GETTING AMONG FARMERS

No End Save Health

Toshikazu Wakatsuki

What had amounted to an "exile" – as he was literally banished as a wartime renegade to an unheard-of clinic on the outskirts of civilization from Japan's highest institution of medical education just before Japan's defeat in World War II – eventually occasioned him to walk along a simple path in the rest of his life. Spending his first few years as a surgeon there he was utterly alarmed by the appallingly feudalistic practices in which locals were incredibly indifferent to their own health, as if living under the yoke of Japanese feudal rulers, whose maxim was "Neither let the peasants live nor die."

Given an environment where a physician was commonly called a "death certificate issuing agent" and where people would matter-of-factly say that they would "buy," instead of "consult," a doctor, as though they were to pick up some street girl, he realized that the situation could hardly be remedied in any way merely with the delivery of modern hospital care, coming to his firm conviction that locals would have to awaken themselves to the importance of disease prevention with measures that were worked out and implemented at their own initiative with the technical guidance of medical workers. By so doing, he thought that they would come to realize that prevention is better than treatment – and less costly.

With this in mind, he was determined to devote his entire life to health promotion in medically underprivileged rural communities, even though his colleagues advised him to try to go up all the way to the highest rung of hierarchy in the Japanese medical academy.

Born as a son of a peasant in the mountains,

(Continued on back flap)


TOCHIGI
IBARAKI
SAITAMA
TOKYO
Tokyo
Narita
KANAGAWA
CHIBA

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-- No End Save Health --

Toshikazu Wakatsuki

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A FEW WORDS

From the Saku Central Hospital's Director

It has been the long-cherished dream of our hospital staff to publish in English Dr. Toshikazu Wakatsuki's book, the original Japanese edition of which was published under the title of "Fighting off Illness in the Hamlets" in 1971. At long last, we have managed to give shape to this dream to the unfathomable delight of our staff. Enjoying worldwide fame as the "father of rural medicine," the author is of marvelous vigor and wedded to scientific pursuits today, whilst he is past ninety-two

Today, our province, Nagano, deep in the mountains of Central Japan, ranks first in the world, when it comes to longevity. On top of that, our prefecture spends less money on the delivery of medical care to the elderly than any other province in our country. With those facts officially confirmed both by the national and prefectural governments, "Let's learn from the Saku Central Hospital" is now the catchword of workers devoting themselves to the delivery of health and medical care not only across rural Japan but in some Asian countries as well. Many foreigners will often visit our hospital to acquaint themselves with our systems. It was no one but the author

himself who took the lead in establishing and developed them.

Assigned to the hospital in 1945, the farseeing Dr. Wakatsuki immediately began to go out to see patients in hamlets where no physicians were wholly available under the slogan of "Together with the Farmers." Before long, he began a comprehensive health screening system for over-15s in the village of Yachiho deep in the mountains, as he came to take to heart the need to prevent and early detect disease. In due course of time, this system came to encompass the whole area of Nagano Prefecture with a population of 2,215,000, eventually enabling this rural province to rank first in the world in terms of longevity, about which it could boast to the world.

Besides, Dr. Wakatsuki has evolved a wide variety of activities both at home and abroad in the milieu of agricultural medicine and rural health, to say the least of the cold, spinal caries, pesticide poisoning, farm work accidents and the *Nofusho* Syndrome. Dr. Wakatsuki was one of the founders of the Japanese Association of Rural Medicine (JARM) and later the International Association of Agricultural Medicine and Rural Health (IAAMRH). He also received the Ramon Magsaysay Award in 1976, known as the Asian equivalent of the Nobel Prize. The author dwelled on the realm of rural medicine and declared in his opening speech at the first JARM congress in 1952 that what this group would do should not be "learning for learning's sake," stressing the need to organize and manage "in line with the principles of democracy and humanism" and to go hand in hand with local health and medical workers. Half a century later today, this philosophy remains immortal for the associations.

This book documents all sorts of difficulties Dr. Wakatsuki had tided over in the delivery of medical care in the pre-modern rural setting before 1971 when its original Japanese edition was brought into the world. It may well be described as a monumental work in the annals of the International Association of Agricultural Medicine and Rural Health as well as those of medical care in postwar Japan. Fully

convinced that the teachings in the book are as valid as ever, I wish this insightful and fascinating book to be read by many people who devote themselves to the delivery of health and medical care worldwide – in the developing world, in particular.

Many thanks are due Shinichiro Yoshimoto, adviser in international relations to our hospital and an honorary member of the IAAMRH Executive Board, who has translated this book, to Herbert K. Abrams, professor emeritus at the University of Arizona, and to L.W. "Pete" Knapps, professor emeritus at the University of Iowa, who have been friends with the author for so many years, for their advice and unstinting cooperation in paving the way for this English edition, and to the members of our hospital's Editorial Committee as well.

Shigefumi Shimizu, M.D.
Director
Saku Central Hospital

PREFACE

To the English Edition

Health is the first requisite after morality
Thomas Jefferson

Time flies like an arrow, as Henry Wadsworth Longfellow put it. It sticks in my mind as though it were yesterday that the original Japanese edition of this book came out in the Iwanami Shinsho series of paperbacks, the Japanese equivalent of Penguin. In sober fact, thirty-two years have already gone by since then. Really, it surprises – and pleases – me very much to learn that the Saku Central Hospital has decided to put it out in English. By so doing, they are in hopes of brining it to the attention of our colleagues around the world – and in the developing countries, in particular, where rural people still have all sorts of problems, to say the least of hunger, malnutrition and dehydration, and have yet to be blessed with modern health and medical care.

What I did really want to say in this book is this: first, how

important it is for us, health and medical care workers, to get among farmers, live with them and know what they really have in mind; second, how difficult and yet important it is for us to familiarize with the reality of rural communities, eliminate the "doctor-less" environment and continue to protect farmers' health; and third, how signifycant it is to liberate them from the time-worn disposition in which they disregard and sacrifice their own health. The important thing is to probe into the conditions where people are "half healthy," rather than "half ill." Indeed, rural medicine is social medicine.

The cardinal motif of this book is to try to triumph over diseases in the rural communities where the delivery of health and medical care is not adequately assured, as the title of the original Japanese edition -- "Fighting off Illnesses in the Hamlets" – indicates. Prevention is better than treatment. It is with this adage in mind that I wish my colleagues around the world – and those in the developing countries, in particular -- to find this book both worthwhile and interesting.

I simply do not know the words with which to express how grateful I am to Shinichiro Yoshimoto, who has been friends with me for so many years, to the Saku Central Hospital's editorial committee that has decided to put out this book in English, and to Herbert K. Abrams, professor emeritus at the University of Arizona, and L.W. "Pete" Knapps, professor emeritus at the University of Iowa, friends of mine for many years, for their warmhearted advice and counsel.

Toshikazu Wakatsuki, M.D.
Honorary Superintendent
Saku Central Hospital

GETTING AMONG FARMERS

CHAPTER ONE

Getting Among Farmers

1. 'Getting Among People'

On March 6, 1945, I proceeded to my post at a hospital on the Saku heights in the Central Japan province of Shinshu. In those days, Tokyo was suffering the ravages of war, as B-29 strategic bombers were on a rampage. As if being snatched from the jaws of death, my wife and I came to the hospital, joining hands with my little son. It still occurs to me that, when we got off at Komoro Station on the Shinetsu Line, the cold air that whizzed down from the mountains and was hard to bear assailed our nostrils.

We could see Mt. Asama, 8,474 feet above the sea, in the north. We could also see the Yatsugatake range of mountains in the west. One hour or so after we had switched to the Koumi Line, known for running in Japan's highest ravine, we arrived at San-tanda [literally, "3-*tan* fields"] Station, which is re-designated as Usuda today. In fact, rice paddies in and around this community averaged 3 *tan* (0.735 acres) a landed farming family, suggesting how poor the local farmers were in those days. From the station, we walked for 15 or so minutes. On the way, we crossed a bridge, while being buffeted by the biting winds that came down the Chikuma River. It was already at twilight when we finally trod into a wretched rustic town where we could sporadically see lingering snow.

With a population of less than 5,000, the town of Usuda has once been a demesne of the Tokugawa Shogunate (1603-1867). Partly because of its historical background, the town had a branch of the local provincial government and a police station, but the

rows of stores and houses along the main street looked deserted. We at last came to an inn with a timeworn main gate. I could at last set my mind at rest with a big sigh, when I had freshened up in a bathtub.

In this mountain town, people said they had never seen any military airplane, either friendly or enemy, before. In fact, "air-raid" wasn't a word for them. I fetched a deep sigh of relief, thinking that we could take a new lease on life at least for some time to come. Despite everything, I was determined to do all I could, somehow, for the medical care of rural people in the mountains.

Situated by the Chikuma River, the hospital belied its name, looking more like a shoddy clinic. I was told that an outpatient clinic had just been completed near the hospital's main entrance. Without that facility, the hospital itself would have come down a peg. Immediately behind it, there was a two-storied wooden pavilion for inpatients. I was also told that this building, once used as a dormitory for silk-reeling women, had been moved from Shinshu Nakano, a rural community in the northeast of this province, and re-erected here. With the reconstruction completed one year earlier, all the inpatient rooms were floored with traditional Japanese straw mats with paper sliding doors and windowpanes. I felt something like hopelessness when I was told that there had since been no inpatients at all.

Talking of the staff, all they had was a hospital director, who grew gray and looked affable and sincere, and a just graduated woman physician, who looked utterly pure in heart. They

were internists. I joined them as chief surgeon. Having his hair closely cropped, a man around forty served concurrently as head of the pharmacy and chief administrator. With a sly look, he looked to me like a caution. Later (or when Japan's surrender in World War II was just around the corner), he and I would increasingly be at daggers drawn with each other. Confessedly, I suspected that I had done something hanky-panky as I had, after all, fled to a region of serenity far away from Tokyo, which was moldered away in incessant American air raids. Nonetheless, I wound myself up for an effort, having realized the very pleasure of being unexpectedly able to work together with peasants in the mountains, of all things, without a spoke put in the wheel.

On what ground was I assigned to this hospital? Quite bluntly, I was detained at the Mejiro Police Station in uptown Tokyo throughout the previous year, or 1944, on the claim that I had violated the dreadful Law for the Maintenance of Public Order. With the New Year just around the corner, I was suddenly released without notice. I lost no time in visiting Professor Kikuo Otsuki, my beloved teacher, at his home and fell prostrate to apologize him. (Graduating from the Imperial University of Tokyo, I was working at the department of surgery at its branch hospital.) That was some cold night in January 1945. Surprisingly enough, he did not call me on the carpet. He had this to say:

"Well, like you said, it looks like we're going to lose this war, no matter how hard we may try. Soon, Tokyo will be reduced to ruins that extend as far as the eye could reach. Serving as a physician in ordinary for His Majesty the Emperor, I'll stay in To-

kyo with Him till I perish. But I wish anyone who has new ideas like you to do the best he can in trying to survive the war for the sake of the people. The [Chinese] saying goes that the country is in ruin; yet its mountains and rivers remain as they were. Even if Japan meets with defeat, I don't think the Japanese people are going to cease to exist as a race. By the way, don't you feel like working for farmers in the mountains to see our country reconstructed?"

I was quite overwhelmed by his unexpected words. His suggestion was exactly what I did wish to do. About that time, the Saku Hospital had asked Professor Otsuki to find a surgeon. That's how my assignment was determined.

What made the Tokyo Metropolitan Police Department arrest me in 1944, anyway? What sort of bad thing did I do? I still cannot find the correct answers. The upshot is that police accused me of involving myself in "moves against war." In those days, I used to have free access to mammoth industrial plants, while doing research work at my university; my visits must have incited their suspicion. In fact, I was up to the elbows in my survey and research work on occupational accidents, visiting plants of Ishikawajima Shipbuilding and Tachikawa Aircraft.

Police said this work of mine was in contravention of the Law for the Maintenance of Public Order. Besides, the prosecution told me that my book, entitled *Work Accidents and Emergency Care* and published by Tokyo-based Toyo Shokan in 1932, contained tens of passages that ran counter to the law. One prosecutor said to me, "You write that the compensation of only several tens of yen for a finger cut off in an occupational accident is too small.

This description definitely sounds illegal in whatever you may look at it."

It still seems to me, nonetheless, that what the prosecution had in mind was to ride me a bit harder -- even though they were fully aware that I was of no importance -- by taking advantage of my commitment to that research work. This is because my name was put on the blacklist, as I had once been suspended from school for my involvement in a student's movement during my university days. I was nabbed by an assistant police inspector by the surname of Tsuge (I would imagine he is still alive). The superintendent of the Tokyo Metropolitan Police Department awarded him for his distinguished contributions to the arrest of Richard Sorge, an internationally notorious Russian spy.

Tsuge once said to me in a jocular vein, "Know what? There's a knack about making a pinch on big shots. Arrest and tyrannize feather-weight, little devils like you, first." What a terrible thing to say! I tried to exculpate myself from the charge before him to the top of my bent and pleaded with him for mercy, stressing that I had had no audacious intention whatsoever of playing a part in any plot to undermine the constitutional structure of our nation.

But Tsuge bawled me out, "You're one of the devils of the worst type." In parentheses, I felt like swinging to the right for the second time in my life.

The first ideological conversion of mine came when the students' movement at the Imperial University of Tokyo gradually broke down from 1932 to 1933. That was a terribly pathetic out-

come. Relentless suppression and white terrors were playing havoc. Our student movement was primarily designed to somehow prevent the outbreak of World War II, imminent though it looked. For young people in those years, it was taking bread out of their mouths. As a matter of course, the student movement was led by what was known then as a Reborn Communist Party. Seigen Tanaka[1] and Jokichi Kazama[2] had a firm grip on the group. The slogan "Down with the Emperor System" was yelled in *Sprechchor*. But that slogan was quite alien to what the Japanese public had really in mind.

I was in charge of the Students' Self-government Association at the Imperial University of Tokyo School of Medicine. All at once, the group was torn to ribbons, leaving a profound sense of defeat behind. When it came to my own health, I feared lest pulmonary tuberculosis I had when I was an eighth grader should recur any time. In a party directive, I was told to join the Japan Communist Party and work for its cell at Nippon Steel Pipes, but I refused to obey the order. That decision marked my ideological conversion and I was allowed to return to school one year later, as the punishment of indefinite suspension had been rescinded.

In 1932, when the initial phase of the Manchurian Incident was over, the May 15 Incident[3] broke out in Tokyo, heralding the prevalence of an increasingly Fascist climate. On the other hand, the suppression of the left wing played havoc. In September, the Red Gang Incident, provoked by spies, took place. In the following month, police made a wholesale arrest of participants in a national

congress of the Japan Communist Party and slaughtered Yoshimichi Iwata[4]. In February 1933, Takiji Kobayashi[5] was also butchered immediately after his arrest. So was Eitaro Noro[6], who was in detention. Japan's war efforts began to spread all over China, and there was an imminent danger that World War II would break out any time soon. For all that, it's all up with leftist forces, on which police increasingly clamped.

A coward that I was, I simply could not commit suicide. In 1936, I was graduated from the School of Medicine at the Imperial University of Tokyo. But there was not a single university clinic that could willingly hire me now that I was on the blacklist. In those days, Professor Sen Nagai, also of the School of Medicine, was in charge of students' edification. Sympathizing with me, he suggested me to call on Professor Otsuki. With a letter of introduction given by Professor Nagai, I called on him at the department of surgery in the university's detached hospital.

Having scrutinized me from crown to toe in a leisurely manner, the prominent surgeon said, "You will never do that again. Promise me?" and then clamped his lips together.

"No, sir. Never will I do it again," said I.

That's how I began to serve my apprenticeship under him. He was quite stern to his pupils. Inferior to other apprentices, I would often catch it from the professor. I must own, nonetheless, that I could not have become a full-fledged physician, though not quite satisfactory, without his advice and counsel.

In January 1937, I was ranked Grade A in a physical test for conscription and enlisted in Company F, 3rd Infantry Regiment,

headquartered at Azabu in downtown Tokyo. The conscription was necessitated in part because of the February 26 Incident[7], all other new conscripts and I were shipped to Qiqihar, a railroad junction in northern Manchuria. For the first time in my military service, I passed in review there. My unit joined in the mop-up of Ma Zhashan, who was commanding the National Salvation Army against Japan. A new recruit though I was, I could pass an examination for cadets in the Medical Corps and was shipped back to Japan in June 1937. Immediately after my transfer, what Tokyo dubbed the Sino-Japanese Incident[8] broke out. Promoted to the rank of non-commissioned officer, I studied at an army medical school at Ushigome Wakamatsu in uptown Tokyo.

Immediately before I was just about to receive a commission in 1938, I fell down with pulmonary tuberculosis, the possible recurrence of which had weighed heavy on my mind. I received treatment in the First Army Hospital for half a year. The fall was wearing away, when I was ordered out of the hospital and then mustered out. That's the last thing I could think of, as I had earlier been told of my imminent transfer to Nomonhan near the desolate Soviet-Manchurian border. I suspected that my discharge could not have been realized without the good offices of Professor Otsuki, who I knew was an old chum of the First Army Hospital's commandant.

Once again, I began to work at the clinic of surgery in the university's detached hospital. I did the best I could in learning more about surgical procedures. I found that the university life simply had no weight with me, when I recalled the bitter griefs and

sorrows of life in the army. All you had to do was to devote yourself to research work in the Ivy Tower. For all that, I felt heavy at heart.

The Sino-Japanese Incident developed straight into World War II. That's exactly what we had learned in social sciences. Wasn't it? What is actually going on testifies, more than anything else, that the theories of liberation are correct, does it not? After all is said and done, so are the theories of revolution, from which I had no choice but to ideologically convert myself.

Then, what made it impossible for those correct theories to make great strides and translate into an actual movement? You could take up a wide variety of reasons, such as slashing suppression, domineering spies, poor organization and clumsy tactics.

But the most cardinal reason is, in my own view, that the movement was not tied in with the masses. However correct it is, theory will not translate into physical force unless it has direct ties to the multitude. Even if the strategy is correct, nothing can be done unless the tactics are placed on solid ground. Revolution is something that is done by the masses; it will not stand to reason unless they set themselves to carry it out. Notwithstanding, is it not that their minds were too much preoccupied with their own affairs to consent to, and accept, the theses of the Japan Communist Party and Communist International?

In the final analysis, this dark picture could not be broken through without self-awakening on the part of the masses. How could the way be paved for it? Suffering pain from my own defeat, I had no choice but to seriously ponder the significance of placing

myself right in the ranks of the masses and struggling with them.

Surely, the road ahead was rough, but could there be another road?

This philosophy of mine might be described as something in common to other converts. It was in those days that Kensaku Shimaki, another convert, wrote a novel under the title of *The Pursuit of Life*. The story evolves around an intellectual who gives up on urban life and goes back to the earth, portraying his qualm and rehabilitation as a convert, his relations with unsophisticated villagers, in whose community the time-honored spirit of subservience and resignation remains deep-rooted.

Even in those circumstances, the novelist emphasizes, you will surely find sympathizers and chalk up a win in the long run, should you continue to stick to the task of reaching out a helping hand to the poor and having a spite at injustice while cleaving to the humanistic spirit. Here, the humanistic spirit may sound abstract and equivocal, but the fact remains for certain that it lays the groundwork for anything progressive.

The philosophy Shimaki expounds here is something indispensable, given the prevailing situation in which any leftist move was suppressed to the *n*th degree. How did he strive to hold faith in something new in the abysm of despair? For any intellectual who simply cannot act on the beck and call of decadence, nonetheless, is there any other option left for him? It was inevitable for him to go underground, conceal himself and live in his own way with perseverance so as to nurture and keep wishes for tomorrow. The ideological malaise of the intelligentsia taunted them,

both mentally and physically, to the hilt.

But, when it comes to the masses, they will not commit suicide, no matter how sad their plight is. They will somehow get over the predicament at all costs with the hope that they can one day hail the advent of a new era.

Joining the masses, or people in general, and conducting myself among them put me in mind of the *khozhdenie v narod*, or "getting among people," movement unfolded by *narodnik*, or populists [in Russia in the 19th century]. They were revolutionaries who were determined to raise riots among peasants in attempts to overthrow Russia's autocracy and the landed class. It is on everybody's lips that Vladimir Ilich Lenin castigated the peasants' moves. His elder brother, Alexandr Ulyanov, involved himself in terrorist moves and was sent to the scaffold. Ivan Sergeyevich Turgenev and other Russian novelists gave a full account of the harrowing failures and agonies of the Russian intelligentsia who took part in the *khozhdenie v narod* movement.

Like Yevgeny Vasilievich Bazarov in Turgenev's *Fathers and Sons* and Aleksei Dmitrievich Nezhdanov in his *Virgin Land*, they were intellectuals who exerted their oratorical power but utterly lacked the power of execution. They uncurbed their revolutionary passions to their hearts' content and joined peasants who were obstinate and tied down to the trammels of convention. Nonetheless, unlooked-for happenings and irrepressible love affairs cropped up one after another and spelled their ruin, far from rectifying the consciousness of peasants. Quite often, such is the

case with practice. For one reason or another, I could not help being captivated by genuine passions of those Russian intellectuals who were known as *raznochintsy*, or "intellectuals not of gentle birth," in those years.

Beyond doubt, their irresponsible posture cannot be condoned. But the fact stands that they strove hard to fight among peasants. Should the driving force of a revolution rest with the masses, the question is, how can they exalt their consciousness and accumulate their revolutionary experience and energy? There is nothing an intellectual, retiring within himself, may gain merely by arguing this or that about revolutionary theories to no purpose. There could be no other option than to plow through difficulties. This holds true particularly in the gloomy days.

I arrived at a conclusion -- to wit, for intellectuals of progressive ideas and, in particular, technicians, the essential thing is to get among the masses and contend with them against difficulties. Besides, technology and knowledge will prove to be weapons of worth for them. That was what I always thought while looking at a thing under a microscope or shaking a test tube at my university laboratory or playing a part in a surgical operation, immediately before the outbreak of what the wartime Japanese government dubbed the "Greater East Asia War," or the Pacific War.

I was a failure as a revolutionary but came to hold an unshakable belief that I had to acquire technical knowledge as much as I could. Not just fighting done by riflemen but unobtrusive assignments, such as done by engineers, as well are just as important.

After all, Adolf Hitler levied war upon the Soviets. The wheels of history started revolving without mercy. After all, the "Greater East Asia War" broke out. In those days, I began to frequently visit mammoth munitions complexes in Tokyo from the university to check into occupational accidents. As a matter of course, I did so from the standpoint of occupational health. They were Ishikawajima Shipbuilding and Tachikawa Aircraft. I also stayed at Komatsu Works in Ishikawa Prefecture facing the Sea of Japan for one year[9]. It is not true to say that no safety campaign was under way at those industrial plants at all. The campaign was designed not to work for the occupational safety of workmen but to boost wartime production.

Many young men died in action day after day. In no circumstances could much importance be attached to health control for workers. Fatal accidents broke out at industrial plants day by day, and it was thought only natural all round that factory workers should be in danger of their lives on the pretext that the workers who produced arms were in the same boat as the rifle-armed infantrymen. Not only did I deliver medical care at many industrial plants and checked into statistical data on diseases and wounds in the name of a university research project, but gave a course in accident prevention methods as well. I presented the findings at a wide variety of scientific meetings.

But I was not supposed to do so (in the eyes of the Tokyo Metropolitan Police Department). The presentation would eventually pave the way for my arrest in 1944.

Thus, I was held in custody till I was released and as-

signed to a tiny town in the mountains. In terms of my adherence to the cardinal spirit of *khozhenie v narod*, the rustication was rather something to which I should look forward with pleasure. It is only natural, I might say, that I should key myself up, while drawing joy from my unexpected assignment -- but not in the negative sense that I was about to be routed out from a metropolis or that I could flee for safety from a mercilessly air-raided city. I think that I am justified in saying that I entertained a sense of tension with pleasure, as I was just about to get among peasants in the mountains from among industrial workmen.

What I have thus far described is the very motive from which I, having undergone "ideological conversion," thought I could -- nay, wished to -- serve somehow for people, as a physician in the middle class, though I had failed to become an industrial worker in the genuine sense of the word. That was my initial intention. As such, I could start studies on accidents at industrial plants and, later, hammer out a science of rural medicine in Japan. In all probability, I thought, I would have to dedicate my whole life to the development of the science of agricultural medicine and rural health.

The question was, however, was that idea of mine correct? Could I ever do this sort of work? Would progressive people endorse my way of doing things, which looked like ingratiating myself with the masses by using high-flown language, such as "position of the masses" and "position of farmers"?

In the severe social upheaval immediately after Japan's defeat, in the chaotic state that came out immediately before and

after the Korean War, and in the high growth of the Japanese economy today -- something I had never imagined before, though -- what is considered correct must be demonstrated with facts in the name of history, not in theory but in reality. For reality is all that matters. It is our mission to work for a better reality.

2. Days After My Assignment

Assigned to the Saku Hospital in March 1945, I was frightened out of my wits at its miserable facilities, of which I had just made a tour. Perhaps, I could not reasonably wish for more now that only fifteen months had passed since its founding. It was quite unreasonable, though, for the hospital to have taken in not a single inpatient before. To all appearances, the hospital was not up to even a clinic as a medical facility. Finding itself in those circumstances, it simply could not afford to deliver modern medical care to serious patients. What in the world made it necessary for me to have studied at a university for so many years, I wondered.

The hospital director, a big senior of mine, and a woman internist fresh out of school provided outpatient services in the morning. After lunch, the director made it a practice to go out by car and see patients in neighboring hamlets. The director would often say that their hands were so full with the present work. I took it upon myself to ask why they could not admit inpatients. He shrugged his shoulders, waved his hand for silence and declared, "Wait a minute. How could two of us ever look to the needs of inpatients?" Internists could come off without looking after inpa-

tients in those days, but not surgeons.

In a room close to the washroom in the farthest corner of the ward, I used to have lunch with the two physicians. In most cases, it was at 2 or 3 p.m. that we finished diagnosing and treating the outpatients who had visited the hospital in the morning. The director was affable; the woman physician tenderhearted. At lunchtime, the doctor told me of the feudalistic nature of locals, who would discriminate out-of-towners as *kitarippo* in the local dialect, or ugly out-of-towners. The rooms other than sickrooms were used unexceptionally as storerooms, where machines, medicines and what not were huddled together. Each room on the second floor of the ward was used at the discretion of seven or eight nurses in all.

Then we had three administrative clerks under a chief administrator, who was serving concurrently as chief pharmacist and X-ray technician. He was at the helm of the hospital staff. I didn't know for certain, but they said he was a son of a local boss and threw his weight around. Branded as *kitarippo*, the hospital director also appeared to raise his hat to the chief administrator. For some reason or other, we took it for granted that he was an incarnation of feudalism. Later, hospital workers would be in great reaction against the way he behaved himself, paving the way for the birth of a workers' union in the long run.

I worked as hard as I could as only one surgeon on the hospital staff. All things considered, I had to begin surgical operations by all means. But the fact is, not a single facility to prepare sterile water was available. I was on the tiptoe of expectation, but that chief administrator was in no mood to procure it. Patients in-

creased day by day, so did the cases that required immediate surgical attention. With a resigned air, I was obliged to pour into an enameled jar the water boiled in a Schimmelbusch boil-sterilizer, designed to disinfect syringes and scalpels, and scrubbed my hands with cooled-off water that came down through a pipe from the jar.

I remember clearly that I operated on a patient for breast cancer three months after my assignment to the hospital. It still appears to me that that was the largest of all operations ever performed in the Saku district. I still wonder if emergency measures had ever been surgically taken on cases with peritonitis from a ruptured appendix in vast South Saku County -- which had 13 towns and villages with a combined population of over 200,000 -- before the Saku Hospital was established as part of the local Agricultural Association and I was assigned there. The district simply did not have any facility whatever where the performance of peritoneotomy, or incision into the peritoneal cavity, could be authorized. That is why peasants in the county joined efforts and established the Saku Hospital.

Later, I learned that Dr. Genichiro Sato began to do peritoneotomy at the private Komoro Hospital in the North Saku County town of Komoro in or around 1936. Before then, patients had had to go all the way to the city of Nagano, 50 miles away as the crow flies, and visit Dr. Chisato Aihara, director of the Nagano Red Cross Hospital, to beg him for help. In those days, it would require a whale of a lot of money for people in the Saku district to ask local physicians in Komoro or Nagano to make a house call. If the family of a patient in the district had asked a physician like Dr.

Aihara to come and see the patient, they could not have afforded to pay the fee -- equivalent to the amount of money you had to pay for the purchase of bushels of rice -- for his diagnosis and treatment, aside from his travel expenses. Not born to an ample fortune, even a landlord could not have had access to the "luxury" of undergoing the dissection of his appendix by Dr. Aihara.

The first- and second-floor rooms of the hospital were littered with all sorts of pharmaceuticals and bric-a-brac. I told hospital workers to take them out and put them to rights somewhere else in an attempt to admit as many patients as the hospital could. Soon, the number of outpatients receiving surgical services began to exceed 200 a day with 30 patients in hospital. I was the only surgeon on the hospital staff but, assisted by a few nurses, diagnosed and treated patients from early morning to late night. Indeed, I denied myself all comforts of life and looked after my patients. And I performed all sorts of operations.

I was listed as a surgeon at the detached hospital of the Imperial University of Tokyo over the period of nine years that started in 1936. During this term, nonetheless, I spent three years in the military and another year in a police detention cell. Which means that I studied at the university hospital for only four-and-a-half years. Now, I did everything in my power in the delivery of medical care at an alpine hospital, while making the most use of all sorts of technologies I had mastered at the university. I brought to the Saku Hospital 10-volume *Die Chirurgie: Eine zusammenfassende Darstellung der allgemeinen und der speziellen Chirurgie*

[Surgery: A Summarized Account of General and Special Surgeries] (Berlin: Urban & Schwarzenberg, 1926-40), edited by Martin Kirschner and Otto Nordmann, from the library of the Imperial University of Tokyo's detached hospital. In so doing, I gave Ms. Fuji Watanabe, with whom I was on good terms in my university days and who was a librarian in the hospital, a written pledge that described those volumes as being "evacuated to prevent them from suffering war damage." I fagged away for surgical subjects, while pouring over those German books.

It was in or around May that I bought *Zentralblatt für Chirurgie* [Central Journal for Surgery] -- the No. 1 issue, published in 1874, through the No. 52 in 1931 -- at the suggestion of Prof. Otsuki from a friend of his who had died after serving as professor at Manchurian Medical University. If I remember right, the price was a whopping ¥25,000 [$70 at the fixed exchange rate of ¥360 to the dollar that prevailed till 1971]. Ryuya Yonekura, managing director of the local Agricultural Association, who had been instrumental in the establishment of our hospital, raised this mint of money. For the "evacuation" of the journal, I went all the way to Tokyo by truck. I had my life insured; in fact, I frequently encountered an air raid in Tokyo. In each air strike, I got off the truck and took shelter.

With consultation of the journal, I performed Cesarean operations. Finally, I had to go as far as to perform Caesarean section and operate on patients for not just chronic tympanitis, or inflammation of the middle ear, but its complication, mastoid sinuitis. To say the least of surgical operations in general, I treated

patients even in the sectors of, say, orthopedics, otolaryngology, oral surgery and urology. In many cases, I simply could not say to patients that I had nothing to do with those specialties. In fact, could I ever tell them to visit some university or general hospital in a big city, which was incessantly exposed to airraids?

That experience I had in those years would eventually motivate me to perform an operation for spinal caries for the first time in Japan, and carry out extensive surveys and studies on tendovaginitis, or inflammation of a tendon and its sheath, and the cold, which were rampant in the rural areas. As far as I was concerned, the needs of patients took precedence over specialized branches of medicine.

The town of Usuda where our hospital was located had once been a demesne of the Tokugawa Shogunate. Officials in the town were keeping watch over the nearby ex-fiefs of Taguchi and Iwamurada. Industrially, Usuda absolutely lacked distinction, although the local provincial government had a branch in the town. That is why there steadfastly remained feudalistic traits and townspeople were correct in observance of formalities.

In the beginning, exalted personalities were very sympathetic with my efforts. After all, Usuda was a small town, where any rumor would spread fast. Word got around that the new doctor at the Saku Hospital was no mean surgeon. Magnates of the town raised money and hosted a welcome party for me, where I was asked to sit above the salt. If I remember right, the party was held when Japan was just about to chuck up the sponge. I was grateful to the local leaders, who received me with warm hands. The chief

of the local Agricultural Association offered my family an outhouse on the premises of his residence, as he said it would cost too much for us to continue living in a local inn.

When I began to go out on my round of sick calls and when the hospital workers' union was founded under my leadership, nonetheless, the local magnates branded me as a Red and began to turn the cold shoulder to me. Perhaps, conservative townspeople suspected that I had double-crossed them. They began to get all the worse and dealt harshly with me.

Japan's war efforts finally eventuated in failure. What should have come at last came. The shock I had at the news of the Soviet entry into the war against Japan after the atomic bombing of Hiroshima is still impressed on my mind. I have a clear recollection of the broadcast in which the Emperor ordered the immediate cessation of hostilities on the noon of August 15, when the irksome singing of large brown cicadas was breaking the silence that eerily reigned all round.

That day, I was staying at home. Chien Tuan-li, four years my junior in the department of surgery at the Imperial University of Tokyo's detached hospital, was with me. His father was a prominent professor at Peking University, known for the translation of *Manyoshu* [Japan's first collection of poems in 20 volumes] into Chinese. On my recommendation, Tuan-li was working on the staff of the Hokushin Hospital newly founded in the northeast of Nagano Prefecture.

I drank one cup after another in celebration of Japan's de-

feat with Tuan-li. Growing tipsy, we bawled at something. I was later told that the family of the Agricultural Association's chief, who leased me an outhouse on their premises, thought we were yelling in tears as we had learned of Japan's defeat.

At last, World War II came to an end with the unconditional surrender of the Japanese military. With the dark wartime marking its termination, we could take the first step in our country's liberation. There was no doubt, however, that Washington would take the lead in administering Japan, which had lost the "Greater East Asia War." Which meant that we would be placed under their rule. I wondered if American capitalism would allow us to liberate ourselves without demur. That's the question Tuan-li and I had at our carousal. I was not in the same status as Tuan-Li, a Chinese, but the fact stood that both of us had put up with all sorts of wartime difficulties. We simply could not paint a rosy picture.

Right after Japan's defeat, Teiji Iijima, an internist at the Imperial University of Tokyo's detached hospital, was assigned to the Saku Hospital. He was a member of my group that had checked into accidents at industrial plants during our university days. Fresh out of school, Teiji was a young physician full of pep. It would be a pretty kettle of fish if it came to the knowledge of the hospital director, another internist, that Teiji was a specialist in internal medicine. We deliberately wrote in his curriculum vitae that he had studied surgery. Later, we would be taken to task as the cat was out of the bag.

With Teiji assigned to our hospital, our activities became

brisk all of a sudden. In February 1946, the Saku Hospital Workers' Union was organized. His activities for its birth had really been outstanding. It is only natural that he should be placed on the blacklist prepared by conservatives in the hospital and, in particular, by the chief administrator-cum-chief pharmacist.

In those years, I was full of vigor, but Teiji was much younger. And he was a trueborn Tokyoite. Having no experience in any military service at all, though, he always wore a non-commissioned officer's uniform. At first blush, he looked more like a solider-turned-black market agent who had just been shipped back from some overseas battlefield. Teiji argued that we had to deprive Japan of remnants of militarism at all costs for its rebirth and see democracy arise spontaneously from among people in the mountains.

In October or so, 1945, the South Saku County Young Men's Association held a convention at the Agricultural and Sericultural School in the town, for the first time since Japan's defeat. I was invited there as a guest. It is a matter of course that men of influence in the town were all seated in a row. I think Ichitaro Ide, who is the incumbent Minister of Posts and Telecommunications (and, in those years, he was yet to take up politics as a career), was also present as the owner of a major *sake* brewery in the town. The convention started with the participants traditionally bowing in the direction of the Imperial Palace in Tokyo. Then they sang the national anthem in due form.

All of a sudden, a man raised his hand and screamed, "Stop that nonsense!" He was no less a figure than Teiji. He yelled,

"It's really awkward to tell the participants to bow in the direction of the Emperor's residence. Are you trying to revive militarism?" Rikunosuke Kurosawa, head of the nearby village of Hozumi, who represented the clan of our hospital's chief administrator-cum-chief pharmacist, chaired the meeting. He was also instrumental in founding our hospital. Taken aback, the village chief immediately began to talk rubbish in an attempt to pour oil on troubled waters and managed to bring the meeting to an end in order. Teiji's outcry would eventually result in kicking off all sorts of troubles.

Albeit as dull as ditch water for some time after Japan's defeat in August, local politicians finally settled down to the task of working for institutional reconstruction. The convention was consequently designed to reinforce the unity of the Young Men's Association. It was against this background that Teiji's refutation popped up beyond all expectations. Participants asked one another, "Who in the world is he?" They were told that he was *kitarippo*, or an ugly out-of-towner, newly assigned to the Saku Hospital. Not just old men but young men as well opened the floodgate of wrath at, and pooh-poohed, him. That was a fine example of narrow-minded localism, to which they adamantly stuck.

"It does not stand to reason altogether that we, the Japanese people, should bow in the direction of the Imperial Palace now that the nation has accepted the Potsdam Declaration [made to Japan by the heads of the United States, the United Kingdom and the Soviet Union in July 1945 to demand Japan's unconditional surrender], renounced war and disbanded the military," argued Teiji. "The sovereignty should rest with the people, but not with

the Emperor." His argument was logically consistent. No participant brought forth a counterargument. But his contention provoked antipathy all the more because it was closely knitted. Thus, townspeople branded him as a Red. As a result, I would increasingly gain notoriety.

Before long, the Farmland Reform Law was promulgated, and the threat this act posed to rural landlords was beyond the bounds of my imagination. It is in those days that reformists in the countryside began to step forward. Commies and their sympathizers began to throw their weight around. It was nothing else than hysteria for landlords and their families had a mortal fear of those Reds. I heard a landowning old lady went out of her mind as she had learned that she had to let go her hold on her plots virtually for nothing -- the only asset on which she had lived for so many years.

The conventional system of land ownership, about which outsiders had been absolutely unable to do anything, had crumbled to pieces. The anger generated by the collapse turned into a savage hatred toward democratic forces, which were thriving in the villages like vermin, and the steam was also blown off, as it was tied in with the consciousness of peasants who were in arrears of the times.

At the night of the convention of the Young Men's Association, I was drinking with Teiji at my home. Sure enough, five or six young men showed up at about eight o'clock, demanding to have "some talk" with Teiji outside. Their behavior had an ugly look. No sooner had I made a quick change than I chased him. Coming to his lodging, I found they rang him round and there was

threat brewing.

"To hell with you," barked one of them. "You still think you're worthy of being called Japanese for all that." I cut in and suggested a quiet talk to bridge over differences. Otherwise, blows must have rained down on my friend.

Today, they are good old papas, serving as directors of the town's Association of Commerce and Industry. By now, that episode must have slipped from their minds in its entirety. Viewed from their attachment for their own town, *kitarippo*, or ugly out-of-towners, who, imbued with Communism, had drifted from Tokyo, must have looked more like traitors. People living deep in the mountains were so pure in heart that nothing could dissuade them from any idea, once it had taken a strong hold on them.

The breach between the chief administrator-cum-chief pharmacist and me was hopelessly getting all the wider. It cut him to the quick that we gave all sorts of advice to the hospital director, taking sides with nurses and administrative clerks. He would make sport out of us, whenever he opened his mouth, such as by declaring, "When all is said and done, the fact remains, though, that we are natives." Particularly, he seemed to take pride of the fact that he was from a family of influence in the town. Nurses and female clerks said to us that he would give them a raw deal and their mid-year and year-end bonuses would be cut down if they clouded his pleasure. They said that the amounts of their bonuses would be determined by the hospital director according to the chief administrator's advice. Placed in those circumstances, they had to feed him for his

night duty. I was told that they brought in pickles and what not from their homes for him. They confessed that they had to make his bed when he was on night duty.

What inflamed our anger most was the rumor that he would quite often visit anyone as he chose in the town for a tea by availing himself of the abundant time he had at his disposal, and that he would brand us as Reds. They said he did so despite the fact that we put our hearts and souls into the delivery of medical care at the hospital from morning to night. We hated him beyond all words.

Unlike me, Teiji was not a crafty fellow. He was so honest that he would often kick up a raw. Particularly when he was not of sober habits, he would often put up a bluff like I did.

Now that the Saku Hospital was under the umbrella of the local Agricultural Association, we frequently met with officials of its town and village branches and drank off the cup. Young officials, in particular, were fond of not just drinking but wordy warfare as well.

One night, it all happened that the talks veered around to the adage that "medicine is a benevolent art." At the top of his lungs, Teiji said it is not true that medicine is a benevolent art. "That can't be. I will take none of your talk," he screamed. Secluded in the mountains, junior Agricultural Association officials were simply unable to decipher what Teiji was really trying to say. The modern expressions he studded in his argument with squibs were all Hebrew to them. They were aflame with indignation at Teiji, whom they finally branded as an unscrupulous physician. All

things considered, what they were trying to show off was none other than the antipathy they had entertained against the presumptuous *kitarippo*. Teiji came close to drubbing, when I made an intercession to young fellows for him.

Surely, it is impossible in the real sense of the word to argue that medicine is still a benevolent art today, and any affirmative argument runs counter to the truth. In the eyes of peasants, nonetheless, they really wanted physicians to admit that what the maxim says is true. And they would be demoralized if you negated the adage. Here, physicians could not find common ground with peasants. In sober truth, though, Teiji was really translating that adage into action.

3. Rural Plays and Outreach Care

Utterly unaffected by American air raids though we had been during the wartime and living deep in the mountains, we were forced to lead a wretched life in some years after Japan's surrender. I lived on black-market rice but nurses in our hospital's dormitory time and again fell down with diarrhea, as they had to substitute barley and sorghum for rice. To all appearances, the patients who had evacuated from Tokyo were undernourished, and many children had the itch and were infested with lice.

My family also had to trade for Chinese cabbages the Japanese dresses and furniture we had had treasured as heirlooms in our family. Railway trains on the local Shinetsu Line overflowed with passengers on a foraging trip, and robbers and holdup

men assaulted many of them.

The first round of farmland reform that shocked otherwise peaceful villages had something to do with "absentee" landlords and was not more than lenient. Put into force in 1947, the second round made it mandatory for resident landowners to bring down their possession to one *cho* (2.5 acres) and release the surplus. It is not an exaggeration at all to say, therefore, that the second series of farmland reform drove the conventional system of parasitic landlords to crumble to pieces. Surely, conservative landlords in the rural communities were thrown into utter consternation.

Besides, landowners and other rural have-beens appeared to be in no mood to deform in any way the Emperor's system, which they believed was the bulwark.

It is not without reason that they offered a tenacious resistance to Dr. Iijima, who made bold to speak against the Imperial institution. Then there were people who took advantage of Japan's defeat in vaunting democracy as they portrayed themselves as leftists, uncovering hoarded goods and playing an active role in a campaign to purge suspected war criminals from public office. Not a few of them who had more or less fallen into discredit with villagers in character exploited reform measures for their own profit.

Having witnessed them to gratify their selfish desires with my own eyes, I simply cannot find any words, even now, in expressing how disgusted I was. Those malpractices incited conservative fellows and banded them together.

Villagers were absolutely in no mood to search their souls on the criminal acts Japan had committed during the wartime. The

conservatism and egocentricity that were traditionally peculiar to rural communities oozed out, when they found it better as an expedient to put on the airs of guardians of "given" democracy -- as they abided by the inevitable as people of a defeated nation -- and to comply with, and take advantage of, the directives that came out one after another from General Douglas MacArthur's headquarters. They simply did not have a sense of modernity.

It is in those circumstances that farmland reform was translated into action and unions were organized for farmers and industrial workers. I think that those moves were taken as a matter of form without any understanding about the spirit of democracy and the laws that were supposed to lay their foundation. I also think that the lack of this understanding would eventually leave a heavy residue of hard feeling in the course of all sorts of social developments. I suspected, for instance, that Japan would be exposed to a recurrent danger of fascism.

Dr. Iijima and I began to make it a practice to discuss with nurses about better treatment to hospital workers once in a while. That was in November, if my memory is correct, when the Usuda Town Young Men's Association asked us if our hospital was interested in having some of its staffers perform a play at the town's theatrical performances. We accepted the offer with pleasant expectations. For one thing, it would give us a good chance to chum up with young townspeople. For another thing, we would be able to put into practice what Kenji Miyazawa[10] taught us -- put on plays in rural communities but not lectures. Here, the Saku Hospital's

Theatrical Troupe first saw the light of the day.

We came about with a five-act play under the title of "Women in White." I blush to own that it was I who wrote the playbook. A Tokyoite though I was, I had no knowledge whatsoever even about the prestigious Kabuki Theater in downtown Tokyo. Having been to a theater in the capital by the name of Tsukiji Shogekijo twice or thrice, it was utterly unbecoming of me to become a playwright. But unavoidable circumstances obliged me to do so. We decided to have Dr. Iijima play the featured role, assisted by nurses.

The story evolves simply around the lives of hospital workers as they were in those years. In the first act, all sorts of patients visit the hospital's outpatient clinic. Having absolutely no knowledge about medicine, an old woman complains that her waist throbs with pain, putting the attending doctor in a fix. Coming from Tokyo, Dr. Iijima could not distinguish throbbing (natural pain) from ache (cinesalgia, or pain in a muscle when it is brought into action). Among the patients, you have housewives and children, who have suffered air raids in Tokyo and evacuated here.

Then an emergency patient is brought in hurry-scurry. Jolted along by truck from Kawakami, a village deep in the mountains, the patient complains about a stomachache. Finding the appendix ruptured in a physical examination, we concluded that he must have been suffering from pandemic peritonitis. Immediately, we have to perform an operation. But it's already dark outside. Besides, both physicians and nurses are dog-tired, as they have overworked themselves all the day. They are to barely manage to have

supper. The nurses raise Cain.

The second act depicts the area where circulating nurses are at work. The story evolves around the lives of nurses who are assigned to the Saku Hospital in those years. The staple foods served at its dining hall are potatoes and sorghum day after day. In particular, the nurses who have come from cities simply cannot have refined rice at all, whereas local nurses can return home once a week and eat rice, rice cakes, pickled green vegetables and what not. Then, someone steals and eats the potatoes they have brought in from their homes.

The third act starts with a scene of the operating room. A surgeon is operating on that patient for peritonitis. In those days, steam heating was the last thing we expected. The room is being warmed at a blazing fire in a tinplate can placed by the operating table. It's really dangerous to do so, if you come to think of it. Beside the fire, the patient is being etherized. In this makeshift stove, the firewood blows up, sounding like the whistle of a steam locomotive running on the nearby Komi Line. In the meantime, a trivial trouble flared up on the stage. The temperature on the stage went down as the nurse who was supposed to stoke the stove with logs was nodding off to sleep. The surgeon yelled, "What if the patient falls down with pneumonia?"

In situations where transfusion was necessary, it was virtually impossible to find blood donors. This is what always drove me as a surgeon to the end of my wits. People in the mountains had no interest in transfusion whatsoever. To be more precise, they simply did not have any experience. They had never under-

gone an operation of the kind that called for transfusion. Apparently, they were convinced that blood is something that should not be given to any one without a tie of blood. The general condition of a patient under the knife is getting worse. One of the nurses by the operating table says she will willingly offer her blood. She does not follow the surgeon's advice that she is too tired after overwork to do so. The transfusion improves the patient's condition..

The fourth act evolves around developments in the sickroom the following day. The postoperative patient achieved a breathing space and stands a fair chance of escaping death. Almost every sickroom in those years was straw-matted, and thick bed quilts were brought in from the patient's home. It was also a practice for relatives to be in attendance on the patient around the clock. Beside his daily necessaries, rice, bean paste, charcoal and portable cooking stoves were placed at sixes and sevens on the corridor. On the stage, a check of the patient suggests that he is taking a turn for the better. This act comes to an end with the attending physician cautioning him that there are signs of pneumonia.

The fifth act starts with a scene of the sickroom on the night of that day. The attending physician rushes to the sickroom in feverish haste in response to an emergency telephone call from the nurse on duty. Having an aggravating pneumonia, the patient is in a serious condition. With his wife, children and grandmother crying themselves out, the patient breathes his last. In a dark change, the physician and nurses on the front of the stage are spotlighted. The physician cries, "At last, he's dead, though he has had an operation. Would it not have been better, had he not undergone it?"

The fact that the patient did nothing about his ruptured appendix over a period of 10 days signifies a tragedy of hamlets where not a single physician is available. The physician asks, "Who in the world is responsible for this mess?"

The nurse who dozed off and inadvertently dropped the room temperature says with tears in her voice, "It was quite an oversight on my part that he died of pneumonia. Forgive me!" Another nurse says, "Doctor, I've made a decision today or never to become a public health nurse and work in some village where no physicians are available and detect appendicitis and other diseases so that I can do everything in my power to acquaint myself with preventive medicine."

The physician responds, "That's right. Otherwise, we would never be able to establish a milieu of rural medicine. The availability of a surgeon who can take out appendixes isn't good enough. We've got to see to it that every community, be it a town or village, has a clinic which can detect appendicitis in an early stage and, if possible, prevent disease beforehand."

What I have just introduced here is a rough picture of the story. It's extremely simple. It's too naive and sentimental in contents. Nonetheless, the play hit the taste of local townspeople and villagers. The contents run counter to Dr. Iijima's cherished view that the adage which describes medicine as a benevolent art is false. But the funny part of the story is that he gave an impassioned performance as the surgeon in the play. On second thoughts, the surgeon's last remark signifies the motif of rural medicine by which we still abide today.

Scatterbrained, I was so elated with the good reputation of the play that I would continue to write a number of scripts. Just about that time, I began to go on a round of sick calls in hamlets where no general practitioners were available. We decided to incorporate thoughts about sanitation and hygiene in the scripts so as to irradiate the minds of peasants in out-of-the-way hamlets. Alarmingly, farmers in those years were woefully lacking in common sense when it comes to medicine. They simply did not know they should suspect the incidence of appendicitis if they had an ache in the underbelly. The pain has nothing to do with *mushibara* - literally, worm-infested stomach (rural people were giving a free run to ascaridiasis in those years) -- so that you have to keep your stomach cooled, but not warmed.

This sort of commonsensical thing had to be incorporated in not just lectures but playbooks, according to which plays would be performed with a tinge of witticism. I subsequently came to keenly feel that the plays could work like a charm in particular while you were on a round of sick calls.

Unlike today, radio and television had yet to spread. Besides, the performance of plays was all the rage with young villagers for some time after the end of World War II. Virtually all villagers would often come together when our hospital's troupe showed up. The visitors went as far as to include men and women in their dotage. They came in hand in hand with their grandchildren. The auditorium of the local elementary school would often have a full-house notice. We made it a practice to deliver medical care up until two o'clock in the afternoon and then perform plays

till the evening. You didn't have to pay admission. All the villagers had to do was, if they could, to set us up to supper. Things just moved carefree in those days.

By the way, many nurses wanted to become members of the troupe in hopes of enjoying a good table (the noodles that were served deep in the mountains were really luscious).

Talking about our plays, we took up the way a democratic rural hospital should be in the five-act play "Hope." Endogastric heterotopy (commonly known as *sakamushi* in old Japan, meaning the roundworm that comes out of the mouth, instead of the anus) was the theme of the two-act play "Catching Alive."

Also in two acts, the play "Insurance Certificate" portrays the reality in which poor farmers would not be able to consult with any physician unless the National Health Insurance Scheme, suspended immediately after Japan's defeat in the war, was once again put into force.

The two-act play "Cough Medicine" deals with a possible infection of tuberculosis among family members. In the two-act play "Stomachache," we demanded the National Treasury to share a bigger burden in financially managing the National Health Insurance Scheme.

Those and other plays, most of which were my works, were extremely poor in quality, but the idea was to take up realistic themes that would satisfy the needs of rural medicine. That is why the hospital staff members who performed them did the best they could and were really caring.

I must say here that we strained every nerve to present

plays, because I learned a lot of things from the teachings of Kenji Miyazawa. He said, "In evolving cultural activities in rural communities, I would like to give you two pieces of advice: Be a tenant farmer and perform plays for rural people." This admonition is cited as his teaching in the chapter that introduces him in Jinjiro Matsuda's book *Cries to the Earth.* His book really struck home for me.

Miyazawa says it is absolutely indispensable to stand on an equal footing with poor farmers in the villages. He adds, "Perform plays for farmers but never give them crabbed lectures." What a wise saying! I was determined to start afresh with this great writer's spirit in mind.

The program under which we would make a round of sick calls started four months after Japan's defeat. The motif of our play "Women in White" represents what we had in mind in coming out with this program. Day and night, we had to look after patients with ills about which it seemed too late to do anything. It would be important to do the best we could in providing treatment to them, to be sure, but would it not be more important to detect diseases in an early phase right in the village? That's precisely what farmers wanted us to do. We thought we had to do something practical in order to satisfy their needs. As the circle of acquaintance we had grew broader, we began to come into more intimate contact with local young men's and women's associations. In response to their request, we decided to make a round of sick calls.

In those days, those visits had yet to be officially author-

ized as part of the routine line of work for a general hospital. We had no other choice but to use our free time on Sundays and national holidays. Acting in response to calls from locals, we expanded our activities, prescribing medicines and performing even urinalyses and stool tests. We offered those services at cost and the money received was turned over to our hospital. As often as not, we came across old men and women whose blood pressure was in excess of 250 mmHg with hypertension, whose whole bodies were bloated with heart disease, or in whose entire stomachs indurations could be touched with gastric cancer. Having detected those symptoms, we felt a chill go down our spines.

Our sick calls went down well with locals. But that led to misunderstanding on the part of our hospital's chief administrator and his cronies who were lording it over in their villages. We heard they walked around and told everybody they met with that we were providing propaganda ammunition to the Communists. Their denunciation would have not been so much intense, had we not performed plays with young people. The sensitivity of local conservatives was intense. Of course, we thought we were keeping our weather eyes open. As you will learn from our play "Women in White," we made it a practice to remain absolutely "apolitical."

All sorts of rumors were abroad about us. One day, an anonymous letter of denunciation of which we were obviously made a focus appeared in the letters-to-the-editor column of *The Shinano Mainichi Shimbun*, the most influential local newspaper. The contributor declared, "Scamping their work as physicians, doctors at a certain hospital in South Saku County visit outlying

villages and unfold political propaganda maneuvers. That is why an inpatient with stomach cancer died. Hospitalized though he was, he died, as the physicians had done nothing about his illness, to say the least of pulsation. Their utter inaction is contrary to the laws of humanity."

Certainly, there was an incident of a kindred nature. Whilst we were out at a settlement in the village of Koumi, six miles south from our hospital, and made a round of sick calls on some Sunday, the patient on whom I myself operated for stomach cancer died. That was a week after the operation. In the beginning, I found it in celiotomy, or surgical incision into the abdominal cavity, too late to do anything about his fatal ailment. That is why I did not perform gastrectomy, or excision of the whole or part of the stomach. Postoperatively, I did the best I could in giving his family a full explanation about his systemic condition, which was so alarmingly degenerated. That day, I gave full instructions to a woman physician on duty, under which I later understood she had done everything in her power for him.

Without loss of time, I wrote a reply to *The Shinano Mainichi Shimbun* under joint signature with Dr. Iijima. Immediately carried in the newspaper, the letter said:

"The first thing we have to say is that we have never made on our rounds of sick calls what is described in the letter as political propaganda. We also are convinced that that is something we should not do. But we will continue enhancing and disseminating preventive medicine of the sort that is required for the lives of rural people. Were it not for this effort, our mission would mean

little.

"Second, when it comes to that particular patient with stomach cancer that was 'past cure,' the duty physician took full measures for him.

"Third, it is quite important to make a round of sick calls in order to put a period to the appearance of such past-cure patients and detect ailments in an early phase. We must continue to develop this approach. There is the need to grave in the heart the truism that prevention is better than treatment."

As luck would have it, that's all there was to it; nothing serious happened later.

I still believe that sort of heed is required in keeping in touch with locals. Working deep in the mountains, we will often be annoyed by all sorts of incredible rumors. Should you do your routine work like a bee, however, you will eventually be able to get support from a broad range of farmers.

Called though it was a round of sick calls, what we used to do in those years was far from what we do today, when we breeze along whatever mountain trail there is aboard a jeep fully loaded with medical instruments and pharmaceuticals. We had to proceed by rail to the station nearest to the destination and then go there on foot.

We would often go there on horseback or aboard a cargo-loaded oxcart, which rattled along toward the village. With one of the wheels fallen into a deep ditch, we had to desperately keep on the cart the big white bundle that contained medical instruments, as it was just about to tumble down on to the ground. As we came

to the peak, the splendid view of a range of mountains dyed in purple opened out before us. I felt as if I were in a dream. Just then, the guide said as if making an apology, "As the trail sharply slopes downward from now on, we can no longer use the oxcart. Terribly sorry, but I have to ask you to move on foot with your gear on your shoulders."

We used to stay overnight in the village's public hall or detached classroom. Honestly, we found it a great pleasure to make a round of sick calls in an out-of-the-way village, where we would be treated to a taste of white rice, inaccessible virtually anywhere else in Japan for some years after the end of World War II.

Making a momentary digression, here is an episode when we visited Oyazawa, a sub-village in the town of Koumi. As the performances were over, how easygoing of us to enjoy drinking delicious local *sake*, when a villager rushed in and screamed, "Good God, the truck you're supposed to ride overturned and tumbled into the Aiki River! The driver escaped death." We were scheduled to go aboard a local lumberjack's truck to Koumi Station and catch the day's last train back to Usuda. We had forty minutes before the train's departure.

It was everyone for himself as our 12-man group rushed along a six-mile mountain trail in a light snow. Having finally made it to Koumi Station, we were pleased, hard as we were breathing, that we were in time for the last train, when the stationmaster showed up and declared, "The last train is two hours behind the schedule. It's just departed from Kobuchizawa, the station of origin."

All of us dropped our heads suddenly. That's what we used to come across in 1947 or 1948, when no telephone services were available in sub-villages and public transportation was hardly accessible.

While I am on the subject, I must confess the long and short of it is that the round of sick calls we made in "doctor-less" villages was none other than a one-time try. In plain language, we made it a practice for a visit to one particular village to be followed by a visit to another one. Each visit was made in response to a call from a village, provided we had enough time to spare. In the eyes of villagers, therefore, our services were far from being worth even an annual visit by Santa Clause in terms of blessing. A health checkup once several years alone could not be good enough for you to keep your health. In course of time, you might have cancer or your kidney might fail to function unawares. That is why we decided to encourage locals to undergo a regular checkup once a year without fail. The idea came out of documenting the data of each health screening and the clinical course in each examinee's register. Nonetheless, it would take many years before realization of this screening system. It was in 1959 that a mass health screening system for all villagers in Yachiho, aged 15 and over, began in the initial phase. Let's leave this subject till later on.

4. Inauguration of Hospital Workers' Union

On February 9, 1946, or the year following Japan's defeat in World War II, we rallied to organize a Saku Hospital Workers' Union.

That was three months after the formation of a hospital troupe. Although some hospital executives and two or three employees servile to them raised objections to its organization, it is not too much to say that the union was almost unanimously formed. The rally was held with the approval of all staffers, who numbered only a little more than 20, including three physicians in those years. The union's journal *Saku Hospital* had this to say about that day:

> At 7 p.m., all participants had a mixed sense of uneasiness, expectation and excitement. About 20 delegates represented the local labor unions, farmers' unions and reformist political parties. They came in, saying "Congratulations!" in unison. Some participants failed to realize what's auspicious all about the convention. Following a report about developments that had led to the union's formation, the participants deliberated on the draft of its statute. Then, they discussed what they should demand of the management. The demands included an across-the-board raise of 30 percent in pay, improvements in the facilities of the nurses' dormitory and raises in allowances for overnight and holiday work. Then they elected the Executive Committee. The inaugural speech made by the newly elected union chairman, Dr. Wakatsuki, was received with a clapping of hands and a shout of encouragement.

The guests from the reformist political parties included Teru Takakura[11], an inpatient under the treatment of our hospital. Mr. Takakura appeared to be not the type who could stay still as an inpatient for any moment, as he waved into his sickroom young

people in and out of the hospital. Then he gave himself over to a lecture on socialism. He was an erudite of encyclopedic knowledge and, what's more, silver-tongued. His refined face as an old man was always wreathed in soft smiles. Indeed, Mr. Takakura was a scholar who gave off personal magnetism. Listening to him, you would be tempted to feel as if a revolution were to take place any time soon, enabling the Communists to hold their own

Following the union's rally, Mr. Takakura gave a special lecture for one hour, in which he expatiated in an easy style what the Potsdam Declaration was all about. Analyzing where the international solidarity of labor unions stood, among others, he emphatically concluded that postwar democracy "will certainly be replaced by socialism." His speech left a deep impression on the minds of the audience.

As always, his argument was convincing to the point. I felt like the crabbed Communist jargon studded in the lecture edged in and finally held the audience spellbound.

Approved at the inaugural convention, the union's five slogans are virtually the same as what we have today: to wit, (1) Stabilization of the employees' lives and elevation of their cultural levels, (2) Thoroughgoing democratization of the hospital, (3) Enhancement of health care for dwellers in the Saku district, (4) Establishment of rural medicine as a milieu of science, and (5) Tie-up with other democratic organizations.

I may be flattering myself, but it really reflects our singular way of doing our tasks that, not long after Japan's defeat in the war, our workers' union already incorporated the enhancement of

community care and the establishment of rural medicine as a realm of science, among others, in its slogans.

Then there is another singular example. It concerns the degree to which qualifications for unionists should be extended. For any hospital, the medical staff, the nursing staff and the administrative staff constitute their three pillars. Even in the administrative staff, there is much difference between deskwork and manual labor -- kitchen and cleaners' work.

The way I understood, some hospital workers' unions refused to give membership to physicians. We thought it better to involve as many employees as possible, including the medical staff save the hospital director. By so doing, you would be able to have a powerful union. I argued that we should go as far as to welcome even the chief administrator to the union, when it comes to members of the administrative staff, and the director of nursing, when it comes to those of the nursing staff. To my suggestion, hospital workers raised a variety of objections.

On this issue, I got a summons to be at the Prefectural Council of Labor Unions. In fact, unionists at any small station of the Japanese National Railways and any municipal post office were also in the same boat as I was in those years. The council maintained that anybody in a supervisory position had no qualifycations for unionists. I could not go in for this view. I thought there was no point in getting stuck in mire as the staff of our small workplace split into two and both were emotionally pitted against each other to the satisfaction of the invisible enemy. Should a

workers' union really come to shoulder the destiny of the future, the proletariat will naturally have to have a broad perspective and lofty ideals.

You don't have your "real" enemies in your own workshop, and they hang around way up in a politically high echelon of society. In the sense that we could gather as much information as practicable and look at things in as broad a perspective as possible, I thought it better to welcome any staff members, including even the chief administrator and the director of nursing, to the union, as long as they did not manage the hospital.

The smaller the group, the more likely they become radical in their ideas, to be sure. Yet in another perspective, the struggles launched by unionists tend to be flash in the pan. Essentially, their struggles should be something that is tied in with the people's interests and improvements in their lives. The fact is, however, the other way round in many cases; the unionists look like "thieves" in the eyes of the masses.

Some pundits asked if it would be advisable to allow physicians and other intellectual technicians to join a workers' union. Blessed with by far higher pay than nurses and administrative clerks, they would never find themselves in straitened circumstances as long as they have a physician's license. (The gap in wage between physicians and other hospital workers was egregiously enormous in those years; I was paid ¥550 ($1.5) a month when I was assigned to the Saku Hospital in 1944 with the average pay for nurses standing at a mere ¥15 (¢4) on the average, a marked difference from today.)

Physicians could have access to a skyrocketing income, should they establish themselves in practice. Typically, they were *petit bourgeoisie*. That is why they would become fanatics of the far left but later turn around to become preys to terrible defeatism. The power of any hospital workers' union would be reduced by half, however, should physicians be kept away. Nor would the unionists be able to have their own way in coming out on a strike.

Be that as it may, the important thing to us was -- though we had had no experience in union activities -- for all hospital workers to join forces with one another in organizing a labor union and managing it democratically. This notion was in line with the spirit of my ideological conversion, or that of Russia's *khozhdenie v narod* [getting among people] movement, and took a deep hold upon my mind, as I believed that we had -- more than anything else -- to move forward hand in hand with the masses. Nay, we had to move a step ahead of them -- but not three steps, which would amount to overdoing.

And several years later, or in 1950, a federation of unions was organized for the workers of all hospitals placed under the umbrella of the Nagano Prefectural Federation of Agricultural Cooperatives for Health and Welfare (Koseiren). The workers' union of the Saku Hospital would play a leading role. When the National Council of Agricultural Cooperative-Affiliated Hospital Workers' Unions was established later, it would spontaneously become a practice to choose successive chairmen from among the Saku Hospital's union leaders. Dr. Iijima would succeed me as chairman. Later, he would become, and stay long as, chairman of

the Workers' Unions of the Nagano Prefectural Federation of Agricultural Cooperative-Affiliated Hospitals and also of the Workers' Union of the National Federation of Agricultural Cooperatives for Health and Welfare.

When it comes to our struggles in those years, Dr. Iijima has this to say in his article "The History of the Saku Hospital Workers' Union" (No. 1 issue of the union organ *Saku Hospital*):

> In the first half of 1946, movements arose spontaneously from among democratic forces around the nation. In the Saku district, too, the unions of industrial workers and farmers played a leading role in organizing a people's council. Hoarded goods were uncovered and moves for democratization unfolded by young men's associations with eclat. More than one thousand workers and farmers got together on Mount Inari in Usuda Town to celebrate the first May Day in South Saku County. Acting as chairman of the hospital union, Dr. Wakatsuki urged the establishment of a united front for workers and farmers. The hospital's demonstrators, all in white, added color to the local May Day celebrations. But our activities were not confined just to participation in the workers' festival. Focusing on our unique position, we advocated the need to democratize the delivery of medical care and go as far as to give up our holidays in untiringly visiting mountain villages to talk about health and hygiene, see patients and perform plays on the stage, while making it a motto to call for the elimination of communities without physicians and a resumption of the National Health Insurance Scheme.

Immediately after organization of our hospital's union, we visited the head office of the Nagano Prefectural Agricultural Association, under whose management and control our hospital was placed, for collective bargaining with the management. The association was represented by the managing director, Ryuya Yonekura, and Naoto Komatsu, one of its councilors. Having since hobnobbed with them, I have gained an impression that they are men of character and knowledge. All things taken together, nonetheless, they did not seem to have convinced themselves of the fact that we sometimes betrayed our emotions in speech and behavior as union leaders.

Notably, Mr. Yonekura was the very person who made an earnest appeal to Professor Otsuki, my honored teacher, for my transfer to the Saku Hospital from the Imperial University of Tokyo. Right before the final decision for my reemployment, or in January 1945, I made a visit to the town of Usuda to check and see how the hospital looked like. Wearing boots, Mr. Yonekura took me to the hospital in the snow. That night, he invited me to an inn at the spa of Yudanaka. My heart often warms toward him, as I recall he escorted me nearly three miles on the snow-laden path to the inn on foot, as there simply couldn't be taxis in those years.

Good gracious, we are turning against each other. I shall never forget that image of Mr. Yonekura who was sitting at the labor-management negotiation table with his head between his hands, while I did all the talking with a triumphant air.

Masato Iijima, the incumbent chief administrator, entered the service of our hospital two months later, or in March. Having been on

the staff of the Agricultural Association for many years, he is an old hand in accounting matters. He just got out of uniform, shipped back from abroad. That chief administrator-cum-chief pharmacist with whom we had been at daggers drawn left his job, and his replacement came with Mr. Iijima's assignment.

I never thought it possible, but the new chief administrator turned out to be a purgee from public service under the directives issued by the Occupation Forces, as he had been an agent of the wartime Nagano Prefectural Police's secret service division for many years. Branding our hospital as a Communist stronghold, the head office of the Nagano Prefectural Agricultural Association was said to have sent him in. We were told that he used to boastfully say, "While working as a secret service agent, I put my hand on as many as eleven Commies and gave them a raw deal."

Assigned though he was as chief administrator, he turned out to be utterly a rank amateur when it came to accounting matters, over which Mr. Iijima had to have full competence. There seemed to be no doubt that he was assigned to our hospital for no other purpose than to keep an eye on our union's activities. We were ever on the lookout for this one-time secret service agent but rather favorably disposed toward Mr. Iijima, who had once been a noncommissioned officer in the Imperial Japanese Army.

Referring to the storm cloud that was gathering over the hospital, Mr. Iijima had this to say in *The History of the Saku Central Hospital Workers' Union*:

> Before long, reactionaries made their appearance. Entertaining a sav-

> age hatred toward the Saku Hospital Workers' Union, conservative forces in the outlying villages began to give us a kick in the pants. In their obstructive tactics, they dealt out handouts in threatening language: to wit, "Police should crack down on your clan" or "Get the hell out of Usuda at once, if you hold life dear." They resorted to violence. With a one-time secret service agent assigned here as chief administrator, an unnamed daily newspaper charged, "The round of sick calls made by hospital workers was none other than a Communist propaganda offensive and, in fact, the hospital itself is nothing but a den of Reds." The situation is so appalling that there is really no end to the list of harassment. Such pinpricks came to the fore particularly when nationwide demonstrations were mounted to demand more food on May 19. There is no doubt that the local fanatics have taken advantage of the anti-Communist statements made by [Secretary of State Dean] Acheson and General MacArthur.

For a certainty, it was in those days that there emerged signs of a sudden change in the occupation policy of the General Headquarters of the Supreme Commander for the Allied Powers (SCAP). Shigeru Yoshida, a liberal politician, was appointed president of the governing Liberal Party. There were growing signs that the United States was pitted against the Soviet Union in the quadripartite Allied Council for Japan. The occupation forces' general headquarters was determined to pin down Japanese labor unions, which began to get all the more powerful immediately after the war-end, and back up Prime Minister Yoshida's Liberal Party. It vanished like a vision dream that the political offenders confined in prison during the wartime were all released two months after the Japan's surrender, the jubilated Japan Communist Party going as

far as to praise American occupation forces as a "liberation army."

Spurred by the head office of the Nagano Prefectural Agricultural Association, a powerful drive was unfolded to try to shut down the Saku Hospital. And the leaders of its workers' union were strongly urged in and out of the hospital to throw up their employment. Misjudging the circumstances in which he was placed, one of its antiunionist executives suddenly changed his posture and felt it better to tender his resignation, as he learned that the association was ready to pay an increased severance allowance to the retirees.

With things at sixes and sevens, the fainthearted Dr. Seiji Matsuoka, the hospital director, went increasingly discouraged. He said that he was in bad shape and suspected he was suffering from cancer of the rectum. Finally, he filed his resignation in September. The Agricultural Association's leadership persistently demanded us to close down the Saku Hospital Workers' Union. Otherwise, they said they would carry out its closedown by force.

In coping with this drastic demand, our union held a convention, where I was recommended as hospital director and Dr. Iijima appointed union chairman as a result of secret voting. The unionists resolved to have me as successor to Dr. Matsuoka and demand the association's management to conclude a labor contract and guarantee the status of the employed. We rose up against the proposed closedown of our hospital. The first thing we should do was to reinforce the solidarity of our union. For this, we established a joint struggle committee with the workers' union of the Hokushin Hospital, affiliated with ours, in northeastern Nagano

Prefecture.

About that time, some executives of the Agricultural Association called on Professor Otsuki at his home in Tokyo. One of them said to him, "We are terribly sorry to say this, but we would appreciate your replacing that Wakatsuki, who is a Red much to our annoyance, with someone else better qualified."

Professor Otsuki asked, "What do you mean when you say he is a Red? Tell me what sort of bad thing he has done."

The visitor said, "He appears to have something to do with the Japan Communist Party. That's too bad for any hospital."

My teacher snapped, "You've said he has something to do with the Communist Party, but is it not that that party is a legal one authorized by the central government? Who do you think can complain about that? Tell me -- specifically, that is -- if he has done anything wrong."

He replied, "Nothing in particular."

Professor Otsuki concluded, "If that is the case, then, I don't see any reason why I should keep listening to you people." To make a long story short, the peremptorily challenging executives were turned away.

Here again, let us quote from the book *The History of the Saku Hospital Workers' Union:*

> In September, we rode a truck and moved to the city of Nagano, singing workers' songs aloud. Our red union flags looked brilliant against the background of the autumnal sky that shone as if never getting to the end of it. The executives' room was crowded with association

representatives, newspaper reporters and the public admitted. As a result of a dozen of labor management talks, we finally succeeded in having the management install Dr. Wakatsuki as hospital director and conclude a labor contract.

The conclusion marked an epoch in the history of our union. The reason is because the workers' unions of all other Agricultural Association-affiliated hospitals had yet to negotiate about a formal labor contract. Nor did any other hospital under the umbrella of the Nagano Prefectural Agricultural Association have a workers' union. The right of personnel management, the management council, the union shop and other basic matters incorporated in our labor contract remain intact today. The contract enabled us to establish a management committee and a council of workshop delegates. It also gave occasion to establish the Nagano Prefectural Council of Medical Workers' Unions, Nagano Prefectural Agricultural Association Workers' Union and its young men's department, Nagano Prefectural Council of Labor Unions, Saku District Council of Workers' Unions and All-Japan Council of Agricultural Association-affiliated Workers' Unions.

CHAPTER TWO

Tiding Over All Sorts of Trials

1. Designated as Hospital Director

Stepping up in-house democratization efforts, the Saku Hospital Workers' Union, of which I was chairman, succeeded in having me assume the hospital directorship. Finally, the tide turned in favor of its workers. With the advent of the year 1947, no longer was there anybody on the hospital staff who tried to frustrate us in our path, enabling us to unfold a broad range of cultural activities. We exercised our imagination in coming out with a wide variety of new tasks for a rural hospital. Yet in another aspect, however, we would have to tide over all sorts of trials.

When it comes to the hospital's facilities, first, we built a nurses' dormitory and the First Pavilion. In July 1947, we opened up a clinic in the village of Taguchi. Those developments attested to the fact that we finally began moving forward hand in hand with local farmers not just in organizational terms. In October, we overcame the ongoing nationwide food crisis in coming out with a system in which meals could be regularly provided to inpatients. The project was so daring that we looked like flinging our caps over the windmill. In fact, it was the first ever attempt in the postwar years for any hospital other than those under the management of the central government.

Talking of our cultural activities, we took advantage of the town's annual festival, known as "Komansai," a local festivity for sericulture, in throwing open our hospital to the public. Today, the Hospital Festival is counted as one of the annual events for the Saku district. Posters we prepared under the theme of rural medi-

cine in common parlance and put up on the hospital's walls headed the list of exhibits at the local prefecture's autumnal Life Culture Exhibition and given the Prefectural Governor's Prize.

It was to be marked with a white stone in our hospital's history that the Nagano Prefectural Rural Medicine Research Group held the first congress at our hospital on July 22. This group would turn out to be the parent of the Japanese Association of Rural Medicine, which would be established in 1952. Presumably, none of the participants in the congress ever imagined that their group would one day develop into a national organization. I shall dwell on its founding later.

At a seminar of surgeons in Tokyo in October, I presented a paper on "Intestinal parasite-induced alvine cellulitis," or diffuse inflammation of the soft or connective tissue due to parasites in the intestines. This work was an attempt to pursue the clinical images of the harms caused by roundworms and hookworms, which were running riot everywhere in Japan in those years.

I have earlier discussed the difficulty of having access to blood transfusion for major operations. In an attempt to solve this pressing problem, we secured the cooperation of war-bereaved widows, who could hardly secure their livelihood, in launching a campaign for the establishment of day nurseries and founding a "blood donors' association." Taken up by the mass media, the "blood-selling widows" had major repercussions all over the nation. Professor Tamotsu Fukuda, my honored teacher at the Imperial University of Tokyo, who would one day be appointed president of the International Association of Blood Transfusion, said

that ours was the first such organization in Japan, which was supported by nongovernmental groups.

Focusing on the significance of educational activities for young men and women, we invited young workers in and out of the hospital, and gave lectures in the milieu of social science and philosophy at night. Called the Wednesday Workshop, progressive local youths got together every Wednesday night. Whilst I taught them during the off-duty hours, there were limits to what I could do as a lecturer. I gave them quite an elementary introduction to life and society. I am very much pleased to say, however, that some of those who once attended my lectures say, even today, that they learned a lot. In the meantime, our round of sick calls in villages and our performance of plays under the theme of rural medicine were getting all the more brisk and extensive.

Also in 1947, our workers' union institutionalized a minimum wage system. The formula under which the minimum cost of living is calculated from the charge for board according to Engel's coefficient remains intact today as the basis for the demand of a raise in the basic wage rate. We are proud of the fact that we worked out our own system in as early as 1947, as it is for the first time in 1956 that Japanese labor unions barely managed to give serious thought to the need for a minimum wage system.

Another thing in which we can take pride is that all the work projects we are doing today stemmed from what we used to do in 1947-48. To take a bit closer look at our activities in those years, let us see what the February 20, 1965, issue of *The Saku Central Hospital Workers' Union News* had to say under the head-

line of "The Saku Hospital's Past Twenty Years." [The Saku Hospital was re-designated as the Saku Central Hospital in 1951.]

Zenzaburo Funazaki (chief surgeon, currently serving as union chairman): In 1947, we started an inpatients' feeding system, which was known as the first of its kind in postwar Japan (save the national and university hospitals), and established a Blood Donors' Association the members of which would consist primarily of local war-bereaved widows. By so doing, we took up problems the solution of which was urgently demanded by local communities in those days. I began to work on the staff of our hospital, when you were just about to start providing inpatients with meals (Dr. Funazaki was my junior, taking part in the Industrial Accident Research Team as I did, when I was on the staff of the Imperial University of Tokyo's detached hospital. He later escaped death by the skin of his teeth on the battlefield. After Japan's defeat, he was reassigned to the hospital. In February 1947, he began to work on the staff of the Saku Hospital). The food situation appallingly aggravated in this district, let alone Tokyo. Without redoubled courage, it would have obviously been impossible to start providing inpatients with meals. Working on the staff of the hospital administration, Mr. [Yoshitaka] Fujimaki, you must have gone through the mill in procuring rice, vegetables and what not for the cookery.

Teiji Iijima: In the first place, you went as far as to earn the nickname of "Fuji The Black Market Agent."

Yoshitaka Fujimaki: I was employed by the hospital in February 1948. Each outlying village already had a forwarding union for the hospital as the hospital leadership had exerted itself to the utmost. Shortly after my employment, we used to compute the food supplies required for the inpatients and hold meetings with cultivators on sowing. Virtually impossible though it was to eat rice, we some-

how served it to them with soybean soup, frizzled vegetables and pickles. We procured what we needed from the neighboring villages of Kirihara and Taguchi. We could buy them virtually at cost price through the good offices of farmers there. Being members of the local Farmers' Union, they sacrificed their personal interests to the hospital's good.

Yasushi Tajima: In those years, even eggs and milk were hardly accessible. Told by the hospital director, we used to raise chickens and pigs. At last, it was suggested that we raise milking cows to enable inpatients and employees to drink milk everyday. But this suggestion was not put into practice.

Toshikazu Wakatsuki: The reason is because we didn't have enough grassland. When we tried to come out with some constructive idea or the other, an undisclosed physician on the union's Executive Committee raised objections to our annoyance. He argued that it sounded like taking a cup in the dark to suggest an inpatients' feeding system, no matter how good it might be for them, at a time when we didn't even know where our next meal was coming from. Being utterly unable to draw a satisfactory conclusion, we decided to have a try at the feeding system any way. The night when this decision was made, Dr. Iijima sought cooperation from the leadership of the Farmers' Union in the village of Kirihara.

Iijima: The following day, we concluded a formal contract. We could do so, presumably because our union had fostered organizational ties with the Farmers' Union, while we had made a round of sick calls and given lectures on health and hygiene, and because villagers were more than willing to stand by our hospital on their own initiative.

Funazaki: In July, that year, we sponsored the first congress of the Nagano Prefectural Rural Medicine Research Group. We all agreed that we should not fall behind in the research and development of rural medicine. The truth of the matter is that we resigned

ourselves to the sense of hollowness that inevitably came after Japan's defeat, thinking that research work was of secondary importance, as we could hardly keep the wolf from the door.

Wakatsuki: Yes, we did all those things, because we were resolutely determined to work for farmers and go forward together with them. That's the way the staff of the Saku Hospital did. The hospital leadership was one and undivided. Besides both of us had strong ties of solidarity with local farmers. Without any of those elements, our efforts must have gone up in smoke.

Funazaki: The mindset you've just talked about is accepted by hospital employees. It was spontaneously fostered in their minds, as they had made it a practice to place themselves in the same social status as local farmers, while doing a round of sick calls in their communities.

Wakatsuki: That's right. We served for local residents, while they taught and supported us. Otherwise, we could not have done all those sorts of things. We have expertise in medicine and health care. It is none other than the masses that turn them to their advantage. What we can teach is just specialized technology -- nothing else. When it comes to other matters, we've got to learn from the masses. We would be unable to do anything worthwhile without their support.

The Agricultural Association was disbanded in 1948. The general headquarters of the Supreme Commander for the Allied Powers (SCAP), General Douglas MacArthur, issued a directive in 1945 that called for the liberation of farmers. The idea was to democratize Japanese farmers and agriculture that had been placed under the yoke of feudalism for so many years. It is now a fact patent to all that the defunct Industrial Union during the prewar years served

for landlords and that the Agricultural Association, in particular, was an organization in the jingoistic Imperial-Rule Assistance System. In 1947, the Law for Agricultural Cooperatives was enacted and promulgated. In August, the following year, the agricultural associations around the nation were disorganized and replaced by agricultural cooperatives. The law focused on the principles of freedom, the establishment of farmers' independence and restrictions on the administrative agencies' right to supervision. If that is the case, could the ideal of agricultural cooperatives "of the farmers, by the farmers, for the farmers" be thoroughly understood by members of the agricultural cooperatives? And could they abide by this principle in putting their new organizations on the right track? Those were the basic questions that had yet to be solved.

The Occupation Forces imposed those perfunctorily democratic slogans on farmers. The fact of the matter is that, following the SCAP directive that forbade a nationwide strike scheduled for February 1, 1947, the General Headquarters began to expose its undemocratic posture that reminded us of the Cold War years, such as by authorizing establishment of the Japan Federation of Employers' Associations (Nikkeiren), which would eventually grow into one of Japan's foremost business lobbies, and putting a ban in a directive on strikes by public service workers. Those inconsistent policies cast their dark shadow on the policy under which the newly established agricultural cooperatives were to be organizationally fostered.

With the agricultural associations reorganized into agricultural cooperatives, our hospital was also to make a fresh start as

part of the division of medical care in the Nagano Prefectural Federation of Agroindustrial Associations in September 1948. In the course of this organizational reform, the existing labor contract ceased to be legally valid, and it was decided that our status would not be guaranteed till we were newly employed as members of the Nagano Prefectural Federation of Agricultural Cooperatives.

Before the dissolution of the Agricultural Association, we had had talks with its executives about our hospital's position in a new federation and I thought we had more or less secured their consent. Visiting our hospital later one day, however, one of them declared, "The state of affairs is now of disadvantage to your hospital in no small measure. The executives who belong to conservative political parties have so strong an antipathy against your hospital that they are understood to take a hard-line attitude in dealing with you people. Their posture appears to be so aggressive as to go to the other pole, as they say that they will never reemploy anyone of you unless you accept a variety of conditions they are to set forth before you."

One day in October, we bargained with leaders of the Nagano Prefectural Federation of Agricultural Cooperatives at a Japanese inn in the city of Nagano. One of the executives who were imposingly sitting above the salt began to read an 11-article document that contained their demands to us: to wit, "1. You will have to secure a prior approval of the Federation whenever you are to hold a meeting in your hospital. 2. People other than patients and employees shall be banned from going in and out of the hospital. 3. No posters shall be put up on the hospital walls. 4. No contact shall

be established with any other labor union. 5. You should not take part in May Day and any other rallies ....."

The leaders threatened that, unless those conditions were accepted, they would not reemploy all those who were on the staff of our hospital. We did not flinch before their ultimatum, as we had been prepared for some time past to risk our jobs. "Terribly sorry," I said to them, "but we could never accept those conditions," demanding their wholesale relinquishment. The thrust and parry of debate ensued for several hours. Time and again, I argued that it would run counter to the principles of democracy to thrust those conditions upon workers. We were tenaciously determined not to give up a jot of our demands. Then, a strained silence hung for long.

"All right, let's retract the conditions," declared the federation president, Toichi Shiokawa. Then, he set fire to the document. How exultant we were! How jubilant the representatives of the Hokushin Hospital Workers' Union were, as they joined forces with us! It was 12 o'clock midnight. At the Saku Hospital, the employees were all awake, waiting for the reply. That was quite an episode, as it came at a time when the then president and vice president of the Nagano Prefectural Federation of Agricultural Associations were members of the Nagano Prefectural Assembly, and with this organization's disbandment, its division of medical care was to make a fresh start as part of its successor, the Nagano Prefectural Federation of Agroindustrial Associations.

Thus, the talks on the 11 articles came to a successful end. At the

very moment when I realized that we could carry away the garland, however, I wondered that it would do well if we were incessantly given to puffing up with victory. To cut matters short, I arrived at the conviction, on second thoughts, that we would have to listen to farmers in a humble manner, should they find reasonable any of the conditions set forth by the federation. A case in point was Article 2, which reads: "People other than patients and employees shall be banned from going in and out of the hospital." Preposterous as this clause may sound, it is true that radicals, belonging to reformist political parties, walked around in the hospital in a lordly manner to try to establish clandestine contact with some hospital employees. If those outsiders' behavior had proved too much for local farmers, the federation would have naturally had to come out with this sort of forbidden clause. Unless we behave ourselves under strict self-discipline in this mountain district, where remnants of feudalism stay intact with a doglike tenacity, we will never be able to do our work the way we should. We should not be self-conceited just because the 11-article document had been burned with flame. Should we do anything on which people would look with scorn, it would undoubtedly produce a negative effect.

One day, it all happened that, when I came back to the hospital at 2 or so in the afternoon and I saw an olive-drab military jeep parked in front of the main entrance. I simply didn't have time to wonder about the vehicle, when Mr. Fujimaki, of the hospital administration, rushed out of the main entrance and screamed, "D-d-d-doctor, guys from the Occupation Forces!" He is apt to stutter when he

works himself up. He said to me that the Americans are from the cavalry detachment stationed in the prestigious summer resort of Karuizawa, 20 miles northeast of our hospital. In hot haste, I dashed into the Office of the Hospital Director on the second floor, where I found a military policeman and his interpreter who looked like an American of Japanese ancestry. "Don't tell me a lie! You're a big liar!" I heard the MP bawling Dr. Iijima out.

Without the faintest idea about what in the world was going on, I introduced myself as director of the hospital. But the American soldier did not take me at my word at all. I must look to him like a scatterbrain or something. He must think a cub like me couldn't be the hospital director. I produced my visiting card, but he still stared me with suspicious eyes. There is every appearance that his interpreter is an ill-bred fellow. His translation of what I said in Japanese was altogether a poor stuff.

Thrusting a print into my face, the MP demanded me to sign it. It says that in the event that I give ungrounded replies to any questions put by a military policeman, I shall have no right to complain about being ordered to military court. I decided to put my signature on it.

For I have done nothing wrong. Assuming a defiant attitude, I said to him, "Let me hear what you've got to say, first."

The first question was, whether I am a Communist. Well, let me see. That's a purely private matter. I don't have to answer his query. I was deliberately noncommittal, when I replied, "I wouldn't say that I'm not indifferent to Communism. But I am not sure whether you can call me an out-and-out Communist." I was

not sure that he had successfully "deciphered" my wisecrack, but instead he entered into the subject in question.

"We hear that you have thrust Communism upon hospital employees with the full knowledge that they are up against it and sacked those who have not complied with your order. That's why a dozen nurses have recently quit hold of their jobs. Do you really think you're worth remaining the person responsible for a public hospital? We've received many letters to that effect," the MP bulldozed me, flashing something that looked like a bundle of letters.

Gracious, that's all there is to it, I thought. Emphatically, I said, "Never am I a man who does that sort of thing which you say I've done. In the first pace, do you really think it feasible to forcibly subjugate man's mind and ideology? Absolutely impossible. Your accusation does not stand on any evidence. A dozen nurses have stepped out in the past several months, to be certain, but absolutely not under my pressure. Give me the names of nurses about whose resignation you think is dubious, and I will give you full details about it till you find them utterly satisfactory."

Apparently, the MP's pocketbook lists the names of a dozen people. In fact, he is well informed. As he reads the name of one nurse after another, I give him the reason, such as "to get married" and "to look after her parents." In the meantime, he stops lording it over.

"All things considered, let me see your sickrooms," the MP demanded. Jumping at his request, I began to escort him on a tour of our hospital. He must be really surprised, more than anything else, at the ramshackle Japanese-style sickrooms with worn-

out paper sliding doors and straw floor mats, that jam-packed inpatients. Next, I took him to the operating room, where he looked dumbfounded when I spoke of routine operations on the stomach and intestines. Picking up a roundworm-filled bottle on the shelf of the operating room, I said to him that they were "worms in the stomach." He screamed in spite of himself. I explained, "I took them out of the intestines when I operated for some stomach disease. Filled up with them, the intestines will sometimes be obstructed." The MP and his interpreter looked uncanny and could no longer keep up their spirits. Returning to the Office of the Hospital Director after a tour of hospital facilities, the soldier looked like a lamb. Leaving a pack of American cigarettes behind, he trotted out of my office.

In those years, some Japanese people dared get in touch with the General Headquarters to make an advantage of its supreme authority. Their stratagem was utterly contemptible. As long as you work earnestly with the masses, there is nothing that you have to worry about. As long as you have their support, you have nothing to worry about.

2. Confrontation with the Branch Hospital Faction

The Hospital Branch Faction aroused trouble in 1949-50. We established a branch in the village of Taguchi next to Usuda Town in 1947, and Dr. Iijima was assigned there as the first director. One year later, he was taken over by a young physician under a rotation system.

Nonetheless, this physician swung to extreme leftism unawares. Presumably, this is because he became a district committeeman of an undisclosed political party. By nature, his ideological conversion was dreadful all the more because he was really a man of sincerity. It became a practice for two physicians and 10 or so unmarried nurses to get together with him, and they eventually formed what they called a "branch hospital faction." The group began to charge me and other staff members of the main hospital for a lack of the "revolutionary spirit."

Toward the end of that year, the main hospital's Pavilion No. 1 was razed to the ground, bringing the dispute between the main and the branch hospitals to the fore. In fact, there was a danger that the Saku Hospital's staff might be split into two at any time. For this, an in-house ideological struggle was responsible. And the struggle left a disagreeable aftertaste.

In 1949, the General Headquarters drastically changed its Japan policy, and the nation was thrown into utter ideological confusion. One dreadful incident after another took place in Japan to the bewilderment of its people. Elsewhere in the world, the People's Republic of China was founded in October. The following year witnessed the outbreak of the Korean War. Things grew quite strained everywhere.

It is in those circumstances that the young physicians assigned to the Branch Hospital in the village of Taguchi began to play a leading role in not just studying politics every night -- with which there could be nothing wrong -- but cry out on, and raise objections to, the management and control of the main hospital one

and all. Their criticisms were of a strikingly political nature, arguing the Saku Hospital's staff and its workers' union were playing second fiddle to the hospital director. The splinters also criticized that they simply did not have class perspective and that their bourgeois spirit made them reactionaries with their attention focused merely on management and learning.

For instance, suppose I drank with the chief of the District Public Health Center, I would be censured as "giving a helping hand to a reactionary." Suppose they charged me for having turned into a reactionary, does it mean that there was nothing wrong with me before?

At any rate, they think it "revolutionary" to cry for "revolutionary theories" at each meeting of theirs, and our unobtrusive routine work in the sector of "rural medicine" and "rural health" must look ridiculous to them. Carefully listening to their argument, we sometimes find reasonable elements. Nonetheless, we've got to do our routine work. Theorization alone would not pave the way for the development of rural medicine. As there should naturally be freedom of criticism, we were sitting on the fence ....

As things got all the worse, "the young physicians repeatedly launched a show-off, if not tricky, attack on the main hospital. They stopped at nothing to gain their end" (The No. 1 issue of the Saku Hospital Workers' Union Journal *Saku Hospital*). They would often induce, if not instigate, inpatients with whom they personally kept company or interns who knew nothing about the hospital to criticize its management "on behalf of the masses."

We were obliged to hold a union conference and respond to their demands through the union. From the beginning, their criticisms were not constructive so that rank-and-filers were getting sick and tired of them. Besides, they never tried to understand our position. We made allowances for their youth, but they were really mad with excitement. In the meantime, they went as far as to demand pay raises in what they dubbed the "district people's struggle," though it was absolutely impossible to do so at a time when the hospital was placed in straitened circumstances. They also began issuing the organs the masterheads of which read *Branch Hospital Wall Posters* and *Saku Hospital Women's Group,* in attempts to propagandize their campaign to expel the leadership of the main hospital's labor union and the hospital director.

We expounded that it was reasonable to maintain a minimum wage system (they contended that was all humbug for employees). We explained that it was important to keep the hospital's management on the right track in straitened circumstances (they charged that was "nothing but management for management's sake"). We pointed out that it was necessary to develop our medical skills because ours was an institution for medical care (they described it as "technology for technology's sake"). And we explained that we had to get among rural people to research and survey health and hygiene (they denounced it as "a reactionary act to get farmers lost in a reverie"). By so saying, we urged them to reconsider their position, but we ended up pouring oil on the flame. They failed to recognize their real enemy and picked us up as the primary target in their struggle.

By that time, our hospital had somewhat expanded. The physicians assigned to the departments of medicine and surgery had increased, and a department of obstetrics and gynecology was established. With Pavilion No. 1 reconstructed, we now had one hundred beds in all, and the number of employees exceeded sixty. Of them, a dozen employees, including physicians and nurses, belonged to the Branch Hospital Faction. Though its strength was less than a quarter of the hospital staff, the terrible thing was to deal with a group of young nurses under the leadership of physicians in bachelorhood. What's worse, they were instigated by reformist groups outside the hospital. They said, "Japan has now come to a diverging point, revolution or non-revolution. For the oppressed class, revolution must come before everything else. For revolution's sake, the Saku Hospital could go bust anytime." Their argument is quite simple and clear but, when we think of it, terribly pernicious.

Who could ever start what they called "revolution?" Were they trying to assert that even a small band of political parties or ideologues could carry it out without the support of the masses? Was it really possible to do so in light of the real circumstances in which Japan was placed? When it comes to understanding about the masses and farming populations, it seemed to me that we were somewhat preponderate over those young physicians. The masses were not so opportunistic as they were. The masses were heterogeneous in contrast to egocentric and materialistic ideologues who had a habit of theorizing about nothing. Besides, it would never pay to provoke the masses. Yet in another aspect, they follow the dictates of reason and put up with their misfortune, if any, with

stoical fortitude. In the long run, they hope they will play a leading role in history.

In the first place, we are not politicians. We are medical workers and technicians. I have earlier talked with tiresome iteration about the need to keep this in mind, while referring to how I converted from Communism. Shouldn't there be the need to ponder over the limits to which we can go as medical professsionals? I simply could not turn into what Lenin called a "professional revolutionary." That's why I became a physician.

In the meantime, nevertheless, I engraved those limits in the heart and, on second thoughts, decided to serve for the masses in the field of medical care. I thought it inadvisable for us to pose as half-baked politicians, despite the fact that our essential mission is to safeguard medical institutions. In the first place, our hospital is not run by any single political party. It belongs to an agricultural cooperative that runs under the slogan which goes "of the farmers, for the farmers, by the farmers" (granting that this phrase is not something we have thought out). In reality, however, you can say, all things taken together, that farmers remain anachronistic in not a few aspects. Ours is a hospital for them. Should we go too forward for nothing without democratically securing consent of all unionists, we would certainly be given tit for tat in their names.

We have it for our primary object to protect the health of farmers. Without full medical knowledge and skill, how could we ever serve for them? I would often read a passage in Lenin's letter addressed to a bosom friend of his, Maxim Gorki, who was a prominent Russian man of literature, for young physicians. In the

passage, Lenin said, "Keep a sharp lookout on our comrade physicians and, in particular, Bolshevik doctors! As a good doctor has once said to me, ninety-nine out of one hundred comrade physicians are quacks ...." (Lenin in Krakow to Gorki on Capri Island in November 1913). In no circumstances should we join those quacks. Nor should we degrade ourselves to the position of "charlatanic eggheads," who are neither physicians nor politicians in the genuine sense of the word.

As a matter of fact, the Saku Hospital, which after all was our "fort," would eventually fall to pieces, unless we continued to staunchly defend its management. It was to be noted that we found ourselves in a medical insurance system in which fees for medical treatment were mercilessly cut down. A little neglect may breed great mischief, driving our hospital to fall apart. Nonetheless, if we padded out bills or made out false bills, as we contended that the existing medical care and other systems in society did not stand to reason, the whole situation would infallibly assume menacing proportions. It would not pass current with the world to falsify bills simply because the official rates of fees for medical treatment were kept unreasonably low under the insurance schemes. The logic is the same as that of the assertion that, should you commit theft, you would be branded as a thief.

Some of those "revolutionary" young physicians went as far as to throw their weight around in justifying padded bills, but we raised strong objections to their contention. They said that we unilaterally imposed low pays and forced labor on employees in sympathy with the government's policy. But we had striven to ap-

peal the populace in our own way how terribly low the officially formulated fees for medical treatment were. Or was there any other way to do so? That is why we had to join forces in struggling for higher fees. And the struggle had to be made so broad as to involve people in general. For this, our persevering efforts were required.

Just then, or in March 1949, the popular Zenshinza Troupe joined the Japan Communist Party en bloc. Setting it aside, it was strongly suggested that the Saku Hospital also might as well – nay, should -- do so. The suggestion came from the young physicians who belonged to the Branch Hospital Faction, or to be more precise, their supporters. I did not know what sort of organization the Zenshinza was and how its management and administration were done. Consequently, I was not in a position to say this or that about the troupe. The application of its way of doing things to our hospital was another matter.

In the first place, ours was an agricultural cooperative-affiliated hospital, but not one under the umbrella of any specific political party. It is up to each employee to choose a political party to which he or she is to accede, as long as it is a legal one. But it would be quite high-handed for all employees to join the Communist Party at a single stroke. We may easily imagine the consternation into which our accession would throw local farmers. Would it turn out to be a plus factor to the development of our hospital? I thought I was well aware of the personality and thought of each one of the 60 or so workers who were placed on our hospital staff. There had to be opponents to the admission. Is ideology

something that can be fiddled with like a plaything?

As a matter of course, I did hesitate to accept the young physicians' suggestion. The hesitation reflected not just my own view but also the conclusion that had come out after my full talks with leaders of the union. Told of the decision, the young physicians immediately jumped on me, branding me as an opportunist and non-revolutionist. I told them that I didn't like to thrust ideology on anybody. They said that's not what they were doing, adding that they just wanted to bring out the revolutionary spirit that was asleep in the minds of the employed and the masses. Here, I keenly felt that a pretext is never wanting.

Being director of a hospital, I was less blamable. The Saku Hospital Workers' Union was labeled as a "mouthpiece" for the hospital management. I felt terribly sorry for Dr. Iijima, who was acting as union chairman. Placed in a union shop system, the union's Executive Committee (elected in a secret vote every year) took part in the hospital's Management Committee. Only the hospital director and the deputy hospital director represented the management. It rested with the Management Committee to decide personnel, budgetary and all other matters. That is why the unionists were fully aware of all sorts of things, such as the hospital's benefits, redemption and dividends to investments from the local agricultural cooperatives, let alone the hospital director's pays and traveling allowances.

Above everything else, the system was so formulated that the hospital's annual budget could not take effect without an approval of the union. Admittedly, it does not mean that the system

itself may be left out of consideration. Nonetheless, it was something our union had secured after a series of struggles against the management with the belief that it would enable the union to have the advantage of management.

But those young physicians did not care about it. They argued that involvement in the Management Committee was a fake and nothing but a means to assure coordination between labor and management. They also said that the posture of going all length in fighting against the management was gone somewhere else. Our hospital is neither national nor prefectural, however. I did not think that they could get something out of an agricultural cooperative-affiliated hospital that was badly off deep in the mountains (apparently falling under the category of a smaller business), even if they antagonized its management.

As the devil would have it, it all happened at the dead of night on December 28. The wind was howling frightfully with the snow dancing and whirling, a fire broke out in or around a room of Pavilion No. 1, where an unmarried physician on night duty was to stay overnight. The whole building including the dining hall was reduced to a charred and smoldering waste in the twinkling of an eye. That night, I was staying at the Hokushin Hospital in the northeast of our province to attend a year-end conference of hospital directors and chief administrators. Told of the fire, I ran out of the hospital in hot haste. Alas, all that was available in those days was a passenger car driven with charcoal as its fuel. Frozen, the engine did not run. Making railway connections, I came back to

my hospital at eleven o'clock in the morning. I saw all the employees mingle with their tears.

Immediately, I asked all of them to gather at the ruins of the fire. At all events, it was a redeeming feature of a misfortune that all the inpatients had been successfully moved out of their sickrooms. At the meeting, we passed three resolutions: that we would do everything in our power to reconstruct the building, that we would solicit the cooperation of locals, and that we would make sure that none of the employees were to be held responsible for the fire. Hand in hand with one another, all of us sang the Song of Solidarity between sobs.

At that very moment, some employees were looking out of the corner of their eyes or turning away. They belonged to the Branch Hospital Faction. I was told that Dr. "I," who headed the group, was sticking up straight with his hands in the pockets of his greatcoat like a statue, while the building was burning down by the spreading fire. This attitude of his inflamed the anger of the hospital's rank-and-filers.

We broke up and accommodated the burnt-out inpatients in the conference room for the medical staff and the town's Public Hall, several hundred yards away from the hospital premises, and made sure that nothing went amiss for their care. Wearing traditional Japanese work pants gathered at the ankles, even many nurses dealt with the aftermath of the fire and got rid of burnt appliances. I also carried a heavy straw bucket on a pole in the work.

We visited and apologized senior officials of not only the

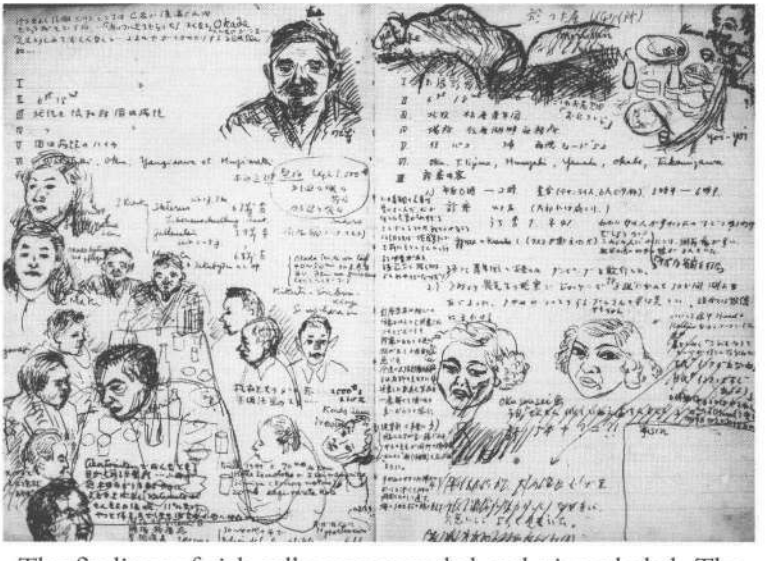
local agricultural cooperative but also the administrative offices of Usuda and its outlying municipalities, supplicating them for cooperation in the reconstruction of the ward. We were utterly unprepared for the exceedingly profound sympathy locals entertained for the Saku Hospital, which we thought was branded by people in general as a fort of Communism. After all is said and done, the great expectations they had harbored on our hospital remained intact. We had our mind set on repaying their kindness.

How much cooperation locals rendered to us, wishing as early a reconstruction of the Saku Hospital as possible! It is a never-to-be-forgotten event that townspeople in Usuda – members of its young men's and women's associations, in particular – were in open street and evolved a fund-raising campaign for our hospital's reconstruction on the New Year's Day, though the snow was falling thick. In parentheses, we were afraid that they had incessantly done nothing but criticized the excesses they claimed we had done. They badly needed the Saku Hospital for all its shortcomings: without it, the town and its neighboring villages would have once again tuned into "doctor-less" communities. Yes, that's right. Here lay its need for the locals.

In the upshot, the local agricultural cooperatives and municipalities established a 50-member Saku Hospital Reconstruction Committee. With a ¥5 million ($13,900) fund established, ambitious plans were formulated not only to reconstruct the demolished ward but also to construct a new pathological laboratory. The amount of ¥5 million was really stupendous in those years.

Medical workers of the Saku Hospital ready to make a round of sick calls on horseback. (1956)

A scene of the drama "Stomachache" the script of which is written by Dr. Wakatsuki. The Hospital's mobile medical team made it a practice to stage a play after the medical checkups. (1965)



The findings of sick calls were recorded and pigeonholed. The picture shows two facing pages of a master health register with the illustrations made by Dr. Wakatsuki. (1952)

Dr. Wakatsuki giving a lecture to villagers. To add to their stock of knowledge about the need for disease prevention, lectures were given in plain language time and again. (1946)

Locals going through the hospital's main gate to make a tour of the hospital's facilities at the two-day "Hospital Festival," an annual open-house event in May that usually draws more than 20,000 visitors. (1950)

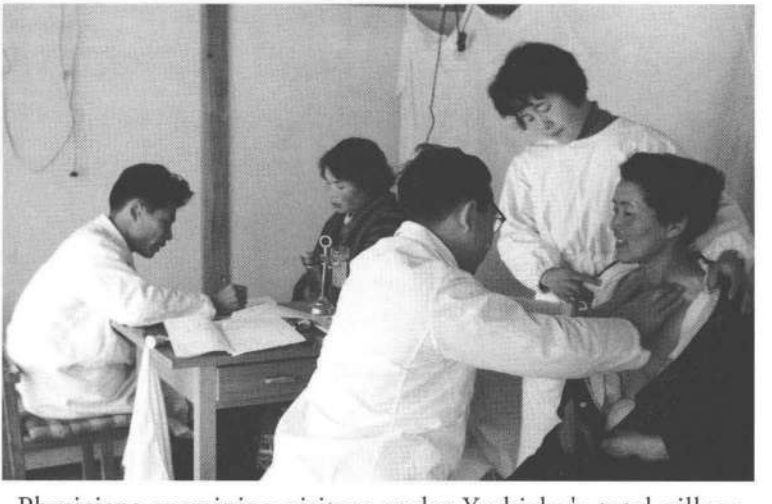
Recovering from spinal caries, ex-patients posing for a photo op. with caries inpatients bedridden in front of them after having established a Caries Society. Dr. Wakatsuki operated for spinal caries for the first time in Japan. (1952)

With a total-village health control program started for Yachiho in 1959,Dr.Wakatsuki briefing by wire broadcasting telephone about how to make entries in the individual Health Pocketbook.

The envelope for an individual health pocket-book (right) is seen pinned down on the wall along with a bag that contains traditional folk medicines. (1959)

Farmers entering their village's Public Hall with their health pocketbooks in hand to undergo a mass health screening. (1960)

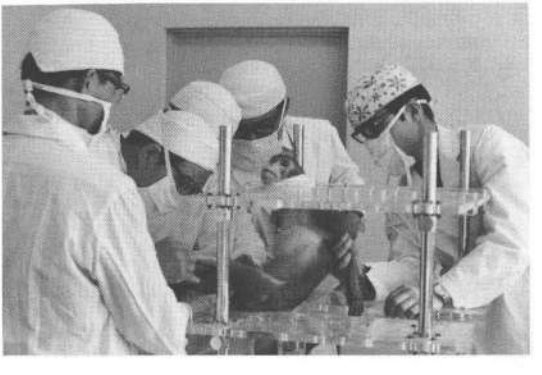
Villagers doing "farmers' calisthenics," designed to minimize the prevalence of the *Nofusho* Syndrome among rural people that includes stiffness in the neck, lumbago and the numbness of hands and legs. (1962)



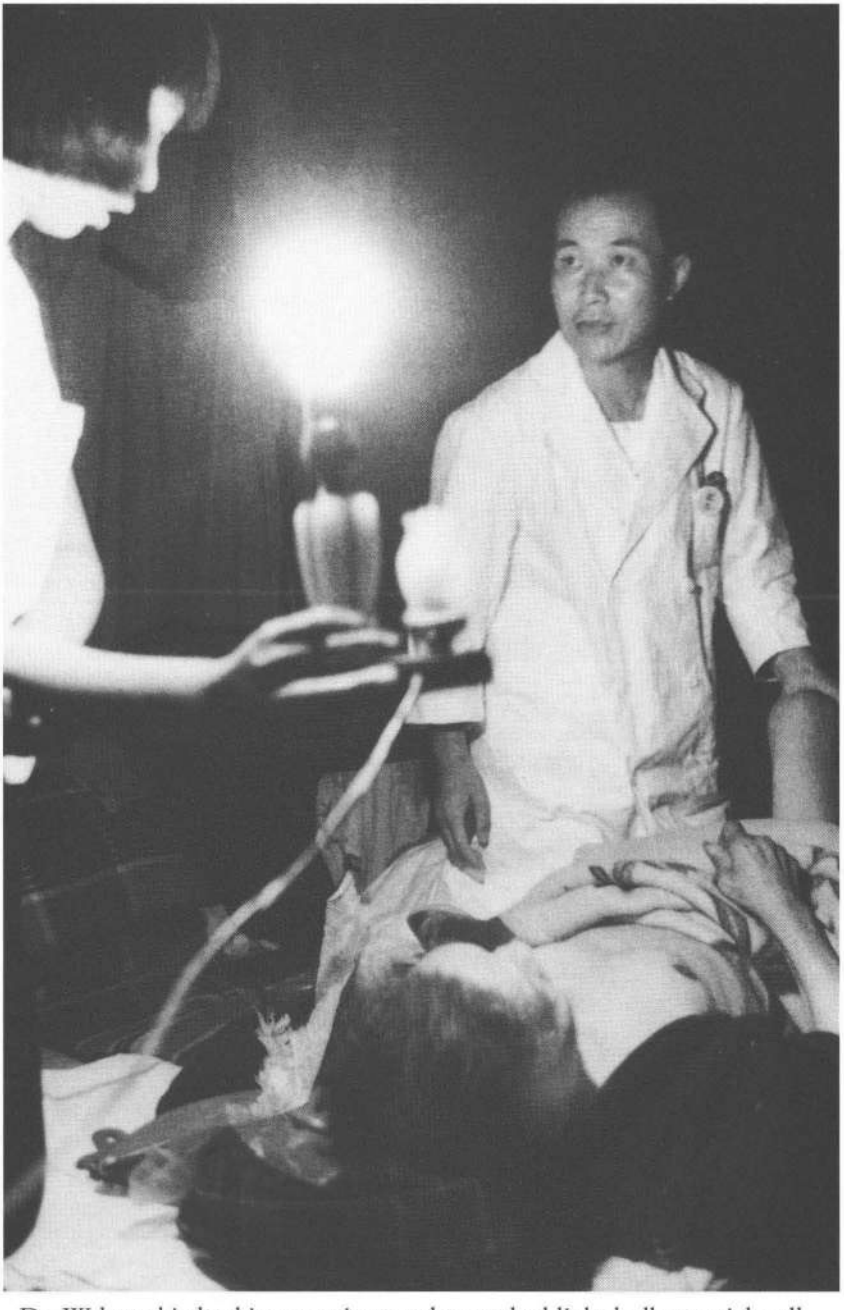
Physicians examining visitors under Yachicho's total village health control program, under which two doctors and 10 or so other hospital workers visit each hamlet to do a mass health screening. (1965)

Dr. Wakatsuki talking with the farmers. Farmers' health was deteriorated by rising calls for increased output and for the spraying of more pesticides and chemical fertilizer. (1971)

A helicopter spraying pesticides in the Saku district. Chopper spraying was seen everywhere in rural Japan in the 1970s.



Lab technicians doing an animal test with monkeys and dogs to clear up the adverse impacts of pesticides on man's health. The hospital started this program in 1966.



Dr. Wakatsuki checking a patient under a naked light bulb at a sick call.

Sarcastic fellows went as far as to ridicule the Saku Hospital, saying "Fish in troubled waters." The Association of Town Mayors and Village Headmen in South Saku County -- which we thought had frown upon our hospital -- turned out to be cooperative with us and decided to donate ¥2.5 million ($6,900) to the Nagano Prefectural Federation of Agricultural Cooperatives for Health and Welfare (Koseiren), under whose umbrella the Saku Hospital was placed. The donation would produce a significant impact on the management of the hospital. It is not that this issue was confined to the Saku Hospital alone. The ties of funding between agricultural cooperatives and municipalities would have a sizable psychological effect on the management of more than 100 Koseiren hospitals around the nation.

Ours is called an "agricultural cooperative-affiliated" hospital, but it does not mean that we medically examine only members of the agricultural cooperative. We covered all residents in the local villages. It is only natural, therefore, that the local municipalities should more or less finance agricultural cooperative-affiliated hospitals. Our reconstruction project can be described as having broken through the barrier between agricultural cooperative-affiliated hospitals and local municipalities.

At any rate, the reconstruction project came to a successful end in August 1950. The question of the Branch Hospital Faction that was brought to the fore at the time of the fire after it had smoldered for a long time blew up in the hospital with a terrific explosion and was brought to a settlement all of a sudden.

With our campaign for reconstruction of the Saku Hospital under way, the Branch Hospital Group clearly threw off their disguise. Far from cooperating at all either in our fire-fighting activities or in our reconstruction work, they meddled in every work for the distribution of relief goods sent in to the sufferers. They overstated trifle matters. For instance, they attacked the hospital secretariat for having unfairly distributed eggs and made this accusation to the public in their *Branch Hospital News* and by some other means of communication. The upshot is that what they wanted to assert was that the reconstruction was a make-believe and the employees' pays should be raised. In other words, their argument was that it would be utterly nonsensical to do the reconstruction without doing something about "forced labor and low wages." One of the headlines in the *News* declared, "A Saku Hospital Nurse Sells Blood Just to Eke Out Her Existence." The story said that she had to sell her blood as she was unable to make a living with a pittance, but a closer check revealed that she had only donated her blood to her aunt, who had to be operated on for stomach cancer. She wept and got into a rage.

By that time, two of three physicians who belonged to the group were no longer too zealous, presumably because they thought that the odds were against them. The smaller the membership became, the more radicalized they were. Finally in mid-March, the main hospital workers' union rose up. Its leadership decided to hold a convention and call for the splinters to reconsider their position. They could no longer stand on the offensive. The attendees were thrown into an uproar. When a young physician

from the splinter group yelled, "The union is nothing else than undemocratic!" Splinter nurses pounded the tables and screamed, "No objections! No objections!" Finally, one splinter stood up and cried, "We can no longer continue to be members of this sort of union," when all his sympathizers rose and moved out of the hall at a quick step, chanting "No objections! No objections!" The worst has happened.

After the thrust and parry of barrister and witness for many hours that night, the union dismissed 11 splinters from membership in accordance with Article 16 of the union's regulation, which states that he who has "disarrayed the order of the union may be dismissed from membership with a majority of two-thirds or more of the employees." With our union placed under a union shop system, the dismissed could no longer be on the staff of our hospital. I was told that it would be absolutely impossible to overrule the decision. The unionists at the main hospital had sustained patience upon patience. Nevertheless, the hospital would go to the devil, should things be left as they were.

One employee turned upon me and said, "This sort of mess would not have taken place, unless you had been a hospital director of flabby will." There were many young employees in the Main Hospital Faction, or the Hospital Director's Faction, as was the case with the Branch Hospital Faction. Most of them were hot-headed young nurses. But what if the hurly-burly got abroad? Split into two, the reform-minded comrades had snarled at each other and then one group routed the other out of the union. What a pity! I was driven into hot water in every sense of the word.

Just then, an emissary of Kyuichi Tokuda, secretary-general of the Japan Communist Party, came to the town and said he would be ready to serve as a peacemaker. Having listened to both parties and checked into the circumstances in which they were placed, the arbitrator declared that there was nothing for the Branch Hospital Faction but to follow the union's decision. The splinter workers were thrown out of job and moved to cities in quest of hospital work.

Some time later, I made peace with the splinters. The nurses who had once lambasted me made it a practice to come to the Saku Hospital, when there was occasion for it, just to say hello to me. At this distance of time, I sometimes wonder what on earth make my heart warm toward them. The appearance of an offshoot is the most unfortunate incident in the history of the Saku Hospital Workers' Union. Fortunately, there have since emerged no splinter groups at all, however. We learned a lot from the incident. The rent in organization is really a terrible thing. The greater pressure from outside, the stronger our repulsion and resistance. But you can't do anything about any pressure, which comes from among your fellow workers.

A Japanese song about day laborers goes "you don't need a sword to kill navvies; all you need is ten days of raining at most." Turning this passage into a parody, you can say, "You don't need coercion; all you need is a faction of radicals." That's the way I felt when I stood face to face with the splinter group.

In parentheses, it does not follow that all of us were utterly possessed all along with the trouble the splinter group had

stirred up. As I have said before, we took it upon us to go out to villages and give lectures on hygiene and make a round of sick calls though we were at sixes and sevens, to say the least of Pavilion No. 1's reconstruction. Nor did we suspend our research work. In February or in the midst of our dispute with the splinter group, I introduced a paper at a meeting of orthopedic surgeons in Tokyo under the title of "Spondylodesis -- A method to cope with spiral caries." [Spondylodesis is the operation of fusing the vertebrae by a short bone graft in case of tuberculous spine]. The following month, I also reported about "Hookworm-induced mesaraic adenolymphitis" [an inflammation of lymph nodes] at a scientific meeting of surgeons in Tokyo. No wonder that I had been abused violently by the splinters as sticking to the management-first and learning-first principles.

3. Upholding the Agricultural Cooperative-affiliated Hospital's Traditions

No sooner had we solved the problem caused by the Branch Hospital Faction than another serious problem cropped up, as our hospital was to be placed under the umbrella of the Federation of Agricultural Cooperatives for Health and Welfare (Koseiren) – as it is today, coming from under that of the Federation of Agroindustrial Associations (Nokoriren). There was nothing wrong with the reorganization, to be sure, but there began a new tactical move to harass us. Some leaders of the Nagano Prefectural Federation of Agricultural Cooperatives were understood to have demanded the

placing of our hospital under the jurisdiction of the Nagano Prefectural Government.

In May 1950, we held an employees' rally in the big hall of the Zenkoji, a majestic Buddhist temple, in the city of Nagano to raise objections to the demand. At the rally, a debate evolved about "what our agricultural cooperative-affiliated hospital is." Then the policy "for the establishment of a democratic prefectural Koseiren" (I had drawn up in response to a request from my co-workers) was presented to override the ongoing crisis of medical care in the rural setting. The policy was unanimously approved to veto the proposal to place our hospital under the authority of the Prefectural Government. Following are some of the main ingredients of this policy, which I think is quite an important instrument that provides for the basic characters of our hospital and its workers' union.

(1) The weaknesses are not all that we have for the hospital.

Infallibly, the agricultural cooperative-affiliated hospitals were at stake in terms of organization and management. The four such hospitals in Nagano Prefecture (the Hokushin, Showa and Azumi hospitals belonged to the Nagano Prefectural Federation of Agricultural Cooperatives beside our hospital) came out with an aggregated annual deficit of ¥2 million ($5,600), suggesting that we were on the verge of bankruptcy. Yet another terrible thing was that our outstanding accounts far exceeded a whopping ¥10 million ($2.8 million).

Nonetheless, was this plight good enough to justify the

opponents who would often take it for granted that the agricultural cooperative-affiliated hospitals were worthless and therefore unwanted? It was wrong to suggest that as things stood, it might as well put under the management of the Prefectural Government useless hospitals that could not make both ends meet. For it was to be noted that we could manage to have an income of ¥40 million ($11 million) from our delivery of medical care, though the deficit admittedly ran up to ¥2 million ($5,600). This suggests the very fact that we diagnosed and treated 25,000 farmers as our patients, while faithfully adhering to the government's list of incredibly low fees for diagnosis and treatment.

As long as the government policy of curbing fees remained unchanged, the harder we strove to provide conscientious medical care and abide by the policy so as to sustain the National Health Insurance Scheme, the more inevitable it would be for the question of deficits and outstanding accounts to tag at our heels.

What on earth made us consistently follow that policy in the first place? This is because we thought that, when it came to the delivery of medical care, the most pressing issue concerned fees for diagnosis and treatment. The thorn in the side of any villager for whom money was always the first consideration is literally that of our hospital. The only solution left for this was to rally round the National Health Insurance Scheme. It was an important task for our hospital to launch a campaign for this. The spirit with which it was to be unfolded would be lost, should our hospital turn into one under the Prefecture's management in a "the powers-that-be will foot the bill" posture. Our agricultural cooperative-affili-

ated hospitals exist in the interests of rural people, and our mission ought to be the democratization of medical care in the rural communities, or we have to see to it that even the poor in the villages may have access to sophisticated modern medical care.

(2) It is a basic mission of any agricultural cooperative-affiliated hospital to save rural villages from poverty.

It was our cardinal doctrine to fight for farmers – in particular, those who were too poor to consult with physicians. What in the world does the word "rural" mean when we talk about "medical care in the rural setting" and "science of rural medicine"? It means none other than "uncultured," "unscientific" and "semi-feudalistic." What's worse, more than half of our nation's population were eking out their existence in the rural villages. Most of those communities represented villages where no physicians were available at all and the environment where few means of communication were usable and there was a sheer lack of hygienic care.

It is in all those trials that our agricultural cooperatives-affiliated hospital was born and grew up as it was encouraged by cooperatives-minded farmers and their organizations. Today, our hospital belongs to the Prefectural Federation of Agricultural Co-operatives (the successor to the wartime Agricultural Association). Originally, it started as a "union-affiliated hospital" in the early part of the Showa Era (1926-88) under the umbrella of the "industrial unions." The doctrine I have just introduced is that of the union-affiliated hospital. We must always be as naïve as we were when a novice.

Consequently, our dearest wish was to be always with

farmers who toiled in an appallingly wretched rural environment and to fight for the safeguarding of their interests, but never to put as many patients into hospital in attempts just to keep the balance in the black. Rather, it would be ideal for farmers not to get sick, reducing work on the part of their local hospitals. In this context, our primary mission was to establish preventive medicine as a milieu of science. For this, it was an important task, as far as we were concerned, to inform rural people of its necessity and unfold activities for their enhancement.

The existence of this peculiarly uncultured life environment made it necessary to develop a unique type of rural medicine. In the rural setting, you have many themes you can hardly elucidate merely with the medical knowledge developed in the Western civilization. Cases in point are the questions concerned with such intestinal parasites as roundworms, hookworms and other enterosites, the peculiarity of tuberculosis in the rural villages and the multiplicity of neurogiform diseases.

The pressing problem posed for medical facilities in the rural setting is how to work for villages where no physicians are available. That is why we had to make a round of sick calls on a non-regular, if not regular, basis. It was an important task for us to make a round of out-of-the-way hamlets, deliver medical care and talk about health and hygiene with the hope that villagers themselves would unfold a campaign for a better lifestyle.

As shown in Figures 1 and 2, a prefecture-specific check indicates that the more remote the village, the less the availability of clinics and the shorter the average longevity of human life.

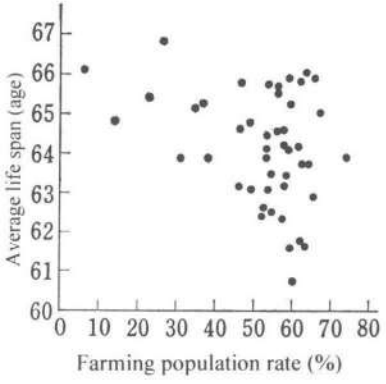


Fig. 1 Number of hospitals life span and farming population rate in 1955

The black dots denote the prefectures.

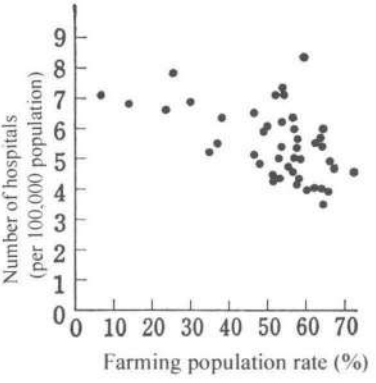


Fig. 2 Average life span and farming population rate in 1955

The black dots denote the prefectures.

Given this fact, we used to argue that even remote hamlets deep in the mountains should have as good medical facilities and technicians as well-developed modern cities. Another mission entrusted by rural people to us was to establish rural medicine-based hospitals in which we could have pride.

In the final analysis, the question of deficits and outstanding accounts had something to do with disease insurance schemes. The days will inevitably come when there arises the need of a struggle for increased shares by the public purse and raises in the fees for diagnosis and treatment. This important issue is something that has yet to be solved hand in hand with farmers along with tax, quota delivery and land. That is a mission the employees of agricultural cooperative-affiliated hospitals have to carry out

now.

Indisputably, we are not on the side of the government, as we take that position. Ours is antipodal to the bureaucratic position of a prefectural hospital. In the critical juncture of things that get all the more deteriorated in agriculture, so will the crisis the agricultural cooperatives face today. Yet in another perspective, we might as well say that the spirit unique to farmers or that of democratic campaigns would all the more grow in the course of those developments. By no means has the historical mission of agriculture cooperative-affiliated hospitals come to an end.

(3) How should the new Koseiren hospital be?

If the ideal that goes "of the farmers, by the farmers, for the farmers" remains intact, we are tempted to ask the new Federation of Agricultural Cooperatives for Health and Welfare (Koseiren) to abide by the principles of democracy at all costs. While searching our minds on weaknesses in the past management and organization, I wish to appeal with great emphasis that the abidance is the only way in which we may be able to tide over all sorts of troubles we are to face in the future.

From the standpoint of our hospital workers' union, the way the prefectural federation has done things in the past is bureaucratic, tenaciously adhering to the management-first principles. How much those principles have hampered a wide variety of cultural activities and the working of specialized technology and welfare and wrought havoc with the spirit of humanism in the field of medical care and welfare! That has been a great distress to us for long.

It is yet another serious problem that vestiges of bureaucratism remain in the cooperatives' movement like a doglike tenacity. They have turned out to be a gangrenous evil to the enthusiasm and creativity of field workers. As they dampen our will to work, there can be neither streamlined management nor proper control. There have been signs that our hospital is disposed to degrade itself to a despicable entrepreneurial existence presumably under the pressure of senior federation leaders.

On the other side, what about the hospital workers' union? Is it true that we have proved worthy of the farmers' trust, as we stuck fast to them and fought in their interest in the genuine sense of the word? The fact is, we have yet to join the ranks of farmers in the sector of medicine and welfare. Nor can we say that our delivery of medical care goes as far as to broadly cover the poor in the villages. Can we asseverate that the science of rural medicine in which we are engaged is really founded on the basis of rural reality?

Here, we declare that we will continue to uphold four slogans as we have done in the past. They are (1) the stabilization of employees' lives and the enhancement of culture, (2) thoroughgoing in-house democratization, (3) campaigning for the democratization of medical care delivered to local farmers and (4) establishment of the science of rural medicine. Along with a campaign for democratization of the newly established Koseiren, we wish to clamor for a closer tie-up with our sister hospitals and a broader network of medical care across the prefecture.

What I have just introduced is the gist of a standing policy

that was approved in the name of the Workers' Union of the Nagano Prefectural Agricultural Cooperatives-Affiliated Hospitals on May 5, 1950.

Thus, the bill for the placing of agricultural cooperative-affiliated hospitals under the jurisdiction of the Nagano Prefectural Government fell through, and the Nagano Prefectural Federation of Agricultural Cooperatives for Health and Welfare (Koseiren) officially made a start. Here, an unheralded crisis was in the offing. That was what was commonly known as the Red Purge in Japan.

Even before this drastic measure was taken, conservative local bosses had several times contrived to purge us somehow or other on the ground that we were "Reds." Of them, the major attempts, when those in the days of the Agricultural Association immediately after Japan's defeat in World War II, came, as I have earlier introduced in regard to talks on the 11-Article Demand, when the Agricultural Association was reorganized into the Federation of Agricultural Cooperatives and when the Red Purge was unfolded with the Koseiren coming into being. Whenever the newly appointed Koseiren bosses got together, they would often tend to get nervous about the "Red" hospitals under their management and try to find fault with them. Here, the desire to make a clean sweep of Reds in all its hospitals may be but natural to the human mind. As it is, the federation leadership has many conservative prefectural assemblymen. The rumors that prevailed among them about us, as I was told, were really outrageous. Naturally, they would vanish like mist one

day when the masses came to realize what we were and became long acquaintances with us.

When the Korean War broke out in June 1950, General MacArthur promptly ordered the Japanese Government to organize quasi-military forces, dubbed "National Police Reserves," and reinforced the Maritime Safety Agency, the Japanese equivalent of the U.S. Coast Guard. In October, he issued a Red Purge directive. The eviction was designed to "rout out Communists and their sympathizers who arouse vicious troubles detrimental to the security and peace of businesses." General MacArthur's headquarters articulated objections to Communism and ordered government agencies and businesses to dismiss Communist elements and union leaders. The directive was also relayed to us by way of the Koseiren's head office. On the procession of events, our workers' union organ *Saku Hospital* (No. 1 issue) has this to say:

> We had many suspects in our hospital. Now that it was the Occupation Forces that invoked legal authority, the mass media focused on, and reported about, our moves day after day. Quite bluntly, some employees were in commotion. With the conviction that the right-minded would support us, we immediately launched a signature-collecting campaign against the purge. The representatives of local municipalities and agricultural cooperatives gave support to us without exception. The collected signatures increased day by day, and we could have as many as 45,000 signatures in the first seven days. Our campaign against the Red Purge came to a successful end one month later.

Late in autumn, all our employees went out in several parties to make a door-to-door visit in the medical jurisdiction of our hos-

pital or stand on the street so as to collect signatures against the purge of physicians in our hospital. The energy they displayed in the campaign was a perfect marvel. Inpatients also played a leading role in the campaign. The list of 45,000 signatures collected from local residents in a week moved Toichi Shiokawa, who had just been designated as board chairman of the Koseiren. Mr. Shiokawa must have concluded that it would be inadvisable to force the purge. On second thoughts, we had never done anything "pernicious" that could come within the purview of the Red Purge directive. All we had done in a concentrated manner was the delivery of health care to rural people, which ought not to fall under any provision set forth for the elimination of Communists and their sympathizers. Even General MacArthur's headquarters could not go as far as to have its own way against all reason in utter disregard of the voices of people. I now think that whether the American military did actually order our purge is open to question.

Down at the bottom, the Koseiren president told us to make ourselves easy about the purge, as Mr. Shiokawa said he had no intention whatever of dismissing anyone of us at the Saku Hospital. In parentheses, he asked us not to instigate rural people too much with a signature-collecting campaign. From our point of view, however, it is the association's management that started kicking up a dust under the threat of a purge. That is why we simply could not remain still without making any resistance at all till the threat of our dismissal for no reason was withdrawn. If they said they "won't pit ourselves against you" and buried the hatchet, then,

there would be absolutely no need for us to "pit ourselves against you," either.

Once again, we expressed our deep appreciation to locals for their support and inscribed their formidable strength on our memory. With this tumult subsided, it was brought home to us that our consistent policy and practice of health care for farmers for five years since the founding of the workers' union in 1951 was broadly supported by locals. With the hurly-burly as a momentum, the union's solidarity became all the more impregnable. In order to justify the trust they have in us, we keenly felt it absolutely necessary to evolve brisk activities in the delivery of medical and health care to them. We had to hone our skills and seriously push forward in our work.

In March 1951, an isolated ward was completed after four years of construction work. Tiding over the trouble with the Branch Hospital Faction and the trials of the Red Purge, the hospital and its workers' union began to rapidly evolve free and aggressive campaigns. The substance and scale of their progress were clearly distinguishable from those of our previous efforts, suggesting the advent of an entirely new chapter in our history. Describing as the First Phase the period of time since the founding of our hospital, we distinguished it from the Second Phase, a period of construction. The First Phase may also be called the preparatory stage for the hospital. It was a period that corresponded to what the Germans dub *Sturm u. Drang*, or Storm and Stress [that featured their literature in the late 18th century]. Thinking back to our past days, what we call the spirit of the Saku Hospital today fully made

its appearance in the First Phase. We are surprised that the basis for its development, or the germ of its spirit, was present already in that period.

CHAPTER THREE

Development of the Hospital

1. Constructing a Quarantine

Our quarantine was completed in March 1951. A year later, Pavilion No. 1 that had been reduced to ashes was reconstructed with the all-out cooperation of local people. It was our first experience to complete such a special ward as the quarantine with the cooperation of local municipalities. For its completion, however, it required four years to make preparations, during which time local farmers raised strong objections. I would often bring many episodes about this project to remembrance. Gleaning lessons from this experience, we later began to construct one ward after another. They included a ward for tuberculosis, a ward for caries, a ward for psychiatry, a ward for *Seijinbyo*, or lifestyle-related diseases degenerative over time, and a ward for pediatrics and the like.

As a matter of fact, when I was determined to become a fixture in this mountain town, the very thorn in my side was the town's pest house where patients with contagious diseases were taken in. Close to a sacred Shinto shrine at its verge, there was a hovel-like house of one story (which would be disinfected and turned into a nursery in the busy farming season). The paper-pasted windowpanes were holed and the straw floor mats tattered. Water had to be manually drawn up from a well. When I was told that this was a quarantine facility where patients with legal epidemics were compelled to stay, I was really shocked and at the same time stupefied with horror.

Anyone who fell down with some communicable disease or the other would be housed there and checked by a visiting

physician once a day. A public health nurse visited the house from the town's administrative office to serve three meals of gruel a day. All things considered, all that you had to do was to isolate patients from townspeople. Backbiters called it a "death house," instead of a "quarantine house." Still in those years, typhoid and dysentery were turning riot in the villages; God knew for sure who would fall prey to them next. I shuddered at the bare thought of this plight, as I felt as if it were my own affair.

Immediately after Japan's defeat in World War II, there was a quarantine house not so far away from the Aonuma Village Primary School. The facility housed three patients with typhoid. Soon, the two public health nurses who attended to them also caught their disease. Even if they had made it a practice to scrub their hands, they could not have destroyed the germs with so many flies swarming around and the washroom left filthy. The three patients were cured, but one of the nurses died.

Late at night, a public health nurse in the town knocked me up. In a condition of clouded consciousness, I was told that a kid with diphtheria accommodated in the town's quarantine house looked like dying soon. She said his throat swelled, just about to be bunged up, and at midnight, he suddenly began to labor for breath. His face gradually swelling in purple, she added, she just couldn't watch him, as it looked as if the life were being choked out of him. "Being at loss what to do," she said, "I've made the best of my way to ask you, doctor, to surgically open his throat." Though I had never performed tracheostomy, or the surgical creation of an

opening into the trachea through the neck, before, I thought -- judging from what she had said about the child -- that his life could probably be saved if his throat was cut open. In that tumbledown house, nonetheless, even scrubbing could not be properly done at all. She asked, "Will you operate on him, if I bring him to your surgery?" I said, "Yes. I'll do it. Hurry up!" I did it at midnight.

As I had the throat cut open and put a scalpel into the trachea, I heard the air lodged in the throat shoot out. In almost no time, he began to breathe in a smooth manner and his swollen and cyanosed face improved every moment. It's really incredible. I inserted a small cannula into the opening. Pleased as a peacock, I said, "Let him stay overnight here, and he will be completely cured in a few days."

The following morning, however, I had a phone call from the chief of the local Public Health Center. He was of quite an obstinate nature and more or less bureaucratic. I cannot say that we always were on good terms with each other. I was utterly off the guard, when he began hurling words of thunder at me on the phone.

"Perhaps, you think you've done a good thing," the chief yelled, "but I am obliged to lodge an accusation against you for a violation of the Law for Communicable Diseases."

I was dumbfounded and asked what in the world was wrong with me.

He said, "Hold your tongue! What a shame that you took a patient out of a quarantine house and admitted him into your hospital! Common sense ought to tell you not to do so. Don't you

ever forget that you'll be prosecuted for a violation of the Law for Communicable Diseases."

At that, I flew into a blind rage and turned upon him. "Oh, yeah? I think I've saved the kid's life in answer to the dictates of my conscience. He must have departed from life by now, had I not opened the throat the previous night. He who has saved a kid's life will be punished; here enters the comical climax. Go right ahead!"

The chief retorted, "You can talk your mouth off, but you've got to know that ignorance of the law excuses no one."

I did it only the more to spite him (an incorrigible vice on my part). "What's waiting for, chief? Go right ahead and punish me. The kid has a cannula in his throat; you can't take it out in two or three days. Nobody knows for sure what's going to happen, how and when, so that I can't let you take him out of hospital immediately."

"You have other inpatients in the ward that houses the kid. What if they were infected?"

I said, "The kid is in a single-bed room closest to a washroom at one end of the ward."

"But is it not," the chief asked "that inpatients pass by the front of that room on the way to and from the washroom?"

"The room is partitioned off with a screen."

"Do you really think it possible to prevent germ contamination merely with a screen?"

"How come you allow healthy people to pass along right in front of your quarantine house as though it were not there? What difference does it make?"

"Give me none of your sauce! You can't stretch the law to suit yourself."

"Why the heck don't you lodge an accusation against me? Go to the devil!"

"You'll have to pay for it!"

The vituperation endlessly went on between us on the phone.

The head and tail of it is that he appeared to have realized that it wouldn't help him in any way to hurl words of thunder at me. A few days later when I realized the boy was visibly on the road to recovery, I took the cannula out of his throat and allowed him to go back to the town's quarantine house. Thanks to his return, I was not accused. The whole case ended in smoke.

Nonetheless, many of the operations we performed in those days were not so simple as the one I had done on that body. In some cases, you had to perform celiotomy, or surgical incision into the abdominal cavity, and cut the intestines. There were many cases with typhoid in those days. Once in a while, you have cases in which the typhoid ulcer rips and causes a perforation. For this particular case, you have to immediately conduct celiotomy. You simply cannot do it in that ramshackle quarantine house.

With all sorts of incidents taking place one after another, a novel idea flashed on me. I found it absolutely necessary to build a modern facility in place of that quarantine house and annex it to a general hospital in our district, where surgical operations could be performed without hindrance. I thought that the best thing would be to attach it to the Saku Hospital. I talked the headman of Usuda

Town, Sumio Kawamura, over to my suggestion.

Mr. Kawamura expressed his approval. He had rendered cooperation in the reconstruction of our hospital's burnout ward. On the whole, he made it a practice to take a very constructive posture, when a suggestion came out for the construction of some public facility or the other. From then on, we would be much indebted to Mr. Kawamura for his kind assistance and guidance. Serving as president of the South Saku County Association of Town and Village Headmen, he was in on the ground in a fund-raising campaign. He was also good at getting money from the government.

Besides, one of his followers was the president of a construction company. To my suggestion for the construction of an annexed isolation ward, Usuda's headman said, "Okay. That's quite interesting. Why not construct it?" Then he began to talk the headmen of other municipalities into compliance. Mr. Kawamura believed that measures against contagious diseases were something that should fall under the jurisdiction of municipalities. That is why he was convinced in legal terms that the national and prefectural governments should provide financial aid in the construction of an isolation ward. He presumed it meant no expense on the part of his town.

Then, bitter objections were raised against the construction project. They came from Usuda's townspeople – farmers, in particular. There would be hell to pay. One of the local bosses said in a threatening posture, "To think that we bring, of all things, catching

sicknesses into the town! Look, the hospital is situated, of all places in the town, along the upper reaches of the Chikuma River. The hospital sometimes discharges filthy stuff into the river. If they decided to build an isolation ward at all costs, we would mount a mass demonstration against the project." The project came to a standstill.

Besides, there had been no end of trouble at our hospital. When it comes to the project, we passed our time in idleness. I was in the fidgets. Certainly, what the masses need is different from what they desire. That's what I took to heart. If you fall with some contagious disease or the other, you immediately can see the need for an isolation hospital. We, medical scientists, always see it. If the man in the street assesses the raison d'être of a quarantine hospital in a typically lay perspective, he is apt to draw a conclusion in marked contrast to the actual need. It came home to me that, for the masses to correctly understand the necessity in the real sense of the word, it would often take a long time and require painstaking efforts for their enhancement.

Nevertheless, what had never entered my mind happened, and the tables suddenly turned in favor of the construction. Presiding over all matters associated with public health, including communicable diseases, General MacArthur's headquarters called in a directive for the Japanese government to revamp the conventional system of quarantine houses in rural Japan and, if possible, to annex a modern isolation facility to each general hospital. This instruction was exactly the same as what I had in mind. Immediately, the Ministry of Health and Welfare came out with a bill in

line with the American order. The law obligated the national and prefectural governments to share two-thirds of the construction cost.

The quick-eared Mr. Kawamura heard of the nation's new policy measure somewhere and said, "We've got to build one here. That's got to be No. 1 under the new Japanese Constitution." Given objections raised in the town, the headman decided he would hold one meeting with townspeople after another till he could successfully talk them into agreeing on the construction project.

On July 5, 1950, Usuda Town's board of trustees invited the executives of various organizations to the town's Public Hall. Mr. Kawamura; Ryoichiro Sejimo, director of the Nozawa Public Health Center; and I as director of the Saku Hospital spoke of the project at full length. Many townspeople attended and there was an animated discussion on this subject. On the night of July 8, the Usuda Town Young Men's Association held a free discussion in the auditorium of the town's primary school. After I had talked about the project as hospital director, Mr. Kawamura and Tokuji Terashima, a straw floor mat maker, spoke on behalf of the supporters, whereas Chohei Ide, a farmer, and Hiroshi Nakamura, a restaurateur, represented the opponents. All of them were town assemblymen and prominent orators in the town. They enthusiastically voiced their conviction. In the question-and-answer session, participants dispatched a volley of questions. Some of the questions and answers are cited below from the town's newspaper *Usuda Minpo* (most of the answers came from administrative offi-

cials of the town):

Question: I would like to hear from the responsible official just how much it would cost to build the ward.

Answer: The existing quarantine house in the town, or the "house for death," is not good enough to provide full medical care to inpatients. Dr. Wakatsuki and Mr. Kawamura, the town's headman, have long been in hopes of constructing a nice isolation hospital one way or another. We have recently heard that the Ministry of Health and Welfare and the prefectural government each will share one-third of the construction cost. We think we should have our share of luck. The estimated total cost would come to ¥2 million ($5,600). Two-thirds of it, or ¥1.3 million ($3,600) or so, would come from them as a grant-in-aid.

Q: Will each one of the municipalities that are to jointly establish an isolation hospital have to bear the remainder?

A: The construction cost is estimated at ¥10,000 ($28) per *tsubo* [4 square yards]. I would think that the actual expenditure is smaller than that. If things went smooth, we would be able to construct the ward only with the grant-in-aid. Even if each municipality had to bear some portion of the total cost, the share would be quite small, now that you have 13 towns and villages in the county.

Q: What makes you construct it right in the midst of the town and along an irrigation channel? Is it not a common practice to have it in the suburbs?

A: Incidentally, the common practice has recently changed. Inpatients will not be able to have access to full care, if a physician visits a quarantine house outside the town only once a day. If there is a sudden change in the condition of an inpatient, we will leave him or her in the lurch. It is no longer warrantable to give over a patient with some communicable disease or the other for death, without doing anything at all about it.

Q: But why bring in from other towns and villages the patients

with contagious diseases who are in the bad disgraces of townspeople?

A: There is an element of truth in what you've just said, to be sure, but now that the construction of an isolation hospital is to be officially subsidized, we will have to accept patients from other towns and villages, too.

Q: But is it absolutely necessary for this town to be saddled with encumbrances in other communities? Their admission would be detrimental to the development of this town as if we were overtaken by the deity of poverty. If many patients were admitted from other towns and villages, people would say, "Don't do shopping on the main street, which is close to the dangerous isolation ward. Even if you visit Usuda on a day of festival, do shopping not right in the town but near its local railway station, which is far away from the ward."

A: Some people might follow your advice. But I would say admissions eventually could bring in additional profits to stores on the main street in that the families of inpatients had to buy daily necessities.

Q: Wouldn't sales fall off for fish shops and confectioneries?

A: A case in point is the Nagano Red Cross Hospital, which has had an isolation ward for long. I've never heard that nearby stores are adversely affected.

Q: In whatever way you may look at it, it would be quite dangerous to build a ward along the irrigation channel.

A: What you're trying to say is, it would be dangerous, if you didn't have any facility to protect it from the ward's effluent. There would be no danger as long as you had competent facilities. In the first place, physicians and nurses would constantly be with inpatients. Dr. Wakatsuki has pledged his word that contagious diseases have nothing to do with the nearby irrigation channel.

Q: In any case, the proposed construction of an isolation ward really makes me nervous.

A: That's a matter of how you feel. We can't do anything about it.

Thus, the debate continued without a break. In the last resort, the meeting came to an end, when one representative of the townspeople said, "Let's get through with this meeting, leaving a final decision to town councilors and assemblymen of sound judgment, who we believe give full heed to the town's development and prosperity." Notably, Ryoichiro Sejimo, director of the local Public Health Center, with whom I had once clashed on the phone, stood up at the end of the meeting. He declared: "Under instructions from the Occupation Forces, we have decided to depart from the conventional system of quarantine houses -- in which emphasis was put on the segregation of inpatients far away from residential areas -- to a system of isolation wards, in which patients with communicable diseases would be able to have access to the absolutely same kind of opportunity for treatment as those with non-communicable diseases. This new system is based on the principle of annexing an isolation ward to a qualified public hospital at the center of a town or village easy of access." He concluded, "If the Saku Hospital had a fully equipped isolation ward, residents in one town and 12 villages [in the county] would be able to receive inpatient services without anxiety." His remarks would turn out to be instrumental in bringing the opponents to their feet. That sent me a thrill of joy.

2. Performing operations for spinal caries

It was in or around 1950 that I unhesitatingly began operations for spinal caries at our hospital.

What I have described as spinal caries here is osseous – spinal, in particular – tuberculosis. If the bone is invaded by tuberculosis, pus will permeate throughout the body, eventually courting death. In those years, there were many cases with pulmonary tuberculosis, but it is beyond imagination today that there were a far greater number of cases with osteoarticular tuberculosis, or tuberculosis that affects bones or joints. Particularly, a patient with spinal tuberculosis cannot stay in an upright position. All the patient, put in plaster and bedridden, can do is to look at the ceiling with a fixed gaze. The phrase "seven years with caries" used to be on many lips. Which means that the patient will die – but not cure -- in seven years. Medical common sense in those years told you not to operate for caries. They said that you would open the "gate to death," if you lent yourself to the operation. That's what we learned in our medical-school days.

When I made a house call to a farming family, I found a young woman in caster bedridden in a pitch-dark room of their barn. There were several openings on the stomach, from which pus was spouting out. They were giving out a bad smell because of mixed infections. Flies were swarming upon her. She was too much reduced to a mere skeleton to chase them away. Ever since my transfer to the Saku Hospital, I had seen an amazingly large number of patients with caries, presumably because the miserable lives with which Japanese people had to put up right before and after their country's defeat had something to do with this appalling phenomenon.

Instead of idly doing nothing about caries, isn't there any

positive therapeutic methodology, if not a surgical procedure, to lay the ax to its root? If a bone graft is implanted in the rear region of the spine and the affected upper and lower ribs were fixed, cannot the spine be fixed? In real earnest, I groped for a breakthrough. This surgical procedure is kindred to what is known as "spinal fusion" in the old textbooks. I was determined to do it in a new surgical procedure where a spinal graft would be implanted in the affected part. This method was simple and did not involve any risk. The postoperative course was exceedingly good.

Having used this methodology for a number of cases, I presented a paper at a scientific meeting of orthopedists in Tokyo in February 1950. Sure enough, prominent orthopedists bombarded me with questions and I had to stand against the storm of bitter criticism. One panelist asked, "What in the world drove you to open the 'gate to death'?" Another lambasted me, saying that it was unreasonable of me to do, of all things, an operation for spinal caries. Apparently, a third one thought I had broken into his domain, when he outspokenly said, "You are a mere surgeon, but not an orthopedist." Perhaps, poverty warped my disposition when I felt so. Later, a colleague of mine was stung to fury, when he said, "Those specialists didn't have to put on such a patronizing air." (Ten years later, the undisclosed professor who had chaired that panel discussion put out a book under the title of *Operations for Spinal Caries* to my surprise. He referred to me at several places in the book.)

We made another step forward and began vertebrectomy, or excision of the vertebra. In this procedure, we not only fixed the

spine but also cut directly affected corpus vertebralis open and perform the curttage of, or excise, the purulent region. It was in those days that we could start using streptomycin. The development of chemotherapy, such as with not only streptomycin but penicillin and sulfamine as well, made it easier to use positive surgical procedure of the kind which had been regarded as dangerous. As had been expected, the postoperative course of our patients was markedly favorable. Almost at the same time, Professor Eishi Kondo at Kyoto University, urged orthopedists to operate for osseous tuberculosis with streptomycin. It also came to light that J. Kastert in Germany and G.R. Girdlestone in Great Britain went ahead with vertebrectomy.

We introduced our surgical procedures and the results of our treatment at many national scientific meetings. At a congress of the Japan Surgical Society in Kyoto on April 1, 1952, and a conference of the Japan Orthopedic Society in Osaka on April 6, we reported about our surgical procedure for spinal caries. At those meetings, questions and comments were made on our presentation that concerned the surgical procedure we had taken for spinal caries. Taking part in the discussion were Daiji Kashiwagi, assistant professor at Kyushu University, Masao Kurusu and Kenji Kawamura, professors at the Kyoto Prefectural University of Medicine, Yotaro Mizuno, professor of orthopedics at Osaka Municipal University, and Professor Kondo, among others. Most of the discussants were in favor of our surgical procedure in sharp contrast to the comments made at the scientific meeting of orthopedists in Tokyo two years earlier. Having just returned from a tour of so-

cieties of orthopedists in the United States and Great Britain, Prof. Mizuno surprised participants at the Osaka congress, as he reported that spinal fusion for patients with spinal caries was just as popular as appendectomy, or surgical removal of vermiform appendix.

Patients with spinal caries at the Saku Hospital founded a Caries Society and began to put out its journal *Sebone* (The Spine) in 1951. The establishment was a good incentive for patients bedridden with caries across the nation. The hospital's group came into being with the hope that patients both in and out of hospital, who were apt to damp their ardor under prolonged medical treatment, could encourage one another and exchange information among them with a new hope in life. It is particularly notable that the society decided to hold a general convention at the hospital once a year with the participation of physicians, nurses, inpatients and discharged patients, where physicians would enhance their knowledge about caries and give lectures on the ever-advancing treatment of tuberculosis. The group also made it a practice for discharged patients to take advantage of this occasion in undergoing an X-ray examination and having themselves carefully examined by their attending physicians. It was also decided that discharged patients would talk to inpatients about how they were completely restored to health.

The Caries Society has since held a general convention once a year, though it was later re-designated as the White Birch Society as a result of its merger with the self-governing Associa-

tion of Patients with Pulmonary Tuberculosis at the Saku Central Hospital [The Saku Hospital was re-designated as such in 1955]. The gravure section, entitled "Health Conference," in the July 1956 issue of the journal *Sebone* has a story about how the fifth general convention of the Caries Society was carried out.

Page 1 carries a picture that depicts patients carried on stretchers on the way to the venue under the escort of nurses. The caption says, "Pleased to meet discharged patients once a year, patients are seen being stretchered to the venue." Pages 2 and 3 also carry pictures that show discharged patients who seated themselves with stretchered inpatients. Under the headline of "Bedridden Though We Are, We Have a Pleasant Day Today," the story has this to say:

> Discharged patients arrived at the main entrance to the hospital one by one in the rain. The sight in which, meeting after a long separation, they smilingly greet one another with a handshake and then have the precipitation of their blood measured and undergo radiography make us smile. Of 50-odd inpatients, only four can walk. Mr. "M" who is in charge of the proceeding and Mr. "T" who is serving as master of ceremony are in a whirl of business. With 100-odd attendees, the meeting began at 10:30 in the morning. The general assembly reached the climax one hour after its opening. After the hospital director's presentation on a new surgical methodology and its achievements, Dr. [Zenzaburo] Funazaki showed some slides for his scientific presentation, before the morning session came to an end. The inpatients in the auditorium were engrossed in chatting with one another at lunchtime, while biting at *sushi*, or fresh fish and rice. At last the rain stopped with fresh young birch leaves in the full sun, and the discharged patients posed for a souvenir photo with the hospital

director.

The afternoon session began with the Hospital Chorus's performance. It was followed by the long-cherished projection of a documentary film that would introduce the vertebrectomy performed at the Saku Hospital. How this surgical procedure was taken was vividly reproduced in color. The audience was wholly taken aback as there was much punch in the movie. Out of sheer desire to see the motion picture, a mother came all the way from Tokyo. Beads of sweat popped in her forehead when she kept her eyes upon the scene in which her six-year-old child was operated on.

Caring nothing for the lapse of time, discharged patients introduced their experience in a question-and-answer session. At this year's meeting, heavily tanned attendees stood out clearly from others. Dr. Funazaki who had performed the operation gave a debriefing with the aid of illustrations. Both inpatients and discharged patients were all attention. They looked simply unable to get their fill of talking but broke up under promise to meet again in the coming year. The clapping did not seem to die down.

In 1956, by which time six years had elapsed since we started operating for spinal caries, we came out with a scientific paper under the subject of "Long-span findings of vertebrectomy" and presented it to that year's congress of the Japan Surgical Society. As regards the findings of the operations, the rating "efficacious" accounted for 90%, of which "cured" came to 30% and "favorable" to 60%. What a striking difference there was from the conventional sort of therapy in which a bedridden patient with caries had been kept just in plaster!

The findings of a survey we had conducted on patients with caries

in the mountainous Saku district revealed that, when it came to many of the patients who had not undergone an operation (bedridden in plaster at home), the poorer their families, the greater the number of patients with caries taking an "unfavorable" course or eventually courting "death." Of 14 patients with caries who were from farming families with their monthly per-capita income at less than ¥1,000 ($2.8) in 1955, as many as 12 occasioned "death" or were in an "exacerbating" condition. When it came to patients who had been operated on, no such correlations were observed between prognosis and income. It came to light that poverty, a social factor, infallibly held sway over the prognosis of patients who had not undergone surgery. Notably among caries patients who were from farming families and bedridden at home, a greater number of them were destined to court "death" than those from non-farming families.

How farming families' malnutrition and the pressure of work for them in the busy farming season (in which even patients could not be at rest) exacerbated the post-treatment course was indescribably alarming, indeed. Contributing an essay about the congress in a medical journal, an anonymous university professor said, "Presumably, this is the first time in the annals of the Japan Surgical Society's congresses that such a social analysis is presented." Maybe, so.

Patients with caries began to visit our hospital from across the nation. I decided to build a fully equipped ward for them. New surgical procedures to address caries were important. But you cannot

cure caries only with them. After all is said and done, it is necessary to prepare an environment that is favorable for recuperation. The Caries Ward was completed in 1957. About this new facility, I had this to say in the No. 4 issue of the journal *Sebone*:

> When it comes to various issues that concern the phase of recovery, we wished to have, more than anything else, a sanatorium designed exclusively for patients with tuberculosis of bones and joints with the employment of a therapy in which patients are exposed to, or blessed with, nature and fresh air – the one which would enable them to enjoy bathing in the sun, reading books or listening to the radio in their well-ventilated sickrooms with the sunbeams pouring down through the windows or at the courtyard – or, I mean, the kind of sanatorium which is described by P.G. Kornev, a prominent Soviet physician, in his book about tuberculosis of bones and joints. Last year, we raised about ¥20 million ($5,600) mostly from the private sector and constructed the Caries Ward. We built it at the Chikuma River, because we wanted to prepare a stretch of greensward, replant high trees and beautiful flowers and put cots side by side on the riverside, blessed with fresh air, so that patients could watch the misty Mt. Asama and the snow-capped Yatsugatake range of mountains while basking in the sun. The staircase was so designed as to enable patients in the phase of recovery to wheel themselves out to the surf from the second or third floor. The ¥20 million required for the construction was partly invested by the local Agricultural Cooperative with the rest borrowed from the central Agricultural, Forestry and Fisheries Fund and other financing institutions. The central government's contribution was a mere ¥2.5 million ($6,900). In and for itself, the government's subsidy for the construction of a tuberculosis facility was legally set at one-third of the total cost, so much so that we could have had access to ¥7 million ($19,400).

The problem was not just that the subsidy was too small for a tuberculosis facility. Funding for treatment was not done as prescribed in the Tuberculosis Prevention Law. In particular, medical subsidies for patients covered under the Law for Relief of the Poor were trimmed down.

Problems cropped up particularly about patients with caries who had to go on relief. In normal circumstances, it would have been authorized to have a nurse attend to each postoperative patient for one or two weeks. The welfare offices "restricted" or "knocked off" the assignment by reason that it was "too expensive." As the standardized number of regular nurses had yet to be assigned to our hospital, we would be unable to operate on any patient on relief, who was not to be attended to by a nurse. We had no choice but to fight against the bureaucracy. I myself filed a petition with the Nagano Prefectural Assembly. We went as far as to besiege the local Welfare Office with a row of loaded stretchers.

Later, we assigned the standardized number of nurses to the Caries Ward earlier than any other ward. We also increased their number to have access to added remuneration scores under the National Health Insurance Scheme. In a nutshell, we did everything we could for the improved treatment of patients with caries. "You cannot go straight up to the third floor; you have to climb to the second floor, first, and then to the third floor," I explained myself in the *Sebone.* Perhaps, I might be reproached for sticking too much to "reformism."

3. Psychiatric Ward and Instruments for Cancer Treatment

By all manners of means, I really wanted to have a psychiatric ward in our hospital. For I wanted to have advice and counsel from specialists in psychosomatic medicine on so many occasions, while engaging in routine surgical diagnosis and treatment. Let us assume, for instance, that a patient with terrible gastroptosis, or downward displacement of the stomach, was referred to me from the Department of Internal Medicine. No matter what medicines he took and how many, there were not signs of an improvement. Would it not be better to surgically haul up the drooping stomach and cut part of the loosened stomach to put it in better shape? By so doing, the stomach would stay in good shape for some time. But it would once again hang down bit by bit with the patient coming away none the better. Yet in another case, the patient had severe chronic constipation. X-rays showed the colon was evidently long, thick and sagged. Suppose part of the colon was cut off to put it into better shape, it would grow eventually to the original length. The constipation would also return to what it preoperatively used to be.

Those patients suffered from neurosis. Essentially, there was something wrong with their nerve. Putting the stomach or colon into better shape would merely produce a temporary effect. When it comes to those cases, a close observation of their postoperative course suggests the possibility of eventually suffering from schizophrenia [any of a group of severe emotional disorder, usually of psychiatric proportions] or depression. That's against my bet-

ter judgment.

The tendency strongly persisted for physicians to diagnose no more than affected organs. They were apt to check the stomach or heart but no other regions, when there was something wrong with it. They simply forgot to come to grips with the symptoms in systemic terms. It goes without saying that parts move within the confines of the whole body. Now that we are human beings, the central nervous system significantly holds sway all over the body. Surgeons are apt to forget all about this very fact before they knew what was happening. Come Hell or high water, they are apt to operate on patients. Even veterinarians must treat cattle with the effects of the central nervous system taken into full consideration.

Naturally, it was a serious problem in the mountains that there were many mental and nervous diseases, about which nothing was done. Patients with severe psychiatric diseases would often be locked up in an isolated room. He who once saw the weird countenance of a patient with severe psychosis cooped in the pitch-dark storehouse of his farming family would never forget about it in his lifetime. With the hair unkempt and the cheeks cavernous, he had a dubious smile playing about his lips and his glaring eyes shining vacant. What was more lamentable was the crestfallen countenance of a relative who had to bring three regular meals to the patient.

I consulted with Shiho Nishimaru, professor of psychiatry at Shinshu University, a classmate of mine at the Imperial University of Tokyo. He sent in his disciples to our district to perform a

fact-finding survey on psychiatric patients. The findings revealed a grave situation in which nothing was done for them, as not a single care facility was available in the district. Prof. Nishimaru complimented me when he said that it would be quite an interesting idea for us to establish a department of psychiatry in our rural hospital.

With the cooperation of Professor Akira Kasamatsu at the University of Tokyo and Dr. Tsutomu Ezoe at the Matsuzawa Hospital in Tokyo, both university classmates of mine, we decided to construct a psychiatric ward where open-method therapy could be performed in a new method (this therapy could hardly be conducted at university hospitals and in Tokyo). With this in mind, we called for the designing of a "psychiatric ward without bars" in line with the spirit of Philippe Pinel (1745-1825), a French psychiatrist who advocated a humanistic approach to mental cases during the French Revolution.

In the fall of 1956, I called at the office of Risaku Yamazoe, governor of the Tokyo-based Agriculture, Forestry and Fishery Finance Corporation to borrow ¥40 million ($111,000) for the construction, accompanied by Toichi Shiokawa, president of the Nagano Prefectural Federation of Agricultural Cooperatives for Health and Welfare, and Ichitaro Ide, a member of the House of Representatives on the Liberal Democratic ticket from the town of Usuda, where our hospital is located.

Governor Yamazoe asked, "Is it not true, Dr. Wakatsuki, that the prevalence of psychiatric disease, also known popularly as 'culture disease,' is higher in the cities?"

I said, "No. Sir. The prevalence is higher in the rural ar-

eas." Then I produced the findings of a survey we had conducted in the Saku district to corroborate my assertion. "Perhaps, this is because bad genetic factors overlap one another as the traditional practice of consanguineous marriage remains intact in the rural setting, particularly in the mountain hamlets. Besides, there is no doubt that the closed lifestyle in the villages, tied in with poverty and convention, stimulates the incidence of psychiatric disease."

Then I referred to an actual case we had come across in the village next to our town a month earlier. The anger of a young housewife flamed at her crabbed mother-in-law and struck blow after blow at her to death with a hatchet while she was doing her laundry. Then the young woman went to her parents' home and took her life by leaping into the well, which was the one into which her mother by blood had jumped to death more than ten years before. There was no way of knowing what drove the mother to do so. Presumably, she had endogenous psychosis, which in turn was passed on to her daughter.

"O.K.," said the governor. "We will accommodate you with money for the construction of a psychiatric ward. You've said, Dr. Wakatsuki, that you would build it in two phases over a period of two years. That would be a costlier undertaking. Why don't you do it at a single swoop?" We borrowed ¥40 million ($111,000) at once (that was an enormous amount of money for a construction project in those years). Dr. Ezoe and other specialists designed a three-storied ferroconcrete pavilion round in shape. Later, agricultural cooperative hospitals across the nation began to construct psychiatric wards as though they were trying to keep up with the

fashion of the day.

Our hospital bought a cobalt 60 system to treat cancer. This machine was unavailable not just in our prefecture but also at agricultural-cooperative hospitals across the nation. The main body of this system, known as quite instrumental in treating cancer, cost ¥3 million ($8,300). The price of 100 curies of cobalt 60, imported from the United States, was ¥800,000 ($2,200). The total expenditure was ¥7 million ($19,400), including the cost for an underground hall in which the machine was to be installed.

Add the outlays for interest and redemption, and the aggregate cost would soar to a stupendous amount for a rural hospital. With an ordinary amount of irradiation, the fee for treatment would run up to ¥700 ($1.94) or ¥800 ($2.22) a time. Now that irradiation had to be done more than 30 times before the end of the treatment (no benefits were available from the National Health Insurance Scheme in those years), you would have to set aside ¥40,000 ($111) to ¥50,000 ($139) in cash. That would include expenses for the treatment and for trips to and from the hospital. Consequently, it was really a forbiddingly high outlay for any ordinary farming family. That is why it was absolutely necessary that isotope treatment should be covered under an insurance scheme. We initiated a campaign for this through the press. The *Mainichi Shimbun* asked on July 28, 1957, if isotope treatment was "far beyond our horizon." Noting that it could pave the way for the treatment of cancer patients, the influential daily said that there were rising calls for the coverage of irradiation under the National

Health Insurance Scheme, as the expenses were piling up for the patients.

Quoting from its interviews of our hospital staff, the newspaper declared, "Not a few patients abandoned isotope treatment after five or six times of irradiation because the cost was too high. In the mountains, patients would go home with a heavy heart, as they simply did not have enough money for isotope treatment. The insurance scheme should be invoked for anybody who should be given isotope treatment, a potent and indispensable agency in our modern civilization."

Fortunately, the government decided to invoke it for radiotherapy the following year. On top of that, the fee for this treatment was set at ¥750 ($2), exactly the same in amount as what our hospital had earlier computed on the basis of cost accounting.

Another episode about cancer radiotherapy was that we equipped our hospital with a betatron in 1968. More powerful than the cobalt 60 system, this machine was so designed that we could perfectly cure any cancer up to the depth of 3 centimeters from the skin. Surgical procedures were no longer required for the treatment of skin cancer, cancer of the tongue and cancer of the penis. Made by Simens A.G. in Germany, the machine was priced at a whopping ¥100 million ($278,000), as it had been designed exactly according to its specifications. The Ministry of Health and Welfare granted a subsidy of ¥13 million ($36,000). With the fee set at ¥700 ($1.9) for 200 roentgens under the National Health Insurance Scheme, the project would not pay at all. In the first place, there

were not so many patients with those kinds of cancer. Add interest and redemption to that enormous amount, and there would be danger lest our hospital should show a huge loss. In plain language, that means that we would lose ¥50,000 ($139) every day. Just pocket my pride, and I would think that the purchase of the betatron was really a good choice now that there was no doubt about its therapeutic effects.

A farmer in our town with whom I was well acquainted had been husky for one or so year. A nose, ear and throat specialist in our hospital diagnosed him as infallibly suffering from pharyngeal cancer. The operation for it is not a simple one. You have to enucleate the whole pharynx. The enucleation itself is dangerous, but the trouble is that the patient is unable to restore his preoperative lifestyle (he will be out of voice). Nonetheless, the man in question, irradiated with a betatron, had no pains at all and completely healed several months later. Besides, he completely regained his voice. Partly because he was not told that he had had cancer, he looked as if nothing had happened to him. When he happened to come plump upon me on the road, all that he had to say was, "Hi, doctor, are you getting along all right?" That's like him.

What I have recently learned is that the Welfare Work Corporation newly established in the Nagano Prefectural Federation of Agricultural Cooperatives for Mutual Aid is reportedly poised to compensate more or less for the loss sustained by agricultural-cooperative hospitals. As they say, one good turn deserves another.

CHAPTER FOUR

Beginnings of Rural Medicine

1. Beginnings of Rural Medicine

Buffeted and transfigured by modernization and urbanization, if not in substance, rural communities nowadays are visually different to a significant degree from what they used to be long ago. Infallibly, talk of villages has up until recently reminded you of hamlets in straitened circumstances, poor in business management, culturally underdeveloped and environmentally squalid. All things considered, there persistently subsisted remnants of the kind of living "peasants" led in feudal days.

Tokugawa Ieyasu (1542-1616), founder of the Tokugawa Shogunate, declared, "Let peasants neither live nor die." With the laying of crushing taxes extending over several hundreds years, the way peasants were leading a life in those years may well be summed up in a single phrase -- the sacrifice of their health. When a famine visited in the era of Tenmei (1782-87), Japan's total population, which stood at 26 million, dropped by one million. History tells that food was totally unavailable for peasants, who were compelled to eat human flesh against their will. The directives issued by the Tokugawa Shogunate, such as "peasants shall never wear anything but cotton clothing" and "peasants shall never eat much rice," clearly suggest what sort of lifestyle they had every day in those years. The usurpation that came in the form of *Goko Gomin* -- the system in which the annual land tax would have to be paid with one half of the harvest with the other half retained as a yearly income -- compulsorily kept peasants in extreme distress. The malpractice in which parents would "cull out" their own ba-

bies or forsake their own old mothers deep in the mountains extensively pervaded the hamlets. Apparently, the Europeans also seemed to be in the same boat long ago. Peasants there in feudal days were also compared to "oxen without horns."

Why is it that the peasants who had so much sacrificed their own lives, their own health and even their own life were utterly deprived of blessings from the sciences of medicine for so many years? Why is it that the science of rural medicine has had to belatedly make its appearance now? The reason is because peasants were not counted as humans. In the era of the Shogunate, physicians served only for liege lords, and there were no medical doctors worthy of the name in the villages. Just imagine, and you will realize that peasants who were on the verge of starvation could not have money enough to pay for physicians. In other words, none of the villagers talked of medicine other than the physicians patronized by landlords.

By the irony of fate, the Prime Minister, Gen. Hideki Tojo, who drove Japan into World War II, with Lt. Gen. Chikahiko Koizumi serving as minister of health most enthusiastically preached the need for medical care and sanitation in the rural setting. But they did so not because they set their affection on farming populations but because they needed manpower in their war efforts. Naturally, there were a number of researchers in the science of rural medicine who were working hard from the standpoint of farmers. Published right before Japan's defeat in World War II, Minoru Takahashi's *Corroborative Studies on Rural Health* and Shunichi Hayashi's *Introduction to the Science of Rural Medicine*, praised

as historic monuments, remain invaluable even today. Literature in the milieu of rural medicine published long before them include Naoyoshi Ishiguro's *Hygienic Survey of Colonial Militia in Hokkaido.* Published in 1912, Osamu Ishihara's *Workwomen and Tuberculosis* deals with tuberculosis in the rural setting. Particularly in the milieu of parasitology, many unique studies came out in regard to tularemia and *wakana* disease, a symptom caused by hookworm infections.

Shortly after Japan's defeat in World War II -- or August 20, 1947, to be exact -- we held the first congress of the Nagano Prefectural Association of Rural Medicine at the Saku Hospital. That must probably be the oldest of all societies of rural medicine in Japan. It is still fresh in my memory that the conference, held shortly after the war end, was honored by the presence of two delegates from the Allied Occupation Forces. With a rank of master sergeant, one of them spoke at the opening ceremony. The meeting was well attended: the hospital's second-floor hall was so jam-packed that participants could not move around at all. A check of the titles of papers introduced to the congress suggests that they covered all sorts of problems in the milieu of rural medicine, such as tendovaginitis highly prevalent in the busy farming season; paronychia, a disease peculiar to villages; and alvine cellulitis. Moreover, the presentations went as far as to cover such themes of rural medicine as the statistical observation of outlays for medical care to my surprise. Those themes had not been taken up at any medical congress before.

On top of that, the first congress of ours featured the participation of all sorts of people: not just physicians but public health nurses, hospital nurses and officials involved in the National Health Insurance Scheme. Besides, even the representatives of newly founded local farmers' unions, to say the least of those who represented ordinary farmers and local agricultural cooperatives, were present to ask animatedly about problems in the milieu of rural medicine and put forward requests on behalf of farmers. This traditional feature remains intact in the Nagano Prefectural Association of Rural Medicine and incorporated in the spirit of the Japanese Association of Rural Medicine today.

In the next five years, we accumulated many studies and surveys in the sector of rural medicine. We were gradually moved by a rising desire to organize a scientific society that would encompass the whole nation and exchange scientific achievements and views. In those days, the directors of hospitals placed under the umbrella of the National Federation of Agricultural Cooperatives for Health and Welfare made it a practice to get together at one time or another. A conference on remuneration for medical care under the social insurance schemes was also held once in a while. It was urged at those meetings to establish a Japanese Association of Rural Medicine in order to forge the solidarity of physicians in the rural communities and arouse their morale.

That's an ingenious idea, yes. Properly speaking, physicians in those days were utterly unwilling to practice medicine in the country; they would grudge being transferred, in particular, to agricultural-cooperative hospitals, griping about "getting sent to

the boondocks." They simply had deep contempt for villages. Besides, university education was responsible. It stuck too excessively to technology-first principles. Is it not in accord with the principles of humanism in the delivery of medical care to work in poor villages? Is it not true that there remain a host of important medical themes in the routine delivery of medical care in the countryside that have yet to be solved?

Among us, there was a rising call for the exercise of our faculties, to be sure, but when we were put to the push, no one dared to lead the proposed national group. After all, I had to do so as people around me said to me, "You said it first, so you do it first." That's how I was designated as the first president of the Japanese Association of Rural Medicine (JARM).

In July 1952, the First Congress of the Japanese Association of Rural Medicine was held in Nagano City. Despite the scorching heat of summer, two hundred or so members got together in the third-floor main auditorium of the Industrial Hall. Having officially become a member of the Japan Medical Congress, the JARM is now carrying weight with the International Association of Agricultural Medicine and Rural Health (IAAMRH). In the years immediately after its founding, it was impossible to tell what our association would become. There remained a mountain of issues that had yet to be solved. Caustic criticism was leveled at the group, such as by asserting that such an association, even if organized, would soon be unable to collect scientific papers from rural physicians, asking if there could be a science in the name of rural

medicine, and pointing out that there could be no difference in medicine between the cities and the villages. Besides, all those harsh comments came, alas, from within our association.

Now that it had just come into being, we had to do the best we could. We should not forget our original resolution. What I felt about its establishment was expressed in the opening article of the Volume 1, Number 1, issue of the *Journal of the Japanese Asso- ciation of Rural Medicine.* I think that the essay still has life given to the JARM's character. The gist follows:

> Is it true that rural medicine exists as a milieu of science? Suffice it to say this way in answering this question. In rural Japan today, the question of medical care and hygiene is cast aside. In a semi-feudal and uncultured environment that reminds us of other parts of Asia, diseases come out in peculiar form, and the measures with which to cope with them must take their own way. More than anything else, a broad segment of the peasantry is poor, and medically underprivileged peasants call for readier access to that sort of medical care. In light of those realities of rural communities and in response to peasants' fervent calls, the Japanese Association of Rural Medicine has come into being. Next, I wish to introduce some features of this scientific society. For they demonstrate how the milieu of rural medicine ought to be.
>
> First, what we do in our association should not be learning for learning's sake. To the most degree, our learning should be the one which is designed to improve the living standard of farmers, step up their output and protect their life. Nowadays, physicians concentrate in big cities, absorb themselves in "study for study's sake" or pursuit of profit from the delivery of medical care. Unlike

them, we are standing it out in the countryside. That is why our association inevitably takes on a character of noble humanism and assumes a strong posture against academism.

In fact, it is evident that none of the scientific papers presented to the first congresses was apparently designed to receive a degree. That does not mean that we are pitted against universities to no purpose. The fact is that we were honored by the presence of many university professors at this congress in full agreement with the association's tenets, and that they are really making invaluable contributions to our association's development.

Second, that our group takes on a nongovernmental character makes it mandatory as a logical consequence for us to organize and manage it in line with the principles of democracy. In our association, therefore, there could -- and should -- not be what people call "academic sectionalism" and "arbitrariness on the part of a handful of bosses."

Having said that, our association, which has set itself to work for farmers in response to their realistic demands, is poised to go hand in hand in the sector of health care not only with physicians but also people engaged in the management and control of medical care, specialists in health insurance schemes and all other people, to say the least of nurses and midwives in attempts to solve problems posed for health and welfare in the Japanese rural setting. I can say, therefore, that one of the association's features is that the milieu of science to which it devotes itself takes on a significantly multidisciplinary and practical character.

What sorts of themes did we take up in those years? They included, among others, worm-induced inflammation of the gall bladder, jejunitis caused by hookworms, tendovaginitis, stiffness in

the neck, lumbago-derived muscular rheumatism, the cold and diseases of the sort about which nothing was done out of regard to other family members. I don't think my memory is far out when I say that those were the central themes with which the Japanese Association of Rural Medicine had grappled before 1960 or so. Here, let me describe developments and motives that led us to take them up for our survey and research.

Time was when roundworms were everywhere in the countryside. Particularly in the days immediately before and after Japan's surrender in World War II, they were such a nuisance. The findings of the stool tests we performed on patients who had complained of a stomachache and visited our hospital showed roundworm eggs accounted for an alarming 70 percent with hookworm eggs at 12 percent and Trichuris at 10 percent. The results of fact-finding surveys we carried out in outlying villages revealed that the ratio of villagers from whom roundworms had come out, be they farming or non-farming, came to 30 percent. Deep in the mountains, in particular, it was as high as 38 percent.

Right before and after the war end, it was so difficult to have access to santonin, an ascaricide, that the victims could not purge the bowels at all. The reason was ascribable in part to the indiscriminate use of human feces due to an absolute lack of chemical fertilizer, but I would assume that the fundamental reason was, more than anything else, because the lives of villagers had generally turned into a regular germ bed. In peritoneotomy, or incision into the peritoneal cavity, I used to find astonishingly many

worms. Even in palpating the intestines by the hand, I would often either see or touch the skin pushed up by many worms that coiled like a ball of noodles. I also found them in the appendix and there were many cases in which I would cut them off when I performed appendectomy. With the appendix fenestrated, I would often come across worms that were "swimming" in the pus produced by peritonitis.

We wished to have villagers take in vermifuges by some means or other. Hereupon, we prepared medical decoctions from wheat straw and sweet-flag root and had them drink the infusions. Sweet-flag root would stimulate the stomach and intestines, causing a stomachache at some times, but the decoction made from wheat straw proved very efficacious. In the end, we built a cottage, where we installed a cauldron to boil it down and produce its decoction in massive quantities. Now that it was made strictly according to the Saku Hospital's formula, people call it "Saku-nin," making a parody of santonin. Later, we would often have primary and secondary school students and the staffers of agricultural cooperatives drink "Saku-nin" in groups. In those years, it was utterly impossible to procure even Corsican weed, to say nothing of santonin, so it made a hit with everybody.

A staff of the Japan Broadcasting Corporation (NHK), Japan's version of BBC in London, wanted to introduce in a radio program how we had come out with "Saku-nin" and taped my talk. But it was not broadcast at all on schedule, replaced by some other program. Later, an NHK man showed up and apologized, explaining that an official of some pharmaceutical company, who was on

the NHk's Radio Program Screening Committee, brought forward a claim. The introduction of "Saku-nin" by radio was cancelled, he said, because the committeeman challenged and cautioned that it would not be desirable to publicize something of a folk remedy. That argument stirred my blood, on the one hand, but on the other, I suspected that they found fault with me as I had here too again been branded as a commie.

Out of pity, I decided not to bully the NHK man, and over time, the whole ruckus ended up in smoke. In so far as I was concerned, though, I remained convinced that straw was readily accessible to by any farmer, and that scholars should publicize its decoction, because it was firmly established that it excels as a vermifuge and that it does not have any side effects. Later, pharmacists at some university in Japan came to recognize its efficacy and worked hard to pave the way for its mass-production. They succeeded in preparing a liquid extract but failed to pulverize it after all their efforts for its marketability.

As I had been assigned to the Saku Hospital, I came to realize that many local peasants had gallstones. At the outset, their broad prevalence did not go down with me at all. For the primary cause to a gallstone is cholesterin according to Western medicine I learned during my university days (by the way, I applied for a degree by presenting a thesis on gallstones). That is why people with great intakes of animal fat tend to have gallstones. In my district in those years, nonetheless, it was hardly conceivable that peasants would take in many animal proteins.

Here is an episode. One day, I went to the village of Taguchi and talked of food in a health lecture. I emphasized the need to take in more fat to raise the calorie intake but advised the audience to prefer vegetable fat to animal fat, which sometimes proves not conducive to health. Then I proposed the cultivation of sesame, the oil of which could be used in cooking Japanese deep-fat fried food. Later, village elders got hopping mad at me, however.

For it is handed down by tradition in this district, I was told, that sesame cultivation should incur the divine wrath, eventually resulting in the visit of a natural calamity by the end of the year. When I asked what this legend is all about, I was told that when Takeda Shingen (1521-73), a legendary warlord, assaulted the Saku district, his eyes were accidentally stabbed with sesame leaves. Sesame cultivation has since been put under a taboo. Such being the case, vegetable fat had nothing to say to local farmers.

Then what in the world drove so many farmers in such a traditional dietary pattern have gallstones? Defining the cholelithic stroke as a "spasm of the stomach," and its repetition was called *shaku*, or roughly "convulsions" in the local dialect. That amounts to what is commonly known as a "return of the old spell." That infallibly amounts in symptomatology to what is known as gallstones in Western medicine in which we are engaged. The funny part of it is, nonetheless, that what we detected in many cases was not stones but worms. That's what we learned for the first time in operations.

After World War II, the occupying U.S. forces importuned the Japanese government to exercise strict control over morphine.

The fact stood, though, that many of the people who had a "return of the old spell" were morphine addicts. This is because their attending physicians had time after time given them morphine injections as a painkiller. Given increasingly strict control over morphine, local physicians came to think twice about giving morphine shots. The outcome is that it became a practice for those patients to visit our general hospital, as they were thrown down by local practitioners.

This episode reminds me of the fact that patients with gallstones would unexceptionably turn around and go away in the prewar years when I urged them to undergo an operation. Curious, I checked into the matter and learned that local practitioners used to discourage patients with gallstones from undergoing an operation unless they wanted to "pop off the hooks."

Now then, I came to realize to my utter astonishment in operating on patients with a "return of the old spell" that what had actually come out of the gallbladder or biliary tract was worms, but not stones, in almost every case. To be precise, they were roundworms. In an extreme instance, I found that the biliary tract was plugged up with as many as seven of them. Extract them, and what was thought to be a "cholelithic" symptom would pass away as if for a wonder.

In some cases, I detected stones, but they looked like clods of blackish mud, which would instantly fall apart if you pinched them between your fingers. They were quite different from whitish, hard stones, as we had learned in Western medicine. In many Western cases, the stone was made up of cholesterin but

the main component was bilirubin in our cases. Besides, we came to realize that the core of our stone consisted of the corpses or eggs of worms. On this score, Tetsuo Maki, professor at Hirosaki University, gave a detailed account in the report on a research assignment presented to the 1953 congress of the Japan Surgical Society. Nothing got the necessity of rural medicine more powerfully implanted into my head than local conventionalism about gallstones.

Among outpatients, we used to come across farmers with their wrist bound with a string of black cotton thread in the busiest farming season. Seized with curiosity whenever I counted the pulse, I at last asked my client what that string was for. The patient said that's a charm by which to conjure away *koude*, or the disease with which the wrist swells and gives the patient great pain in replanting or reaping rice. Local farmers believed that the illness would spontaneously pass away if a string of black thread was kept fastened to the affected part. People also said that this method would be particularly efficacious if the string was tied by the youngest son for the mother or by the youngest daughter for the father. That was nothing more or less than a practice that had been handed down among peasants from old, we were told.

A further check revealed that the practice of this charm spread all over Japan. As one might put it, this custom was a folk remedy among farmers who cultivated rice on the irrigated fields. But the appellation of this symptom varied, depending on the region: *sorate* or *soraude* in the northeastern part of Japan's main island and *karaude* on its southern island of Kyushu. By the time

when the fastened string had frayed and worn out, the year's busiest farming season was over, banishing the fatigue of the wrist and spontaneously making *koude* go away.

Nonetheless, it all happened one day that a young housewife in a family way came to see me for a check, and her symptom really knocked breath out of me. Having engaged in reaping rice, she complained that she had an aching arm and could not sleep. Eye observation revealed that the whole part of the carpal joint swelled in red. Besides, part of its middle part swelled up as big as the tip of the little finger and ached. What was it? Leaving the reason out of the question, I applied a poultice to the affected part and suggested her to visit me every weekday, as I wanted to check and see how she would be getting on. The recovery was at a snail's pace. One or two months later, I decided to cut out the affected part and sought her consent. Having laid it open, I was really surprised as it turned out that what had been suspected to be a swelling was actually a tendon. To add to the surplus, the tendon ruptured, bursting open like a pomegranate. In medical jargon, that's "tendinous laceration." What a terrible condition that was!

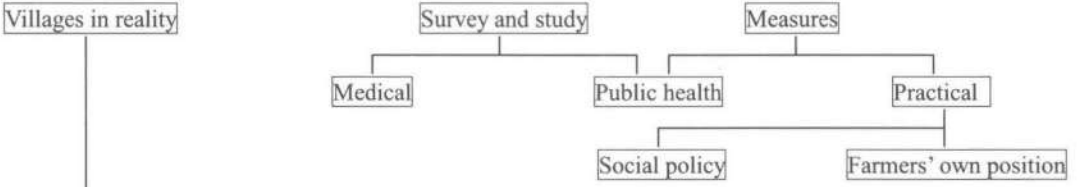
In a patho-histologic probe, I could identify this case as "acute overwork-derived tendovaginitis." Besides, I checked to see the degree to which what was known simply as a "disease in the busiest farming season" was prevalent among farmers in general -- now that it had been passed over as *koude* -- and how many such pitiable, serious cases there existed. I reported the findings to the 1954 congress of the Japan Surgical Society.

Veterinarians said that they had often observed among

horses the laceration of tendovaginal sheaths caused because of overwork. They included chargers, racehorses and draft horses. When it comes to horses, overwork results in cutting off the tendon of the pedal flexor. That reminded me of the days when I used to be called on the carpet by a lance corporal while serving for the Imperial Cavalry Regiment. The senior comrade yelled, "you god-damned knucklehead! Groom the limbs of your horses well, or their tendons will be torn apart. Understand?" No I didn't. How could it be? On second thoughts, I didn't say it. But I now realized he's right. And man is no exception. There is an old Japanese saying that peasants were overdriven "like oxen and horses," meaning that they were compelled to work like a beast of burden. That said, I gave up myself to deep emotion, as it came out that humans, oxen and horses were all in the same boat.

Also in experiments with animals, we probed into the process in which *koude* damaged the tendon. We came to know that if you ran by bicycle for several hours every day with a dog at your heels, a phenomenon of *koude* would appear in its limbs. The Usuda Town Women's Association raised objections, however. The experiment was quite hard on the dog, they said. We're entirely with them on that. But the question is, what can you do about the very fact that farmers (even those today at that) would suffer from *koude* as though the affliction itself was the order of the day? Talking of the findings of our experiment, we unmistakably realized with histological samples the process in which the sheaths of the overburdened tendon would gradually fall to fragments.

Table 1 Overview of themes of rural medicine (Wakatsuki,1952; *Jap J Rural Med*)



	Social causes to illnesses	Rural medicine (in a narrow sense)	Rural health	Improvements in lifestyle
Agricultural factors	Causes from crops and cattle	Poisoning with mulberries, anthrax, actinomycosis, brucelliasis	Science of contagious cattle diseases, methods for their prevention	Dissemination of methods for disinfection
	Filthy farmland (paddy fields, upland fields, forests)	Ancylostomiasis, paddy-field dermatitis (gray-starling schistosomiasis)	Science of occupational diseases, parasitology	Moves to check hookworms and their egestion, better working clothes
	Overwork on the farm (particularly with a stoop)	Diseases in the busy farming season: tendovaginitis, lumbago, neuralgia, sun-stroke, *Nofusho* Syndrome	Overwork on the farm and measures to cope with it, rationalization of farm work	improvements in agricultural technology, communization, farmers' calisthenics
	Accidents caused with farm implements and by cattle	Digital severance with a sickle, bone fracture by cattle, cultivator accidents, operators' miscarriage	Traumatology for farm work, human engineering for farm work, measures to cope with labor accidents	Methods for handling of farm implements and cattle, methods for first aid
	Pesticides and fertilizers	Poisoning with parathion, poisoning with mercury and arsenic, poisoning with calcium cyanamide	Toxicology on pesticides and controls on sales of deadly poisons	Campaign for prevention of hazards from organic chlorine agents, handling of pesticides, first aid

Farming families' factors	Unsanitary dwellings (Filthy washrooms, no heating)	Communicable diseases of the digestive organ, the cold in the wintertime	Hygienics for dwellings and clothing, improved designs for washrooms	Improved dwellings (kitchens, washrooms), use of heating stoves
	Unreasonable nutrition (excessive intake of white rice, in particular)	Chronic gastroenteritis, avitaminosis (B_1 in particular), calcipenia	Rural dietetics, practical nutritional guidance, vans for nutritional guidance	Campaign for better dietary life, communal cooking, enriched rice, food storage
	Afraid of giving trouble to other family members (due to patriarchism and communal life)	Constraint-induced diseases (constipation, in particular), rural neurosis	Psychosomatic medicine and social psychology for rural areas	Family democratization, such as through family talks, recreation
	Pregnancy, childbirth and child rearing in filthy circumstances	Pregnancy- and childbirth-induced complications, incomplete growth of infants	Measures for protection of mothers and children in the rural setting	Family planning, young wives' societies, seasonal day nurseries, guidance on child rearing
	Old people, forsaken old women	Geriatric diseases (stroke, stomach cancer), farmers' geromorphism	Measures for seniors, prevention of geromorphism	Human "docks," seniors' homes, issues on people's pensions, savings campaign for health care
	Medical outlays from low household budgets	Latent and too-late-to-cure diseases	Issues on the National Health Insurance Scheme	Campaign for health care savings
Rural villages' factors	Climate, geographical features, soil, wildlife, insects	Endemics (trematodiasis, local goiters, tularemia, Vitamin B_2 deficiency-derived perlèche	Endemiology, medical climatology	Studies on endemics, measures to cope with them
	Superstition and lack of knowledge about hygiene in hamlets	Do-nothing type, private therapy based on superstition	Dissemination of knowledge about ethnology and hygiene	Criticism of customs and religions
	Unsanitary village environment (unavailability of service water and sewer systems)	Massive outbreak of dysentery, spread of roundworms	Environmental hygienics, waterworks, sewers, dirt and other impurities	Installation of small water supply systems, water disinfection, extermination of flies, mosquitoes and rats, mass health care campaign
	Rural environment without physicians	Latent diseases (the perseverance type, in particular)	Measures for "doctor-less" villages and joint health care programs	Mass campaign for health care

When all is said and done, the essential thing is, as it comes to health issues in the rural setting, that it has been a long-established posture on the part of farmers to sacrifice their own health to farm work and pay no attention to it. In the village, illnesses were seldom brought to medical attention and left wholly unattended. To sum up, they remained "latent," or likely to eventually come out at any time. On this score, the rural setting is different from the urban setting. What I describe here as latent is entirely different from cases in which the disease itself is still in the initial phase. But no clear subjective symptoms are evident, thus driving the patient to forget all about the need to consult with his doctor in an unguarded manner. Because of some sort of symptom you've already had, you have pains here and there, but you are simply in no mood to consult with a doctor for one pretext or another. Precisely, that's what prevailed in the rural setting. In the final analysis, you could well say that diseases were latent, socially but not medically.

For years after its inception, the Japanese Association of Rural Medicine, subsidized by the Ministry of Agriculture and Forestry, made it a practice to do fact-finding surveys at rural general hospitals. Published in 1953, the first report covered a statistical survey of "Diseases at the Hospitals" affiliated with the Prefectural Federations of Agricultural Cooperatives for Health and Welfare, and the second one that came out the following year dealt with those of "Diseases Detected at Sick Calls to Villages." But the findings of the statistics taken from across the nation suggested that the diseases detected among patients who visited rural hospitals were different for one reason or another from those found at

front-line clinics and also those we came across in rendering field services in rural communities. For instance, many of the diseases we detected at our hospitals proved serious, whereas those we came across at our front-line clinics were familiar ones, the prevalence of which decidedly high, such as stomachache, tonsillitis, worms, sores, eczema, conjunctivitis and hypertension.

That said, we can hardly escape the charge of incompetence when it comes to all sorts of reports we made at scientific and other meetings on the basis of the data we had collected at our hospitals. Outpatients decreased throughout the month of February not because the incidence of diseases was on the downturn but because patients were in no mood to plow through the snow to the hospital or clinic. They drastically dropped in the rice-planting season not because farmers were blessed with health but because, even if they were out of sorts, they were too busy to consult with the doctor. Those social factors constrained them from receiving medical attention. In effect, those social factors -- to wit: pressure of work, poverty, seclusiveness, constraint and, in particular, the inclination to sacrifice health to farm work -- deterred them from visiting a hospital or even the nearest clinic. That eventually paved the way for disease latency.

That said, you shouldn't sit and wait at your hospital or clinic, if you really want to know all about illnesses that are prevalent among farmers; let it sink into your mind that you should go straight into the village and make a check by yourself.

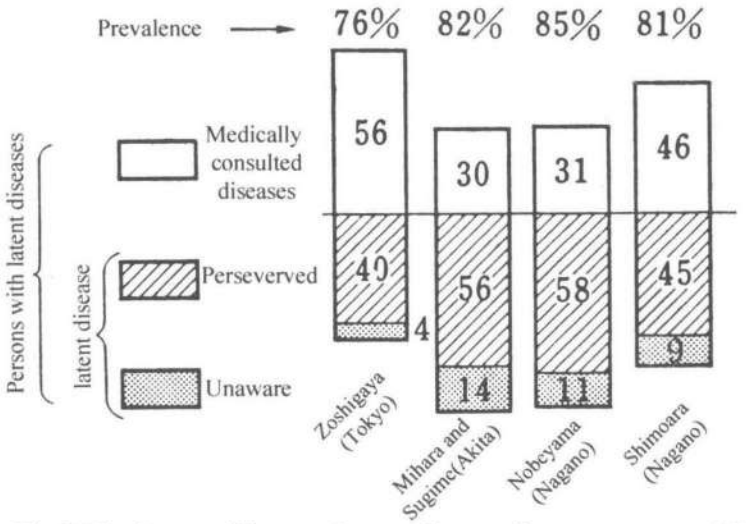


Fig.3 District-specific prevalance of latent diseases per year (1995)

With this in mind, we chose Nobeyama, a highland settlement terribly cold in the wintertime, and Shimoara, an outlying community in Usuda Town with the Saku Hospital -- both communities in South Saku County in 1957, and we ourselves went there many times to find out how many latent ones there were among all diseases in the communities a year (Figure 3). The findings showed that the number of illnesses per person a year was 1.95 in Nobeyama where no physicians were available, and that medical attention was paid only to 31% of all diseases with the rest remaining latent. Of the latent ailments, "persevered" accounted for 11% with "unaware" at 58%.

In Shimoara, situated in a relatively flat area of paddy fields, the findings were comparatively better as 46% of diseases

were brought to medical attention with "persevered" at 45% and "unaware" at 9%. Presumably, the number of cases with latent diseases -- particularly, those of the "persevered" type -- was smaller in this community, from which the Saku Hospital was readily accessible to.

In an attempt to compare our data with those of another district, we organized a caravan medical team and dispatched it to the hamlets of Mihara and Sugime in Hiraka County of Akita, a northwestern prefecture along the Sea of Japan, through the good offices of the Hiraka General Hospital. In those villages where no physicians were available, the rate of latent diseases was virtually the same as in the Nobeyama hamlets.

Now then, how about Tokyo and other major cities? We chose Zoshigaya, one of its western uptown neighborhoods, to carry out quite an identical survey. Coming up to our expectations, the rate of diseases brought to medical attention was by far greater at 56% with latent diseases accounting for a mere 44%. Judging from the data we had gathered, the ratios were decidedly smaller. Yet in another perspective, one may wonder how come there're so many latent ailments even in Tokyo?

What surprised us in performing a fact-finding survey in Tokyo, many of the Tokyoites -- a little less than 80% of those beyond forty, in particular -- hailed from rural communities. That said, it followed that very many "rural" elements still remained tenaciously in their lifestyle that ranged from their food, clothing and shelter to their way of thinking, however they looked like on the

surface. That time, it came home to my heart that the gaps between the urban and the rural communities, significant though they were, by no means were intrinsic in nature. I could not help conceding that the peasants' spirit of bearing hardship and privation in devoting themselves solely to farm work at the sacrifice of their own health drifted to cities and steadfastly took down roots there, stylishly fashionable though they are with plush ties, their disposition remains bound by pre-modern elements. In parenthesis, Figure 3 that showed the rates of latent diseases in villages was reprinted in a German textbook on occupational health to my surprise. Later, I learned that it appeared there in response to a strong recommendation from Gito Teruoka, who had once been director of the Japan Institute of Labor Science.

2. Struggling Against the Cold - What Is the Better Lifestyle?

It was in 1952 or so that we took up the problem of the cold among farmers. At the outset, we began a fact-finding survey on the room temperature of farmhouses and the lifestyle there. When it comes to farmhouses with drafts whizzing in through the door crevices, there was no difference in temperature between the inside and the outside. The average temperature in the dead of winter stood roughly at two degrees Celsius. Moreover, we built an electric refrigeration chamber and set its temperature at two centigrade or so. With humans or animals kept in it, we conducted elaborate experiments on how they were physically affected by the cold.

The very temperature -- that is, two degrees centigrade --

was precisely the one at which Hans Selye, a [Canadian] medical scientist who advocated stress theories, performed animal experiments on the stress caused by the cold. In our experiments done in an electric refrigeration chamber, it came to light that the blood pressure of any person in ordinary attire who were staying there with the temperature at two degrees Celsius would rise in a mere thirty minutes, resulting in a significant decrease in acidocytes in the blood and the well-defined appearance of what could well be described as stress-like disorders. Should it be assumed that the average room temperature of farmhouses was virtually the same in the midst of winter, some of the dwellers were bound to impair their health one way or another. They had *kotatsu*, or a foot warmer with a quilt over it, all right, but that's not a heating system; you just use it to warm your feet.

Let's suppose that you're invited to the New Year's dinner and feasted at some farmhouse or the other. Warming himself at a *kotatsu*, the Old Man is gay with cups of *sake*. But it suddenly flashes across your mind that his wife isn't at the feast. On the way to the washroom, you will take this opportunity to look around and find her squat on her hams and warm *sake* near an earthen furnace in an odd corner of the bleak, vast kitchen. "Well," she remarked, "it would have been far better to install an *irori* [a hearth sunk in the floor] as in the old days, than a *kamado,* or a Japanese kitchen range. With the old *irori* replaced by an improved model, the cold really tells hard on us." Asked what had made her family go in for the "improved" one, which couldn't assure as much warmness as the old version, "You see," she guffawed, "the cost is now down

tow-thirds. That's why."

That reminded me of what a bureaucrat, who flashed up into my memory, had once said to me. "I would think," he said, "that farmers feel gloomy, because their houses are gloomy. That's precisely the way I felt while making a tour of farmhouses in the United States; the houses were repainted in white every year with their kitchens in bright colors. Above everything else, the *irori* fire is a sheer waste of money. Any attempt to work for a better lifestyle should start by getting rid of *irori* and doing away with that sooty smoke." To be sure, "improved" furnaces cropped up across rural Japan like mushrooms after rain. Presumably, nothing was put into so wide use in the early postwar governments' project to better the rural lifestyle than improved furnaces. But the thing is, farmers readily accepted them to their great satisfaction, simply because the cost of their use proved by far less expensive. As housewives would often remark, farmers could get off with one-third of the cost required for the *irori*.

The *irori* invented by our ancestors (history says that a stone hearth was placed more or less underground in the midst of the floor of a farmhouse during the Japanese Neolithic cultural period). They helped heat the farmhouse in which all the family had to stand the cold of a bitter winter. If *irori* were defined in a clear-cut point of view as a tool designed simply to cook rice and "rationalized" for this purpose, then, the cost would go down as a matter of course. That said, the cold came to physically gnaw housewives to an increasingly serious degree.

Perhaps, this sort of argument may sound harsh to bona fides bureaucrats who take charge of lifestyle improvements. What I really wanted to say here is the very need to lay it on heart that any campaign for a better rural lifestyle always entails those possible risks, and that we are no exception in letting this necessity sink in our minds. A case in point is *fukujinzuke*, or sliced vegetables pickled in soy sauce. It would be wholly unwarrantable at least today to encourage busy farmers to eat them in the year's busiest farming season and then dub the encouragement as part of an eat-preserved-food campaign. Is it advisable to take housewives to sacrifice the time required for cooking to farm work and, instead, have their families eat rice mixed with *fukujinzuke* or some other salty side dish? Isn't the campaign for improvements in the rural lifestyle designed to merely teach farmers means to tide over difficulties in their slave-like lives?

Rural housewives would often say that they passed a poor night when it was cold, and that they had to go to the washroom time after time. They felt stiff in their necks. The waist throbbed with pain. The hands and feet numb with the cold. They all said, "The cold is bad for your health." Those voices of housewives and old people motivated us to scientifically probe into the cold.

Certainly, there had been some medical studies on how the cold affects the human body. But most of them dealt with frostbite and death from the cold in the inclemency of weather. An annual research assignment on "low temperature and ecology" was reported about at the congress of the Japan Surgical Society in 1943. Obviously, the research work was in tune with military

medicine. In those years, there were proponents for an incursion into the Soviet Far East with Moscow besieged by Hitler's forces. Taking advantage of the encirclement, why not make a raid on Siberia from behind? So went their argument. If that idea had been put into action, the Imperial Japanese Army would have been compelled to fight against Jack Frost. That said, the research report was designed to explore a possible invasion from a medical point of view. You could say that the theme was one and the same, but that study was done for war's sake, whereas ours on the cold among rural moms was for peace's sake.

As is commonly known, the prevalence of stroke and heart disease is high in the Tohoku and Hokuriku regions of Japan's main island. Then what makes it lower on Hokkaido, another cold region, which constitutes Japan's northernmost island? Genetics does not provide an answer. It has been only one hundred years since attempts began to open up a new world there. Many of the settlers were none other than those from the Tohoku region. Should it be true that stroke and heart diseases are adversely affected by the cold in many aspects, then, it would be only natural that attention should be paid to the factor of heating, which is popular particularly on Hokkaido, the northernmost insular prefecture. The prevalence of those diseases is relatively low there, presumably because it has something to do significantly with the way of living in which they use stoves in the wintertime. It is not just Western countries that stoves are used. Is it not that Chinese and Koreans enjoy a warm winter with *pechka*, or a Manchurian stove, and *ondoru*, a

Korean floor heater, respectively?

Having said that, we conducted fieldwork on the effects of heating on human bodies in 1971. We selected 15 full-time farmers in Saguchi, a neighborhood in the village of Yachiho, and provided them with a coal stove of the Hokkaido type on an experimental basis every winter. Then we investigated into their health and lives for three years. The average room temperature of stove-furnished farmhouses ranged from ten to twelve degrees centigrade in February, the coldest month, and was up two degrees in March. In the group of stove-unfurnished houses picked up as controls, however, the average room temperature stood at two or three degrees Celsius and remained at four or five degrees even after March had set in.

What impact did heating bring about on farmers' bodies? To sum up the findings of a three years' experiment, the effects particularly on hypertension were better as against the controls. In the final analysis, indications were that heating served to reduce hypertension. Therapeutic effects were also observed for rheumatism, neuralgia and the numbness of hands and feet for patients with palsy. The incidence of stomach achlorhydria dropped, so did that of the *Nofusho* Syndrome, to which reference will be made later in this chapter, to a significant extent. And heating produced favorable mental effects in the depth of winter, such as "getting patient" and "being in the bosom of the family."

But that did not mean that everything was settled. How did the farmhouses involved in the test go along later? Calling at their village a few years later, we were disappointed -- not a little.

Only half of the families to whom a coal stove of the Hokkaido type had been provided in the experiment still used it. We asked, "Why not using it?" They said that the room was too hot, adding that they were "unworthy of that luxury." Setting aside somewhere else the stove used in the test, they bought and used a small kerosene stove. With kerosene, you can get around with ¥40 ($11) per *sho* (0.4 gallon) a day for fuel. With coal, you had to spend twice as much, however. They complained that they couldn't afford to spend that much. To hear their contention, we felt as if we were held responsible for all they learned about the luxury.

Certainly, it has recently become a growing practice for farming families to use a stove. As I have just introduced, many of them are small kerosene stoves. You could argue that their use marked an improvement or a step forward, but the fact stands that they are by far inferior to stoves of the Hokkaido type. What makes them put up with inferior ones? The main reason had to do with something purely economic. But let me put this way. In the first place, the stove without a chimney, be it kerosene or gas, is quite dangerous, unless it is electrically operated. For one thing, you have to think about the hazards of toxic gas generated as a result of incomplete combustion. Recently, it has become a practice even for farming families to use aluminum sashes. Which suggests possible poisoning with carbon monoxide from a charcoal or gas stove without a chimney. For another thing, you have to be careful about a possible fire. The portable stove is apt to turn sideways. In the recent time, kerosene stoves are held responsible for the outbreak of many fires.

On the earth floors of many farmhouses, we would often see kerosene or gasoline drums. Are they fully controlled to prevent a danger, really?

Having said that, we realize that the "lifestyle improvements" entail quite many issues. For the reality remains that you think you have to get things at low cost, first, with your own health and things in your future left, willing or unwilling, as though they were of secondary importance. That's why, while making a fuss about one improvement or another, what is initially thought to be a change for the better will end up as a change for the worse. Penny wise and pound foolish, they say, because attempts are made only to work out elaborate plans without fortifying financial resources for them. Taking advantage of this tendency, makers who want to sell off as many products as possible put ads in the mass media, while playing on the weakness of farmers.

3. Nofusho *Syndrome and Diseases Degenerative Over Ttime*

Today, the phrase "*Nofusho* Syndrome" is on everybody's lips.

"I've fallen down with the *Nofusho* Syndrome at last, doctor. Now then, I've come over here, 'cause I want you to pronounce an elaborate diagnosis."

So shouted a farmer of middle age at the top of his voice, while taking off his shirt. This sort of scene is no longer rare today. The phrase has spread itself into farmers before we were aware of it, and it appears that they have included it in their everyday vocabulary. They use it as a kind of manual for their self-diagno-

sis.

It pleases us very much that farmers have come to realize the need to take care of their health in the upshot. A pain here and another one there -- those used to be inevitable accompaniments of peasants' lives. That's why they thought it too much to consult with a physician just because of something inevitable. That way of thinking, peculiar to the old days, will dissipate one of these days.

The *Nofusho* Syndrome is scientifically established. As the conditions of farmers' disease and health or the actual state of their overwork are discussed at all, no one will skip out without referring to the *Nofusho* Syndrome and its data. They are taken up not just in the Japanese medical community but also in the White Paper on Health and Welfare put out by the Ministry of Health and Welfare and the White Paper on Farming Families' Lives by the Ministry of Agriculture and Forestry.

The *Nofusho* Syndrome was taken up for the first time by Keizo Fujii, director of the Asahikawa Kosei Hospital, at the first congress of the Japanese Association of Rural Medicine in 1952. He presented a report, titled "A Clinical Survey on *Nofusho*," on the basis of caravan medical services across Hokkaido, Japan's northernmost island..

The phrase *Nofusho* originated from "Farmers' syndrome" [also pronounced *Nofusho* in Japanese] used by Taichi Kumagaya. As a member of the Medical Service Brigades organized by *The Yomiuri Shimbun*, a vernacular newspaper, to provide caravan medical services in the mountains of the Tohoku region in northeast Japan, Dr. Kumagaya came to note that what could be typological-

ly described as a phenomenon of progeria, or premature senility, was observed in the subjective symptoms of farming women -- middle-agers, in particular -- in the mountains. He pro- posed that it should be taken up in a "special investigation." That's how the tale about *Nofusho* started. Later, Shunichi Hayashi, direc- tor of the Oji Seikyo Hospital in Tokyo, introduced it in his book entitled *A Lecture on Rural Medicine* in 1949. Three years later, Dr. Fujii once again took it up.

This problem was of absorbing interest to me, too. If it is confirmed that the syndrome for which stiffness in the neck, cramps and cricks in the back and other subjective symptoms are primarily responsible is highly prevalent among farmers in the real sense of the word -- even though uncertain factors may intermingle -- the syndrome itself is something that must be taken into account, and its theoretical verification could be relegated to the second place. Moreover, the syndrome may be described as a manifestation of overwork or premature senility. To put in another way, that amounts to something like a "prime mover" for what are commonly known as "diseases peculiar among farmers." That said, our primary mission ought to be the eradication of those prime movers. It will be quite instrumental in awakening farmers to their symptoms and reminding them of their own health to take up this issue for a further probe. No other issues are so substantial as this one in urging them to pay more attention to their health. In those days, I was firmly determined to take it up. Was there no need to take it up from a "pre-clinical," rather than "clinical," point of view? By probing into the realities, I was determined to throw premature

senility into relief and go as far as to check into the living and working conditions that were responsible for that phenomenon.

We presented a report under the title of "A statistical observation of the so-called *Nofusho* Syndrome" at the fourth congress of the Japanese Association of Rural Medicine in 1955. Could it not be vouched that this syndrome was highly prevalent among farmers? We checked into farming families in the Saku district with non-farming Tokyoites picked up as controls. As a result, it was verified, to be sure, that the syndrome was of much more frequent occurrence among farmers with statistically significant differences from Tokyo. One survey after another, we gradually came to realize that it frequently occurred particularly in localities where people were poor or overworked and in mountain hamlets.

In taking up the *Nofusho* Syndrome, what put us to great embarrassment most was to what extent and how we should probe into the syndrome. At the outset, Dr. Kumagaya enumerated such symptoms as stiffness in the neck, oppressive sensation in the back of the head, a sense of dilatation or distention for the stomach and underbelly, lumbago, cardiopalmus, abnormalities in the digital sensation, dizziness, and pectoral and digital pains. Thus, the syndrome covers so wide a range of symptoms. Which one of them should we take up to define what the syndrome is all about? Was it absolutely necessary to take up all of them (in fact, Dr. Kumagaya enumerated twenty of them)? Should those symptoms be differenttiated, depending on their gravity? I had not the remotest idea. Perhaps, I should use my head but, if so, whatever I came out with would not turn out to be objective indicators. Here, unless you go

beyond something of a "clinical" perception, whatever you choose will not broadly serve as useful indicators in the milieu of preventive medicine as well.

On the basis of the wide variety of statistical data we had gathered (with some of them taken into account according to Hans Selye's stress theory in pathological terms), we pigeonholed Dr. Kumagaya's symptoms and narrowed them down to the eight most important ones. They were stiffness in the neck, lumbago, digital cramps, nocturnal polyhydruria, shortness of breath, insomnia, dizziness and heaviness in the stomach. To come to quantitative grips with the *Nofusho* Syndrome, we proposed a scoring method -- that is, two points for persons who have had one of the eight symptoms "at all times" in the preceding month, one point for "occasionally," and zero for "never." We decided to define persons with a total score of zero to two points as not having *Nofusho* (-), three to six points as suspected of having it (±), and upwards of seven as having it (+). When it comes to the cardinal question of whether *Nofusho* comes in aggregation of the kind that fits its name, instead of its symptoms separately coming out in all directions, we used a statistical methodology and tried to verify that its symptoms would come out in duplication as they were peculiarly associated with one another.

If it is assumed that the *Nofusho* Syndrome frequently occurs among farmers, then, what factors of their lives are mostly frequently correlated to the syndrome? We definitely ascertained that the greater the area of land under cultivation and that of rice

paddies, in particular, the more frequent the occurrence is among farmers, and that the greater the non-agricultural income, the fewer the occurrence among farmers. With much confidence, we encouraged public health nurses, volunteers for extension of a better lifestyle and those for lifestyle guidance to disseminate knowledge about the *Nofusho* Syndrome and have them use it in their communities.

On the other hand, we could also verify that the *Nofusho* scores were substantially correlated to the findings of surveys on fatigue, so were they closely to the degrees of senility. That said, it follows that we came to have good authority for expatiating that *Nofusho* is a kind of "chronic fatigue" and a phenomenon of senility. Here, much credit is due to members of the Japanese Association of Rural Medicine for the strenuous efforts they have made for many years to probe into the syndrome. They were Masaichi Tatsumi (Hiraka General Hospital in Akita Prefecture), Tatsuya Suzuki (Ibaraki Prefectural Kyodo Hospital, Ibaraki Prefecture), Kiyoichi Noda (Kanagawa Dental College, Kanagawa Prefecture), Akio Uchida (Institute of Environmental Epidemiology, Chiba University, Chiba Prefecture) and Hideo Misonou (Saeki General Hospital, Hiroshima Prefecture), among others.

After medically checking persons with high *Nofusho* scores, in fact, we ascertained that the prevalence of diseases would go up in response to a rise in the *Nofusho* score. For the group with *Nofusho* symptoms (+), the prevalence was an astounding 90%. What did get the prevalence so high? In almost all cases, the responsibility rested with diseases of the sort which is increas-

ingly degenerative over time, or what we term "diseases peculiar to farmers" or "chronic stress disease." In a nutshell, this gives countenance to the view that the *Nofusho* Syndrome is a "harbinger" of those diseases.

None but cases in which people had fallen ill were routinely argued about in conventional medicine. The important thing is to probe into the conditions where people are "half healthy," rather than "half ill," before they get sick. Not only did we use the *Nofusho* Syndrome as part of a screening for an early detection of diseases, but we thought that we had to make effective use of it in providing lifestyle advice for prevention and health care, while pondering over how to maintain health and what measures we should take to prevent *seijinnbyo*, or diseases increasingly degenerative over time -- the diseases which after all are an end result of *Nofusho*. Here lies the reason why we took upon ourselves to use stress theories in etiologically expounding the *Nofusho* Syndrome. This theory is superior in that it clearly defines exogenous causes to stress. You can find exogenous causes to stress in our everyday lives. Now that our bodies have power of resistance, most stresses will not come to the fore. With an elapse of 10 years and then another 10 years, you will eventually lose it all. Prof. Selye verified, both clinically and in an animal experiment, that chronic stress diseases would occur with power of resistance lost. They include rheumatism, hypertension, arteriosclerosis, nephrosclerosis, myocardial degeneration and chronic gastric ulcer, among others. In the final analysis, they are diseases increasingly degenerative over

time, corresponding to diseases prevalent among farmers.

If it be so, what are the exogenous causes to stress? In terms of stress theories, those which are common in the everyday life include overwork, mental tension, malnutrition (avitaminosis, excessive intake of salt, calcipenia and protein deficiency, in particular). They also include infections and parasites as well as the cold in the wintertime. The important thing is to encourage rural people in concrete terms to avoid those exogenous factors. There would be little point in merely threatening them with a possible affliction with *Nofusho.* In line with the theories, I prepared and used a wide variety of figures and tables in explaining them all about this syndrome in plain language.

Casually, I was watching a TV commercial that gave a buildup to an anonymous drug, which was described as "good for *Nofusho*." To boot, it had a song that declared, "Let's eradicate *Nofusho* from the ground up" with that medicine. The commercial added that the syndrome was reduced when an anonymous doctor had administered the drug. Perhaps, the commercial might be right. But we didn't believe that *Nofusho* could be cured with one kind of drug. I don't have to go to the trouble of referring to the prominent poet, Takuboku Ishikawa (1888-1912), when I say that causes to *Nofusho* lie deep in our everyday lives. Some kind of drug or other may partly play a good role. But it would be no joke if you eventually cheated farmers by substituting "the parts" for "the whole."

Next, let us take a look at the issue of *seijinbyo*, or diseases among adults that would increasingly degenerate over time. On February

8, 1964, *The Asahi Shimbun*, a prestigious daily, had this to say under the headline of "A *Seijinbyo* Center Established in a Rural Community."

> A *seijinbyo* center with state-of-the-art facilities has been completed at the Saku Central Hospital placed under the wings of the Nagano Prefectural Federation of Agricultural Cooperatives for Health and Welfare at a construction cost of ¥130 million ($361,000).
>
> On the day when ceremonies were held in commemoration of its completion, Dr. Toshikazu Wakatsuki, the hospital director, said with his eyes moist with tears, "With this center completed, one of our wishes has come true. We renew our determination to do the best we can in doing the mass health screening and treatment of rural people and working for disease prevention. Nonetheless, I wish such a facility to come out one after another in the countryside."
>
> Dr. Wakatsuki's facilities center on those with which to cure hypertension, rheumatism and neuropathy, the prevalence of which is high in the rural setting, and to rehabilitate persons who are cured of those illnesses. The in-house Rehabilitation Center has a room for functional training, a room for massage, a room for locomotion in the warm water, a room with a Hubbard tank and a specially designed bathroom.
>
> For many of the patients with hypertension, rheumatism and neuropathy, limbs will remain paralyzed or joints will become hardened and immovable even after their recovery. In the room for functional training, specialists will have patients walk along parallel bars or undergo training with a tool with which the ankle is moved many times. In the room for locomotion in the water, handrails are fitted to the inside of a large bathtub, and a patient in

the tub will take advantage of buoyancy and practice walking. In the Hubbard tank, a patient who is unable to move around will take a bath in the supine position and then will be given massotherapy to soften joints.

Dr. Wakatsuki said, "Farmers replant rice with their hands and feet in the water. They reap it with a stoop at all times. They spend time in their cold houses. They do not take an adequate rest every day. Many farmers bow even though they are still young, and the joints of their limbs do not move. Urbanites simply do not have any idea of what they are like.

"Our rehabilitation center may look too much for us, but this kind of sophisticated facility is precisely what you really need for rural communities. At some urban hospitals, you will have to pay several thousand yen to cover the balance, between the charge for hospitalization and the amount of money given under your health insurance scheme. At our hospital, all employees discussed about the advisability of raising the highest balance from ¥60 (¢ 11) to ¥100 for ten days. The raise was really painful to us."

Stricken with paralysis, an old woman is still left bedridden and unattended in a dark bedroom (even in a silkworm rearing room during the year's busiest farming season) of her house. Having once gained the character of being stout at heart in the neighborhood, though, she is just lying down without saying a word, while she is constantly plagued by flies. She has scruples about asking her daughter-in-law to help her in relieving nature. That's why she tries to eat as little food as possible.

The masses have believed from old that once you have fallen down with paralysis, you will have to always remain bedrid-

den. In the first place, physicians themselves did not give them adequate advice. To conceal nothing, however, treatment in the initial phase will enable you to recover from the illness. The disease may heal completely in some cases. Once the dangerous phase is gone, you must start the exercise of the paralyzed hands and feet as soon as possible. That's the conclusion drawn from a new science on functional training. For that, it is advisable for patients with paralysis to receive treatment at a competent hospital for some time.

When it comes to cerebral hemorrhage, the exercise of hands and feet starts bit by bit three or four days after onset (specialists say it may start right on the day of onset for cases with encephalodialysis). Initially, the caregiver will slightly move the paralyzed hand and foot every two hours or seven times a day. Three or four days later, massotherapy will start. By so doing, the blood circulation will improve, thus preventing the hardening of the muscle and joint. Specialists say that the subsequent course for recovery will be totally different, depending on whether those measures are taken right after onset. I have to candidly confess that we, physicians, did not have an adequate knowledge.

I wanted to have a special hospital that could provide that sort of treatment. In response to my advice to Toichi Shiokawa, president of the Nagano Prefectural Federation of Agricultural Cooperatives for Health and Welfare, a balneotherapeutics center was established at Kakeyu in 1956. Thirty-eight miles from our hospital, Kakeyu is a town of hot springs in the mountains. We invited Yoshio Oshima, professor at the University of Tokyo, and

received his guidance. As we were urged to think of local poor farmers, who were simply unable to visit Kakeyu in terms of both cost and distance, the Saku Central Hospital at last decided to build a similar center in our town. The question was the equipment and staff that would definitely be required for functional training. We don't have any spa in our town, but we could keep the bath ready the whole day over, should we stake money.

Be it paralysis, rheumatism or the trauma caused in a traffic accident, rehabilitation evolves around the treatment of what is commonly known as a sequela with attempts made to have the patient tax his strength and provide him with positive guidance to realize his reversion to his family life and enable him to serve for society. As we had established a new rehabilitation center, it came home to my heart that the establishment of facilities such as this one was really a costly undertaking. I thought that a rehabilitation center was something that ought to be built at the responsibility of the central government or some other public institution. Considering that patients with those symptoms have to stay in hospital for long periods of time, there will be the need to use medical insurance benefits in trying to solve the problem of the doctors' bills.

For patients with persistent sequelae or incontinence, who will change the diaper? This question leads us to conclude that there ought to be many nursing homes for the elderly. The "special nursing homes for the elderly" prescribed for in the Law for the Welfare of the Elderly seem to look after those seniors, but they are not adequately available. In 1967, there were 45 such homes with a

combined accommodation capacity of 3,300. Which means they account for only 14% of the 23,000 seniors (0.4% of all seniors) counted in a fact-finding survey on the elderly. And a check of those facilities indicates that the nurses have no end of trouble. What is the trial for them? Nothing is much bitterer than the assignment in which they help patients take a bath, to say the least of the trouble of changing the diaper and bedpan. Nurses said that they had talked their school juniors about that task and found that none of the juniors were willing to take them over. They concluded that they would not be able to do anything about this situation unless a greater number of nurses were made available.

Even in the milieu of rural medicine, the issues that concern diseases among the elderly who increasingly degenerate over time have been taken up on few occasions. That reminds me of the fact that rural health in the wartime consisted mainly of tuberculosis and child and maternal measures. As importance was attached to young men who went to the front or engaged in production, greater efforts were concentrated on measures to cope with tuberculosis than anything else. And measures for children and mothers in the wartime were designed to give birth to as many boys as possible for increased war potentials. No attention was ever paid to the health and medical care of old people, who were cast aside as "no longer worthy." This phenomenon may well be described as amounting to a continuity of the spirit of old people's abandonment prevalent in the feudal times.

In the postwar years, in part because the people have enjoyed a more stable life, mortality rates have been on the down-

swing with the number of old people on the upswing, it is worthier of note than anything else that the people as a whole have become increasingly conscious about human rights. Man does not live only with things immediate in mind; there must be assurances that he is able to enjoy a healthy and comfortable life in his old age. This notion has taken root in the masses, including farmers. In or around 1955, it became a practice to hold study meetings and introduce scientific papers one after another on geriatrics and life science in Japan. Medical scientists were stimulated by the development of gerontology in the West, to be sure, but the fact that a growing consciousness about health on the part of the Japanese people turned out to be driving force for the rapid development of measures to cope with *seijinbyo*, or diseases of the sort which was increasingly degenerative over time, must not pass unmarked.

4. Compensations for Traumas in Farm Work

About the time when I was assigned to Saku, the figures of peasants who were hoeing in the field or plowing with a cow-driven spade were everywhere. The scene in which they tilled a field with a grub hoe in preparation for the replanting of young rice plants or treadled a threshing machine in the fall still haunts my memory. In the postwar years, however, power farming machines were made increasingly available. Particularly in the years when Japan's economic growth was accelerating at a miraculously rapid pace, their rapid popularization rode the crest of a cultivator boom. Tractors ran on the farm road where farmers had once walked with their

hoe on their shoulder. Spring set in with the quiet purr of cultivators; fall was gone with the dust kicked up by power threshers. Given those changes in the pastoral landscape, the injuries sustained in farm work also changed to a significant extent.

We took up the question of traumas in farm work for the first time at the fifth congress of the Japanese Association of Rural Medicine in 1956. Entitled "Statistics of Farm Work Traumas Treated at the Saku Central Hospital in the Last Five Years," a paper was presented there in the names of Zenzaburo Funazaki, Kazuo Sakamoto and Shinji Sasaki, who were surgeons at our hospital. Classified though they were as "traumas," they were none other than the injuries caused by hand tools, such as sickles and straw cutters, and by treadle threshers at the very most. Moreover, they were tiny hand and foot wounds. Given no immediate treatment, their purulence was also at issue. Occasionally, there were some serious injuries, including those caused as the farmers had been lashed out by horses or horned by cows. With power farming machines coming into general use later, however, the injuries caused by them were different from those in the earlier days and the occurrence of more serious injuries was on the increase. Those traumas gradually became a clinical theme that drew an increasing interest in the milieu of rural medicine. Eventually, the days finally came when farmers began to harshly complain about the fact that the injuries caused in farm work alone were not covered under any occupational accident insurance schemes.

In 1960, I presented a paper in *Saigaiigaku* (*Traumatology*, Vol. 3 No. 4) under the title of "Statistics on Farm Workers'

Accidents." I do not flatter myself that the treatise was probably the first of the kind which took up agricultural accidents in Japan in earnest. In the essay, I inquired into what were commonly known as "agricultural accidents." First, I clearly distinguished "agricultural accidents" from "agricultural diseases." I argued, for instance, that ancylostomiasis, which chronically comes out, is an "agricultural disease," but that a "blow in the eye" that results from impact with jutting rice leaves or wheat ears falls under the category of "agricultural accidents" because it occurs all of a sudden. But such a disease as tendovaginitis also suddenly comes out but does not coincide with the concept of an accident in the normal sense of the word and can hardly be classified as a trauma. Consequently, I argued that it should fall under the category of "agricultural diseases." The injuries that are inflicted on children who are playing on the field may be classified as "rural accidents" but can hardly be called "agricultural accidents" in that farm work does not responsible for the outbreak. Farming families will often leave straw cutters and other such instruments in the kitchen. The injuries caused by tripping against a straw cutter by accident could be a "farmhouse accident," but not an "agricultural accident." Moreover, accidents in forestry should be separated from "agricultural accidents," but farmhouses in the mountains will often engage in felling trees and taking out lumber and in many cases, farming work can hardly be distinguished from felling work. That said, there is the need to pursue an argument with all those points made clear.

As I have pointed out, the injuries caused by power farming machines -- tillers, in particular -- sharply increased in proportion to their rapid dissemination. Dr. Shinji Sasaki, a surgeon at our hospital, reported in 1964 that as many as 11 patients with wounds caused by cultivators visited the hospital in the summer of that year. Besides, they included three farming housewives. The causes to tiller-involving accidents come roughly in two kinds. One is the type in which injuries occur while cultivators are in use. The other is the type in which they are caused while tillers are running on the road, or a kind of traffic accident. In the former, the most troublesome thing is that the leg which had accidentally slipped into the field was clawed by the rotary, screw or plow of the tiller the man was driving. Here, the injury is different from the one inflicted on the hand by sickle in that mud goes deep into the wound, frequently driving the patient to fall victim to tetanus and, in the worst case, lose his life. Besides, with the direction of the machine changed many times, the chest is hit by the handle or the rib fractured in many cases. Then there also are many cases in which the operator's hand or arm is injured as the edge of his sleeve was caught and pulled by the exposed belt of his cultivator.

The traffic accidents are also terrible. Not so much safety precaution is taken for cultivators as for passenger cars. A case in point is the brake. With the operator sitting on the middle part of the cultivator that drew a cart, the visibility is poor particularly at places like a railroad crossing. Nowadays, huge trucks are seen running at full speed even on the country lane. Consequently, it would be dangerous for incomplete farm vehicles, such as tillers,

to rattle on a national or some other highway -- quite dangerous, in particular, when they go over a grade crossing or come out on a national highway. Often they are bumped by a train or truck in a major traffic accident.

Members of the Young Men's Department of the National Federation of Agricultural Cooperatives began to kick up a dust in or around 1963. No compensation at all was available for injured farmers. That did not stand to reason, they argued. They started a campaign, demanding invocation of the Insurance Law for Compensation of Industrial Accidents for farm workers. The demand created a sensation. They energetically addressed themselves to the Ministry of Agriculture and Forestry as well as the Ministry of Labor in the name of the National Council of Young Men. Just about that time, ILO Convention 121 was concluded, calling for the coverage of self-supporting businessmen and farmers under the law. Stimulated obviously by the recommendation, the Ministry of Labor at last began to go at it wholeheartedly. The National Congress of Agricultural Cooperatives in 1964 came out with a resolution that called for the "establishment of an insurance system for the compensation of occupational accidents for farm workers." It was also decided that this campaign be stepped up as one of the activities of the Central Union of Agricultural Cooperatives. In January 1965, the Ministry of Labor finally amended the Insurance Law for Compensation of Industrial Accidents and came out with a bill for "partial inclusion" of the self-employed, such as farmers. The bill passed at the 48th Session of the Diet [parliament] in June

of that year, or two years after the National Council of Young Men had taken up this issue for the first time.

In response to a call from the Central Union of Agricultural Cooperatives in June 1965, an expert committee was established to deliberate on application of the law to farmers two years after the Young Men's Department had taken up this issue. Under the chairmanship of Tadashi Fukutake, professor at the University of Tokyo, the committee was made up of several members, including myself as president of the Japanese Association of Rural Medicine, Mitsuru Kanai, managing director of the National Federation of Agricultural Cooperatives for Health and Welfare, and Mitsuru Katayama, an investigator at the Bureau of Agricultural Administration, Ministry of Agriculture and Forestry. The committee was designated as the Workshop on Compensatory Insurance for Occupational Accidents Among Farmers. The group's conclusion should have been exactly the same in substance as the new system which was to be implemented in November of that year. That's expecting too much. To make a long story short, the steps determined by the ministry were poles apart from our conclusion. As they were finalized to our sheer dissatisfaction, we felt terribly aggravated and disgusted. Given the ministry officials' final decision, we felt like being held up to ridicule with our propositions brushed aside as a paper plan.

In the final analysis, what the ministry wanted to assert was that their paper work for 19 million workers already covered under the existing scheme was complicated and too much and, therefore, that

the coverage of an additional 12 million farmers was really something they couldn't tolerate at all. That's why they argued that they had no other choice but to impose much stricter restrictions on the invocation of the law for them. In plain language, they wanted to minimize the scope of farmers who could be blessed under the law. Indeed, they were really an incarnation of bureaucratism. Down at the bottom, they decided to give insurance benefits only to farmers who would sustain injuries while operating self-propelled farm machines.

The chairman, Prof. Fukutake, had this to say in the February 1966 issue of the journal *Nogyo Kyodokumiai* (Agricultural Cooperatives).

> No matter what we proposed in our group, our power alone was not big enough to produce any tangible reaction. Whether we can put things on the right track depends on whether a broad segment of farmers can emphatically demand improvements. At the same time, it is important, as Dr. Wakatsuki has emphasized, to prevent occupational accidents. I wish farmers to take better care of themselves.

The Ministry of Labor did not categorize farmers, doing farm work on their own account, as "workers." They excluded from the list of persons eligible for occupational health insurance benefits the farmers whose income was smaller than that of non-agricultural workers, although their land and means of production were limited, and they had to work harder with a higher health risk than their counterparts in the non-agricultural sector. What in the world had

agricultural diseases and farm work accidents, such as pesticide poisoning, abortion caused by vibrating tillers and anthropozoonosis, to be excluded from those benefits? This is simply because they were "self-employed." What a heartless posture that was toward farmers! What a bureaucratic attitude that was with reality not taken into account at all!

5. Cultural Activities in Rural Communities

Having dwelled on a variety of problems in the science of rural medicine, let me introduce subsequent developments in the Theatrical Troupe of our hospital for a change.

Having earlier said that the troupe is the flower of activity by the Saku Central Hospital Workers' Union. It does not follow, though, that the unionists were utterly free from trial and error.

The story here goes back to 1959. That year or so, we came out with a playbook under the title of "Konkichi Series." That was quite a simple one, the kind of drama the hospital's medical staff could readily present to locals after they were out on their round of sick calls. It could be played by a physician and two nurses or so after they had visited patients. You required neither a big movie house or theater nor a large number of actors. You could play it in a tiny village assembly hall. You did not need any theatrical appurtenances, either. The play looked more like cross talk with songs. Occasionally sending the audience into a roar of laughter, we gave topics about problems of the kind which was tied in with

rural medicine. For the playing of dramas, I had taken hint from *yangge* (song for rice re-plantation) sung by the Chinese Communist Party's rural cultural propaganda brigades. I could well be chided as a scatterbrain, but that's what I had done. Perhaps, I had a swollen head, when I thought I could disseminate knowledge about preventive medicine by presenting something of a show with songs, rather than a serious drama. For some time past, Mao Zedong had thrown considerable energy into the dissemination of rural medicine. But we seemed to be ahead of Communist China's founder in the sense that medical care was integrated with cultural work on our part.

"Stomachache" was a one-act play in our series of dramas. This drama was called to account. Since 1946, we have made it a practice to celebrate what we dub the "Hospital Festival," or an open-house event with health illustrations on exhibit on the occasion of Usuda Town's annual festival, Komansai, on May 21 and 22. At the festival, we present plays and documentary motion pictures, hold a cooking class and give guidance on what we call "farmers' calisthenics." Taking advantage of this event, we give a banquet in honor of men of influence under whose care our hospital is placed (for us, this is an important event, too.). The guests include the presidents of local agricultural cooperatives beside the chiefs of local municipalities, government agencies, public health centers, public schools, police stations, fire brigades and medical associations.

Now then, it was on the afternoon of the second day of the Hospital Festival with its health exhibition just about to come

to an end that we thought we would be able to fetch a sigh of relief if the customary banquet for VIPs went smooth. At the very table, I suspected that there was something wrong with the behavior of the local agricultural cooperative's chief. He was cutting up crusty. With a gloomy foreboding, I approached him helter-skelter with a tiny bottle of *sake* in my hand.

"Shame on you, hospital director!" roared the boss with his unshaven face all aglow, the moment he had turned his eyes upon me. "You shall smart for it this time or never. What in the world did you do that for?"

His breath that came through the nose was terribly odorous with alcoholic fumes.

I asked, "What's this all about?"

"What d'ya mean by that? What the hell drove you to come up with Lockheed[12]? What the heck are you driving at with Lockheed? How in the world does your rural medicine have to do with Lockheed? You've got to tell me how come?" he barked. That's precisely what I had been afraid of. Here's a nice mess, I thought.

To tell the truth, we presented a one-act play to our guests at the banquet under the title of "Stomachache." The drama had a reference to the Lockheed scandal. In the drama, a father has the gripes but was in no mood to consult a doctor. To make a long story short, his son, Konkichi, gives his father the medicines he has got from some physician. Having vomited intestinal worms, the father looks unconcerned as if nothing has happened to him. Konkichi admonishes his father for having adamantly refused to

go and see a doctor. The father says, "I really hate physicians. They scare me into paying them a lot of money in cash, even if I produce my own medical insurance certificate." Here, Konkichi suggests that the father will be able to get away merely by producing his certificate, should he have assurances that the village administrative authorities will pay his share of the medical expense on his behalf. "Baloney," screamed the father. "To add to our misery, we are already troubled with high insurance premiums. If we act as you've just suggested, they will never fail to raise our shares one after another." Then Konkichi asks, "Why not ask the central government to raise its share?"

> Father: No wonder they call you an ultra. Where in the world can the government hit on a source of revenue for that? If you did what you'd suggested, you would end up with a big raise in our share of national taxes.
>
> Konkichi: Wait a minute, dad. My suggestion could translate into action, should the government decide not to buy Lockheed aircraft. I hear that they cost you ¥500 million ($1.4 million) per plane. If you set aside the money required for the purchase of 100 planes, you would be able to pay for all the expenses required nationwide for medical care under the National Health Insurance Scheme.
>
> Father: Haven't they said that they're going to purchase as many as 200 planes?
>
> Konkichi: You're darn right. All you had to do here would be to halve that number.

This dialogue is followed by Konkichi's singing that runs

"Let's stop buying Lockheed aircraft ....." There could be no objections to the giving and taking of those amusing and laughable lines and songs. On reflection, however, it is hardly possible to persuade men of different ideas simply by giving a wealth of captious and unguarded phrases.

The drama is so simple in form that its substance tends to get recitative. Here, we were liable to leave ourselves open to misunderstanding. Is it not that what we did in the drama was contrary to what we had actually learned from Kenji Miyazawa [*see* Pages 32, 39] to whom I had looked up as my teacher? Is it not that the writer of juvenile stories admonished us to perform a play, instead of chopping logic in a bookish lecture, in making friendly overtures to rural people? Is it not that whatever you try to persuade them must stand to reason?

In the first place, many of the banquet guests were village leaders in favor of Japan's rearmament. The situation here was different from that of, say, China. As a matter of fact, the head of the local agricultural cooperative emphatically declared to me, "Listen, hospital director, I am in favor of the remilitarization." He queried, "How in the world can you ever defend Japan's independence without rearmament? Don't they say, 'Providing is preventing'?"

"Terribly sorry," said I with a humble bow. What really pleased me was that I had been criticized right in front of the boss, but not behind my back. (By the way, that was the third time he called me on the carpet. At one time, he lectured me because he said the matchboxes available in our hospital did not bear his

agricultural cooperative's logo. At another time, he huffed me because he said many of our hospital's nurses were not aware of the agricultural cooperative's manifesto.)

His reprimands did not bother me at all, because I paid my high respect to the boss, who in fact was a man of sincerity with fervent zeal. Once, he dressed me down for half an hour over cups of sake, but I kept fervently acknowledging myself in the wrong. It is I, but not Konkichi in the play, who was an ultra. I must say that I was so vain-conceited that I lost sight of reality.

Meanwhile, the boss took out a book and declared, "You must act upon the maxim of this wise man." Then I was told to read aloud a certain page of a book that introduced the results of a study on Ohara Yugaku[13]. The very page he wanted me to read carries passages about "things that ought to be kept in mind by physicians during their lifetime." One of the passages declares, "Physicians are absolutely forbidden from drinking any alcoholic beverages through life." Beastly drunken though he was, the boss commanded, "That's why I will never allow you to have even a little drink till doomsday!"

Candidly speaking, Japan's remarkably high postwar economic growth was really the last thing I could think of. In tune with an ever-growing transformation of the rural landscape, our hospital's cultural activities could not help undergoing change. Pompous though they had been, our troupe's activities began to go out of vogue in 1955 or so. With remote villages blessed with television, grandmas and kids increasingly lost their interest in the plays we

presented after repeated rehearsals. Movie theaters no longer attracted townspeople, and one of them was converted into a plant for electrical appliances. Once very popular though they were, the theatrical activities done by local young men's associations utterly went out of fashion. In the first place, young people drifted to big cities in waves, thus disabling the local young men's associations to do things to their satisfaction.

Thus, we were compelled to drastically change the way we had evolved our publicity and enlightenment activities. The conventional plays presented by our amateur actors and actresses could no longer wring the heartstrings of the masses; they had to be more realistic and strong enough to vividly catch the public eye. Unless they were endorsed by scientific documentation, moreover, the audience would never find contentment in them. That said, some of us began to use photographs and slides in the name of an "audio-visual education team." As a matter of course, we produced and showed them in villages. Making a step forward, we started using recorded tapes, thus enabling us to use a slide auto-projector that would automatically show synchronized slides one after another. Eventually, those moves led to the formation of a motion picture team in the hospital.

The group was organized in as early as 1952, as we were stimulated to produce a documentary movie of the First Congress of the Japanese Association of Rural Medicine in Nagano City. Tasting the benefits of success, we concluded that there would be nothing better than movies to unfold activities for enhancement and publicity in any attempts to stir profound emotion in the audi-

ence. The conclusion was due in part to the boundless enthusiasm exhibited by the hospital staff, particularly Dr. Funazaki, a surgeon, and Dr. Teiichi Yamada in the Department of Obstetrics and Gynecology, who had a demonic passion for the production of 16mm movies. For enlightenment of the science of rural medicine, we came out with a two-reeler, titled "Calisthenics for Farmers in Yachiho Village," in 1962, and "*Nofusho* Syndrome" again in two reels the following year, and they met with favorable public approval. With those two motion pictures, we wanted to give an expository comment on the prevention of the *Nofusho* Syndrome in touch with the realities of farmers' lives. The former was designed to emphasize the significance of calisthenics of the kind with which to recover from work fatigue, whereas the latter discussed ways of protecting farmers from the injurious effects of the cold.

In 1962, we began to take up pesticide poisoning accidents as a new theme in the milieu of rural medicine. At the start, we conducted a fact-finding survey on acute poisoning among farmers. The following year, we established a research institute of rural medicine to check by ourselves the quantities of residual organic mercury and chloride in rice, vegetables and fruits. Put simply, we started focusing on the residue of those chemicals in food. Moreover, we concluded that we would have to confirm their chronic disorders in experiments with animals. Undoubtedly, the most telling tool to caution farmers against poisoning would be a motion picture that documented the findings of the survey.

One day, staff members of Group Gendai, a Tokyo-based

independent movie production, visited our hospital without notice. They said they wanted to enlist our help as they wanted to make a film of the realities of pesticide poisoning at all cost and warn society as broadly as possible. Keeping up the conversation with them, we gradually came to realize that we were absolutely of the same opinion. Eventually, the group came out with three-part "Pesticide Disaster" one-and-a-half years or so later.

Lodging in our hospital's night watchman's room, the production team looked around in every nook and corner of the local communities and filmed every aspect of the way in which farmers sprayed pesticides. They stayed here over a period of five months. No sooner than had they heard of a farmer poisoned with pesticides than they shot off to the scene with a heavy and bulky camera, no matter how deep it was in the mountains and what time it was. It occurred to me that firmly determined though we were to stake our lives for medical care in this remote countryside, the sheer force of their will was far greater than ours. Well, that's how artists devote themselves to their own work, I once again granted.

That's how our hospital's movie team learned, not just technically but spiritually as well, from movie producers of Group Gendai. Certainly, the films we subsequently produced turned out to be markedly better than ever before. Then the team came out with two-reeled "Fatigue from Cultivation" in 1967 and "Paralytic Old People" in three parts the following year. The latter, in particular, was eagerly sought after by women's groups in general and seniors' clubs as well as agricultural cooperatives. The appearance of

old people with paralysis in hospital -- and those who wet and soil their pants -- is really heartbreaking. Our team filmed the nurses who were quite assiduous in helping inpatients eat a meal and take a bath and in exchanging diapers and bedpans as they were. Moreover, the group also made a film of old people bedridden in their ill-lighted farmhouses -- from whose lips the words "I wanna perish quick" poured out in a steady flow -- as they were.

The film was projected at the Ninth Congress on Farmers' Health held in downtown Tokyo in January 1968. Later, I was told that delegates from agricultural cooperatives across the nation, who filled up the conference hall, were all in a state of shock. Leading Group Gendai, Yoshinori Furukawa saw this film and later said to me, "Having had the pleasure of seeing your movie, I believe that we will have to criticize ourselves in all seriousness. The film with which you have come out as amateurs contains far more truths than ours."

Naturally, we would not get too big for our boots to let his comment go to our heads. But I had second thoughts. What is truth, anyway? Not improbably, the Goddess of Truth may allow us to catch a glimpse of her graceful pose if we are to put ourselves in the shoes of people and grapple with the task of reforming realities.

Thus, our preventive medicine-oriented enlightenment and propaganda campaign may well be described as having now developed from efforts by a theatrical troupe to those of a state-of-the-art movie production team. But it does not follow that the dramatic company no longer exists. The troupe has places, themes

and subjects of their own. Having accomplished their original intention, they are playing a significant role in the activities of the Saku Central Hospital Workers' Union. Several years ago, we established a training center for rural medicine. With a huge stage, the center's hall has a seating capacity of 500.

The theatrical troupe played two-act "From a Small Window" when a short course of study, dubbed "Summer University for Rural Medicine," was held in the hall last year. (Most of 500 "auditors" were public health nurses and volunteers for guidance on a better lifestyle.) At a subsequent banquet, one of the public health nurses said, "I was utterly unaware that the colossal pressure of politicians and businessmen had had to do something with scientific studies, such as on pesticide poisoning. No longer can I believe that science is on neutral ground."

CHAPTER FIVE

Health Care in Rural Communities

1. Picking up Yachiho as Pilot Village for Health Care

We began to evolve activities for all-inclusive community health care shortly after the founding of our hospital in 1945. We used to make a tour of "doctor-less" sub-villages to deliver medical care. The idea was not just to heal the sick but also strive to work for the elimination of diseases. In the villages, we did so because the prevalence of "latent" diseases was alarmingly high. We thought it an urgent task to detect them in an early phase. At the same time, however, we also thought it more important than anything else for rural people to realize their own health so that they would not be laid up with illness. With this in mind, we began to unfold activities for their enhancement. In making the round of villages to deliver medical care, we made it a practice to present theatrical plays, picture-card shows, hand puppets and motion pictures, among others. Also, there was the need to establish the science of rural medicine in order to put the enlightenment of rural populations on the right track.

Now then, the method we employed for our beat was apt -- whatever else might be said -- to turn out to be something just to suit the occasion or become perfunctory. Our visit to some village, when we were not on the go in the hospital, to deliver medical care as though it were like something "bestowed from above" will amount to no more than a mere "inquiry" that is customarily made about health once every several years. In our self-criticism, we concluded that this practice was too haphazard, by far. That's why we decided that we should perform on a regular basis mass health

screening of the sort that could involve every one of the villagers from the beginning, instead of covering only those who could afford to come and undergo a screening, or the idle-rich.

Yet in another aspect, the data gathered from the screenings must not be left in disorder; every one of them must be pigeonholed. For this, there is the need for a master health register. There is also the need for a health pocketbook in which each examinee will make entries about his health from the standpoint that health is something he should protect by himself. In a nutshell, we came out with the idea of covering all villagers in a health care program with the master health registers kept by our hospital and the health pocketbooks by the individuals. It was in the village of Yachiho that we put this idea into action for the first time.

Here is an episode that led us to come out with that idea. While making house calls deep in the mountains, we learned in a casual conversation with farmers that master health registers were kept updated for cattle (known in those years as "cattle registers"). There was no documentation, though, about the health of humans, the most important of all creatures. That's out of all reason, we thought. They said that the master health register for cattle carried data about their weight, genetic factors, the course of their diseases and preventive injections, among others. That reminded me of the fact that stock raisers and dairymen were very learned and talented to our astonishment about the health care of cattle that ranged from environmental hygiene to preventive injection, to say the least of their feed. And yet they were utterly ignorant when it came to their

own health and their children's. They could administer an enema to cows, but not to their children. This emblematizes, more than anything else, the spirit of health sacrifice inherent to farmers. We concluded that there should be master health registers for humans, or that there should be health pocketbooks of the kind in which they could make entries by themselves on a regular basis.

The important thing is, the master health register ought to have entries about lifestyle and environmental factors -- but not just the findings of a checkup done by a physician. For the pursuit of correlations between the lifestyle and environmental factors, on the one hand, and health, on the other, on the basis of the documentation will be quite instrumental in the improvement of the lifestyle. Cases in point are correlations between patients with stomach cancer and their dietary practice and between hypertensives and their lifestyle factors with special reference to the living conditions causative of the cold, and to the backdrop factors responsible for the *Nofusho* Syndrome. The findings of the medico-ecological researches and studies we had done over years were unexceptionably the outcomes from the pigeonholing of the entries made in the master health registers.

Yachiho's formula for the delivery of health care to all over-15s was in line with the basic imperative of enhancing their consciousness about health promotion, so that we exerted all possible efforts in enlightening and talking with them, but not just in technologically working for better examinations and screenings. It is not few and far between that, after we had finished making house calls, we

sat by the fireside in the sub-village's public hall and spent our time to the best advantage in chatting with locals over cups of *shochu*, a kind of distilled spirits, far into the night. Studying in the Office of the Hospital Director later at night, I would often hear a jeep come back to the main entrance to our hospital. Undoubtedly, they had been singing in chorus on the way back; the melody of the hospital's song "Together with the Farmers" rhythmically came out of their mouths, as they were alighting from the jeep. (This task of ours could no longer be carried on, should the unionists find it in their hearts to demand an overtime allowance for the extra work they did out of sympathy for rural people. For the work could not be legally funded with no benefits authorized for disease prevention under the prevailing National Health Insurance Scheme. Nor could our hospital afford to hit on a new source of revenue. Should an attempt be made to raise outlays for the health management of rural people with the expenses fallen on each villager or the village administrative office, it would undoubtedly run against a snag as things now stood.) For the time being, there would be no alternative but for our hospital to do something about this contradiction, such as by offering gratuitous services for the sake of charity. There is no gainsaying the fact that the whole problem had yet to be solved, however.

For the task of protecting health in any village, the highest degree of responsibility could be described as resting with the National Health Insurance Scheme, under which the bulk of the village's expenditure for medical care was covered. In and for itself, the National Health Insurance Scheme is so designed that

efforts should be focused on the delivery of not only medical care but health care as well. In the first place, this insurance system is designed for *health* care, as its name definitely implies, but not just for *medical* care. In fact, it was made a practice to focus activities for preventive medicine with the assignment of public health nurses from the inception of the National Health Insurance Scheme in 1957. As things stood, however, the activities under this system were confined to the delivery of medical care, and officials looked quite unconcerned about "benefits for disease prevention" before one knew what was happening. With their attention riveted on the deficit and other financial issues associated with the scheme, there were signs that they tried to have public health nurses do only paper work on health insurance. What should please us as rural physicians is not that we can profit by a rise in the prevalence of diseases; what should please us together with the villagers is a drastic drop. For this, adequate benefits must be granted for disease prevention under the National Health Insurance Scheme. We knew from our 10 years' experience in the delivery of health care to all over-15s in Yachiho that it would be quite feasible to do so. In plain language, outlays for disease prevention will make it possible to eventually reduce the village administrative office's outlays for medical care to a significant degree under the scheme. Prevention is better than cure, and that's the truth. I shall expatiate upon this matter later.

What led the Saku Hospital to come to make arrangements with Yachiho for the delivery of health care to all over-15s in the village,

about six miles away from the hospital? The project started in July 1959 after talks with village authorities. That was the year in which the new National Health Insurance Scheme Law was enacted, marking the establishment of a system in which the health of all the Japanese people would be universally insured. It was also the year in which a new security pact was inked with Washington and Prime Minister Hayato Ikeda's national-income doubling program placed on a solid basis.

One or two years before then, controversy flared up on the over-the-counter payment of consultation fees under the National Health Insurance Scheme. Under the old system, all you had to do when you were to seek advice from a doctor was to produce your insurance certificate (your village administrative officer would later collect your share), but that system was so altered that you would now have to pay in cash over the hospital counter your share that accounted for half the charge. Which meant that the poor farmers who had no sources of cash income could not afford to seek medical advice, thereby increasing "latent diseases" in the villages. We declared ourselves against the new system. The majority of the local Medical Association took part with us, though some of its members preferred the new system, which they argued would enable them to "get cash on the instant.." (Most of the physicians in the whole prefecture supported the new system.) Of all local town and village headmen, the most powerful opponent was Kokichi Ide, chief of Yachiho village. Together with village assemblymen, he forced himself into the Prefectural Government, demanding an immediate abolition of what he called a "bad" law.

He did so not a few times. Adamant though they were, government officials probably failed to realize how to deal with an inexorable headman. In response to a summons, I called on the director of the Prefectural Government's insurance division one day, wondering what he wanted to see me about.

The official declared, "Mr. Ide must have raised objections at your instigation. You simply can't do anything about a law, which has already passed through the Diet [parliament]. I want you to talk him into compliance. The sooner, the better."

I retorted, "Mr. Ide is not the kind of man I may be able to talk over to your view. I really mean it. I would be rather excused from this sort of business." On second thoughts, I knew I was not in a position to hurl defiance at the official, either. For it would adversely affect our hospital's revenue under the National Health Insurance Scheme, if he did something mean to us. (In those years, the hospital's earnings under the scheme were so strictly assessed that hundreds of thousands of yen was pared down each month. Incidentally, that division chief would soon be sacked because of his involvement in a graft scandal.)

To make a long story short, Mr. Ide's fierce campaign against the new insurance system ended up as nothing more than a threat to the Prefectural Government. It is at that moment that his village's health control program got off the ground. In regard to the process of events, Mr. Ide has this to say in a pamphlet the title of which reads: "Health Care in Yachiho Village – The Past Five Years."

Without money, you can't consult any doctor. I hear that in a country whose social security is well advanced, the national government will take care of you when you are sick. That's exactly what we have wanted for long to realize in our country. As we candidly talked with Dr. Wakatsuki and his lieutenants from time to time, the government decided in 1957 to adopt a system in which patients would have to pay over the hospital counter half the charge for their consultation with physicians. Under this system, he who cannot afford to consult with a doctor even in normal circumstances will find it more difficult to do so. That's why we filed a petition with the Prefectural Government many times with the consent of all villagers, and we carried on this campaign for more than one year to raise objections to the last. But our petition was rejected.

Then, Dr. Wakatsuki suggested that we might as well start a project in which health care could be delivered to all villagers. I said, "So it is, to be sure! We stepped up a campaign against the over-the-counter collection of medical fees in hopes of doing something for the sick. With the help of the Saku Hospital, why not have all villagers join a campaign to protect them from getting sick?" We appealed to all of them and began this health control program.

Thus, 10 years have elapsed since this project got under way. Our association with the village of Yachiho began by far before the start of this program or, to be exact, from immediately before or after Japan's defeat in World War II. There has once been a nation-

al sanatorium in the village. A "quacksalver" has once been assigned to this medical facility. So has a self-appointed professor of Keio, a prestigious private university. It was in those days that we started making house calls and giving lectures on health in the village's pubic hall. While Dr. "O" was taking charge of the local clinic, we made it a practice to see patients there on the afternoon of every Wednesday by all means. (We did so over a period of two years. The long and short of it is that the doctor threw up his job, as he was unable to make himself agreeable to villagers with the result that the clinic was shut down.)

The circumstances in which the doctor found himself in the village had to have something to do with the fact that I could hit well with Mr. Ide. Really, the village headman was an incarnation of conservatism, whereas I was increasingly gaining notoriety as a reformist. I could come into close association with him at least because I myself felt great respect for him. Always driven by unselfish motives, he was quite equal to anything. Never did he knuckle to power. In the sight of the headman, I was always ashamed of the fact that I was really a greenhorn. The greatest of all pleasant moments was when Mr. Ide treated me with a cup of *sake* after another. Time and again, he used to sing a packhorse driver's song. In a hilarious frame of mind, he went as far as to dance to the tune of "My Sweetheart Is a Headman's Daughter," a song popular in the 1930s, for me.

Legend has it that ill luck would sometimes have it. When the feasibility of developing the village's wasteland into a tourist spot was at issue, a report was going around that a spa developer

had cheated Mr. Ide. With this as a momentum, the villagers broke up into two factions. Quite a man of persistence, he did not budge an inch. Ultimately, Mr. Ide, defeated in a subsequent election by a slim margin, had to yield power to the incumbent, Kurazo Sasaki. Soon after having contracted pneumonia perhaps because of his overexertion for the election, Mr. Ide died in our hospital.

A villager said that Yachiho's health care program was a product of two local bosses, or Mr. Ide as village headman and me as hospital director. Weren't there any other factors? The course of events ought to bring everything to light. With Yachiho's electorate split into two, the opponents to Mr. Ide carried the day. As a natural consequence, administrative policy was to be newly scrutinized in every aspect. When it comes to the health care project, nonetheless, there were no signs that it would be altered in some way or the other. "The health care project is a wonderful one for Yachiho," declared Mr. Sasaki in the capacity of the newly designated village headman. "We will continue to do whatever is good for our village without regard to whether it was initially planned by my predecessor. We will spend a much greater effort on it." The words signify impartiality on the part of the new mayor. Had this project been a deal between the predecessor and me without the consent and support of all villagers, what could have made it possible to carry on this program? In no way am I trying to say here that Yachiho's approach is an ideal one. I trust that you will come to realize what I am trying to say here when you come across my self-criticism later on in this book. Nonetheless, I can say that sustainability is the most essential of all elements for this kind of

program. We wouldn't call it a health care program in the genuine sense of the word for program of the kind that is given a citation several years after its inception.

2. Ten years' developments in Yachiho

In plain language, how is Yachiho's total-village health control program under way? Now, let us take a closer look at the system our hospital has for it. The staff of our hospital's Health Care Department is made up of four physicians, two public health nurses, and one pathological laboratory worker and four clerks (of whom the regulars include one physician, two public health nurses and four clerks). The hospital's public-heath activities (not just the delivery of health care in Yachiho) are all done by the staff of the Health Care Department and the Caravan Medical Team of the hospital workers' union. Why is it that the workers' union finds itself in a position to organize a team that will visit one community after another in delivering medical care as one of its activities? It goes without saying that a workers' union exists to protect its members' lives and stand on their rights. Their campaigns are not confined simply to the safeguarding of their vested interests, however. Their ultimate objective is to liberate all workers, to be sure, but their everyday struggles must be unfolded in close association with local community residents and, in particular, with farming populations. This association may perhaps be described as a kind of collaboration between workers and farmers. Be the matter what it may, it is necessary for workers to go along with local

farmers and ordinary inhabitants with interlocked hands, carry out joint struggles for a better life and deepen their interchange and sympathy. Any struggle staged by a hospital workers' union must not be something that will end up with a demonstration or a strike. That said, there is the need for hospital workers to get among residents by taking advantage of their work, irrespective of whether the matter concerns a farm work accident or pesticide poisoning. It is from this very perspective that the workers' union came out with the idea of making house calls in the local communities.

With Figure 4, which gives an organizational chart of Yachiho's health care project, let us check and see how it is organized and managed. The main entities are our hospital and Yachiho's Health Committee. They constitute the core of the organizational setup and the main lines of management policy are worked out in talks between the two parties. Both have various ties of association with other institutions, including the competent Public Health Center, and when it comes to our hospital, it is necessary to closely coordinate particularly with the local Medical Association. With each village made up of sub-villages, we will be unable to accomplish our task in the genuine sense, unless we focus on those hamlets. Besides, the local Agricultural Cooperative is yet another important institution. Our role is indeed great as we are affiliated with the local federation of agricultural cooperatives.

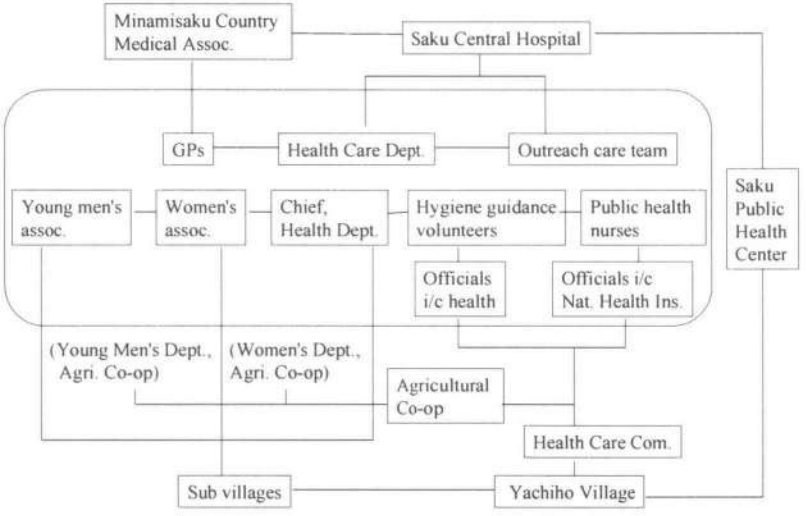


Fig. 4 Organizational setup for health care inYachiho

Immediately under the village's Health Committee, you have health officials or officials in charge of administrative work on the National Health Insurance Scheme in the village administrative office, which has public health nurses under the director of its health department. Besides, the hospital's coordination with the local Young Men's and Women's Associations is of importance. With the hospital's Health Care Department integrated with its union's Caravan Medical Team, we performed mass health screenings and work for the enlightenment of villagers on health problems. For this, there is the need for multilateral and brotherly ties with various village groups. Without those ties, the sustainable delivery of health could not be assured. Quite bluntly, it is quite an

easy task to draw an organizational chart. For example, the village headman is the law around there, and a village health committee may be established without trouble. The question is, however, whether the health care system is inseparably tied in with each one of the families in the village or every one of the villagers. There is no point in plowing the field and forgetting the seed.

The most active players in the delivery of health care are hospital technicians, general practitioners in the local communities and public health nurses who work under the National Health Insurance Scheme. However, we attach more importance to the roles played by the so-called "health guidance volunteers" elected from among the members of the local Young Men's and Women's Associations. Equivalent to health *activ*, or activists, in the Soviet Union, they speak for inhabitants and the examinees of heath screenings, instead of health technicians. They play an important role in enhancing residents on health. Fact-finding surveys on the living environment, for instance, could not be conducted the way they should without the positive cooperation of health guidance volunteers. The fundamental requirement for health control in any village is every effort that is made by villagers on a voluntary basis. Yachiho has 30 health guidance volunteers. It is an important task for us to train them. We make it a practice to hold a meeting with them once a month without fail. Together with them, we also study specific themes in the health and medical sectors.

How much does the village administrative office have to pay for a

round of mass health screenings (the cost represents the total amount of money they set aside for their health control.)? In 1968, we agreed to check up the health of villagers for ¥250 (¢69) per person, of which each individual would share ¥100 (¢28) with the remainder reimbursed by the village administrative office. As a matter of course, it was decided that the total amount be defrayed out of the village coffer for poor villagers for whom the Livelihood Protection Law was invoked, however. As it was pointed out later that the amount to be borne by the hospital was too much, the charge was raised to ¥350 (¢97) a person in 1970. But the individual's burden was left intact, or at ¥100. In those days, this amount was good enough for a grandma, living deep in the mountains, to buy some snacks for her grandchildren. It could well be described as a reasonable share, when it was considered that villagers would be able to protect their own health at least over a period of one year with this paltry outlay. Villagers appeared to be quite satisfied with this system. Yet in another aspect, the fact remains that a by far greater burden will have to be shared by the hospital and its employees. That is the question. In our cost accounting, it has turned out that the cost for a health screening includes outlays for all sorts of projects for health care, such as lifestyle guidance, the pigeonholing of statistical data and debriefing. It has been concluded on a minute calculation that this health care project in Yachiho alone drives the Saku Hospital to go into the red to the extent of ¥70 million ($194,000) or ¥80 million ($222,000) a year. We show the balance sheet to village officials, yes, but they do not seem to be in a mood to do something about the deficit on the

strength of the village's poverty and financial straits.

The other day, Yachiho's senior officials and health guidance volunteers made a fact-finding tour of the village of Sawauchi in Iwate, a prefecture in Northern Japan, as its health care efforts had been introduced in Takeo Kikuchi's *A Village – People Hold Their Own Lives Dear* (Tokyo: Iwanami Shoten, 1968). How impressed they were by what they had seen there! What a large amount of money the village authorities had had to invest and how much thick and thin they had had to go through, before they went as far as to come to a point where they could begin to take care of physicians and manage a hospital by their own work! How firmly determined the village authorities were, when they decided to furnish 10 percent of the expenses required for the medical care of infants and seniors! Locals would say, "Know what? We're in a better position, 'cause we have the Saku Hospital." By no means will this sort of posture help spread a campaign for mass health screenings across the nation.

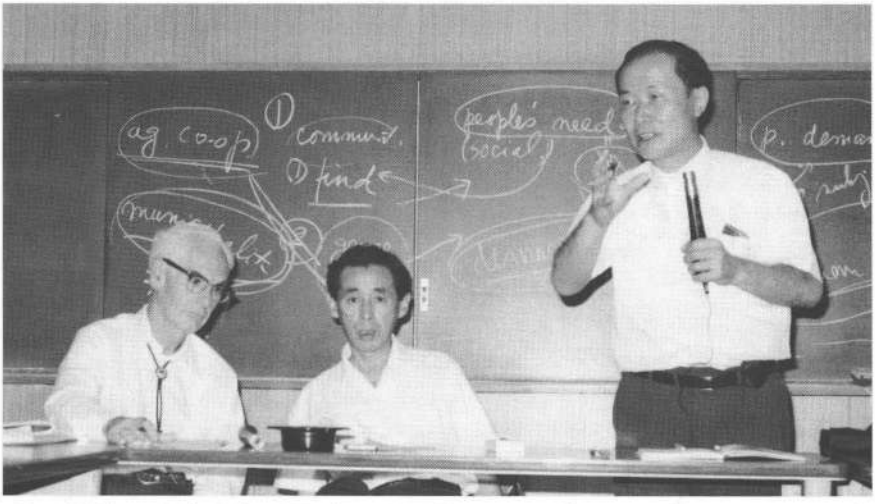
Yachiho's mass health screening program covers 3,000 over-15s. Sent by our hospital, a 10-man screening team makes a round of 22 sub-villages by jeep. In the three-month wintertime with farmers free from farm work, we make it a practice to perform mass health screenings every weekday. With villagers gathered in the village's public hall, we conduct interviews, medical examinations and tests and give advice and counsel on health and the lifestyle. For the bedridden, we make it a rule to visit them at their homes.

After the period of mass health screenings that extends for

Hospital workers dancing in traditional Japanese attire at the farewell party held for participants in the Fourth International Congress of Rural Medicine in the gym of the Yachiho Middle School. (1969)

Prof. Pavel Macuch (Czechoslovakia) giving a keynote speech at the Fourh International Congress as president of the International Association of Agricultural Medicine. (1969)

Foreign delegates spending a pleasant time at a local farmhouse. (1969)



Dr. Wakatsuki briefing Herbert K. Abrams, professor at the University of Arizona, about rural medicine in Japan with Shinichiro Yoshimoto giving linguistic assistance. (1975)

The 1976 Ramon Magsaysay Awardees posing for photo op. From left to right, Henning Holck-Larsen (Denmark), Dr. Wakatsuki, Elsie Elliott Tu (Britain), Hermenegild Joseph Fernandez (France) and Sombhu Mitra (India).

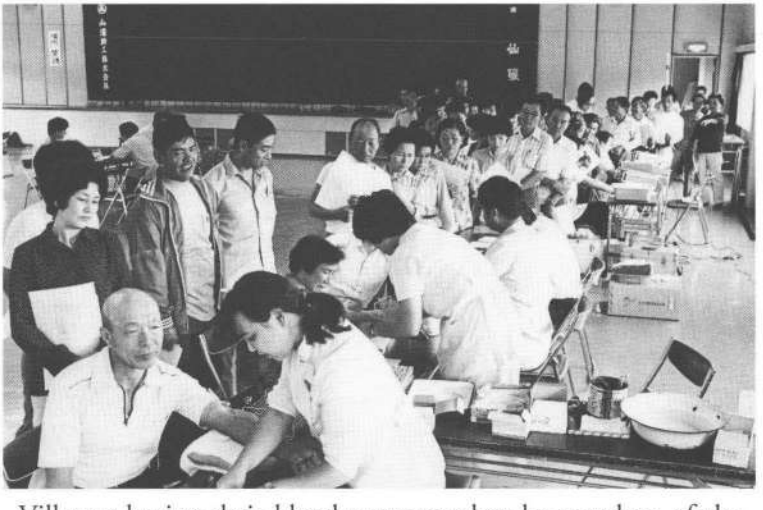
Dr. Wakatsuki (third from right) chatting with guests at a Reception held in commemoration of the publishing of his book "Fighting off Diseases in the Hamlets." (1971)

Dr. Wakatsuki dancing with Shichiro Fukazawa, a popular writer, at a commemorative party with the Second Class Order of the Rising Sun conferred upon the doctor by the Emperor for his contributions to the development of rural medicine and the delivery of community care. Watching in traditional Japanese attire in the foreground is Dr. Wakatsuki's wife, Tsugie. (1981)

An unidentified speaker giving a lecture at the 20th series of lectures on community medicine and community building which, dubbed "Summer University," is held at the hospital every year, attracting many health workers from across the nation. (1980)

Health workers relaxing at a party while attending a series of refresher courses that started at the Japan Rural Health Care Training Center near the hospital in 1977 under the motto of "Learn while doing discussions."

With the snow clogging on their boots, though, members of the hospital's mobile health care team are seen carrying gadgets to start a mass health screening at Kinasa Village. (February 1981)

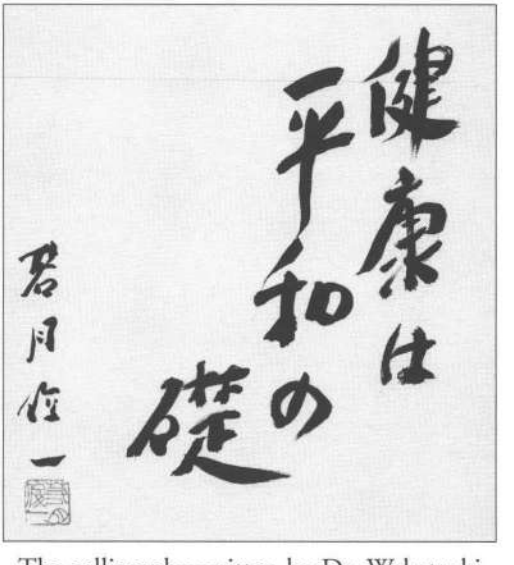


Villagers having their blood pressure taken by members of the hospital's health screening team in the hall of their village. (1990)

Hospital workers and locals listening to Dr. Wakatsuki, who introduces his philosophy and experience. The course is dubbed "Wakatsuki School" as written on the wall. (1996)

Dr. Wakatsuki answering a question in plain language from one of the visitors to the Hospital Festival. This session turns out to be a "leader" to this annual open-house event. (1985)

An airscape of the Saku Central Hospital as seen today. (2002)



The calligraphy written by Dr. Wakatsuki in a skillful hand reads: "Health is the cornerstone of peace."

a little more than three months, we are up to the elbows in trying to pigeonhole the findings that come in two kinds – health and the lifestyle. We visit the sub-villages once again with the completed data and hold a debriefing, where we exert a much greater effort to enlighten them about their health. Beside the health pocketbook in which each villager is asked to make entries on a regular basis, we fill out the Master Health Register (that consists of three sections – individuals, households and sub-villages). In an analysis of indicators for health and the living environment, we try to identify correlations between the two and use the findings in visiting families or providing guidance in sub-villages. This task takes a great deal of trouble and time, really.

Here, let us see what sorts of impressions do our hospital employees have about the mass health screening program. What follows is cited from the booklet entitled *Five Years' Developments in Yachiho Village's Mass Health Screenings.*

> The place was the public hall at Yadoori where there was a draft. It's so cold that I felt like my blood pressure soaring up at any time soon. I just finished interviewing a villager while warming up my hands over the charcoal fire, when an old lady sat in front of me and promptly asked, "Don't you have to ask me about the same old difficult stuff?" she asked. "You know, no change at all in the last year. Why don't you write down the same old stuff?"
>
> I didn't know what answer to make. Not just this granny but also many other villagers say that, though they don't

mind undergoing a checkup, the interview made before it is irksome and unpleasant. Some interviewees feel so, to be sure, but so do the interviewer once in a while. Here, you must not fly into a temper; that's what I know for sure. In what manner we should ask questions so that interviewees can answer with a good grace is always something that is left open in abeyance.

Now then, I suddenly found myself in a position to explain how environmental surveys have something to do with health. I was up a tree .... I simply did not have confidence in my own ability to give a satisfactory answer to that question. When I timidly started an interview, she nodded her head, even though I did not know for sure that she understood what I was trying to say..

"Granny, do you go out and work on the field in the busy farming season?"

"I'm too old to work out there."

"Oh, yes. You eat fish and meat, don't you? How many days apart?

"Fish and meat are my pet aversion. You know, I'm moss-grown.

"How often do you take a bath? How many days apart?"

"Let me see. Every two days in the summertime, but not so often in the wintertime. Why don't you write down 'once a week'?"

(Chiiko Shiraishi, Secretariat)

I was assigned to take blood pressure. An old man smiled a sweet smile, when I said, "Thank God! Your blood pressure is by far lower than last year." Immediately, he mounted the high horse and declared, "Which means I can drink a bit more at a dinner, does it not?" And I said, "Though it's a fact that your blood pressure has fallen, they say he that is too secure is not safe, don't they?"

"Next!" I declared. An old lady of quite sturdy build presented herself. She was hypertensive with her blood pressure at 180/68. She said, "I get up three times at night to pass urine." When I said that she must be careful about salty food, she said, "Yes. I also make it a practice to take good care of myself. I try to banish my fatigue. I also try not to feel cold." She was wise to everything presumably because she had learned a lot from the Saku Hospital's lectures and public-information activities.

(Sachiko Hinata, nurse)

One more example. A housewife in Yachiho has this to say about calisthenics done by villagers on a regular basis.

Our home's telephone hooked to the village's wire broadcasting system blared, "The time for farmers' calisthenics! Let's snap into it!" I stopped eating breakfast and stood on the unfloored part of the kitchen to practice calisthenics. My husband watched me with a grin, and one of my children said in sarcasm, "That's not the way you should do it, mom." For some time after I had begun to do it, I was criticized and abashed. I have never had

gymnastic exercises for the past 30 years since my schooldays and no wonder. All I have done is work and sleep.

Nowadays, my bones and muscles are so stiff that I simply can't do calisthenics the way I want to. I can't lithely turn my body, nor can I move to the next step, as I find my knees impotent when I try to bend them. When I try to twist my body, I will cry "Ouch!" out of myself. No wonder my children make a mockery of me. But I've made my mind not to end up as a woman of weak will. Some way into my fifties, I have stiffness in the neck, numbness in the hands and lumbago, among others, which come in what the Saku Hospital calls the *Nofusho* Syndrome. I am doing my best with the hope that I can give a new lease of life to me with farmers' calisthenics.

One year has passed since this gymnastic exercise started in one of Yachiho's sub-villages. As it has produced exceedingly favorable results, such as the cure of the *Nofusho* Syndrome and drops in blood pressure, it was decided in May to spread it across the village. Each sub-village holds a lecture meeting. In the morning, at noon and in the evening, the broadcasting system blares, "The time for farmers' calisthenics!" Things have improved to a point where my children come and remind me of the exercise, while I am feeding our cattle on the field.

On the way home from the field at noon, I breathe fresh air to my heart's content, I will often do farmers' calisthenics, the due order of which I am already familiar with, by giving words of command by myself, "one, two, three, four." I am now able to skillfully do it as my body has become pliant. Long ago, I

used to be so completely frazzled out that it was beyond thinking to practice gymnastics. I have now come to realize the necessity of doing it to get a kink out of a muscle. I make it a practice to do farmers' calisthenics every day with plenty of confidence in myself as I wish to live to be 70 or 80 years of age.

(Kiyo Yamazaki, housewife)

3. Achievements in Yachiho's total-village health control program

With Yachiho's total-village health control program carried out for more than 10 years, how have the health of villagers and their living environment been improved? More important, how have their consciousness about health and their volition been enhanced?

To state my conclusion, first, they have surely been improved at least on the surface. When it comes to the living standard, the village's mortality rates (infantile and tuberculosis mortality rates, in particular) have conspicuously dropped. The falls may be corroborated with statistical data. A more elaborate check into the reality reveals that the health conditions have been upgraded in the genuine sense of the word. Particularly, the villagers' consciousness about their health is in serious question. Now, let me explain it in concrete terms.

First, there has been little change in the total number of diseases in the village (Figure 5 presents a comparison between the first program year, or 1959, and 1967).

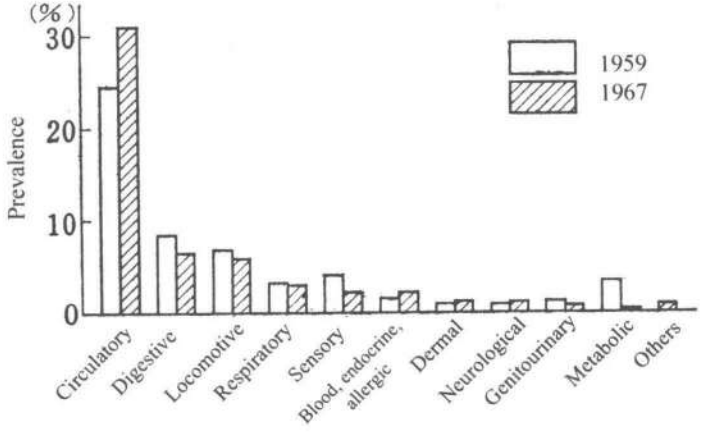


Fig. 5 Annual trends in disease-specific prevalence

The prevalence of circulatory diseases – hypertension, in particular – has rather increased possibly because of the rise in the population of seniors but, even if it is statistically adjusted, the outcome is not favorable. Digestive diseases have decreased, but allergic ailments have rather increased. By any reckoning, it is hardly possible that those routine, minor diseases can be so easily eradicated only by doing health checkups once a year and debriefing their findings. The results of our efforts in Yachiho in the last eight years do not go beyond what you see in Figure 5.

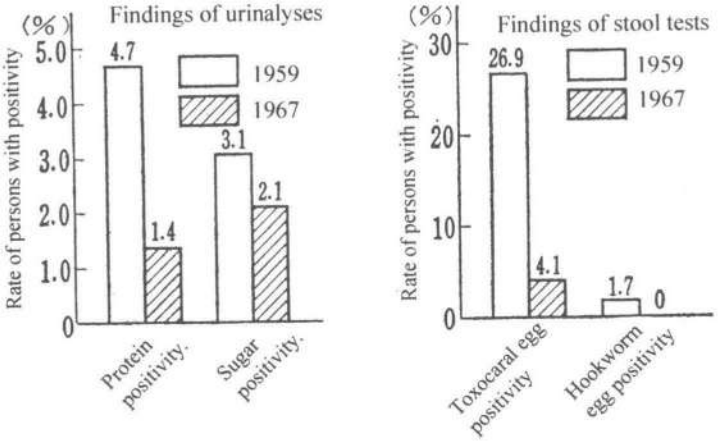


Fig. 6 Year-specific trends in findings of urinalyses and stool tests (Yachiho)

As a matter of course, there is a favorable outcome. The positivity rates of protein and sugar in urinalyses have considerably dropped, however. In particular, there have been significant drops in roundworm eggs or hookworms (*Dochminus duodenalis*) (Figure 6). The main causative factor for the decreases is that farmers have recently stopped applying manure to farmland. The question is, nonetheless, they gave up its use not necessarily because our efforts to enlighten farmers about health and hygiene have come near fruition. They simply do not have time to carry pails of manure over their shoulders because of a lack of manpower. That's how rural communities actually stand today. They can spray chemical fertilizer they purchase from their agricultural

cooperatives. Today, farmers do not seem to have the spirit of enriching the soil by bringing in pails of manure over their shoulders or using compost and barnyard manure.

Now, how about the *Nofusho* Syndrome? Indications are that it has more or less decreased year by year. But the Syndrome recently bottomed out virtually with no drop since 1965. Rather, there have recently been signs of a rise. Among women in their fifties and sixties who take care of farm work in place of their husbands with non-agricultural jobs, in particular, the *Nofusho* scores have gone up to some degree (Page 165), as in Figure 7.

The living environment of rural communities is rapidly changing these days before we know what is happening.

One thing we know for sure is that gross family income has significantly soared. It means, nonetheless, that non-agricultural earnings are on the rise, but not agricultural earnings. Dads work away from home or are employed at some commutable nearby towns. Which means that their wives do homework in the slack farming season. In the final analysis, they have to do another kind of work, while they take charge of farm work in place of their husbands. In particular, mothers have no end of trouble. Beside farm work, they have to devote themselves to the care of their children and to their domestic chores. Communal cooking remains as it used to be in the old days. Public nurseries have more or less increased. An improvement, if any, in the domestic chores is the availability of electric washing machines at the very utmost.

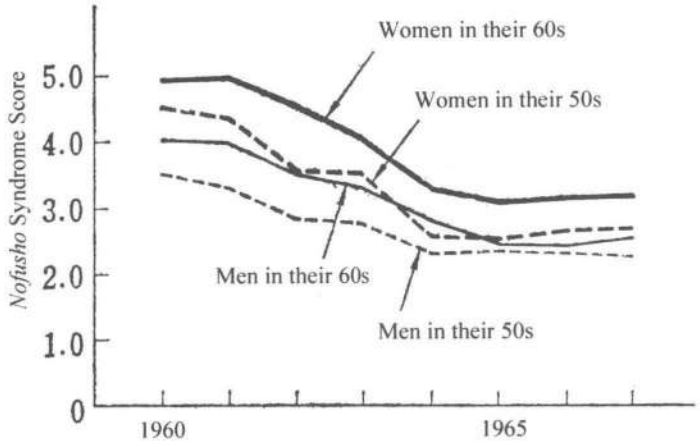


Fig. 7 Year-specific trends in *Nofusho* Syndrome Score (Yachiho)

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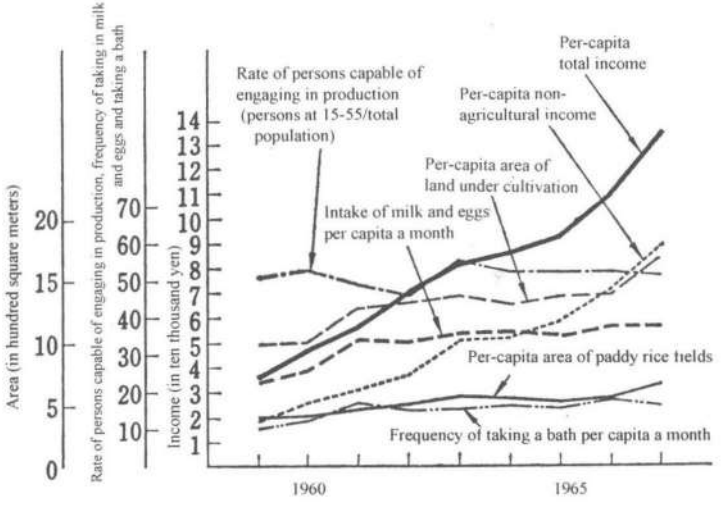

Fig. 8 Year-specific Trends in Main Living Environment Factors (Yachiho)

Given those circumstances, the *Nofusho* scores have risen for farming housewives.

With non-agricultural earnings on the rise, the intakes of eggs and milk and the frequency of taking a bath are also on the increase. The indices on hygiene are leveling off though they have gradually risen in the postwar years (Figure 8). There have been virtually no signs of a rise since 1963 or so. The intakes of eggs and milk are so small that they are quite insignificant in an international perspective. The upshot is that farming families these days have greater earnings but are under the pressure of business. It is the very word for them that "rich men have no leisure," but not that "poor men have no leisure" as the saying goes. This causes invisible "fatigue" and harms the health of farming housewives, in particular, thus forcing them to bear the brunt of a great strain.

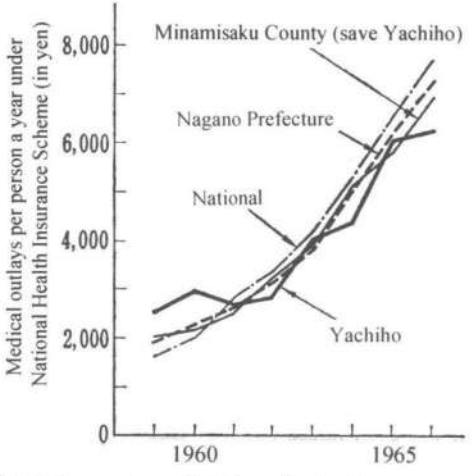

Fig. 9 Comparison of total medical outlays per person under National Health Insurance Scheme between Yachiho and other municipalities, Nagano Prefecture and the nation

Here, I must say that what follows may well be described as a wonderful achievement, when it comes to Yachiho's health care project. That is a drop in the total amount of medical outlays by the village authorities. That is to say, the total amount of per-capita medical outlays that have to be shared by the village under the National Health Insurance Scheme has clearly dropped (Figure 9, Table 2). The village's share was by far greater than that of South Saku County as a whole. Today, it is lower. Once standing at 1.24, the village's rate gradually fell, coming to 0.85 this year, or the eighth year after the start of the program. The reason is not because of a drop in the prevalence of ordinary diseases. A further elaborate check has revealed a drop in patients with serious ail-

ments. In other words, which means that patients with seemingly past-cure diseases who have to stay in hospital for long and pay as much as ¥500,000 ($1,389) or ¥600,000 ($1,667) have decreased (Figure 10). When it comes to stomach cancer, for instance, you will have to stay in hospital for three or four months, should you have to belatedly undergo an operation, but if it is detected in an early stage, you can get around with ¥50,000 ($139) or ¥60,000 ($167) after staying in hospital for three weeks or so. You will have to bear the cost of ¥500,000 or ¥600,000, what with irradiation with isotopes and the administration of cancer-inhibiting drugs. A moment's thought makes it naturally clear that the probability of escaping death will be higher, if the disease is detected when it is still minor and treated in an early phase, instead of being treated when it is already serious. To begin with, you can curb your payment to the hospital. If you can go as far as to prevent disease, the cost will undoubtedly be all the lower. In the case of Yachiho, the incidence of past-cure diseases has decreased, enabling the village authorities to spend less money under the National Health Insurance Scheme and villagers to save their lives. In particular, how much has early recovery – though it is not a straightforward piece of work to calculate its merits – served to make up for the shortage of manpower, which is now called into question in the rural communities? Calculated in pecuniary terms, the merits will reach a stupendous sum. Coming back to expenditure for the health care program, I should say at least on the basis of what we have achieved in Yachiho that the National Health Insurance Scheme be so amended as to pay benefits for disease prevention. To give a

case in point, Yachiho's share of medical outlays under this system has been on the downswing without equivocation. In fact, the drop is several times greater than the cost required for health care.

Table 2. Comparison of total outlays per villager for medical care under the National Health Insurance Scheme between Yachiho Village and South Saku County's 7 other municipalities

	Yachiho Village(A)	Other South Saku County municipalities(B)	Ratio(A/B)
1959	2,520 yen	2,037 yen	1.24
'60	2,919	2,165	1.35
61	2,716	2,536	1.07
62	2,822	3,207	0.88
63	3,994	3,863	1.03
64	4,374	5,129	0.85
1965	6,071	5,880	1.03
66	6,222	6,944	0.90
67	7,248	8,483	0.85

Now then, how has the villagers' consciousness about health and their volition changed? It is extremely difficult to conduct a survey about consciousness and we are likely to draw an erroneous conclusion from survey to survey. With this in mind, we really drew on kid gloves in checking into their consciousness about health. For the survey, we did not use any hospital staff members and mobilized university students. The survey included

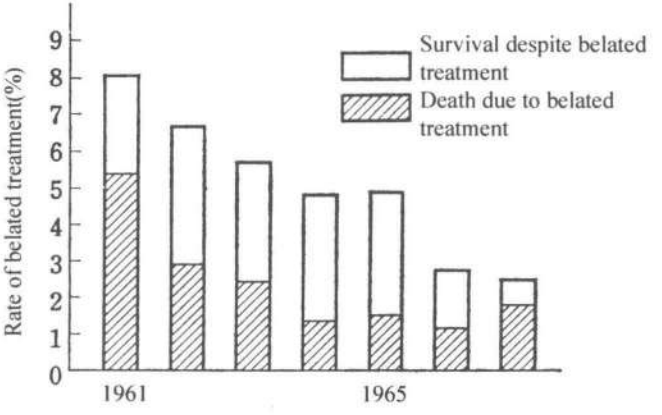

Fig. 10 Trends in mortality rates of belated treatment and deaths due to belated treatment

knowledge about health, villagers' consciousness about health – for example, their willingness to protect their own health and their thought about the public share of medical outlays – and relations between disease-associated social factors, on the one hand, and the healthy life and politics, on the other. The survey itself was of the first kind in the village. We performed it without any advance notice.

How were the findings? The control was the village the conditions (population, industry and remoteness, among others) of which were similar to those of Yachiho and the name of which started with "K" in North Saku Country. Certainly, it was found that Yachiho was better with a significant statistical difference. Asked about the *Nofusho* Syndrome and relations between mental

troubles and heredity, among others, the number of correct answers was greater in Yachiho. When it comes to relations between blood pressure and the dietary practices, there was little difference between the two villages, presumably because people in general were already familiar with them thanks to television and other media.

But how about the villagers' consciousness about their health? The greater number of respondents in Yachiho correctly answered than those in "K" about the need for the protection of health, but there was virtually no difference between them when they were asked about whether they were ready to protect it. When it comes to social consciousness about whether the government should shoulder medical expenses, Yachihoites yielded the palm to the controls, though we believed -- when we considered where Japan actually stood and, in particular, from the standpoint of farming populations -- that the government should stand medical outlays. As regards the questions of "disease-associated social factors" and "relations between politics and the healthy life," too, villagers in "K" had by far more progressive views to our utter astonishment, even though they were undergoing many hardships in what amounted to a "doctor-less" environment absolutely with no knowledge about health care. How did this happen? Is it not that Yachihoites have nothing to worry about their health as they know that our hospital will take care of their health in all aspects for only ¥100 (¢3) per person a year? Does it not lurk in the hearts of Yachihoites that they are doing well thanks to the Saku Central Hospital? It has come to light that villagers in "K" have more enlightened views, such as that disease intrinsically stems from a

wide variety of factors associated with social life, and that health has something to do significantly with politics. In a nutshell, the findings of our survey have astonishingly failed to meet our expectations.

Then, how much do Yachiho's village authorities spend on the health care program? Their payment stands at a mere ¥144 (¢4) a villager, accounting for only 0.53 percent of their annual total budget. The village's share in the expenditure for health care comes to ¥802 (¢2) per person, or 2.52 percent of the total annual budget. Then, how much does the health care program cost as a matter of fact? The cost accounting of the hospital's expenditure shows that it costs ¥2,000 ($5.6) a person. The amount of money the hospital receives from the village administrative office is a mere ¥250 (¢70). No wonder that the program is criticized as something which could not be carried out without the good offices of the Saku Central Hospital.

Masao Fukazawa, headman of Sawauchi village in Iwate Prefecture, asserts that 10 percent of the total budget should be set aside for health care under the National Health Insurance Scheme (including the money transferred from the General Accounts) and for hygiene. He is quite right. The sum of money transferred from Yachiho's General Accounts to the National Health Insurance Scheme Account stood at 0.4 percent of the total budget in 1967, or one-tenth that of Sawauchi.

When the findings of the survey on consciousness about health are

taken into account with attention focused on those phenomena, it follows that we have succeeded in reducing past-cure diseases under Yachiho's total-village health control program in the last ten years, but that the efforts we have made to lead villagers so that they become increasingly conscious of health strictly in a social context have proved baffled or, to be exact, have turned out to be a minus factor. This means that villagers, by far more conscious though they are about their own health in a narrow sense than before, have yet to relate it to a social dimension.

There is no need to go as far as to cite examples of environmental disruption in pointing out that health could not be protected in the genuine sense of the word without social perspective. When it comes to health control with the whole village's involvement or to the village administrative office's medical grants, the long and short of it is that things must be straightened out in a social or public perspective. Having said that, it follows that political consciousness and action are required to develop the mission that is designed to protect health.

Having said that, some people may argue that it would be more effective for you to get right among villagers and do propaganda work, instead of going to the trouble of doing something like the delivery of health care. But I will not go in for so impetuous an argument. We are not politicians at all, nor do we specialize in any social campaign. Now that we are physicians deep in the mountains, our primary mission ought to be the accumulation among villagers of the achievements we have made in the delivery of health care, no matter how roundabout the way we do it looks.

It is true, nevertheless, that some people go overboard and harshly censure our posture. They assert that we are playing the worst of all roles now that we are misleading and spellbinding villagers and getting it firmly in the heads of the masses that everything goes well with them, and that we are drawing a veil over the contradictions inherent to the Establishment while serving as its subcontractor. We must candidly admit, I would say, that we may by any chance run into peril of this sort. That is why we must bring this danger to the light before the world and must not hoodwink the masses.

After all is said and done, I can't help concluding that we must not steep ourselves in political propaganda work, however. (This is not to say that we may toss aside social and political perspectives in our delivery of health and medical care.) While providing health and medical services, we wish the farming populations, the masses and the people to eventually draw the correct conclusion for those troubles. At first blush, the masses look dull, but I do believe that's not the picture.

Will our campaign pave the way for the achievement of work of the kind that is really tied in with the masses? Quite bluntly, the like of me simply has neither a realistic plan nor foresight in the turbulent 1970s. For all that, I believe that we must go forward "together with the farmers."

CHAPTER SIX

Working in Ever-changing Rural Communities

1. Coping With Pesticide Poisoning

It is in 1957 or so that pesticide-poisoned visitors to our hospital began to increase at an alarming pace. Report has it that the spraying of parathion (Holidol) over irrigated rice fields in Japan began in or around 1951. Deaths from poisoning with this chemical started appearing in the statistics compiled by the pharmaceutical affairs division of the Ministry of Health and Welfare in 1954. They have since increased at a rapid pace year by year. (It is also in 1951 or so that the farmers started using organomercury agents that would incur chronic poisoning.) At the outset, we took up pesticide poisoning (acute poisoning, in particular) as a calamity for spraying farmers.

In the name of scientific common sense, we must say that such toxicants as parathion look like having a smack of Hitler's Nazism. The reason is because it is a fact patent to all that G. Schrader at Germany's Farbenfabriken Bayer invented parathion in 1943 and came out with, and started producing, nerve gases (salin and toman, among others) of the same system as parathion. I say they are of the same system, because they are organic agents and the same in structure. They contain cholinesterase, an enzyme, which inhibits working of the nerve system.

In other words, insecticides, as they are used as pesticides, may be turned into a nerve gas for chemical warfare. In fact, the Nazis used this organic phosphate at the Auschwitz complex of concentration camps to commit holocaust. Fortunately, this nerve gas was not used anywhere else during World War II. While we felt relieved, Japanese farmers began to spray it over their paddy

fields to exterminate rice-stem borers (*Chilo suppressa*) in 1946, the year following the end of the global war.

Then, Tooru Kaneko, president of the Takeshi Village Agricultural Cooperative in eastern Nagano prefecture, said in deep dudgeon, "Admitting that there is absolutely the need for a boost in agricultural output, it is outrageous to ask farmers to cultivate rice at the sacrifice of their lives. We flatly refuse to use that kind of dangerous pesticide."

As a matter of fact, members of his agricultural cooperative have never sprayed parathion over their paddy fields before. All that is needed to realize that pesticides and scientific arms are a double-edged weapon is to recall the indiscriminate spraying by U.S. troops of 2,4-D and 2,4,5-T in what they dubbed "Operation Orange" during the war in Vietnam.

In those days, how many clinical cases of pesticide poisoning among farmers did we have to deal with at our hospital? We had 31 cases from 1964 to 1966, or 10 or so a year. Of them, six were systemically poisoned, 21 had skin disorders and four had eye problems. With cutaneous and ocular disorders, patients who came to our hospital to undergo treatment for the pains were so terrible that they could hardly work. With headache, dizziness or some other common symptom, however, patients tried to put up with it, instead of receiving treatment.

The most frequent and terrible of all cases with acute poisoning (all those cases I have just introduced were acutely poisoned beyond doubt) is the one that is poisoned with parathion. This holds true for all organophosphorous agents, which reduce the

activity value of cholinesterase, an enzyme, though it is indispensable for the transmission of nervous signals around the body. Here, the question is that even when the value of this enzyme has dropped by half in the blood from the normal level, no symptoms make their appearance, merely driving the patients to feel that they are more or less in unsatisfactory physical shape for one reason or another. With this latency, farmers tend, quite often, to ignore the risk. They will often seem too sure, saying that they have sprayed parathion but that there seems to be nothing wrong with their health. The truth is, nonetheless, that the toxicity accumulates unawares, suddenly giving rise to a terrible symptom and leading eventually to destruction beyond all expectations. For another thing, farmers are so quick to give up by their nature, once some accident or the other has broken out.

Aside from visitors to our hospital, to what degree are farmers affected with pesticides in their routine work? We have carried out a fact-finding survey on pesticide poisoning among farmers in South Saku County every year since 1964. We picked up hamlets that used pesticides in large quantities, as they were classified by main product, such as rice, apple, chrysanthemum and vegetable, distributed them pesticide poisoning-associated health calendars and asked them to make entries. Then we interviewed them to make sure what the entries were all about.

Talking of the data we gathered in 1965, we checked 838 pesticide sprayers of 705 families in eight sub-villages from June to September. The findings follow.

The rate of some kind of symptom or the other caused by pesticide poisoning during that period came to 23.6 percent for men and 21.5 percent for women. In particular, the fact that there was not much difference in occurrence between both sexes is something that must be scrutinized from the standpoint of protecting the health of housewives now that their burdens in farm work become increasingly greater. Should we not do something about the very situation in which housewives, responsible though they are for pregnancy and childbirth, have to engage as much in dangerous work as men? Incidentally, the frequency of poisoning per person came to 2.4 times a year. All those high ratios baffled our imagination.

Table 3. Survey on sub-villages and pesticide sprayers

Municipality	Sub-village	Main crop with pesticides used	House-hold surveyed	Pesticide sprayers surveyed
Saku City	Sakurai	Paddy rice	215	179
do.	Kishino	Paddy rice	166	171
Usuda Town	Irisawa, Tokamachi	Apple	84	102
do.	Taki	Apple	40	57
do.	Sanjo	Chrysanthemum	34	51
Saku Town	Hanaoka	Chrysanthemum	53	99
Yachiho Village	Sakita, Anahara	Chrysanthemum	45	52
Minamimaki Village	Nobeyama	Vegetable	68	127
		Total	705	838

Table 4. Sex-specific rate and aggregate total of persons poisoned with pesticides (June-Sept., 1965)

	Pesticide users (A)	Users Poisoned with pesticides (B)	Rate of users poisoned with pesticides (B/A)	Aggregate total of cases poisoned with pesticides (C)	Average number of cases per person poisoned with pesticides (C/B)
Male	633	149	23.6%	351	2.4
Female	205	44	21.5%	104	2.3
Total	838	193	23.0%	455	2.4

A crop-specific check of the rates of persons poisoned with pesticides indicates that they were highest for vegetable plantations, followed by apple orchards, and lowest for paddy fields. Particularly many men were poisoned with pesticides in the chrysanthemum plantations, where there was a practice in which pesticide spraying would not be assigned to women, wherever possible. The occurrence of poisoning concentrated in July, in which it was alarmingly high particularly in flower plantations and orchards (Figure 11).

On the whole, organophosphorous agents caused poisoning most frequently, and parathion and other highly toxic chemicals were responsible for 37 percent. They were followed by endrin and other organochlorine agents with 26 percent. Consequently, the rate of those two agents alone exceeded 60 percent.

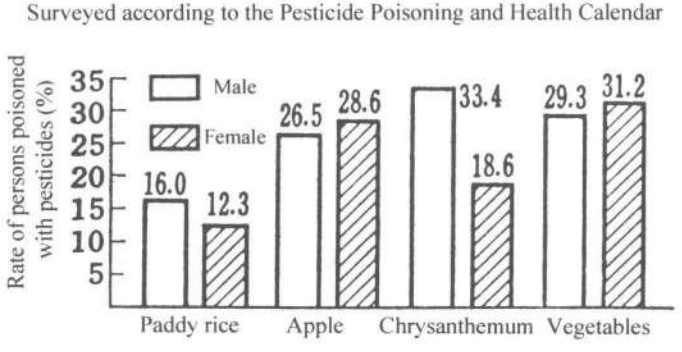

Fig. 11 Sex- and main crop-specific rates of persons poisoned with pesticides (June through September, 1965)

Then, what sorts of symptoms came out? In broad terms, acute poisoning with pesticides causes headache, dizziness, nausea and languidness. As a matter of course, the symptoms included ocular disorders by Blasticidin S and other chemicals and dermal disorders by DDVP and NIP, among others. The occurrence of ordinary symptoms, such as headache, dizziness and languidness, which are common to all types of pesticide poisoning, are so significantly similar to those caused by heat prostration and fatigue that some specialists were skeptical about our data. When I presented them to a symposium on pesticide poisoning at the 17th general assembly of the Japan Medical Congress in 1967, a professor, whose name is withheld, branded our survey as "epidemiologically meaningless."

But I still attach importance to a report that takes up in an unexaggerated manner the symptoms, which farmers complain, have broken out of their spraying work, and to the significance of coming to grips with all aspects of the symptoms. In the fields, farmers spray a wide variety of pesticides for all sorts of crops in different management systems, so that innumerable factors are intertwined, directly or indirectly. More than anything else, we attempted to take a broad view of the disorders Japanese farmers had suffered from pesticides. The quantity of pesticides they sprayed per unit of area under cultivation in those years was already larger than ever in the rest of the world.

Undoubtedly, most of the cases poisoned with pesticides in the fields were minor. It came to light as a result of a survey that only 14, or 3 percent, of the 455 cases we had covered in the survey proved relatively serious and had to "take at least a day's off." One-third of them got around without consulting with any physician.

What we had to take into serious account was the very reality in which farm workers were already out of sorts. As the popular phrase "farm work by three *chan*'s" suggested, the fact remained that farm work was sustained by *ka-chan* (moms) who got bone tired, *ojii-chan* (gramps) and *oba-chan* (grannies) who were to fall down with some geriatric disease or the other at any time as they had had gone through all sorts of hardships for long. Some savants performed experiments with young men of spirits as subjects and then went as far as to thoughtlessly declare that there was nothing wrong with their health, though they had taken in

many grams of a parathion solution, diluted 1,000 times. Those savants ought to give serious thought to the fact that they force danger upon farmers.

When it comes to the toxicity of pesticides, the Ministry of Health and Welfare is implementing a control law, classifying the toxic chemicals into four categories: "specified toxicants," "toxicants," "violent substances" and "ordinary substances." It is safe to bet that the ministry has determined the degrees of toxicity on the basis of the lethal doses found in experiments on the acute poisoning of mice. Simply on the basis of the median lethal dose (LD_{50}) for mice, you cannot say that due consideration is given to chronic poisoning. To our utter astonishment, there has been virtually no research work, nor have there been any animal tests, when it comes to chronic poisoning.

Little was known in 1965 or so about the chronic poisoning of pesticides, including organomercury agents sprayed to the amount of 400 tons a year to exterminate rice blight. But Minamata Disease[14] and chronic poisoning with drugs for dermatophytosis (caused by methyl mercury in this particular case) gave us the shudders. We concluded that we could not help coping with this alarming situation, and the Saku Central Hospital paved the way for the establishment of a Japan Institute of Rural Medicine on its own account. Perhaps, I fancy myself wronged when I say that scholars and university staffs unexceptionably appeared to be afraid of giving trouble to business and government. Residue and pollution could not be scientifically verified without gaschro-

matography and atomic absorptiometric analysis. Talking of research work on Itai-Itai Disease[15], the clincher was the cadmium analysis made by Dr. Jun Kobayshi, an agriculturist. In gaschromatography, we at last came to realize by ourselves that rice and other foods contained fairly large amounts of mercurial pesticides. Prof. Tadanoshin Ukida, professor at the University of Tokyo, found in a series of tests that the hair of Japanese people in general contained considerably much mercury, and this finding aroused the interest of Japanese society. The data accumulated at our hospital revealed that the amount of mercury in the hair of all neonates was greater than that of their mothers. We also ascertained that farming families had much more residue than non-farming ones.

When it comes to chronic poisoning, animal tests must be performed over a period of two years with mice, three years with rabbits or five years with monkeys. We built an animal laboratory that stood comparison with the one the National Institute of Hygienic Sciences had. Some scholars loudly criticized us, nonetheless, arguing that research and survey of the kind we had in mind were not required, that mercurial pesticides produce few hazards, or that phenyl mercury is not so hazardous as methyl mercury that is responsible for Minamata Disease. For what, for whose interest and by whom were they egged on to rebuke us with a vengeance? We would not do so if there were assurances that those chemicals are not hazardous at all. But what if they are dangerous? The fact stood that pesticides were massively sprayed, thereby polluting nature and food. Warning about how dangerous it was to spray enor-

mous quantities of mercurial agents with poison of the sort which is inherent to heavy metal over paddy fields (some foreign chemists threw scorn upon the practice and cracked, "Why not go to paddy fields in Japan, if you want to get mercury?"), we were run down, such as at a Japan Broadcasting Corporation TV forum. When all is said and done, what the critics wanted to say is: "Supposing rice output drops by, say, 20 percent, because pesticides were no longer used, do you really think you can hold yourself responsible for the drop?" Thus, senior officials of not only the Ministry of Agriculture and Forestry but the Ministry of Health and Welfare as well bawled me out.

No matter what critics might think otherwise, we carried on our research work. Eventually, we verified that if phenyl mercury was taken in bit by bit, the epithelial cells of the kidney would be adversely affected, thereby causing nephrosonephritis, or a renal disease with nephrotic and nephritic components, and, in particular, that it has something to do with allergic reactions. Before we arrived at this conclusion, we had performed animal tests for two years. We also confirmed that inorganic mercury in the soil would be methylated by some species of bacilli. That said, you simply could not argue that there is nothing to worry about sprayed phenyl mercury. Finally, the government put a total ban on the spraying of phenyl mercury over paddy fields in 1968. But the chemical that had been massively sprayed over them each year over a period of 15 years would stay intact till doomsday.

The story here dates back to 1965 or so. "M," managing director of

an unnamed agricultural cooperative-affiliated foreign trade firm, hit the idea of gaining money with a wet finger by exporting mercury to China. Everything was ready, when his Chinese counterpart showed up and said to his regret that he had to cancel the contract. Demanded the reason, he remarked, "You know, we have enormous expanses of paddy fields from Guangdong province in the south to Shanghai in the northeast, some of which are adversely affected with rice blight with the weather generally unsettled. Learning that your country has quite a telling pesticide, we unhesitatingly found your proposal quite inviting. But we made further checks and learned that some kinds of pesticides would pollute land and rice and incur the danger of chronically poisoning human bodies. Our country makes it a rule absolutely not to use anything that is likely to adversely affect man's health. I beg you to understand our position." Not a word passing his lips, "M" was shame-faced. Presumably, such unrestricted spraying of mercury as was done in Japan must be something the world has never seen before, and there is no doubt that the global community will never see it again. Here, Japan's inherent posture of giving a preference to increased output above everything else is seen projected in a global dimension.

Another problem with which we had to grapple in earnest concerned organochlorine pesticide. Particularly in recent years, hexa chloro cyto-hexan (HCH) has been massively sprayed over paddy fields. Vegetables and other crops have also been sprayed over with drin agents. Like DDT, those chemicals are so powerfully

residual that even a small dose is highly likely to give rise to chronic poisoning. In or around 1966, we started fact-finding surveys on the residue of organochlorine in food and tests on chronic poisoning. When it comes particularly to DDT, controversy began over its toxicity elsewhere in the world. With the accumulation of a wide variety of data, some countries banned its use. Here again, nonetheless, I would often wonder why there were not a few scholars in Japan whose posture is to refute this correct direction.

In April 1969, when the Swedish prohibited the spraying of DDT (as we knew from newspaper reports in those days), I still remember, many of the Japanese scholars who were well known as specializing in this scientific field declared that the data which were now available warranted no need for an immediate ban, that drastic though the Swedish had gone, there seemed to be no need to go that far, or that censorious though they were about agricultural problems, even the Americans had not taken the bull by the horn.

In December, the United States had no sooner clearly come out with a ban than the Japanese specialists turned their coats. For some reason or the other, the Japanese chemical industry took the initiative and then the Ministry of Health and Welfare came out with announcement of the kind that suggested its acknowledgement of HCH toxicity. The data contained in the announcement on the residue of HCH in cow milk were what Dr. Masahiko Ueda, a senior researcher at the Kochi Prefectural Institute of Hygienic Sciences, introduced to the congress of the Food Hygienic Society

of Japan held at Tohoku University two months earlier. In the December 18, 1969, issue of *The Asahi Shimbun*, a leading daily, Dr. Ueda noted that as his study had not come into the open, the ministry and the chemical industry feigned ignorance although they were fully aware of the real aspects of residual pesticides.

As is commonly known, it was the late Rachel Carson who was quick to argue about the food residue of organochlorine insecticides and ensuing environmental pollution. In her book *Silent Spring* published eight years ago, Ms. Carson warned the whole world about their potent and imminent risks. Who were they, when they went as far as to brand her as a hysteric? The question waits the verdict of time.

By the way, the Japanese farmers put out crops to the tune of ¥70 billion ($194 million) in 1968. The use of pesticides per unit of area under cultivation in Japan was several times greater than in the United States, thus making Japan to rank first in the world. The total quantity of pesticides used in Europe was by far smaller, whereas their use had yet to spread in Southeast Asia. Here lies precisely the reason why Japan was internationally censured as performing living-body tests. In the first place, what in the world drove Japanese farmers to use massive pesticides? For one thing, Japanese agriculture is so structured that as far as farmers are concerned, there is no choice but to use even dangerous stuff to meet calls for a boost in output. For another thing, Japan finds itself in a peculiar situation where its chemical industry has developed in proportion to the advancement of technologies with which to

synthesize new pesticides. Besides, it must be kept in mind that the use of hazardous toxicants has been left to take its own course without strict control exercised by the government for as many as a dozen years. That is true, but the responsibility that rests with us, physicians and sanitarians, is also great.

The damage caused by pesticides came in the form of visible harm, first, such as on pesticide-spraying farmers and the periphery of the sprayed field. Should pesticides be put to massive use, the damage will gradually become invisible, making farm products, which after all are food, residually toxic and spreading from the soil of sprayed paddy and upland fields to water, to irrigation channels, to rivers and eventually to drinking water. With a broad range of environmental pollution, the national life is inevitably threatened now.

From our experience in the last several years, we have come to realize that you simply cannot do anything in grappling with pesticides and arguing about the damage caused by them, unless you are poised to confront businesses. Never do they make their appearance in censuring our researches and surveys, though some bureaucrats and government-patronized scholars sometimes turn up. Besides, officials of the agricultural cooperatives under whose wings our rural hospitals are placed occasionally come in sight before us (by the way, the agricultural cooperatives have 50-odd percent of the stocks of Kumiai Chemistry, one of their subsidiary firms, and, incidentally, sell pesticides to their members to the tune of ¥60 billion, or $167 million, a year). Then, farmers, too, show up quite often. One farmer came to see me and cau-

tioned, "Doc, you had better not speak ill of pesticides so often. Were it not for them, you know, we would be simply unable to put out green stuff and fruits." His words really drove me to find myself in a painful position. But we, medical workers, are better aware than anybody else that they are potential victims, too.

The story here goes back to the summer of 1969. Dr. Akira Kasai (who was serving as chief pharmacist at the Saku Central Hospital and, concurrently, as chief chemical analyzer at the Japan Institute of Rural Medicine) reported at a congress of the Nagano Prefectural Research Panel of Rural Medicine that he had detected much endrin in green stuff (it was utterly impermissible to allow so much endrin to remain in food). Shortly after, the president of the local Agricultural Cooperative and his lieutenants got together at our hospital and filed an official protest with us. The president flatteringly declared, "You must have undergone all sorts of hardships to perform one fact-finding survey after another. I hear that one of you people presented a paper on pesticides in vegetables at a scientific meeting the other day. In no way am I saying that he should not have done so. But I must say that we are quite embarrassed by his reference to the name of specific areas (that of a specific agricultural cooperative, in particular). The next time you are to present scientific paper of the kind that is likely to have green stuff in this neighborhood fall into discredit, I would appreciate your telling the local agricultural cooperative what this paper is all about before its presentation." His words were an indirect reference to the flaming rage the vegetable-shipping farmers had to-

ward us.

We, physicians in the milieu of rural medicine, take upon ourselves to cast light on pesticide pollution, I said to him, because we simply want to make sure that farmers preserve their health and that agriculture reasonably develops (also to the satisfaction of consumers). Then, I deeply apologized the president and his lieutenants for the trouble to which we had put them and promised them that we would refrain from indiscreetly referring to the names of specific production centers. I said "indiscreetly" in the sense that we would never make unreasonable disclosures – but not in the sense that we would absolutely refrain from making any disclosures. (To my shame, I must say that what I told them sounds like coming from a crafty politician or bureaucrat.) On second thoughts, nonetheless, it would be meaningless in some instances unless the name of the production center or processing plant is *more or less* referred to in bringing the actual state of food pollution to light. Instead of referring directly to the names of the specific municipality involved, you could perhaps say "Saku district" or "Nagano prefecture" in a roundabout manner. But there are cases in which the prefecture's name cannot be referred to. With controversy flaring up on the rice that gave out a stench, we disclosed in a scientific paper in the fall of 1967 that HCH massively found in that particular species of rice was responsible for the foul smell. Officials of the local agricultural cooperatives called us all kinds of names, complaining that the rice produced in Nagano Prefecture was now a drag in the market.

Speaking frankly, the protesters' group headed by the

president of the local Agricultural Cooperative appeared to be at the mercy of businessmen who were making undue profits on pesticides. Unless we are on the lookout, we will find ourselves in a position to constantly have words with farmers, who after all are our comrades in a sense. (I know it's no use trying to excuse myself, but I feel like getting "foxy" in a mazy psychological process.)

But it's a good thing to have it out with locals as our comrades. As a matter of fact, the agricultural cooperative's president said at that meeting with me by fits and starts, "By the way, that's what members of our cooperative were the first to warn about. They wondered if it would be all right to spray over green stuff so much of that terrible pesticide [a reference to endrin, which horrified farmers as it was known to be used for suicide]. Last year, we asked the Saku Central Hospital to check into its toxicity (which obviously means that the hospital staff did not do the check as they pleased; that's something which has never come to my attention). As a matter of fact, your hospital's data disclosed that the tested vegetables contained much HCH. We thought its use risky and decided not to use it any longer."

"A what? Really and truly?" I asked.

"I really mean it. On our decision, we have distributed leaflets to our members. Which means you have evidence."

I shouted in joy, "That's great! You, farmers, have decided not to use a dangerous pesticide on your own initiative. For that decision, an agricultural cooperative-affiliated research institute did a chemical analysis. Don't you think that this sort of good

news ought to be made public? Becoming aware of our genuine intention, consumers would have sympathy for, and confidence in, farmers and their agricultural cooperatives, wouldn't they?"

2. *Moms Shouldering Farm Work with Pops Working Away from Home*

Today, an estimated 600,000 to 1,000,000 farmers are working away from home. It is not that no farmers worked away from home in the old days; for instance, men did so for *sake* brewing and rice re-plantation and women for silk reeling and cotton spinning. In the recent time – since Japan swung into a phase of high economic growth – the extraordinary rise in farmers working away from home is really an eye-popping phenomenon. Many of them are from Tohoku, Sanin, Shikoku and Kyushu regions. Besides householders, or pops, there has reportedly been a rise in their successors working away from home in the recent time.

As a result, moms are compelled to put up with their status as "half-a-year widows." Particularly when they are busy doing some pay job at home, their children are forced to put up with their status as, so to speak, "orphans." Given all those developments, there could be no assurances that farmers and their families may be able to enjoy health. Their family lives are disrupted. I cannot help opening the floodgates of wrath as a rural physician. I simply do not understand why agricultural administrators cannot provide guidance to see to it that farming families can live on farm work but nothing else. Nor do I understand why

they can neither offer assured working conditions to people who have given up their farm work and started working in a manufacturing industry nor guarantee their status as industrial workers.

In particular, what makes me blow my top is the fact that the names of farmers who can easily be identified as working away from home appear in newspaper and other reports on major civil-engineering accidents, including landslides, cave-ins and accidents in subway construction projects.

Of the eight victims in the accident that broke out in the construction of a bridge across the Arakawa canal in downtown Tokyo in 1966, seven were farmers from Aomori, the northernmost prefecture on Japan's main island, It was rotten of the constructors to go as far as to take advantage of Aomori's green farmers-turned-workers in building its girders. The method used for the construction of the piers was reportedly a completely new one that required little manpower and money. But reliable reports had it that the credibility of this method had yet to be confirmed.

The Asahi Shimbun reported on March 23, 1966, "Working away from home, farmers engage in the construction of roads and buildings in major cities. They also work in the building of dams deep in the mountains. They do so as subcontracted workers placed under the worst working conditions. And a tragedy could break out for them anytime."

That's quite embarrassing. The daily wage of ¥2,300 ($6) surely has an allure for farmers working away from home. As is discernible from the accident that involved that bridge in Tokyo, the places where they are to work and the working conditions

should be fully checked beforehand, and should there be anything dubious, the best thing will be to keep away from the job, as the saying goes that forewarned, and forearmed.

For pops who are to work away from home, there is the need to see to it before they sign their labor contracts that benefits are available from the occupational accident and national health insurance schemes. The former offers benefits for injuries and illnesses of the sort that is ascribable to work, whereas the latter does so for those that have nothing to do with work. From what we have seen before, I can say that problems will often crop up about the latter.

Here, they can use the National Health Insurance Certificates issued at their native places. But they do not like to get from the administrative offices of their native places certificates of the type that is usable at municipalities far away from their native places, because their local administrative office comes to know that they are working away from home, asking them to pay extra taxes on their work. In fact, some hospitals refuse to accept the certificates of farmers working away from home, asserting that they have not entered into a contract with the administrative offices of the farmers' native places. Here, patients must advance the payment *pro tempore*. The procedure here is troublesome, sometimes resulting in a loss to the subscribers.

The best thing would be to subscribe to the health insurance scheme of the firm for which farmers are to work, but as you have an insurance scheme for day laborers and a national insurance scheme for civil-engineering workers, the conditions and

qualifications for access to benefits differ, depending on the scheme to which you subscribe. All things considered, the essential thing is to ask the employer to work out a framework in which insurance benefits may be offered for all injuries and diseases (including those while off duty).

In some instances, there are intermediaries between corporations and farmers working away from home. The important thing is to get from them assurances that insurance benefits are definitely available. Some of them are well acquainted with insurance issues, and others considerably dubious. There are corporations that turn out to be doing subcontracted work for a firm that is serving as a subcontractor of yet another company and has a contract to do dangerous work at their shoddy plant facilities. Then there are executives who cannot bear the responsibility for some kind of big accident or the other. That said, it is necessary that farmers working away from home should think about, and probe into, all those problems. With all sorts of flowery words, such as "well-furnished welfare facilities" and "assured social insurance," marshaled in offering jobs today, the days are gone when job vacancies may be offered merely with leaflets and posters. The important thing is to demand those facilities and insurance schemes and, moreover, health management systems as the rights of workmen. That's true, but the more important thing is to come out with a climate in which farmers may be able to engage in, and live on, farm work throughout the year as a matter of course.

Should a system of full employment be established, status and security in the winter of life guaranteed, and a minimum wage

system available as is the case with Western countries, it would not always be necessary to carry on insecure farm work while holding fast to tiny tracts of farmland. With all these left unattainable today, where are farmers, accounting for eighty percent of Japan's population, heading to without any prospect for their self-reliance, while they are buffeted about by waves of trade liberalization? Reduced to what could well be described as "quasi-proletarians," petty farmers now look like being laid aside from social benefits.

Recently even in our district, too, farming moms have begun to work at tiny industrial plants that popped up in and around their communities. They do so to help their family finances. You say that's a capital idea. Nay, I should rather say that's an inevitable one.

Supposing a farmer has 7 *tan* (1.7 acres) of paddy fields under his management and yields 10 *hyo* (0.67 short ton) of rice, his earnings will amount to ¥400,000 ($1,111). Nowadays, a farming family of five living deep in the mountains could neither watch television nor use a cultivator at least without an income of ¥800,000 ($2,222) a year. Nor could they hobnob their neighbors. With prices up today, it is desirable in this particular case to gain an additional ¥400,000 from a nonagricultural job or another.

That said, the number of farming moms with side jobs rises year by year. It does so not just in the slack-farming season but also throughout the year. Performed by the Women and Children Bureau of the Ministry of Health and Welfare in 1970, the Survey on Women Working in the Nonagricultural Sector reveals

that upwards of 70 percent of the workingwomen worked in that sector "throughout the year," and that half of those women were full-timers. Given a situation where they can hardly hire young men and women in general these days, indications are that employers prefer to build a small plant with a staff of 30 to 100 workers – or, preferably, a kind of backyard plant with 10 or so workers – keeping an eye on farming women who they calculated could possibly fill up the shortage of costly young workforce at least temporarily, if not perpetually. The pay for eight hours of work a day is set at ¥800 ($2.2). As a matter of course, their status as workers not guaranteed at all, the employers could sack them at any time in a recession.

By any reckoning, farm work of the sort which is dependent primarily on women's labor sounds awkward in the first place. Why is it that an astonishing eighty percent of Japan's farming families have nonagricultural side jobs with moms accounting for 60 percent of 12 million farm workers? Why is it that moms must bite off more than they can chew and work in the fields? The reason is quite obvious. As their families cannot live on farm work, their dads must go to work in some industry or the other with some of them working far away from home. But their low wages alone are not enough to support their families. If their wives take over farm work and their income together with that of their husbands come to ¥800,000 ($2,222) a year, their families can somehow keep the wolf from the door. In reality, that's where farming families in general have stood ever since Japan swung into a phase of high-pitched economic growth in the early 1960s. Nowadays, that

monthly income won't do, however. An additional ¥200,00 ($556) to ¥300,000 ($833) is required. That's why moms who hold themselves responsible for their families' farm work must go to work at factories or do some pay job at home.

Things having to come to this pass, moms are wearisome; it couldn't be otherwise. Naturally, they are work-worn. There will often arise cases with abortion resulting from the operation of vibratory cultivators, pesticide poisoning and work in vinyl sheet-enclosed green houses, among others. All things taken together, they are overwhelmed with concern about their children. Certainly, they also take thought for their husbands working away from home. With their thin blood, hypotension, stomach disease, neuralgia or premature baby, they are apt to have a neurosis. In light of this reality, nobody can blame moms for working too hard, branding them as blinded by love of gain.

In the village of Yachiho, we performed a fact-finding survey on women with nonagricultural jobs from 1969 to 1970. The findings reveal that 42 percent of farming women worked in the nonagricultural sector and, moreover, that 76 percent of those with nonagricultural side jobs occasionally worked from one year's end to another. They were working at branch workshops for light electric appliances built in their villages, even though we had thought that theirs were well-known shops outside their communities. To our surprise, there have appeared 51 such plants in Yachiho with 29 of them converted from farm sheds and their management absolutely small in scale with a staff of less than 20 (Table 5).

Table 5. Branch factories in Yachiho Village (As of June, 1970)

Number of workers	Number of plants	Branch plants	
		Shed-like plants	Independent plants
～4	12	9	3
5～9	23	16	7
10～14	8	3	5
15～19	2	1	1
20～24	1		1
25～29	1		1
30～34	1		1
35～	3		3
Total	51	29	22

Early in the morning, young women go by bus to work at relatively big plants outside their village, whereas moms work at those branch workshops in their village or do at home the jobs assigned to them by the shops.

Questioned about what had motivated them to work at branch workshops, 46 percent of 332 respondents said "to piece out our family's income." This reply was followed by "for incidental expenses" with 20 percent, "for our children's schooling expenses," with 13 percent and "for a housing fund" with 4 percent.

Workers at the branch plants work from 7:30 a.m. to 4:30 p.m. It means that they must set aside at least nearly 10 hours for the day's work, disabling them to do any farm work at all.

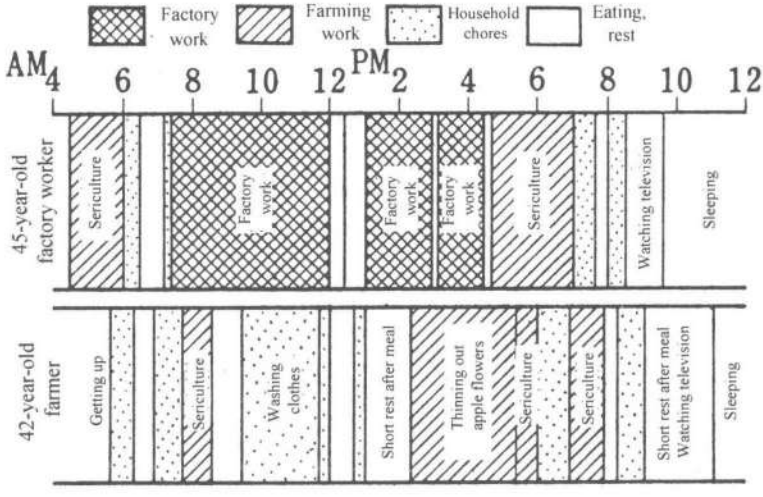

Fig. 12 Examples of farming housewives' daily lives

A check of the allocation of time for their daily lives reveals that they spend four hours on household chores, one hour less than women engaging exclusively in farm work, and another hour on rest, an hour and a half less. Asked in a questionnaire, they have replied that the greatest misgiving they have is about their household chores and children. Particularly when their husbands are working away from home, they have to soothe their troubled thoughts about their husbands. An example is illustrated in Figure 12.

The kind of main work moms do at their branch workshops is delicate but simple handwork, but in part because of their work environment is inferior, they will sometimes reduce them to pulp. In fact, many of them feel stiffness in their necks and fatigue

in their eyes and legs. It has been verified as a matter of fact that the eyesight of many mothers with side jobs at branch workshops for light electric appliances has failed.

The other day, I gave a speech at the home for seniors in the village. Later, I engaged in idle talk with attending grannies. One of them said in a reproachful tone, "Daughters-in-law these days excite our envy. For they can work and get money. We had no experience at all in being directly paid for our work. No matter how hard we worked in the fields in our younger days, the payment went to our hubbies by way of our agricultural cooperative and what we were really in need was apportioned. Once in a while, our daughters-in-law did overtime work and came home late. They often left unfinished the dishes we had prepared at no small pains. In all probability, they had had curried rice on the way home." The old lady also complained, "Once in a while, my daughter-in-law gave me a scanty ¥500 ($1.4) to buy some snack for her kids. That's about the size of it. I simply can't come to feel at ease, because I have to take care of my grandchildren all day. I am quite sick of life."

"Grannie," I asked, "Why don't you have a clear-cut modernistic point of view and ask your daughter-in-law to give you ¥800 ($2.2) that is equivalent to the fee which, had your grandchild been taken care of by a nursing center, she would have had to pay to it." She retorted, "How in the world can I ever do so?" It did not stand to reason to ask for that money, as I knew my daughter-in-law was working for ¥800 a day."

Moms come home late at night after the day's work at

some plants. Dads are working away from home over a period of half a year. Which means that their children find themselves in the saddest plight.

By any thought, gone is the kind of mother in the old days who used to prepare *miso* soup at three meals a day -- affectionately -- in a traditional Japanese manner and, in the wintertime, stitched up rents by the fireside. All children can do today is, say, to go and buy a cup of instant Chinese noodles with a ¥100 coin they have received from their parents and rivet their attention on cartoons and foreign detective stories on television.

Quite recently, particularly since the summer or so of 1970, however, small plants in those villages began to go down one after another to our surprise. Established though they were with great pains, even farm shed-turned-to-plants were in dire distress as orders from their parent firms are on the downswing. Working moms were all in a state of shock.

In those days, a local newspaper reported, "The number of smaller businesses declared bankrupt in Nagano Prefecture by November 1970 came to an all-time high of 173 in the postwar years with accrued liabilities at ¥10,700 million ($30 million). The manufacturers of light electric appliances and electronics took a terrific walloping as imports were controlled by the United States and the output of color television sets was on the downswing. In the Saku district, for one, the "farmers' plants" established deep in the mountains to do something about their depopulation are in dire straits, as some of them are abandoned by their parent firms and

others forced to curtail or suspend their operation.

Now, even an easygoing physician like me cannot say that it's good for the health of pops and moms as they can't go to work because of an ongoing recession. At a time when there are strong calls for cutting back on the acreage under cultivation and on rice plantation these days, there is the need, more than anything else, to satisfy the premise that farming families will be able to make a decent living only when their minimum income comes at least to ¥800,000 a year. Without the minimum standard of living guaranteed, man simply cannot lead a life deserving of human dignity.

CHAPTER SEVEN

Prospects for a Rural Hospital

1. Paving the Way for an International Forum

For four days from October 1, 1969, the Fourth International Congress of Rural Medicine was held at our hospital, at last giving shape to our long-cherished vision. The first one was held in Tours, France; the second in Bad Kreuznach, Germany; and the third in Bratislava, Czechoslovakia. And the town of Usuda was chosen as the venue for the fourth. The hosts were Japanese medical scientists and physicians, mostly from the Japanese Association of Rural Medicine. I was appointed congress president. The conference was attended by 530 colleagues from 26 countries, including 80 from outside Japan.

If you said that it was only natural to hold a conference of rural medicine in the rural setting, that would be the end of it, but there had admittedly been all sorts of troubles before this small town deep in the mountains was finally designated as its venue. Above all things, how could we ever raise the money? Fortunately, the Nagano Prefectural Government contributed ¥3 million ($8,300) and another ¥3 million came from the Nagano Prefectural Federation of Agricultural Cooperatives for Health and Welfare. More than anything else, I was vastly obliged by the very fact that the Japanese Association of Rural Medicine had unanimously nominated me as congress president.

The choice of our town as the venue was a good one for many reasons. First of all, foreign participants could personally see how villages in the vicinity looked like and how farming families

were living. The conference was held right in the middle of the rice-reaping season. They could go and see farmers cut rice with a sickle on all fours in a traditional manner or gather it in with a state-of-the-art combine, albeit small in size. The fact-finding tours were something that could not have been realized, had the conference been held in some city. They also made a tour of every nook and corner of our hospital. What should a general hospital in rural Japan do? What sorts of problems does it have? What makes it necessary for us, clinicians, to get among rural people in order to go as far as to deliver health care? Attending rural physicians from Western countries appeared to have had little knowledge about the origins of those typically Japanese themes of rural medicine.

What surprised them most was the hospital admission fee that was set at as low as ¥1,300 ($3.6) a day with three meals under the National Health Insurance Scheme. Besides, by no stretch of the imagination could they fool themselves into believing that rural hospitals were subjected to heavy pressure in terms of the capital invested in hospital facilities, its interest and their depreciation, a fact that the burden of interest and depreciation alone exceeded 10 percent of their total revenue.

"You are a genius in hospital management," said Charles K. Elliott, a general practitioner in Wisbech, England. "I simply don't understand how on earth you can manage to run a hospital with all that pressure on you, really."

I felt like crying when I replied, "We could not have been able do that without our employees' low wages and extra work."

Undeniably, it must be hard to realize in a Western sense

that general hospitals in rural Japan manage as private businesses down to earth without aid from either the national or prefectural government.

The main foreign participants were from the United States, the Soviet Union, Czechoslovakia, Bulgaria, East and West Germanys, Great Britain, France and Spain. Then we had participants from Kenya, Uganda and Nigeria beside those from India, Indonesia, the Philippines and other Asian countries. Delegates from Romania and North Vietnam could not attend the conference with their passports not visaed in time. There were no participants from China, with which communication could not be established. Under Mao Zedong's leadership, China attached the greatest degree of importance to medical care in the rural setting and the science of rural medicine but did not send in any delegates for some reason or other to our sheer regret.

The official languages were Japanese, English and Russian. The inclusion of the Russian language left us to misunderstanding in some quarters. Critics said that it had never been used at any international congresses in Japan before. As reports had it that unless we came out with any specific reason for its use as an official language, the contributions we collected for the conference would not be exempted from taxation (that is, half of them would be collected as taxes), I rushed to the Ministry of Education in a flurry.

Straightforwardly, I said to the ministry officials, "Our association was born in Europe, and our European colleagues are playing a leading role even today. Of them, those from East Euro-

pean countries are particularly influential, as their countries are known for their agriculture. Situated on the other side of the Iron Curtain, each one of them is using Russian as the first foreign language. Their delegates strongly asked me at the last meeting of our association's executive board to adopt Russian somehow as an official language. I agreed with them, of necessity, though I was fully aware that the adoption of Russian as an additional official language would raise our payment to simultaneous interpreters by another digit ..... Another knotty issue was that the director of a rural hospital like me was to serve as congress president, but the ministry officials gave a ready consent to me with management of the congress exempted from taxation.

Based on the actual conditions of villages and farm work in different participating countries, the scientific papers took up a wide variety of topics on medical and health care, ranging from specific specialty fields to a broad scope of social issues. Liberally, I classified them into two categories: one that covered themes in the field of "agricultural medicine" as a milieu of occupational medicine, dealing with advanced modern agriculture as in the West. In plain language, the issues taken up in this sector concerned pesticide poisoning, fatigue and accidents caused by the mechanization of farm work and anthropozoonoses tied in with stock raising. The other sector consisted of themes on "rural health," which dealt with the lives of poor farmers in developing Asian, African and Latin American countries: to wit, significant malnutrition, prevailing contagious and parasitic diseases and "doctor-less" villages.

Table 6. Scientific Program of Fourth International Congress of Rural Medicine

Main Themes:

1. Toxicological problems in agriculture
2. Ergonomic aspects in agriculture
3. Anthropozoonoses in agriculture
4. Life in rural communities and its influence on inhabitants' health conditions

Symposiums:

1. Chronic poisoning from agricultural chemicals
2. Toxic residues from agricultural chemicals in foods and human bodies
3. Health and medical activities in rural communities
4. Nutrition in rural communities
5. Damage caused by powered agricultural machines and its countermeasures
6. Fatigue in farm work
7. Preventive measures against contagious diseases from livestock
8. Parasitic diseases in agriculture

Free discussion:

1. Parasitic diseases in agriculture: New Castle Disease and foot and mouth disease

One feature of Japan is that it has both categories of issues at one and the same time. With the nation going through a phase of rapid economic growth, there is every sign that the modernization of farm work is going on at a remarkably fast pace. Consequently, new problems crop up one after another in the milieu of "agricultural medicine," to say the least of abortion caused by vibratory cultivators and diseases of the kind which is peculiar to work in vinyl sheet-enclosed greenhouses. On the other hand, there solidly remain aspects of retardation, which could well be described as "semi-feudalistic" in the lifestyle of farmers. It can hardly be said

that the issues associated with the *Nofusho* syndrome and "rural diseases" are on the downswing. Issues on villages without doctors are taking on an increasingly aggravating aspect. That said, various themes of the sort that comes in the milieu of "rural health" are something that must be taken into serious account even today.

Now that I was to host an international congress as president, I wished to make the most of the features of the science of "rural health" in Japan. With the East featuring "rural health" and the West having "agricultural medicine" as the mainstream, Japan comes in between. What I wanted to stress at the opening ceremony was that we wished to serve to cement the bridge of mutual understanding between the East and the West in scientific terms.

In the opening ceremony on the first day, Prof. Pavel Macúch, made a speech as president. Having served as Czechoslovak vice minister of health till a few years before, he is a specialist in public health. Under the title of "Possibilities of international cooperation in the field of agricultural medicine," he stressed the importance of establishing regional chapters and centers around the world. Certainly, it must be emphasized particularly in the Asian and African settings today.

As congress president in the plenary session, I spoke about "Environmental and medical aspects of Japanese rural life." Referring specifically to our 10 years' experience in unfolding a health management program in the village of Yachiho, I em- phasized the importance of getting right among villagers to protect their health, while searching my soul on how difficult the methods used in this project were. Health is something the people should

preserve by themselves but not something which should be spontaneously given "from above," I stressed. But I was wondering how much I could enable Western sanitarians to realize my theory, so to speak, on the delivery of health care in the rural setting.

You could argue about the significance of community medicine, yes, but the question is that rural communities in Japan, though they are called "municipalities" in bureaucratic parlance, are not autonomous in the genuine sense of the word. Having historically had nothing to do with the Renaissance, we must admit that the theories of civil society have yet to be established among the Japanese masses. That said, medical and health care often tends to be regarded as something that comes "from above." Whatever is given "from above" is apt to let autonomy go to sleep instead of awakening it. Is it not that this truth is fully attested to, more than anything else, by the acts of humanity done by Albert Schweitzer? Is it not, in a nutshell, that the colored would have not been awakened as human beings without his philanthropic work?

In a scientific session on pesticide poisoning, the paper presented by Prof. L. Tomatis, of Lyon-based International Agency for Research on Cancer, under the title of "Studies on the potential carcinogenic hazard represented by DDT" particularly drew the attention of all participants.

On this sensitive subject, a Japanese professor took the rostrum at his express request to the chair and admonished that caution must be exercised particularly when reference is made to the carcinogenicity of DDT and other effectively and widely used

pesticides, which is quite shocking to people in general. But Marcus Wassermann, professor at Hebrew University's Hadassah Medical School in Jerusalem – and L.I. Medvied, professor at the Kiev-based All-Union Scientific Institute of Hygiene and Toxicology of Pesticides, Polymers and Plastics, in particular – argued they had to say, putting all data together, that DDT and other residue-cumulative toxicants are dangerous, clearly pointing out that their countries were also poised to put a ban on the spraying of those pesticides as some other countries had done. When it comes to this sort of thing, Japanese scholars and physicians tend to generally take sides with businesses, whereas Western scholars – and particularly those in the Socialist countries – consistently take their position as health care providers with dignity. In meeting with Nobuo Danno, an editorial writer of *The Asahi Shimbun*, one year after the congress, Prof. Medvied said to the Japanese visitor, "I would appreciate your telling Dr. Wakatsuki that our country has finally prohibited the use of DDT," as I had said at that congress." The Russian is commendable as a man of learning.

In the session on "Ergonomic aspects of agriculture" held on the second and subsequent days, we could not help feeling a touch of shame. I was annoyed particularly when I conducted foreign participants on a tour of a place where farm machinery was on display. Checking cultivators and threshing machines, some of them began to hurl me a barrage of questions.

Table 7. IAAM commissions established at the Fourth International Congress of Rural Medicine

1. Toxicology in Agriculture: Pres. U.I. Kundiev (USSR), Vice Pres. F.P. Kaloyanova-Simeonova (Bulgaria)
2. Anthropozoonoses in Agriculture: Pres. Babudieri (Italy), Vice Pres. to be nominated from the U.S.
3. Ergonomics and safety: Pres. H. Dupis (West Germany), Vice Pres. J.H. van Loon (The Netherlands)
4. Living and Working Conditions: Pres. T. Wakatsuki (Japan), Vice Pres. Byaruganga (Uganda)
5. Nutrition in rural communities: Pres. W. Wirths (West Germany), Vice Pres. Sai (Ghana)
6. Youth in rural communities: Pres. D. Rolny (Czechoslovakia), Vice Pres. to be nominated from Japan

For instance, we were asked, "Isn't there the possibility of the driver's sleeve being caught by the belt, which is exposed?" and "Wouldn't that uncovered rotary catch the driver's leg?"

Dr. A.A. Menishov, researcher at the Kiev Research Institute of Labor Health and Professional Diseases in the Soviet Union, and Dr. Shinji Sasaki, a surgeon at our hospital, dwelled on the vibration of tractors. Documented evidence clearly reveals that smaller Japanese tractors are by far vibratorier than their foreign counterparts. In part because of the conditions of farm roads, no consideration whatsoever is given to the cushions of drivers' seats in Japan. Should pregnant farming moms operate tractors of this kind, they would naturally have a miscarriage because of the vibration of their tractors. It drove home on us that Japanese agriculture utterly lacked in ergonomic considerations at all.

When it comes to fatigue caused by common farm work, however, unusually many Japanese delegates presented papers, as we witnessed on the third day, as if that fatigue were none other than an inevitable aftermath of farm work of the kind which is done in Japan. They took up hard work involved in the harvesting of rushes in the South Japan prefecture of Kumamoto and tangerines in Shizuoka, a prefecture in Central Japan, with special reference to the fatigue of workingwomen. The symptoms the presenters pointed out included "something wrong with the stomach" (Nagano), "bent in the back" (Tochigi, a prefecture in Central Japan) and "cases with the hand chord severed because of tendovagnitis" (Niigata, another central Japan prefecture).

In the third session with anthropozoonoses taken up as its main theme, many reports came from Asia and Africa, the environment of which is unsanitary, as a matter of course. In particular, Asian delegates referred to leptospirosis, scrub typhus, *Schistosomiasis japonica*, clonorchiasis, anisakiasis, hookworms and malaria, among others. In particular, Dr. Fujio Otani, of the National Institute of Health, elaborated on Japanese encephalitis. Acting as a vector, *Culex tritaeniorhyncus*, a genus of culicine mosquitoes, breeds especially in paddy fields. Studies in recent years reveal that pigs play a role in amplifying the spread of its virus. In this context, Japanese encephalitis may well be classified as an "agricultural disease."

On the last day, the International Association of Agricul-

tural Medicine held a general assembly to elect new members for the Executive Board. The delegates also decided to establish six new scientific commissions and appointed their presidents

The Executive Board was made up of 10 members with Prof. Macúch re-designated as association president and Jean Vacher, professor at the Tours Institute of Agricultural Medicine, as secretary general. I was appointed honorary president together with G. Preuschen, professor at the Max-Planck Institute for Farm Work and Agricultural Engineering in Bad Kreuznach, West Germany, and Prof. Medvied. I was also nominated as president of the Commission on Living and Working Conditions in the Rural Environment. With this sector representing the quintessence of what I call "rural health," I took my designation as being asked to serve as an organizer of "rural health" in the East.

For the congress, we had raised funds to the tune of ¥60 million ($167,000). The funds were the "votive offerings," so to speak, primarily from agricultural cooperatives and the National Federation of Agricultural Cooperatives for Health and Welfare. Admittedly, there had been all sorts of trouble. We have unreservedly received all sorts of help from the Ministry of Agriculture and Forestry and the Ministry of Health and Welfare, but I do not suspect that the aid was attached with strings. I must stress here, nevertheless, that it would be wholly inadvisable to try to squeeze as much money from pharmaceuticals firms as possible, as is often done by Japanese medical societies. If you do things like this, you will never be able to have assurances for the independence of science in any sense of the word.

The thing is, nevertheless, was the congress held under our sponsorship the way it should be? Did we unmistakably preserve the independence of science throughout the congress? Moreover, were our endeavors for it really tied in with improvements in the national life? On those scores, I still believe it necessary for the Japanese Association of Rural Medicine and, in particular, our hospital that assumed the gravest responsibility for management of the congress to run into harsh self-criticism.

Today, it is not just in Japan that rural communities and farm work are at issue. As I have already pointed out elsewhere, all sorts of problems remain both in the East and the West – and serious particularly in the East. They do exit at places not just in the capitalist system but in the socialist one as well. Having said that, it seems to me that there is the need to ponder from their point of view in a thoroughgoing manner how important the evolution of the task designed to protect the lives of farmers is. The task of preserving their health itself paves the way for all sorts of future possibilities. Here, it is necessary to nurture their buds with much care.

During the congress period of four days, townspeople in Usuda were kicking up their heels with its main street colorfully decorated with congress logo-bearing lanterns and flags. Kids hung around the hospital to try to hunt foreign participants' autographs. Many of them took up their lodgings in the homes of local farmers. On the night of the last day, each host family held a sumptuous dinner party to bid farewell.

2. *Managing a Rural Hospital in Dire Straits*

Having served as hospital director in the past 25 years, I must admit that what makes me puzzle and tax my ingenuity most is how to temporize financial measures for the management of our hospital. For me, that's the most painstaking of all tasks now that I have worked hard to aggressively replenish facilities and services in response to the needs of locals. By nature, rural general hospitals are different from those placed under the management of the central and prefectural governments. They are heterogeneous in the sense that any deficit they incur will not be compensated for by the government's General Accounts as is done for national and prefectural hospitals, the management of which knows their "good old government" will foot the bill. Out of doubt, the general hospitals run by agricultural cooperatives are managed under a self-supporting accounting system. Which means that they are infallibly in the same boat as mom-and-pop stores. Japan has yet to come up with the idea that communities back up hospitals in recognition of their public nature – an idea that is already established in Western countries. On top of that, the policy of pegging benefits for medical care at low levels is in force under the health insurance schemes. That said, hospitals are forced to bear the burden and heat of the day to a by far greater extent than general practitioners. This is more than we can bear.

What makes the management of rural hospitals all the harder? In a word, this is because rural people to whom they offer

services are poor. By no means can they profit as long as their patients were badly off. Farmers are so poor, both economically and in terms of life, that they will often be taken ill. They do hesitate to receive treatment even when they definitely know they are sick. In the old days, I used to go out and see patients in the mountains. Most of the patients were past cure. In effect, I was asked to see them because their families wanted me to tell them that the patients were at death's door, but not because they wanted me to do something about the disease. In hindsight, it seems to me that I should have been there with a Buddhist rosary rather than a stethoscope. Half a month after my house visit, I had a phone call from one of those families. Told that the patient had just breathed his last, I was asked to issue a death certificate. That's how things went in those days, and this tendency remains conspicuous in many aspects. Here lies the very reason why rural hospitals can never do a large practice simply because the number of patients of whom they care is great.

The management of hospitals is attended with all sorts of exactions. And the most responsible factor is, I must say, the Japanese government's policy of keeping insurance remunerations at low levels. The masses seem to be well aware of this measure. It produced a significant adverse impact, in particular, on the management of rural hospitals. It goes without saying that the delivery of medical care is placed under a universal health insurance system. The government adopted this scheme in 1960 as the basic way in which the delivery of medical care should be in the future (this policy

was taken once during the Greater East Asia War by the government of Gen. Tojo with Lt. Gen. Koizumi as minister of health.). Now all that is necessary for any one of the Japanese people to consult a doctor is to produce his or her insurance certificate. There could be no better scheme. The question is, however, that physicians are commissioned to deliver medical care at unreasonably low fees.

There is no institutional difference between the triplex Social Insurance Scheme under which industrial workers are covered and the National Health Insurance Scheme to which farmers and ordinary citizens subscribe, because they are managed in the same system where marks are preset for medical procedures with the unit price also preset for each one of them. In plain language, the fees for medical services, including those for the initial hospital examination, surgery and hospital admission, are officially predetermined. The question is, those fees have been kept exceedingly low. Hence, the name of "policy of keeping remunerations for medical care at low levels." It appears to be a good thing for the people that they are kept low, but they ought to have their limits. If kept unwarrantably low, they would pave the way for the delivery of inferior medical care, shifting the strain to the people.

Fees for medical care under the health insurance schemes are determined by the Central Social Insurance Council, a panel of advisers to the Minister of Health and Welfare, which is made up of delegates from three parties – that is, the Japan Medical Association (physicians), those from the health insurance associations

(payers) and unaffiliated men of experience and learning. Whatever conclusion this panel draws may perhaps sound impartial, but the fact is that it is perfunctory. In any event, the Minister of Health and Welfare nominates the councilors as he takes things easy. In all probability, he knows the right persons do not sit on the council, but the fact is that he just sits pretty.

Strictly speaking, the Japan Medical Association has been at disadvantage from the beginning. To begin with, the reason is because it made little of medical care under an insurance scheme. The Social Insurance Scheme began in 1926 and the National Health Insurance Scheme in 1938. In the first few years, top officials of the Japan Medical Association accepted it without due consideration, as they thought in a hit-or-miss fashion that they could readily confer benefit on limited categories of people, such as poor workers and farmers, under that system in intervals of their examination and treatment of patients on a pay-as-you-go basis. With the change of times, examination and treatment on a pay-as-you-go basis were gradually taken over by those under the Social Insurance Scheme. With a universal national health insurance system put into effect at last, physicians were thrown into consternation, but it was too late to do anything about the new system. They found themselves in a position to examine and treat patients, significantly dickered by the government in part because the insurance schemes were in dire financial straits. In particular, the fees for medical care at hospitals were pegged at incredibly low levels. Here arose the criticism that the Japan Medical Association, which after all was supposed to speak for general practitioners,

was giving the cold shoulders to hospitals.

Take fees for hospital admission and operations as an example, and you can see with half an eye the miserable position in which hospitals are placed. The fee for hospital admission, including "standard nursing," "standard bedding" and "standard feeding," to use bureaucratic jargon, plus three meals is set at up to an amazing ¥1,380 ($3.9) per patient a day. People in general naturally cannot understand all those catches, because all they have to do to consult a physician is to produce their insurance certificate plus the payment of an extremely meager amount of money in cash. At a time when you have to pay as much as ¥1,400 ($4) to ¥1,500 for an overnight stay with breakfast and supper at a people's lodging house operated by municipalities, it really baffles out of understanding that the fee for hospital admission is pegged at so low a level all the more because it includes even an allowance for the midnight duty on which nurses have to go. Their midnight work has now become a controversial issue from a humanitarian point of view. Japan's fee for hospitalization is too excessively lower than ¥6,000 ($17) in Great Britain, ¥7,000 ($20) in West Germany and ¥8,000 ($22) in France, setting aside the United States where it stands at ¥20,000 ($56). Can it be officially pronounced to the world that this is exactly where medical care really stands in Japan, which ranks second in the world in terms of gross national product? Infallibly, the way in which the fee for hospital admission is determined without reason may soon or later sow the wind and reap the whirlwind. Who in the world will take the blame for the

outcome?

In 1952 or 1953, the directors of agricultural cooperative-affiliated hospitals across Japan held a conference in Tokyo. A representative of Gen. Macarthur's General Headquarters encouraged us in a speech to do the best we could in the delivery of medical care in the rural setting. Then, he said he was ready to answer questions about any troublesome problems that faced us. I raised my hand and appealed the present state of affairs in which hospitals were at their wit's end as the officially determined fees for medical care – and those for hospital admission and operations, in particular -- were pegged at extraordinarily low rates. I asked him, "What would you think about the fact that the fees for medical care in Japan are kept excessively low under the Social Insurance Scheme? Given those rates, you simply can't treat patients according to the dictates of our conscience." The American health official hesitated the barest moment but said that with Japan's GNP being one-tenth of the United States', there seems to be nothing wrong with the fees for hospital admission and operations that would also come to that fraction. In all probability, he was not trying to say, I would assume, that we could get around with an appendicitis operation, the precision of which was one-tenth or so that of our American counterparts'.

But there exists something of a safety valve for that low hospital admission fee. Under the Social Insurance Scheme, it is officially authorized to collect the difference between the actual charge for hospital admission and the remuneration the hospital could receive under this system. That said, it is by no means rare in

Tokyo and other major cities to charge ¥2,000 ($6) to ¥3,000 ($8) a patient in addition to remuneration under the Social Insurance Scheme. Not a few hospitals there go as far as to charge tens of thousands of yen. In big cities where many of the residents are in funds, you could take that step, thus reducing the financial burden on hospital management. But things simply do not go that way for rural hospitals. Even if you try to improve your rural-hospital facilities in some measure in expectation of a rise in the collection of the balance between the actual charge for hospital admission and the remuneration you can receive under the scheme, our clients, who after all are poor farmers, will not make good use of them.

Our hospital has 800 inpatients a day on the average. A little more than 50 percent of them are those who must be compulsorily sent to hospital and whose hospitalization and treatment are paid by the government, including patients under the Livelihood Protection Law, patients with psychiatric disorders and tuberculosis patients. Half of the remaining 40-odd percent is covered under the National Health Insurance Scheme and the other half under the Social Insurance Scheme. The balance of ¥300 (¢80) a day between the actual charge for hospital admission and the remuneration receivable under the scheme may be collected from only a tiny fraction of the patients. Even though hospitals are authorized to collect the difference between the actual charge for the sickroom and the remuneration receivable under the scheme, we consider the collection a bad practice in theoretical terms. The reason is because the authorization of this collection will eventually result in incurring "discriminatory" medical care and paving

the way for measures with which to raise patients' pecuniary burdens on some pretext or other.

Now then, even though we could have no alternative but to shift as best we could, we were determined to build a ferroconcrete building to replace the hospital's wooden structure at all costs. In fact, we successfully went through with the undertaking. A wooden building is in danger of suffering from a fire. Heating was yet another knotty issue for our hospital, as it is terribly cold in the wintertime. Then we had to take account of the adverse impact brought about by noise on inpatients (with many serious inpatients, nurses on midnight duty walked around to serve for them). The creaking noise created by nurses who were walking on the wooden floor disturbed the sleep of ordinary patients). Here, we invested ¥1 billion ($2.8 million) or so in the construction of a modern building. The investment was made up of ¥100 million ($278,000) from local institutions, to which a dividend of 8 percent would have to be paid a year, ¥200 million ($556,000) from the Nagano Prefectural Federation of Agricultural Cooperatives and the Nagano Prefectural Federation of Agricultural Cooperatives for Credit with the rate of interest at 7.5 percent a year and ¥700 million ($2 million) from the Agriculture, Forestry and Fishery Finance Corporation at an annual interest rate of 6.5 percent. The interest rates were low, to be sure, but with the investment at ¥1 billion, we would have to squeeze out nearly ¥100 million a year for interest and depreciation. If that was the case, we would have no choice but to raise the fees that were to be collected from the balance between the

actual charge and the remuneration receivable under the insurance schemes. All our hospital employees got together many times to discuss whether it was advisable to take this measure. We also discussed with representatives of the local agricultural cooperatives. As a result, we decided to receive ¥200 to ¥300 a day for the balance.

The National Association of Municipal Hospitals warned in an announcement that they were in dire financial straits, revealing that 20-odd hospitals under its wings had "evaporated" just in 1969 alone. I also hear that many smaller hospitals have recently turned into motels or hotels. Reports have it, on the other hand, that an increasingly large number of nurses have given up nursing to work as bar hostesses with a monthly wage of ¥200,000 ($556). That may well be. What does the government think about the devastation of medical care? Is it not natural that the administration should endeavor to solve all those problems at its own responsibility now that it is enforcing a universal health insurance system? It seems certain that some social insurance associations – and the Government-managed Health Insurance Association and the National Health Insurance Association, in particular – have financially gone deep into the red. Naturally, the government ought to financially subrogate them. Assuming rather a defiant posture, we are tempted to ask as a matter of course what the government has in mind, when it is poised to reduce the burden of the National Treasury for the basic task of protecting the Japanese people's health, even though it is blessed with very rich financial resources with Japan in the midst of a high-pitched economic growth?

3. Plans for a University of Rural Mdicine

Basically, the difficulty of delivering medical care in the countryside today lies in the fact that physicians are not interested in coming to villages or that even when they do so, they will not settle down there. In a phase where the amalgamation of neighboring towns and villages is in progress as at present, the phrase "village with no physicians assigned" is no longer appropriate. The reality in which the assignment of physicians to villages is not done to satisfy the needs of their inhabitants is increasingly inconsistent, nonetheless, now that the needs today are by far greater than in the early years of the Showa era (1926-1989).

Why are physicians not interested in establishing themselves in rural communities? Three reasons have been cited from old. One is that should they be assigned to villages, they will be unable to study by themselves and catch up with developments in the milieu of ever-advancing medicine and will be technologically left behind. Another is that once they depart from the cultural (or urban) environment, they will hang behind not just in medical technology but also in broader terms. For example, they cannot go to a concert, nor can they use a library or go to see paintings at an exhibition. In particular, the more serious matter is that they cannot provide their kids with better education. If their wives want their children to enter medical universities as their husbands did, the wives must have their children pass the exam by cram alone. The thing is, however, the education level of primary and middle

schools in the countryside is so inferior that the schoolchildren are left behind their counterparts in the cities. A third reason is that, as rural physicians always grumble, the very environment of the countryside is not agreeable with them. In plain language, villagers are so excessively nagging that they are readily apt to bear constant enmity against highly paid physicians in their secluded communities.

At the 11th Conference on Farmers' Health held in the Nokyo Hall in central Tokyo, on January 29, 1970, a representative of the Iwate Prefectural Agricultural Cooperative's women's department had this to appeal about the reality of "doctor-less" villages.

> Fortunately, a clinic was established in a neighborhood without physicians assigned under the National Health Insurance Scheme, but the doctor simply did not settle down there. The Prefectural Government has founded a scholarship for medical students on condition that they will work in villages after their graduation. Once graduated, however, some of them refund the borrowed money and refuse their assignment to rural communities, asserting in a nonchalant manner, "What's wrong with me? I've repaid the debt. You know that." What farmers really want to have from doctors today is not just treatment but the kind of help and guidance that is required for the prevention of diseases and pesticide accidents. But the thing is, you don't have doctors there or their number is insufficient. That is even further out of question. What's the National Health Insurance Scheme in force for?

> There's nothing you can gain by getting a health insurance certificate under this system. Certainly, the Ministry of Health and Welfare works out measures for the delivery of medical care to terribly remote hamlets every year. But you can say that would be like throwing water on thirsty soil. In any way, the measures are no more to us than a name. By and large, the issue here is not something that could be settled with meager grants-in-aid. Yes, you can ask, "Why not send doctors out by car to remote hamlets from their community hospitals by turns?" But the fact is that even those parent hospitals are in need of additional physicians.

We have every reason to believe in her words. A check of the way in which the National Health Insurance Scheme actually works out today reveals that the availability of physicians stands at 77 percent for hospitals, 80 percent for clinics and 55 percent for clinics with no full-time doctors available. Looking around in the outlying district, we realize that there is a sheer shortage of physicians in the countryside today, when it is taken into consideration that there are very many cases in which clinics under the scheme have been abolished or their plots and buildings taken over by general practitioners in the last 20 years.

The statistical data given by the Ministry of Health and Welfare on the number of physicians per 10,000 populations enable us to clearly realize how many doctors are wanting in the countryside and the degree to which they are unevenly distributed in the major cities. The number stands at 13.0 physicians for the nation's Big Seven cities, 11.6 for other cities and 6.0 for the rural

counties. The misdistribution alone is not at issue, however. The basic question is that there is an absolute shortage of physicians in Japan at present. Let's take a look at U.N. statistics (1965). In terms of the number of physicians per 10,000 populations, Israel ranks first in the world with 24.5 physicians, followed by the Soviet Union with 21.0, Czechoslovakia with 18.5 and Italy with 17.0 -- with Japan ranking thirty-fifth with 10.9 -- to our astonishment. That figure is really scandalous for a country in the Free World, which is going through a phase of rapid economic growth, ranking second in the world in terms of gross national product.

In 1965, we began to explore the possibility of establishing a university of rural medicine with a committee established in the national organization of agricultural cooperative-affiliated hospitals to cope with the shortage of physicians. As one of the committeemen, I enthusiastically endorsed the plans. Nowadays, young physicians are inclined not to follow instructions from their university professors. In the old days, hospital directors used to pay their respect to university professors, first, and then ask for the assignment of one disciple of his or another to their hospitals. The professors would send them in when they found the conditions satisfactory. This hackneyed practice has gradually lost currency, finally putting a period to the days when hospital directors could make a deal with some professor or other in the same manner as is done between bosses. Besides, you can't depend on the scholarship system for medical students, as that representative spoke at the Conference on Farmers' Health. That said, we came out with the

idea of single-handedly establishing a university with the pecuniary help of the national headquarters of agriculture cooperatives, which after all were enormously funded.

As a matter of course, the basic motive with which we got above ourselves in working out this idea was that we had to reeducate medical students about humanism, which ought to be an essential ingredient of medical care, raising objections against the egocentric way of thinking on the part of young physicians today, or rather the way in which universities nowadays aggravate their egocentrism. But what placed us under the pressure of necessity most was the fact that medical science today is too excessively fractionalized into specialty sectors and lacks in synthetic perspective, including disease prevention, contrary to the people's wishes. In particular, there is the need for a broader range of knowledge about mass health screenings and rehabilitation to society. The same thing goes with environmental disruption, too. Education today goes high-blow and is not closely tied in with the lives of people in general. The tendency still persists to think that nothing is more respectable than the research activities done in the Ivy Tower. In the natural turn of events, this trend drives physicians bent solely on profit. Is it not to be noted that many *chijiao yisheng*, or bare-foot doctors, are at full blast in the out-of-the-way areas in China nowadays?

Neither the reality of rural communities nor the lives of rural people are taken up in Japanese university education today. No university whatsoever is interested in arguing from a medical

point of view about what farm work is all about. Today, universities are out of their social bearings. Now that we are working right in the countryside, it is up to us to fill up this gap. Presumably, humanism in the field of medical care could shoot out buds in the hearts of medical students if they came to firm grips with the reality of farmers' lives. Here lies the possibility of giving birth to an entirely new type of medical education to protect increasingly depopulated rural communities today. Is it not necessary for agricultural cooperatives to join in establishing medical university of the sort that could satisfy the needs of farmers "in their name"?

Our agricultural cooperative-affiliated hospitals are successors to the hospitals placed under the wings of the prewar "agricultural unions." The leadership of the prewar industrial unions, the predecessors of today's agricultural cooperatives, established them of their own will half a century or so ago, or in the early Showa years. They came into being as farmers set themselves to eliminate the distress in which they didn't know what to do about high charges for medical care (with no national health insurance scheme in force those days). We must not forget the historical fact that agricultural union-affiliated hospitals made their appearance one after another across the nation and that a national health insurance scheme, as we see today, came into being. Thus, how can we leave unsettled the important problems that are directly tied in with farmers' lives just because the central government does nothing for them? Nay, the basic approach ought to be for farmers themselves to try to solve their problems by making full use of their organization.

The National Federation of Agricultural Cooperatives for Health and Welfare has 125 general hospitals under its wings today. The Saku Central Hospital is the biggest of all of them with 762 beds (it is decided with the concurrence of the local Medical Association that their number be increased by 100 by the end of this fiscal year.) In close collaboration with the Japanese Association of Rural Medicine, we have strived to practice rural medicine and theoretically fortify the science of rural medicine. Also, we could establish a Japan Institute of Rural Medicine, the first of its kind in Japan, in 1963.

Having said that, the Saku Central Hospital was officially picked up as the possible campus of a university of rural medicine. This is because a resolution was adopted in the name of farmers at the National Congress of Agricultural Cooperatives held in October 1970 to establish it.

The staff of our hospital has worked to protect the farmers' life and health. Tied in with the development of the science of rural medicine in Japan, our tasks came to the point where we had to fight against pesticide pollution. And we are to move a step further to the point where we set up a university of rural medicine. Do we think we are equipped to teach medical students? Naturally, we have no confidence in our own ability. The question is the needs of farmers. Should farmers venture to demand us to establish it, we will have to comply with their request at the peril of our lives as physicians. What we ought to keep in mind at all times is to abide by our original intention, or the imperative of protecting farmers' lives in the Saku district. It would be utterly

meaningless just to come up with university hospital of the sort which looked imposingly grand but to which life is not given. Nay, this kind of attempt could be dangerous today. We should always be as naïve as you were when a novice. Here lies the very mission that is assigned to us, rural physicians, a mission of which we can be really proud.

Epilogue

Having just finished talking about the Saku Central Hospital's 26-year history, I feel like having taken a chance -- rather than abashed. First, it is not I who established the hospital. Without the efforts of all the hospital staff, agricultural cooperatives' cooperation and the guidance and support given by many other people, the hospital could not have come into being. Second, the fact that the Saku Central Hospital has developed from one with 20 beds at first to one with 780 beds as we see today is a matter of secondary importance. Our hospital's sterling worth must be assessed, depending on how we carry out our task of protecting the health of farmers. Rather, this task is something with which we have to grapple from now on.

What I wanted to say in this book is this: first, how important it is for us, intellectuals, to get among farmers, live together with them and know what they really have in mind; second, how difficult and yet important it is for us, technicians in medical and health care, to familiarize with the reality of rural communities, do something about the "doctor-less" environment and continue the protection of farmers' health; and third, how significant it is to liberate farmers from the time-worn disposition in which they disregard and sacrifice their own health and to have them reform their consciousness and enhance their awareness of their human rights. I believe that those three measures may well be tied in with a campaign that is being evolved to protect the peace of Japan today.

Insofar as those measures are concerned, it's a long way

from saying to doing. We have yet to put up practice one on top of the other.

Talking of battles against diseases in the countryside, we have a host of problems that simply cannot be solved in the rural communities alone. As is discernible from the concrete examples I have enumerated in this book, there will be no alternative but to think about the whole aspect of Japanese agriculture, when you take up some disease or other in the rural setting. When it comes to the new set of *Nofusho* symptoms that results from the nonagricultural jobs in which men engage while staying far away from home and from the by-work their wives do at home, there is no choice but to inevitably criticize the way the Japanese economy is developing at an exceedingly rapid pace. The ongoing fight against pesticide pollution would not make a step forward as a matter of course without a confrontation with pharmaceutical manufacturers. The unavailability of doctors is not the problem posed just for one village.

The physician must not end up merely as a technician. Up to now, some medical doctors have been excessively "biologically-minded." The people want them to be conscious about their humanitarian and social position. We, members of the Japanese Association of Rural Medicine, define our milieu of science as social medicine. We wish to make social science-mindedness and the spirit of humanism two pillars for our sector of science.

In writing this book, I must say that I was quite a burden

on our hospital's workers – my secretary, Naoto Uchida, in particular. I do not know how to express my thanks to those colleagues. Now that I have dwelled on the work of the Saku Central Hospital, I should have referred to the names of many more workers, but I could not do so because of the limited space available for the format of this book, a format that is equivalent to Penguin's. I really feel loath to leave them out of it.

My greatest thanks are also to Yoko Natori, Mitsuyoshi Ebihara, Sawako Tabata and Yoichi Goto on the staff of the Iwanami Shoten publishing house.

February 10, 1971

Notes

Chapter 1

1. Seigen Tanaka (1806-93) – While studying at the Imperial University of Tokyo's department of art, he joined the Japan Communist Party in 1927. The following year, he was nabbed in a nationwide roundup of Communists but soon broke jail to reconstruct the Communist Party. He secretly prowled to Shanghai to get in touch with Communist International. Returning to Japan, he was arrested and imprisoned for life. Released on parole in 1941, he turned to the right.
2. Jokichi Kazama – Graduated from the Communist University for Eastern Workers in Moscow, he returned to Japan after attending the third Profintern congress in 1930 to reconstruct the Japan Communist Party. He was arrested in 1932 for his alleged involvement in espionage for the Soviets. After World War II, he established the Labor-Peasant Vanguard Party and became secretary-general. He later swung to the right.
3. May 15 Incident – Ultra-nationalistic navy officers assaulted Prime Minister Takeshi Inukai and gunned him down at his official residence in a coup on May 15, 1932, for a reform of the body politic.
4. Yoshimichi Iwata (1889-1932) – Graduated from the Department of Economics at the Imperial University of Kyoto, he joined the Japan

Communist Party in 1928. Returning from Shanghai after contact with Communist International, he was working on the party's Central Committee, when he was tortured to death by Tokyo police in 1932.

5. Takiji Kobayashi (1903-33) – Born as a son of a peasant, he was graduated from the Otaru College of Commerce. Involving himself in the All-Japan Proletarian Art League, he was known as a writer of revolutionary realism for his novel *Crab Factory Ship.* Arrested in 1933 for his involvement in the Japan Communist Party, he was tortured to death by security agents.
6. Eitaro Noro (1900-34) – Known for his book *History of the Development of Capitalism in Japan* as a Marxist economist, he joined the Japan Communist Party in 1930. While working underground for reconstruction of its central committee, he was arrested in 1933 and later died of illness in prison.
7. February 26 Incident – The Imperial Japanese Army was ideologically split into two factions: one in favor of the Imperial rule and the other that called for coordination with the United States and Great Britain in the early 1930s. Calling for the perpetual sustenance of the jingoistic Imperial rule, young officers in the 3rd Imperial Regiment instigated two other infantry regiments in Tokyo and pulled off a coup d'état. They killed or injured some of Japan's top political leaders. Eighteen of the coup leaders were sentenced to death a year later.
8. Sino-Japanese Incident – The total war in which Japan began to invade China with an outpost skirmish at Lugouqiao Bridge near Tianjin on July 8, 1937, was dubbed "Sino-Japanese Incident" by the wartime Japanese government. Becoming part of the Pacific War with Japan's declaration of war against the United States, Great Britain and the Netherlands on December 8, 1941, it lasted till Japan's surrender on August 15, 1945.
9. The author organized a research group with students from the School of Medicine at the Imperial University of Tokyo. Dr. Zenzaburo Funazaki, chairman of the Saku Central Hospital Workers' Union; Dr.

Teiji Iijima, director of the hospital's Komoro Branch; and Dr. Hajime Nagata, director of the Hokushin General Hospital, used to be members of the group.

10. Kenji Miyazawa (1896-1933) – A celebrated writer of juvenile stories and a specialist in husbandry in the 1930s. He stood unrivaled in his generation as a writer of juvenile stories – known for his *The Galactic Railway at Night*, in particular.
11. Teru Takakura (1891-1986) – Graduated from the Department of English Literature at the imperial University of Kyoto in 1916, he started living in Nagano Prefecture as a man of literature six years later. Playing a part in the founding of a farmers' union, he turned to Communism. He was arrested four times before Japan's defeat in World War II. Elected though he was as a member of the House of Representatives on the Japan Communist Party's ticket, Mr. Takakura was purged under General MacArthur's "Red Purge" directive in 1950.

Chapter 4

12. Lockheed Scandal — a reference to postwar Japan's most con- troversial political scandal in which Prime Minister Kakuei Tanaka received ¥500 million ($1.4 million) from Lockheed Aircraft Corporation, as he had pledged President Richard Nixon at their talks in Hawaii in 1972 to purchase L-1011 Tri-star air buses, F-5 jet fighters and P3C antisubmarine patrol planes. The grafting came to light as Lockheed Vice Chairman A. Carl Kotchian had admitted it at the Senate accounting oversight subcommittee's hearings in 1976. Beside Tanaka, Transport Minister Tomisaburo Hashimoto and other top government leaders and senior trading house executives were arrested.
13. Ohara Yugaku (1797-1858) is known for his leadership in founding mutual aid associations for underprivileged peasants in an era when they continued to have a poor rice crop year after year. He was also a pioneer of agricultural cooperatives.

Chapter 6

14. Minamata Disease – The mercury contained in the waste water drained by Chisso Corporation's local plants into the Bay of Minamata off the South Japan prefectures of Kumamoto and Kagoshima invaded shell fish and then poisoned as many as 2,200 residents, of whom about 700 died, in the 1950s. A similar incident also took place in Niigata Prefecture in northern Japan, poisoning 472 dwellers, of whom 218 were poisoned to death..
15. Itai-Itai Disease – "Itai-Itai" literally means "Ouch, Ouch." The disease was so named, as the patients kept crying "Ouch, ouch." Detected by a local general practitioner, this was a peculiar disease that broke out along the Jintsu River in the central Japan prefecture of Toyama and its main symptoms were renal disorders and multiple bone fractures. Mitsui Metal and Smelting's Kamioka mining com- plex along the upper streams of the Jintsu River was suspected of discharging cadmium-contained wastewater into the river in the 1950s. The government later admitted that the contaminated waste- water poisoned 150 local residents, of whom 134 died.

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SHIZUOKA
AICHI

「村で病気とたたかう」英語版
出版記念祝賀会座席表

平成１５年４月２８日
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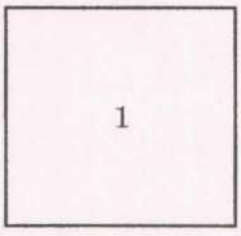

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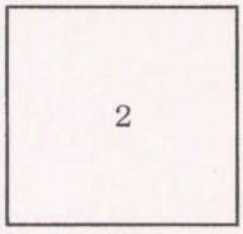
重田　富美子　　佐口　美代子
橋詰　ふみ子　　飯嶋　良子
山田　明美　　小林　由美子
星野　明子　　篠原　裕子　　佐々木　由美子



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飯島　冨士雄　　深海　和夫
小沢　小市　　藤巻　美嵩
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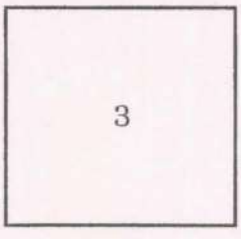

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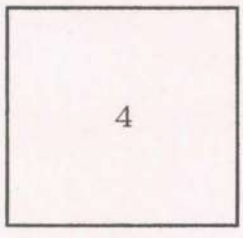

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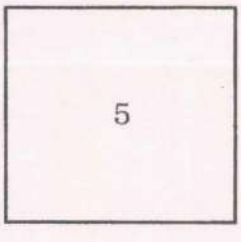

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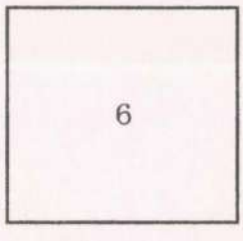

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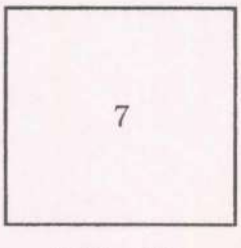

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池田　せつ子　　大塚　裕子
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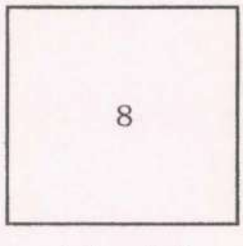

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清水　陽子　　金井　美根子
佐々木　絹江　　大塚　柳太郎
油井　伸一郎　　井出　久治　　工藤　弘典

黒沢　和雄　　宮沢　昭一　　鷹野　弥洲年
市川　隆夫　　須江　茂人
今井　澄男　　嶋田　幸男
輿水　賢治　　市川　英男
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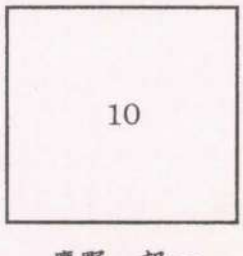
油井　博一　　鷹野　邦一



↑　入口

敬称は省略させていただきました

(Continued from front flap)

he studied medicine at the Imperial University of Tokyo. As a surgeon at its hospital during the war, he was once held in custody on charges of doing a survey "against the interests of the nation." What he did was none other than to statistically check into the health status of factory laymen drafted by the military.

He was let out of prison shortly before Japan's surrender, when his teacher, a revered surgeon in ordinary to the Emperor, told him to work in some remote place, instead of staying in Tokyo under the close around-the-clock surveillance of security agents.

Right before Japan's defeat, he began to work at the Saku Hospital in what is known as the "Japan Alps." There, peasants believed consulting physicians on whatever disease they had picked up—no matter how serious it was – was out of keeping with their means. It was taken for granted that patients would be brought in only when they were at death's doors, and the idea was simply to buy a death certificate. Thus, physicians looked in their eyes like money-grubbing creatures from another planet. How did he cope with all those hardships?

This book takes his reader on a splendid voyage to a little known land, where one is drawn into the incredible events Wakatsuki had to encounter not only by the surreal circumstances but his narrative power. It is a gripping, poignant chronicle of courage, fortitude and, above all, integrity by a physician who always strived to "get among farmers."

Jacket photo by courtesy of
Tokyo-based Medical Principle Co., Ltd.,
publisher of the *Doctor's Magazine*

I have read with fascination Dr. Toshikazu Wakatsuki's *Getting Among Farmers*. The story of how Dr. Wakatsuki built the great Saku Central Hospital and its unique outreach program, against all odds, is doubly meaningful to me since I have seen his accomplishments in action. Even though conditions in Japan are different from the United States, Dr. Wakatsuki's story struck a sympathetic chord with me, for the basic issues are the same everywhere -- a struggle to spread the benefits of science to all the people against the opposition of the vested interests, and cultural backwardness. Dr. Wakatsuki's work illustrates how objective need is translated into subjective demand. He said, "Rural medicine should be social medicine." Every health worker concerned with providing health and medical care to the common people, especially in rural areas, will find this book valuable.

Herbert K. Abrams, M.D., M.P.H.,
Professor Emeritus, Family and Community Medicine, University of Arizona

Having known Dr. Toshikazu Wakatsuki since the early 1960s, as a member of the International Association and Agricultural Medicine and Rural Health (IAAMRH) and as its president for two of its Congresses, as well as having visited Saku Central Hospital on several occasions, I still had only a slight understanding of this modest man's remarkable abilities. This book is inspiring as it reveals Dr. Wakatsuki's dedication to improving the health and safety of the rural people of his particular locale and his tremendous influence on spreading his humanitarian ideals as well as practical know-how far beyond his region to much of Asia and throughout the world. His managerial skills, perseverance, persuasiveness and sensitivity to the enormous political, economic, environmental and cultural changes that have transpired since the end of World War II, and his ability not only to cope with, but overcome the challenges they have presented are an inspiration to anyone wishing to "make a difference" in improving the living conditions of underprivileged populations of the world.

L.W. "Pete" Knapp, Professor Emeritus, Institute of Agricultural Medicine Department of Preventive Medicine, College of Medicine, University of Iowa