, Conn.: Yale University Press, 2021).
[142] Yi Hoil, *Hangmun ŭi kirŭn ŭiji ŭi oegil* (Seoul: Paeksusa, 2004), 228.
[143] *KMKWH*, 114th, vol. 1 (October 18, 1982): 102.
[144] "Ilban hwanja rŭl muryo ch'iryo," *Tonga ilbo*, September 24, 1975.

patients persistently declined from 13.5 percent in 1966 to 4.5 percent in 1978 (table 2). In 1978, "patients for academic work" began to be used, but their proportion was even smaller and also continued to shrink. In 1989, there were merely 796 patients for academic work, constituting 0.16 percent of the patient population. Moreover, these patients were chosen from among those with "rare diseases," which were not useful for professors interested in Korea's common illnesses.[145] More convenient for this purpose was thus the majority of "paying" patients under the NHI, whose sheer number and diversity in age, gender, and symptoms made them optimal for large-scale projects, as far as they did not undergo a cumbersome process of informed consent.

Most prominently, Yi Yŏnggyun achieved a major success using insured patients. In the 1960s, he struggled because most of his patients died after open-heart surgery. His American training and the pump oxygenators from Minnesota and the CMB were not enough, as his patients' mortality was close to 60 percent in the 1960s. Yet he reduced the rate to 7.4 percent in 1981.[146] A manifest factor in this feat was the country's economic growth through a state-driven industrialization, which led to the rise of local dealers of the machines Yi used and improved the financial condition of his patients who had better-nourished bodies and could pay for the operation.[147] For this purpose, the NHI was critically instrumental because it brought even more patients to SNUH by lessening their concern on the cost.[148] Indeed, when the renowned surgeon Chang Kiryŏ praised Yi for his success, Yi was "very modest" in "attributing the outcomes to the NHI."[149] Probably Yi was not so modest: whereas his team's total patient count was just 279 from 1959 to 1976, it became 1,422 from 1977 to 1981 due to the NHI. As Yi acknowledged, this

[145] *KMKWH*, 144th (October 6, 1988): 30
[146] Yi Yŏnggyun, "Han'guk e issŏsŏ ŭi kaesimsul," *Seoul J. Med.* 22 (1981): 449–69.
[147] DiMoia, *Reconstructing Bodies* (n. 1), 87–91.
[148] Yi Yŏnggyun, "Kaesimsul e kwanhan yŏn'gu," *Taehan Hyungbu Oegwa Hakhoe chi* 12 (1979): 434–41.
[149] "Hyŏnhaeng ŭiryo pohŏm ŭi munjejŏm," *STPP*, April 15, 1980.

hike familiarized his team with the surgical processes. The increasing patient numbers also diversified the kinds of cardiac deformities seen on operating tables, broadening the team's understanding of differences among patients demanding distinct surgical approaches.[150] This became important in his medical research, as he extensively tabulated pathological types and performed operations in sixty-two papers published from 1977 to 1980.[151] All this formed significant background knowledge for his team's impressive surgical outcomes.

An even more dramatic result came from Kim Chinbok's study of gastric cancer, which utilized a larger number of patients, most of whom were under the NHI.[152] After finishing his CMB fellowship at Boston, Kim treated a total of 6,589 patients from 1970 to 1990.[153] While Kim operated on 120.9 patients per year in the 1970s, he took care of 489.1 in the 1980s, owing to increased patients after the NHI started. He used these patients in tracing their pathological characteristics, five-year survival, and extent of metastasis. More important was his clinical trial on postoperative therapies. In a study from 1976 and 1981, he divided 138 advanced patients into the control and experimental groups, and only the latter received the chemical and immunological therapy after operation. Another study conducted from 1981 to 1983 included 370 subjects, owing to the increased patients under the NHI. The subjects were then divided into three groups, including the control and the two experimental groups, who respectively received no treatment, chemotherapy, and immunochemotherapy. This work showed the superior survival rates (45.3 percent) of immunochemotherapy-receiving patients over those without any treatment

[150] Yi, "Han'guk" (n. 146), 459, 466.
[151] *Ilsong Yi Yŏnggyun kyosu hwagap kinyŏm nonmunjip* (Seoul: SNUCM Department of Cardiac Surgery, 1981).
[152] "Hwanja pangch'i am chŏngch'aek pujae," *Kyŏnghyang sinmun*, October 13, 1987.
[153] Jin-pok Kim, Oh J. Kwon, Sung T. Oh, and Han K. Yang, "Results of Surgery on 6589 Gastric Cancer Patients and Immunochemosurgery as the Best Treatment of Advanced Gastric Cancer," *Ann. Surg.* 216 (1992): 269–78.

(24.4 percent) and with only chemotherapy (29.8 percent). Kim later became an international celebrity due to this research, along with the "world record" of his gastric cancer treatment during his career, which amounted to 13,680, reflecting SNUH's large patient crowd with NHI cards as well as his American education. He received numerous accolades, including the American College of Surgeons' honorary fellowship, which highlighted SNUH as a major hospital as well as Kim's achievement.[154] In a 2001 volume of *Archives of Surgery*, he appeared along with twenty-three others as a "distinguished international surgeon."[155] The American aid bore fruits for Kim, owing to an institutional factor with a totally different origin.

Conclusion

I have traced a muddled path of SNUH's evolution, reflecting the American influence upon an indigent yet industrializing country after Japanese Colonial Rule. The U.S. efforts to modernize the hospital through fellowships, research grants, incorporation, and an architectural renovation resulted in unanticipated outcomes due primarily to the situations following the NHI launching, which was in part a colonial legacy. The subsequent increase in patient numbers resulted in multiple problems including three-minute consultations, crammed and unpleasant wards, exploited staff, and petty crimes. Under these circumstances, the new building could not exterminate the earlier concerns on bad air. However, the hospital's increased crowds facilitated intern and resident education as well as some professors' research, although few patients were aware of the nature of treatments they received, when human rights were not heeded during the military dictatorship.

[154] *Oegil* (Seoul: Songjuk, 2004), 385–455.
[155] "This Month in *Archives of Surgery*," *Arch. Surg.* 136 (2001): 1105.

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This story implies the limitations of U.S. power in South Korea. The Americans' influence was profound during the Cold War, but they could not dictate the path of development of a Korean hospital with distinct concerns and problems. The Koreans—including doctors, nurses, patients, and others—appropriated, not replicated, what the Americans offered in their country experiencing economic growth under a militarized state, which spawned the NHI, an institution that was initially modeled on Japan's.

SNUH's story discussed here has a broad and long-standing relevance. After the 1980s, Korea's further economic growth and democratization ended many issues, such as pickpocketing and herbal medicine peddling. Bad odor might not be there any more due probably to improved air filtration, and human subjects began to be used only through informed consent after democratization. However, the hospital remains very crowded because of excessive numbers of patients, family members, and caretakers. That the hospital still relies on exploited residents and nurses brings forth continued problems in the 2020s. These problems are not to be avoided in other hospitals in Korea: the three-minute consultation is as nationwide as the NHI. Yet several other teaching hospitals, including Severance and St. Mary's, had religious origins, which may make their histories akin to those discussed by Renshaw and Ebrahimi. That they had lesser stature in human subject research also makes them differ from SNUH, which has been the foremost Korean center of biomedical investigation using patients. All these indicate that further comparative studies of Asian hospitals inside and outside of Korea must be conducted.

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