UNIVERSITY OF CALIFORNIA,
IRVINE

Contours of Care:
The Influenza Pandemic, Public Health, and Asian American Communities in southern California, 1918-1941

DISSERTATION

submitted in partial satisfaction of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

in History

by

Juily Iyn Vo Phun

Dissertation Committee:
Professor Vicki L. Ruíz, Chair
Professor Yong Chen
Associate Professor Ana E. Rosas

2016

DEDICATION

To Mom

I wish I could share
All the love that's in my heart
Remove all the bars
That still keep us apart
I wish you could know
What it means to be me
Then you'd see and agree
That every man should be free

Nina Simone
"I Wish I Knew How It Would Feel to be Free"

TABLE OF CONTENTS

LIST OF MAPS

LIST OF IMAGES

LIST OF TABLES

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My mom instilled in me a love of words and knowledge. She told me long ago to "always do good." I hope that I have made her proud by striving to always do just that. Urged by my maternal grandmother and grandfather, she and my father came to this country to make a better life for their family after the Vietnam War and have given much. Though I have not always had the luxury to devote my full energies to research and writing, my mother's sacrifices have paved the road I travel. While I was busy writing chapters, she watched and cared for Mina. She cooked, cleaned, and made sure I always had a "home." She is the contour of all that I am.

I hope I have made you all proud.

CURRICULUM VITAE

JUILY IYN VO PHUN

juilyfun@gmail.com or jphun@calstatela.edu

EDUCATION

Ph.D. History, University of California, Irvine, March 2016
"Contours of Care: The Influenza Pandemic, Public Health, and Asian American Communities in southern California, 1918-1941"

MA History, California State University, Los Angeles, 2006

BA History, University of California, San Diego, 2000

AWARDS

UC Irvine Humanities Center Graduate Student Research, 2008
UC Irvine Faculty Mentorship Program Fellowship, 2009-2010
UC Irvine, Graduate Student of the Year, GSR Humanities Out There, 2009
UC Irvine, International Center for Writing and Translation, Summer Grant, 2007UC
UC Irvine Regents Fellowship, 2006-2007
Cal State Los Angeles, Center for the Study of Genders and Sexualities Grant, 2005-2006
California State University Grant, 2005-2006
Cal State Los Angeles, History Department Scholarship, 2005-2006
Cal State Los Angeles Graduate Alumni Association Award, 2005

TEACHING EXPERIENCE

Part-Time Faculty, Department of History, California State University, Los Angeles, 2006-Present
United States Civilization I
United States Civilization II
Special Topic in U.S. History (Food Justice)
Gender and U.S. History
Asian American History
World Civilization I
World Civilization II

Part-Time Faculty, Asian/Asian American Studies, California State University, Los Angeles, 2011-Present
Comparative Ethnic Studies
Class, Race/Ethnicity, and Gender
Asian American History
Advanced Seminar in Asian American Studies – Research Method
Advanced Seminar in Asian American Studies – Community Engagement (Domestic Violence and Sexual Abuse)
Advanced Seminar in Asian American Studies – Cultural Competency
Asian American Communities in southern California

Pacific Asian Culture, People, and Society
Interdisciplinary Approaches to Asian/Asian American Studies
Undergraduate Directed Studies
Special Topic in Asian American Studies and Community Engagement (Food Justice)

Teaching Assistant, Department of History, UC Irvine, History Department, Spring 2009, Winter, Fall 2011
History of Chicano Studies
American Legal History
U.S. Colonial History Survey

Graduate Leader, Humanities Out There, UC Irvine, 2007-2009
University outreach program integrating current historical scholarship for Santa Ana Unified School District

Teaching Assistant, Department of Asian American Studies, 2008,
Introduction to Asian American Studies, Twentieth Century
Introduction to Asian American Studies, Nineteenth Century

Home School Teacher, Alhambra School District, September 2002 – June 2005

High School Teacher (History- World, U.S.), San Gabriel High School, September 2000 – June 2001

OTHER WORK EXPERIENCE
California High School Curriculum Writing, Education and the Environment Initiative, UC Irvine,
Fall 2007 – Spring 2008
Graduate Researcher, Rockefeller Humanities Program, California State, Los Angeles, Fall 2004, Spring 2006
Historical Researcher, Cogstone Resource Management, Santa Ana, CA July 2005 – January 2006

COMMUNITY/ UNIVERSITY INVOLVEMENT
Advisor, Community Gardens/Food Justice, Cal State, Los Angeles, Winter 2016
Project Director, "Ties That Bind" Exhibition, Cal State Los Angeles, 2015
Advisor, Sexual Violence/Domestic Abuse, Center for the Pacific Asian Family, Cal State Los Angeles, Winter 2015
Consultant, School Garden/Farmers Market, Our Kids' Community Breakfast Club, Sacramento, CA, Summer 2011
Consultant, School Garden/Farmers Market, Bell Gardens Intermediate School, Bell Gardens, 2010-2011
Student Conduct/Sexual Assault Appeal Board, UC Irvine, 2011
Graduate Student Mentor, SURF (Summer Undergraduate Research Fellowship), UC Irvine, Summer 2009
Member, Advisory Committee on Diversity, Graduate Division, UC Irvine, Fall 2007 – 2012

Volunteer, Grant Writer, Brazilian Cultural Foundation, Los Angeles, CA, 2007 – 2010
Volunteer, Hurricane Katrina Relief, Turkey Creek Initiative, Gulfport, Mississippi, Spring 2007
Volunteer Instructor of Capoeira Angola, Jackie Robinson Center, Altadena, CA Fall 2006 – Spring 2007

ABSTRACT OF THE DISSERTATION

Contours of Care:
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By

Juily Iyn Vo Phun

Doctor of Philosophy in History

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Professor Vicki L. Ruíz, Chair, Chair

The Influenza Pandemic killed as many as 60 million people worldwide in 1918. Contemporary American history renders this specific epoch as part of the "American Experience." Through research in oral histories alongside state archives, this dissertation examines public health and medicine in the interwar period between 1918 and 1941. The Influenza Pandemic offers an entrée into discussions of public health, wellness, and medicine through an examination of care during and after the crisis. Current historiography examines the attitudes of public health officials and local mandates in racializing bodies of color, using disease as the marker for citizenship and belonging. In dialogue with scholarship about public health, this work examines the importance of mutual aid, professionalization, and alternate medicine as challenges to prevalent medical discourses.

Health was a contested environment. Communities of color, especially Asian Americans, navigated through a marketplace of options, making choices grounded on availability, affordability, and an understanding of healthcare and public health. Japanese American physicians and Chinese herbal doctors presented options for communities of color in combating

health inequalities in southern California. In doing so, they formed an important counter conversation to public health that rendered the Asian American community as health menaces. Significantly, the work of these men and women, alongside their families presented a challenge to medical discourses in the early part of the twentieth century.

INTRODUCTION

Contours of Care

In 1978, my parents and I were part of a large migration of refugees known as boat people, fleeing from Vietnam. We landed in the harbor of Hong Kong and were placed in a camp alongside hundreds of other political refugees. One of my mother's most poignant memories involved a public health official who dumped her Chinese medicines into the harbor while chiding her for her backwardness. These herbal medications were among the few items she had brought. My family's relocation and attendant assessment as "fit citizens" inspired this dissertation. Extensive health examinations and medical restrictions experienced by refugees like my mother stimulated my initial inquiries into the historical precedents that associated the body with national belonging.[1] I was also compelled by my mother's motivation for bringing these medicines. What inspired a woman with little more than the clothes on her back and a young child to bring a package of herbs during her journey for political asylum? As we eventually gained entry into the United States and settled in southern California, my mother continued to travel, sometimes over twenty miles on public transportation, to seek out western and eastern medicine to attend to her children's health. Her search for care inspired the academic research and contours of this dissertation.

Maintaining health and getting care compelled Asian Americans to carve a space within a medical profession in which they were often excluded. This dissertation argues that public health was a contested environment that involved day-to-day transactions that did not always involve the state. Individuals exerted their right to choose from whom they received care. I focus on how Asian Americans negotiated sickness and health in Los Angeles from 1918 to 1941, within a

[1] Natalia Molina, *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939*, American Crossroads 20 (Berkeley: University of California Press, 2006).

marketplace of options available to them.[2] In doing so, "Contours of Care" presents health and wellness from the bottom up; revealing the medical geography in southern California among Asian Americans and their children.

My academic entrée into this topic occurred when examining the Influenza Pandemic in 1918. This disease defied scrutiny as distinctive to any one community because of its endemic occurrence; that is, the flu spreads annually across the medical and geographic landscape yearly. Cited by most authors as affecting young adults across class and race, the influenza pandemic did not garner the same attention as other diseases. What reasons account for this extraordinary oversight of the most menacing disease in the twentieth century? What characterized this disease as part of the "American" experience whilst illnesses such as smallpox, plague, and tuberculosis were blamed on immigrant groups and communities of color? Was this simply its numerical affect on all people that allowed this historical amnesia? What about this disease made it so "American"?

Alfred Crosby writes that despite the fact that the pandemic was one of the most devastating diseases in American history, most Americans simply "forgot" the devastation that took millions of lives.[3] However, in choosing to begin with the pandemic, I am struck not by the forgetfulness of the event but by its memory as an "American" disease. To imagine that influenza had the ability to democratize the American experience seemed amiss in an era when who was an "American" seemed in flux.[4]

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[2] This work ends in 1941 for several reasons. First, the beginning of World War II in the United States and the subsequent internment of Japanese Americans irrevocably altered communities in southern California. Secondly, in the history of public health, the development and mass use of penicillin during the war changed the scope of medicine and public health.

[3] Alfred W. Crosby, *America's Forgotten Pandemic: The Influenza of 1918*, 2nd ed. (Cambridge: Cambridge University Press, 2003).

[4] Michael Omi and Howard Winant, *Racial Formation in the United States: From the 1960s to the 1990s* (New York: Routledge Press, 1994).

People utilized different networks of care in coping with illness beyond the immediate years of the influenza crisis. In placing the pandemic within a larger temporal discussion of public health and medicine in Los Angeles, this study interrogates the contours in caring that diverged from public health institutions and mandates. The study of influenza contrasts with the racialization of other disease as noted by previous studies of public health in Los Angeles.[5] In the nineteenth and early twentieth century, epidemics of smallpox, bubonic plague, and typhus devastated communities. Whereas the plague and tuberculosis raised discussions of cleanliness, fitness, and citizenship when leveled at communities of color, it seemed that influenza's affect across race, class, and gender, defied the scrutiny posed by other illnesses. What seems significant about influenza in Los Angeles is the disproportionate numbers of whites afflicted by the disease. For example, of the 2,713 cases noted in the annual health reports, 2,084 of those cases were white.[6] What were the local dimensions of the pandemic and how did people deal with the disease across class and race? How did people cope with health during and after the pandemic? Lastly, what options were available?

While this work begins with the pandemic, it provides a broader picture in exploring implications of sickness and health within Asian American communities in the early part of the twentieth century. Despite governmental (city, county, state, and federal) jurisdiction, reinforced by science and at times actual force, Los Angeles' Chinese and Japanese communities defied the far-reaching tentacles of state, county, and city health agencies. This dissertation examines the many avenues taken by the Japanese and Chinese community to remain healthy and obtain care. Asian Americans were agents of their own individual health but they also created a cross-cut into discourses of public health and wellness in the United States.

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[5] Natalia Molina, *Fit to Be Citizens?*; William F. Deverell, *Whitewashed Adobe: The Rise of Los Angeles and the Remaking of Its Mexican Past* (Berkeley: University of California Press, 2004).

[6] Public Health Reports, Vol. 34, No. 4, 24 January 1919.

The pursuit of wellness was a ubiquitous experience across communities of color and they proved willing to travel for it. This movement of medicine and those who pursue it are part of what I dub the medical landscape of southern California. The physical spread of influenza in Los Angeles was less about geographic spatialization than about racial exclusion throughout southern California. A young boy during the pandemic, Clarence Nishizu, claimed that there was "nobody to care for us."[7] Despite the indifference of public health agencies in southern California, mutual aid became an important component in the everyday lives of individuals. Care was provided to the Nishizu family, not through state agencies, but a traveling family friend who visited Clarence's farm in Garden Grove.

My work heavily relies on Critical Race Studies and Immigration History in race, gender, and sexuality. Historian Natalia Molina has convincingly documented public health as a site of racialization in Los Angeles through a close examination of records that coupled diseases onto bodies of color. The typhus scare of 1916 "stigmatized Mexicans and Mexico alike" as public health officials used this disease as an indictment on lax immigration policies and border crossers. Alexandra Stern's *Eugenic Nation* noted the ubiquity of eugenics thinking and its application in the West, the Pacific, and along the Mexican-American border.[8] In doing so, her work intersects the history of medicine and empire. Health officials used eugenics to determine biological fitness and desirability along the border, marking desirable and undesirable

[7] Clarence Iwao Nishizu, interview by Arthur A. Hansen, June 14, 1982, Honorable Stephen K. Tamura Orange County Japanese American Oral History Project, California Oral History Project, California State University, Fullerton.

[8] Alexandra Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America*, American Crossroads (Berkeley: University of California Press, 2005). See also Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham: Duke University Press, 2006); Vine Deloria, *The World We Used to Live in: Remembering the Powers of the Medicine Men* (Golden, CO: Fulcrum Publishing, 2006); Ann Stoler, *Haunted by Empire: Geographies of Intimacy in North American History*, American encounters/global interactions (Durham: Duke University Press, 2006). These works are in no way exhaustive of the scholarship on the intersections of colonialism and public health. These scholars have compellingly documented the multiplicity of understanding the crossroads of public health as a U.S. colonial endeavor, on and off the continent.

immigrants through medical inspections and quarantines. Stern convincingly argues that different strains of eugenic theories helped form California's cultural and physical landscape. For both authors attributing disease to bodies of color played a crucial role determining whether or not Indians, Mexicans, Chinese, and Japanese were fit to be citizens.[9] My work uses these studies to understand not just the state production of disease, but also the local dimensions of management that dovetailed and contradicted official government policy.

The work of Asian American historians also form an important foundation for this dissertation. Historians Valerie Matsumoto and Judy Yung's groundbreaking work on Asian American women in Los Angeles and San Francisco details the centrality of gender in understanding community formation.[10] Moreover, their work underscores the importance of the family and the nuances of the Asian American identity in the creation of social clubs and participation in public life. Furthermore, historians Erika Lee and Mae Ngai's work have examined the importance of federal legislation in the creation of "Asian" immigrants.[11] In doing so, their work reveals the policing of racial boundaries as part of nation building and assessments of citizenship. "Contours of Care" utilizes their work in examining the Asian American community.

Moreover, Nayan Shah's work on San Francisco's Chinatown demonstrate the intersection of the disciplinary role of the state and the production of what he identified as the

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[9] William F. Deverell, *Whitewashed Adobe: The Rise of Los Angeles and the Remaking of Its Mexican Past* (Berkeley: University of California Press, 2004). William Deverall also discusses physical spaces in Los Angeles. For Deverall, institutional and state regulations upon the city and bodies of color were manifestations of modernity. In "whitewashing" California's colonial past, reformers and city officials marked the Los Angeles River and Mexican bodies as sites of reform for a modern landscape.

[10] Valerie Matsumoto, *City Girls: The Nisei Social World of Los Angeles, 1920-1950* (New York: Oxford University Press, 2014); Judy Yung, *Unbound Feet: A Social History of Chinese Women in San Francisco* (Berkeley, University of California Press, 1995).

[11] Erika Lee, *The Making of Asian America: A History* (New York: Simon & Schuster, 2015); Mae M. Ngai, *Impossible Subjects: Illegal Aliens and the Making of Modern America* (New Jersey: Princeton University Press, 2014); Erika Lee, *At America's Gates: Chinese Immigration during the Exclusion Era, 1882-1943* (Chapel Hill: University of North Carolina Press, 2003).

"subject-citizen" within the reform minded impulses of state agencies of public health and housing.[12] Officials characterized Chinese men as menaces to the heteronormality of families containing both the stigma of homosocial vice and medicalized threat. Along this same continuum, Judy Wu examines Dr. Mom Chung, one of the earliest Chinese American women pioneers in medicine.[13] Possibly, a "sister lesbian," Wu examines Mom Chung's life and the making of her wartime celebrity status in the face of a racially hostile environment. Although the narratives of the racialization experienced by Asians by public health and medicine are explicit in Shah and Wu's work, the work of Asian American practitioners as part of a larger experience of medicine in the first half of the twentieth century remains limited. This work brings together the experiences of Asian Americans and their role in public health and medicine as part of the landscape of medicine.

Lastly, this dissertation also utilizes the field of medical anthropology. Emily Martin's *Flexible Bodies* reminds scholars of the importance of tracking changes in medical language.[14] From the fear of contagion to the notion of "immunity," the discourse of healthy "flexible" bodies has become a powerful commodity and a framing device to highlight bodily differences. Equally important, Michael Montoya's reveals the intricate matrix of ethnicity and race in Type 2 diabetes research in *Making the Mexican Diabetic*. In a process Montoya calls "bioethnic conscription," he highlights the ways that medical researchers continue to utilize race and ethnicity to "simultaneously shape the biomedical production and representation of diabetes

[12] Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown*, American Crossroads (Berkeley: University of California Press, 2001), 7.

[13] Judy Tzu-Chun Wu, *Doctor Mom Chung of the Fair-Haired Bastards: The Life of a Wartime Celebrity* (Berkley: University of California Press, 2005).

[14] Emily Martin, *Flexible Bodies: Tracking Immunity in American Culture from the Days of Polio to the Age of AIDS* (Boston: Beacon Press, 1994). In Martin's capacity as a health advocate for AIDS patients, she conducted a study of people's attitudes towards health. She juxtaposed her work on "immunity" to the material conditions of late capitalism. Although she does not draw a straight line between late capitalism and attitude changes in health, she overlays the two, allowing readers to draw their own parallels between the regimentation of the economy and the regimentation of the body.

knowledge."[15] His notion of "knowledge" acts as a critique and reminder that historicization reveals a much more complex configuration of power in medicine.

The power of medicine, its professionalization, and practitioners serves as a important tool for scholars to examine the relationship of communities of color to the state. However, to see health as an issue of public health officials and state mandates rather than a mixture of public health and private care miscalculates the lengths by which ordinary people underwent to remain healthy, to care for each other, and themselves in defiance of the American medical profession and the state.

Asian Americans participated fully in contesting and shaping the medical landscape despite medical, social, and political restrictions. The simultaneous injunctions as medical menaces and participants of this "American" experience unfolds in a story that outlines the participation of Japanese doctors and nurses, Chinese herbal doctors, and their families within the medical geography of southern California. Through mutual aid agencies, professional networks, and word of mouth, the notion of work and care provided access to affordable healthcare. Despite the fact that the state was still the regulatory agent for these relationships, there was another actor to this medical history. Indeed the market becomes an important feature in understanding how communities of color, but especially Asian Americans, navigated through medicine and public health. I am compelled by the idea of the creation of *sovereign consumers* in health and medicine. While I agree with historian Nayan Shah's assessment of the state's production of a modern "subject-citizen" to help categorize the levels of admission to the body politic, I remain unsatisfied with this concept as the totality of understanding in communities of

[15] Michael J. Montoya, *Making the Mexican Diabetic: Race, Science, and the Genetics of Inequality*. (Berkeley: University of California Press, 2011); Michael J. Montoya, "Bioethnic Conscription: Genes, Race, and Mexicana/o Ethnicity in Diabetes Research," *Cultural Anthropology* 22, no. 1 (February 1, 2007): 94-128.

color as it relates to health. Thus, Shah addresses individuals in relation to the state, I am much more interested in individuals within the *marketplace* of health.

The first chapter explores the 1918 pandemic in southern California. Due to the fact that influenza was not a reportable disease, the first outbreaks of sickness went largely unnoticed except at the Port of Los Angeles and among the military. The flu gained notoriety first given its affect on troops in World War I and then its impact in large metropolitan areas with high rates of mortality and morbidity (sickness without death). While impossible to know the exact numbers of those affected, it is estimated that between 700,000 to one million people died from influenza in the United States.[16] On one level, this chapter deals with the official reports and responses to influenza. In every locality in the United States, cities dealt with the pandemic within the specificity of its public health departments and as I argue, in the local context of race relations. The national effort both by public health agencies and ordinary people to ameliorate influenza's impact pushed this disease to prominence as an "American Experience."[17] The categorization of influenza as a national or even worldwide disease obfuscates as much as it explains influenza in Los Angeles. Despite the fact that influenza was not a specifically racialized disease, that is, ascribed to one group of people, I argue that the treatment that people sought and received was in fact part of the "racial script."[18] The methods people employed to deal with influenza can only be locally understood within the racial politics of Los Angeles even while the disease affected "everyone" on local, state, and national scales. Government records as well as the *Los Angeles*

[16] Jeffrey K. Taubenberger, "Symposium Keynote Address: Fixed and Frozen Flu: The 1918 Influenza and Lessons for the Future," *Avian Diseases* 47 (2003): 789-791.
[17] Robert Kenner, "American Experience: Influenza 1918" (PBS, 1998).
[18] I borrow this term from Natalia Molina's recent article. See Natalia Molina, "The power of racial scripts: What the history of Mexican immigration to the United States teaches us about relational notions of race," *Latino Studies* 8, 2 (2010): 156-175. This term describes the spectrum in which choices were made based on relational racial hierarchies within California.

Times forms much of the archival evidence to chronicle the years of the pandemic however, the story of influenza, however, remains dispersed across family remembrances and public records.

Chapter two chronicles the Japanese American medical community and their endeavors for medical professionalization. In Los Angeles, Japanese and Japanese American found their healthcare options limited. While there were some exceptions, white doctors largely treated the non-white patrons under their own discretion. In response, Issei doctors in southern California sought professionalization in the face of a hostile medical regime. As a result of the of the shortage of medical facilities and the pandemic, Japanese doctors also created their own institution.[19] Issei doctors in Los Angeles first established the Japanese Hospital located on Turner Street, adjacent to where the Japanese American Museum now stands.[20] Dr. Kikuwo Tashiro, alongside other pioneering Japanese doctors and community sponsorship, raised money to create a modern facility in 1928.[21]

Chapter two also focuses on how Japanese internment during World War II disrupted the networks of medicine established by Issei practitioners in Los Angeles. While the United States incarcerated over 120,000 Japanese and Japanese Americans, doctors at various internment camps still founds ways to treat their community. The work of Issei and Nisei doctors helped to reestablish the Japanese medical community after 1941. Pioneering Nisei women doctors like Sakaye Shigekawa proved instrumental for the Japanese community, but especially for Japanese women seeking comfort for their general health and reproductive needs.

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[19] Sakaye Shigekawa, interview by Leslie Ito, December 14, 1997, REgenerations Oral History Project: Rebuilding Japanese American Families, Communities, and Civil Rights in the Resettlement Era, Japanese American National Museum.

[20] *Troy Tashiro Kaji, "City View Hospital and the Japanese Hospitals of California," Discover Nikkei Online Journal, entry posted June 25, 2010, http://www.discovernikkei.org/en/journal/2010/06/11/japanese-hospital/ [accessed December 1, 2010].*

[21] Kaji, "City View Hospital and the Japanese Hospitals of California," part 3.

In chapter three I turn to the role of Chinese herbalists in the landscape of medicine. Due to many factors such as cost and the availability of ethnic practitioners in southern California, Chinese herbalists or doctors filled in a vacuum for low-cost healthcare. In doing so, they offered their services to within and beyond the Chinese community. Their medical work, dismissed by state and local medical officials as "quackery," required creative evasion from the authorities who continually pursued prosecution of their work. They declared themselves herb sellers or what I call merchants of health. One of the most successful techniques they utilized involved the creation of corporations or businesses to sell health. This measure ensured that they could defy state conditions for practicing medicine while establishing businesses to support their families.

Chinese herbal doctors catered to a variety of communities. The most successful of these doctors utilized English language advertisements to obtain European American clients. They employed a form of "orientalism" to their advantage, often wearing traditional robes and decorating their offices as a for of medical tourism for their white clients. However, they also advertised to the Mexican immigrant community in Los Angeles. In doing so, they provided a form of low-cost medical care familiar to the community, emphasizing their professional standing as credible medical men.

Chapter four examines that health was not merely the work of doctors or herbalists themselves, but that the economy of medicine centered on the work of wives and children. While few oral histories assert he possibility of the herbal trade as a profitable business, most herbal families barely survived especially during the Great Depression. Often, narrators remembered childhoods of working in the family business while struggling to adapt to American culture. These children formed the backbone of the herbal trade.

The family remains a crucial site for health. In creating sketches of healthcare options in southern California, I have focused on select groups of actors within the medical landscape of southern California Chinese American communities. However, few histories of Chinese herbalists have documented the ways in which wives, daughters, and sons participated in the family business. Taking jobs outside of the family, the labor of the family form an important part of this final chapter. Medicine did provide some women with opportunities for career advancement within a white, male dominated sphere but they did not easily attain these positions. Due to racial restrictions and gendered conventions, many played secondary roles within families in the herb trade.

Examining medicine in the early part of the twentieth century requires a remapping of how we understand health, especially in southern California. Rather than discourses of health and medicine imagined only in terms of professionalized white doctors and public health officials, "Contours of Care" encompasses the work done within Asian American neighborhoods to serve community-centered practices of health. Oral histories and personal archives give texture to daily life. Rather than focusing on discourses that coupled bodies of color with disease, this work demonstrates ethnic practitioners managed health needs in their communities. "Contours of Care" reveals the multiple strains of health and wellness as a conversation within Asian American communities, rather than about them.

CHAPTER ONE

"Every member of our family came down with the flu": The Pandemic in Los Angeles 1918-1920

"Every member of our family came down with the flu," Clarence Iwao Nishizu recalled. More than sixty years after the global influenza pandemic of 1918, Clarence Nishizu remembered its impact on his family in Garden Grove, a small farming community approximately forty miles south of Los Angeles.[1] The son of Issei (first generation) beet and chile farmers who sold their produce to the Ortega Company in Los Angeles, he vividly recounted the impact of the pandemic on his whole family, "I was only ten or so years old when this epidemic hit. One day we found out that my parents both had been infected, and that there was nobody to care for us." Who would care for him? Who would take on the responsibilities of the farm? According to Los Angeles health officials, they preferred that he not "associate with them" so as to not catch the disease.[2] They recommended that all healthy people "avoid giving it to your family, friends and others" by remaining secluded from them."[3] In Clarence's position, as a young dependent, and perhaps for most people living within small communities, this advice proved impossible; Clarence could not abandon his family. He had to perform the daily tasks around the farm while ensuring the comfort of his kin.

The notion of "care" stands out poignantly in Nishizu's oral history. The influenza pandemic had a deep, enduring impact on his life. For him, "care" centered on the daily textures of life as a young boy on a farm. However, city, county, and state officials' still deemed care unadvised and at various points, illegal during the pandemic. "Care" was not an ordinary act for

[1] Clarence Iwao Nishizu, interview by Arthur A. Hansen, June 14, 1982, Honorable Stephen K. Tamura Orange County Japanese American Oral History Project, California Oral History Project, California State University, Fullerton.
[2] Dr. Luther M. Powers and Dr. Edward A. Ingham, "Important to the Public," *Los Angeles Times*, October 11, 1918. This was a notice from Powers, the Los Angeles City health commissioner and Ingham, the local officer from the California State Board of Health.
[3] *ibid.*

family and friends, but an illicit activity involving the navigation of ordinances and proscriptions in the various locales of southern California.

Born in Los Angeles in 1910, Clarence and his family moved south during prohibition because his father could no longer sell sake. He and his two older sisters, mother, and father settled just outside of Garden Grove, joining other Issei pioneers. Their family first farmed with Mr. Nishizu's uncles and later leased their own land to grow and sell their produce in the Los Angeles markets and canneries. The Nishizu's rented an eighty-acre lot on the Cordinez ranch in Garden Grove where every member of the family helped eke out a living.[4] Life in a small farming community revolved around chores, even for a young child. Clarence remembered doing, "a man's job of cultivating" alongside his older sisters and his father. The farm did not have electricity, so Clarence would clean and light kerosene lamps after he came home from school each day. As they could not afford farm machinery, Clarence's responsibilities included attending to the horses and mules before school. During the harvesting season, he helped his father dry chiles and prepared them for the Los Angeles market. He also assisted in cultivation and dug irrigation channels and wells. His day ended with preparing the evening fire for bathing for his family and for the Japanese boarders who worked on the farm. Each member of the family had tasks and duties that helped to maintain their livelihoods and care for the household.[5] According to another Nisei pioneer, "kids were useful only as workers; they were almost like

[4] Like many Japanese families unable to purchase land due to the restrictions of California's Alien land laws that banned ownership to non "native" Americans, the Nishizus rented land in Garden Drove. The California Alien Land Law of 1913 prohibited "aliens" who were ineligible for citizenship from owning agricultural land. Instead, this law allowed land-leases. The Webb-Haney Act affected Asian-American farmers in California and was implicitly aimed towards Japanese. Some Japanese Americans were able to circumvent the law by having their children (born citizens) stand as owners. See Valerie J. Matsumoto, *Farming the Home Place: A Japanese Community in California, 1919-1982* (Ithaca: Cornell University Press, 1993); Mae M. Ngai, *Impossible Subjects: Illegal Aliens and the Making of Modern America* (New Jersey: Princeton University Press, 2004); Ronald Takaki, *Strangers from a Different Shore: A History of Asian Americans* (New York: Little, Brown and Company, 1989).

[5] For an examination of the multi-generational experiences of a Japanese American community in California see Valerie Matsumoto, *Farming the Home Place: A Japanese Community in California, 1919-1982* (Ithaca: Cornell University Press, 1993).

slaves at that time, especially on a farm. My mother-in-law was the same way. She lived on a farm, and they expected her to work like a man. The wives. They all worked full-time… everyone worked out in the field."[6] With this vigorous schedule, for child and adult, man and woman alike, no one on the farm could afford to get sick. Thus, when the pandemic struck their small rented farm in Garden Grove, the Nishizu family pinned all their hopes on Clarence because he alone did not fall ill.

Clarence experienced much difficulty in caring for his sick family. Once ill, each person experienced a variety of ailments, not always consistent with one another. Early on, the United States Public Health Services downplayed the severity of the disease, considering it akin to the seasonal sniffles stating, "influenza may begin as a common cold or more severely with fever, headache, and pains in the muscles or with a chill."[7] Every year people came down with the cold, flu, or the grippe that passed after a few days. An endemic disease, it existed commonly and annually; recurring every year and from place to place as the virus mutated. Doctors initially believed this strain would behave like any other. However, the H1N1 strain (the scientific moniker for the 1918 virus) caused more serious complications such as muscle pains, shortness of breath, fluid in the lungs, fatigue, high fevers, and left many vulnerable due to compromised immune systems. As a result, many people died of secondary bacteriological infections such as pneumonia, a serious and untreatable condition before the development of antibiotics.[8] The *Los Angeles Times* expressed the lack of concern over the 1918 influenza attack referring to it as

[6] George Jiro Abe Oral History 1763, interview by Martha Bode, February 20, 1984, Nisei Experience in Orange County, California, California Oral History Project, California State University, Fullerton. It is also possible that George Abe's sister, Kiyoko also died in the pandemic. His reference to her death implies a possible correlation though he does not state it specifically. Similar to the Nishizus, the Abe family moved from Los Angeles to Orange County to rent farms and eke out a living growing produce to sell to Los Angeles markets.

[7] L.L. Lumsden, Surgeon USPHS, "Influenza: Avoid It and Prevent Its Spread," *Public Health Reports* 33, no 41 (October 11, 1918): 1732.

[8] Jefferey K. Taubenberger. "The Origin and the Virulence of the 1918 "Spanish" Influenza Virus" *American Procession of the American Philosophical Society* 150, no.1 (March, 2006): 86-112.

"just the grip."[9] But this was no ordinary case of the cold or flu. Those who caught the flu in 1918 experienced asymptomatic features that left them ill for weeks. Though in the prime of their lives, many succumbed.

This first chapter explores the pandemic in southern California by beginning with how families, such as the Nishizus, cared for the sick as individuals, families, and a community. Between narratives of care, public health discourses and city officials vacillated between the gravity of the disease and how to best deal with it while ordinary people actually just coped in the best way they knew how: caring for each other. Their focus was not about the disease but about their experiences with care and the act of remaining well. The heart of this chapter interweaves personal recollections about influenza as when care often meant loved ones curtailing and even defying the uneven regulations made by local, state, and federal officials.[10] Care meant resistance to regulatory agencies that sought to regulate the bodies of the sick during the pandemic. While most histories document the disease or trace the scientific research behind its history, few examine the cross section of both of these narratives. I seek to understand the pandemic in context of the medical geography of southern California.

Narratives have paired the pandemic along with the war without interrogating the specific ways in which racial elision during the war shaped the way families such as the Nishizus dealt with influenza. The history of the pandemic has become disease in vacuum; exempt from the history of other diseases in its racializing impact on communities of color. In most narratives of influenza, the Great War plays a central character in understanding the disease as both decidedly American and its effect as a homogenized experience. Thus, the "Great War" helped shape the

[9] "Fighting "Flu" in Los Angeles: How the Biggest City on the Coast is Adjusting Itself to Revolutionary Conditions Created by the Wholesale Prohibition of All Gatherings," *Los Angeles Times*, October 13, 1918.
[10] A notable exception to the history of the pandemic is Nancy K. Bristow, *American Pandemic: The Lost Worlds of the 1918 Influenza Pandemic* (New York: Oxford University Press, 2012). Bristow interweaves her own family narrative in this social and cultural history of the pandemic.

texture of what it meant to be American by fighting abroad and with the influenza pandemic. However, this pairing appears problematic. The many methods people employed to deal with influenza can only be locally understood within the racial politics of Los Angeles even while the disease affected "everyone." This chapter contributes to the growing body of literature that interrogates the contours of disease within the larger racial landscape of southern California.[11]

The geography of southern California adds another nuance in a complicated matrix informed by race.[12] My work examines the historical precedence of this relationship between geographies, body, and medicine. Specifically, in the case of the pandemic, public health officials wanted to play exclusive intermediaries between bodies and geographies. Seeking care, getting care, providing care represented deliberate acts especially in light of Los Angeles health officials, who curtailed the movement of people with every disease scare.

In every locality in the United States, cities dealt with the pandemic within the specificity and resources of its public health departments. In Los Angeles and throughout southern California, the local context of race relations shaped how influenza was categorized, reported, and understood.[13] On the west coast, the first reports of the disease revealed 372 deaths in Los

[11] The following works examine the racializing process and has furthered my understanding of the racialization process within a specifically regional and historicized context: Vicki Ruíz and Ellen DuBois, eds., *Unequal Sisters: A Multicultural Reader in US Women's History 4th Ed* (New York: Routledge Press, 2007); Tomás Almaguer, *Racial Fault Lines: The Historical Origins of White Supremacy* (Berkeley: University of California Press, 1994); Michael Omi and Howard Winant, *Racial Formation in the United States from the 1960s to the 1980s* (New York: Routledge Press, 1986); Hazel R. Markus and Paula M. Moya, *Doing Race: 21 Essays for the 21st Century* (New York: W.W. Norton & Co, 2010); Henry Yu, *Thinking Orientals: Migration, Contact, and Exoticism in Modern America* (New York: Oxford University Press, 2001). Min Zhou and James V. Gatewood, eds., *Contemporary Asian America: A Multidisciplinary Reader 2nd Edition* (New York: New York University Press, 2007).

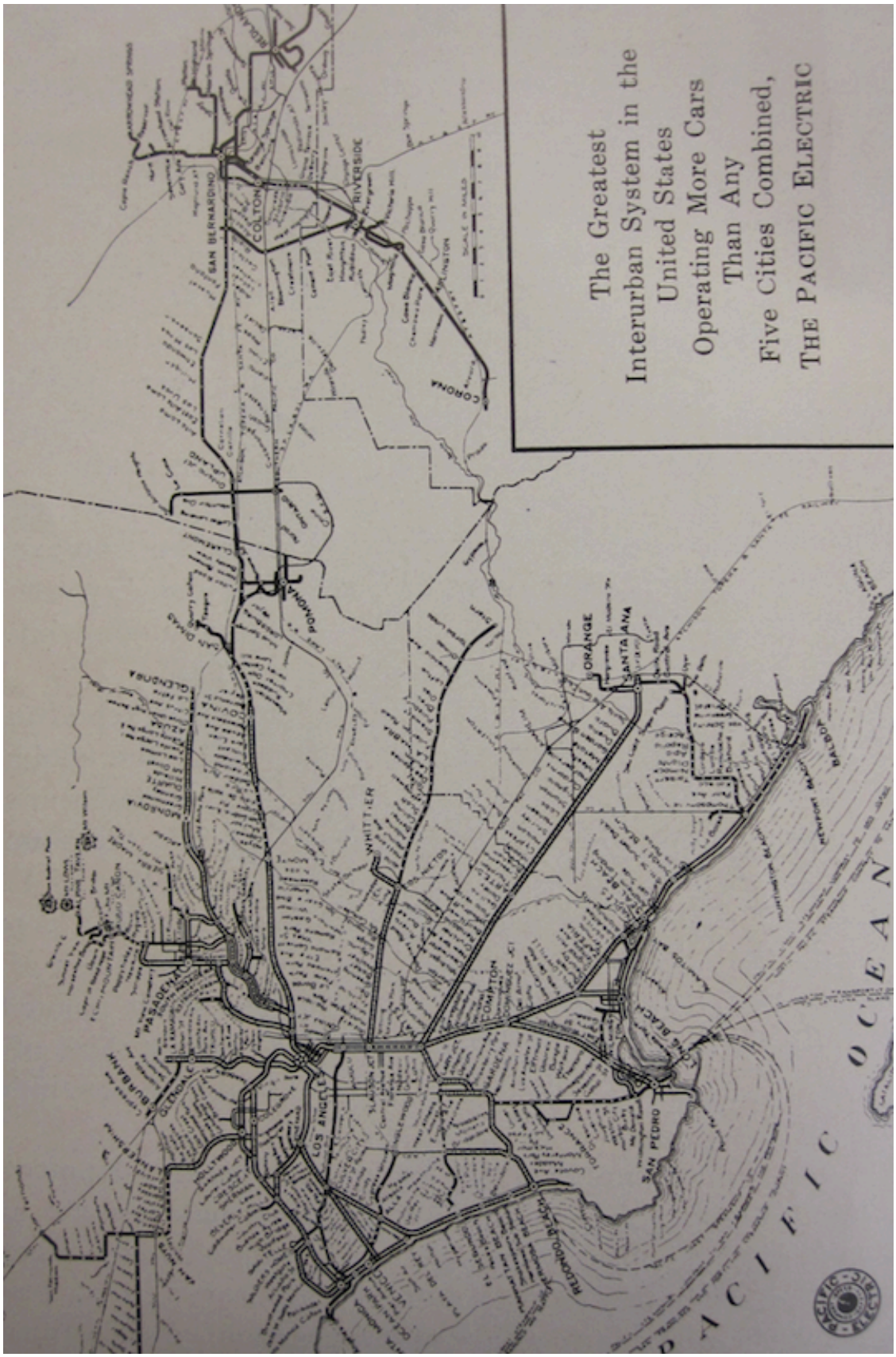
[12] See Edward W. Soja, *Seeking Spatial Justice* (Minneapolis: University of Minnesota Press, 2010), 31. Soja's notion of "unjust geographies involving the human body" is an especially productive way of understanding the medical geography in Los Angeles. Though his case studies involve contemporary examples of social justice and geography, my work examines the historical antecedent to Soja's work. People used the marketplace to intercede between themselves and their corporal bodies are an important component in my work. See also Edward W. Soja, *Postmodern Geographies: The Reassertion of Space in Critical Social Theory* (London: Verso Press, 1989).

[13] Natalia Molina, *How Race is Made in America: Immigration, Citizenship and the Historical Power of Racial Scripts* (Berkeley: University of California Press, 2014). Molina convincingly describes the historic construction of "racial scripts"; a theoretical model based on relational racial formation. These racial scripts informed and shaped

Angeles compared to 139 in Oakland and 272 in San Francisco.[14] These numbers, however, do not explain the ways in which influenza affected California.

the landscape of the United States. Regimes of power employed these "scripts" to create hierarchal models of belonging and exclusion.

[14] "Progress of the Influenza Pandemic in the Larger Cities of the United States," *American Journal of Public Health* 8:11 (1918): 857-859. See also Andrew Jonathan Noymer, "Studies in the Historical Demography and Epidemiology of Influenza and Tuberculosis Selective Mortality." Ph.D. diss., University of California, Berkeley, 2006. This was during a three-week period of the second wave in the fall of 1918.



Map 1.1 Los Angeles interurban system of transportation in 1918

Los Angeles and the southern California landscape[15]

While there exists a formal city center, there exist small municipalities throughout southern California (see Map 1.1).[16] Los Angeles and southern California was a mobile city. The red car system, run by Pacific Electric as early as 1895, connected Los Angeles to the inland empires of San Bernardino and Riverside, and the southland by a system of buses, railways, and streetcars. Though not everyone could afford the fares of the red cars (a nickel in 1920) or automobiles, people still found ways to move around and through different localities depending on the medical services they needed. People traveled to seek care. Overlaid upon the southland tracks, streets, and dirt roads was a medical geography created and refined by experiences and word of mouth. This silent map was not so much secretive as experiential and influenced by a "racial script" that communities of color navigated to seek medical care in southern California. Albert Camarillo provides an important theoretical framework in understanding how communities of color navigated through racial geography and communities of color. "Racial borderhoods were the products of ideas and ideologies about group differentness that were often channeled into policies and practices of exclusion that profoundly affected people of color."[17] His work covers a literal landscape of restrictive covenants and segregation that underlined the ways bodies of color moved through space and time. Mexican Americans, African Americans,

[15] Harry Ellington Brook, *Los Angeles California: The City and County* (Los Angeles: Los Angeles Chamber of Commerce, 1918), 6. Map reproduced from pamphlet at CSU, Northridge, Urban History Archives.

[16] Wei Li and Emily Skop, "Enclaves, Ethnoburbs, and New Patterns of Settlement among Asian Immigrants" in *Contemporary Asian America: A Multidisciplinary Reader 2nd Edition* (New York: New York University Press, 2007). Li and Skop contend that the pattern of settlement for Asian Americans in southern California is a series of ethnoburbs; that is ethnic enclaves in the pattern of suburban settlement. However, this does not account for the overlay of ethnicities in these spaces nor the pattern of development that contained a heterogeneity of people. See also the dissertation of Isabella Seong-Leong Quintana, "National Borders, Neighborhoods Boundaries: Gender, Space and Border Formation in Chinese and Mexican Los Angeles, 1871-1938" (Ann Arbor: University of Michigan, 2010). See also her new article "Making Do, Making Home: Borders and the Worlds of Chinatown and Sonoratown in Early Twentieth Century Los Angeles," *The Journal of Urban History* 41 (January 2015): 47-74.

[17] Albert M. Camarillo, "Navigating Segregated Life in America's Racial Borderhoods, 1910s – 1950s," *The Journal of American History* 100, no. 3 (December 2013): 646.

and Asian Americans navigated and negotiated these spaces by crisscrossing geographic colorlines.

Los Angeles City and County Total Population					
Year	1900	1910	1920	1930	1940
Los Angeles City	102,479	319,198	576,673	1,238,048	1,504,277
Los Angeles County	170,298	504,131	936,455	2,208,492	2,785,543

Table 1.1 Population of Los Angeles City and County, 1900 – 1940

Los Angeles represented many things to different people. At the turn of the twentieth century, Los Angeles city boasted over 100,000 inhabitants. By 1910, the population had tripled to over 300,000 and by 1920, the population of the city nearly doubled again (see table 1.1).[18] As previously noted, the city had dispersive municipalities, with nearly half the inhabitants living outside of the city by the 1910s onward.[19] Though multiethnic, the tables below illustrate the white inhabitants of the city and county constituted over ninety percent of the total population. Not until 1930 did Anglos represent only 86.7% of the total population in the city but also 88.2%, an overwhelming majority in the county.

Los Angeles City Population						
Year	White	Negro	Japanese	Chinese	Mexican	Total Pop.
1900	98,082	2,131	150	2,111	817 (FB)	102,479
1910	305,307	5,101	4,238	1,954	5,632 (FB)	319,198
1920	546,864	15,579	11,618	2,064	21,598 (FB)	576,673
1930	1,073,584	38,894	21,081	3,009	97,116	1,238,048
1940	1,406,430	63,774	23,321	4,736	36,840 (FB)	1,504,277

Table 1.2 Los Angeles City Population by Race, 1900 – 1940

[18] U.S. Census Bureau, "Historical Census Populations of Counties and Incorporated Cities in California, 1850-2010," Historical Census Data Table A-M 145-233. http://www.dof.ca.gov/research/demographic/state_census_data_center/historical_census_1850-2010/view.php (accessed September 09, 2015)

[19] Table reproduced from Natalia Molina, *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939* (Berkeley: University of California Press, 2006), 7. FB denotes foreign born Mexicans, not native born Mexicans.

Los Angeles County Population						
Year	White	Negro	Japanese	Chinese	Mexican	Total Pop.
1900	163,975	2,841	204	3,209	1,613 (FB)	170,298
1910	483,478	9,424	8,461	2,602	11,793 (FB)	504,131
1920	894,507	18,738	19,911	2,591	33,644	936,455
1930	1,949,882	46,425	35,390	3,572	167,024	2,208,492
1940	2,660,042	75,209	36,866	997	59,260	2,785,543

Table 1.3 Los Angeles County Population by Race, 1910 – 1940

Considered a "city on the make" with booster promises and visions of a futuristic city, European American advocates of the city marketed to white eastern migrants to welcome them to the land of salubrious sunshine. The Los Angeles City Chamber of Commerce claimed in their pamphlet for travelers, "This is the land for those who delight in the open air life, and long to get back to nature."[20] This "natural" environment was meant to entice those seeking better health due to the temperate climate that boasted little rain in the winter and tolerable summers. The pamphlet featured the rolling landscapes of Los Angeles county with a variety of cities; a destination that "makes the sick well and the strong more vigorous." With these kinds of appeals, boosters advertised a better environment for better health.

This vision of a Los Angeles as an exotic destination for holiday goers as well as settlers appealed to these midwestern and eastern migrants. Powerful Anglo elites dominated the political history of Los Angeles in its creation and promotion of an ideal space that had the urban appeal of services while maintaining a pristine environment, but this environment was not without its challenges. Historian William Deverall in *Whitewashed Adobe* illustrates the Anglo "perceptions of and behavior toward the ethnic Mexican population of Los Angeles" was part and parcel of the fabric of the "modern city."[21] According to Deverall, Los Angeles was a place in which racial privilege and cultural authority advertised the city as a healthful space for Anglo

[20] Harry Ellington Brook, *Los Angeles California*, 31.
[21] William Deverall, *Whitewashed Adobe: The Rise of Los Angeles and the Remaking of its Mexican Past* (Berkeley: University of California Press, 2004), 9.

migrants in which they attempted to solve diseases, threats posed by nonwhite inhabitants, especially the Mexican population. Historian Natalia Molina's work in Los Angeles also examines the work of public health officials in Los Angeles but also argues that Mexican migrants and the Chinese population responded to accusations posed by these officials. Communities of color answered to unfounded claims of disease and vice by insisting that public health was unevenly applied in Los Angeles.[22]

The positioning of whites on top of the racial order in Los Angeles created a regional lexicon of race, beyond the binary of "white" and "black" prevalent in the eastern United States. Race in southern California "meant that people who were neither white nor black had no clearly defined position in the racial hierarchy."[23] Relative positioning and fluidity of racial categories and hierarchies stood as a hallmark of the racialization process in Los Angeles with whites at the top.[24] Historian, Natalia Molina skillfully demonstrates how public health officials played an intrinsic role in shaping the racial order in Los Angeles city and county by promoting draconian policies shaped around images of disease and vice. However, the Asians and Mexican population did not passively endure these damaging discourses of medical menace, instead "they appropriated legal and medical discourses to challenge dominant assumptions, made gains for their communities, and participated in defining the racial order."[25]

Racialized groups such as Japanese Americans, Mexicans, Chinese, and African Americans responded to public health officials by intervening on behalf of their own bodies,

[22] Natalia Molina, *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939* (Berkeley: University of California Press, 2006).
[23] Molina, *Fit to Be Citizens*, 6.
[24] Tomás Almaguer, *Racial Fault Lines: The Historical Origins of White Supremacy in California* (Berkeley: University of California Press, 2008).
[25] Molina, *Fit to Be Citizens?,* 11.

their families, and communities.[26] These acts of care, demonstrated by the oral history of Clarence Nishizu, constitute another spectrum of intervention outside of public health channels. Not only did racialized groups intercede in response to public health discourses that marked their bodies as non-normative (to use Natalia Molina's term) but actively sought care to remain healthy. Beyond individual responses to illness, communities such as the Japanese American community in Los Angeles developed their own institutions to ensure the wellness of their communities. This dissertation begins with the influenza pandemic of 1918, to examine the avenues of wellness and health available to and created by communities of color.

The Great War and Influenza in Los Angeles

No one was immune to influenza. Certainly, the vast movements of troops and people did not help. The war relegated the significance of the disease as secondary to victories or defeats on the battlefield. Nor did the constant flow of people and goods contain the spread of influenza. What was also unusual about this disease, besides its severity, was its impact on those in the prime of their lives. Early reports by the Journal of American Medical Association, noted that the infection rates appeared "higher between ages of 5 and 45, and lower at ages over 45."[27] Indeed, 99% of all cases occurred in individuals under the age of 65 and "nearly half of the influenza-related deaths in the 1918 influenza pandemic were young adults, age 20–40."[28] Scientists have yet to understand why this age group suffered disproportionately in this particular strain of the

[26] There is a growing body of literature that examines the ways communities of color responded to public health officials. See Keith Wailoo, *Dying in the City of Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: University of North Carolina Press, 2001); Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001); John Mckiernan-González, *Fevered Measures: Public Health and Race at the Texas-Mexico Border, 1848-1942* (Durham: Duke University Press, 2012); Emily K. Abel, *Tuberculosis and the Politics of Exclusion: A History of Public Health and Migration to Los Angeles* (New Brunswick, NJ: Rutgers University Press, 2007).
[27] "The Influenza Pandemic" JAMA 71, no. 20 (November 16, 1918): 1677.
[28] Taubenberger, "The Origin and the Virulence of the 1918 "Spanish" Influenza Virus," 89-90.

virus.[29] While the young and old got sick, the initial reaction caught no one's attention, except those in the military.

When the first soldiers fell ill, few alarms went off. As early as March, cases cropped up in Kansas. In the training barracks at Fort Riley, soldiers fell ill without recovery. Historians conjectured that influenza originated in this training camp.[30] Despite the lack of agreement over its origins, the patterns of U.S. mortality (and perhaps morbidity) appeared similar to that of other developed countries.[31] Wherever the point of origin, young men in the prime of their lives died before they even reached the battlefields. So that by September, Dr. William Henry Welch arrived at Camp Devens, a training camp thirty miles outside of Boston, Massachusetts given mounting evidence about soldiers dying from the flu. Army Surgeon General dispatched Welch to investigate the death initially reported as cerebrospinal meningitis. By the month's end, the camp reported 6,674 cases out of 45,000 men at the encampment, but Camp Devens was not the only army station that was hit with influenza nor was it just a soldier's disease. By the time Dr.

[29] Taubenberger, "The Origin and the Virulence of the 1918 "Spanish" Influenza Virus," 4.

[30] Carol R. Byerly, "The U.S. Military and the Influenza Pandemic of 1918-1919," *Public Health Reports* 125, Supplemental 3: 82-91; John Barry, *The Great Influenza: The Epic Story of the Deadliest Plague in History* (New York: Viking Press, 2004); Katherine Krohn, ills Bob Hall, Keith Williams, and Charles Barnett III, *The 1918 Flu Pandemic* (Minnesota: Capstone Press, 2008); Paul Kupperberg, *The Influenza Pandemic of 1918-1919* (New York: Infobase Publishing, 2008). While historians documented the origination in Fort Riley, there were simultaneous reports of influenza in North America, Europe, and Asia. Taubenberger, "The Origin and Virulence of the "Spanish" Influenza Virus," 3. The origination of the pandemic remains contested because of the simultaneous cases in various global localities.

[31] Though problematic, I use the term "developed" and "developing" to differentiate between the United States and European countries. There was however, a difference between countries that were colonized (formal or informal). The affect of the pandemic on countries such as India or South Africa appeared considerably higher.
The theory behind the disparities of morbidity and mortality of countries is convincingly argued by David S. Jones, "Virgin Soils Revisited," *The William and Mary Quarterly* Third Series 60, no. 4 (October 2003): 703-742. He argues that stress of colonization and conquest is greatly underemphasized in studies that ignore these factors in lieu of explanations that concentrate on the fact that natives had no immunity to European diseases. Thus, while influenza affected "all" Americans and most everyone in the world, there was a great disparity in death especially among native populations. Scholars and scientists continue to debate about these differences. Though, there is not one conclusive argument, Jones' argument about stresses on native health caused by not only the process of colonization but the condition itself is most convincing. See also Linda Tuhiwai Smith, *Decolonizing Methodologies: Research and Indigenous Peoples* (London: Zed Books, 1999).

Welch had arrived, reports of the "Spanish" flu was scattered up and down the east coast and elsewhere throughout the United States.[32]

World War I colors the story of influenza. The first outbreaks of sickness went largely unnoticed and unnoted, except at the Port of Los Angeles and among the military.[33] Similar to other military bases, the flu gained attention in Los Angeles as many troops fell ill. However, the county and city of Los Angeles denied reports that troop movements threatened community health. The Los Angeles Times reported, "A sensational report published yesterday that nearly fifty naval recruits brought here from Memphis, Tenn, are victims of Spanish Influenza was denied yesterday by City Health Officer Powers, who declared that the sailors are suffering from plain old-fashioned grippe… County Health officer Pomeroy investigated several supposed cases of influenza at Long Beach yesterday and found nothing of consequence. He says no genuine case of Spanish influenza has yet come to his attention in this county."[34] In the early stages of the pandemic, while the east coast suffered, public health officials in Los Angeles denied the possibility of it seriousness in southern California. In the land of salubrious health and sunshine, public health officials tacked between complacency and concern.

The domestic war effort took precedence. With the country in full-scale war, patriotism often outweighed the necessities of public health decrees. The patriotic bond drives of World War I, required large gatherings of people. Cities such as Chicago and New York continued their

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[32] Alfred W. Crosby, *America's Forgotten Pandemic: The Influenza of 1918*, 2nd ed. (Cambridge: Cambridge University Press, 2003), 3-5. Dr. William Henry Welch was a well-known pathologist, physician, and scientist holding the distinction of president of the American Medical Association and Association of American Physicians during his career. His work, along with other military physicians called in for duty made military documentation of the disease much more accurate than in the general population.

[33] Nancy K. Bristow, *Making Men Moral: Social Engineering and the Great War* (New York: New York University Press, 1996). Bristow argues that the military's desire to keep soldiers healthy was due to two key factors: creating healthy soldiers and keeping them free from sexually transmitted diseases. Thus, the military kept close tabs on the health of their soldiers.

[34] ""Influenza" is plain Grippe: City Health Officer Denies Naval Recruits Bring Epidemic Here" *Los Angeles Times* October 2, 1918. In a previous article, the *LAT* reported, ""Army Epidemic Still Spreads." There was much conflict in reports in the west coast over the contagiousness of influenza.

bond drives, despite the public health knowledge that large gatherings of people would risk exposure to influenza. The *Los Angeles Times* mocked the severity of influenza, even while noting its large scale impact, with headlines such as "It's Nearly as Prevalent as the Spanish Influenza!"[35] This headline referenced the fervor of patriotism as akin to the spread of illness by stating, ""Uniformitis" is its name. It came in with the war like influenza." One cartoon demonstrates those falling in line with patriotism as a result of the war (Image 1.1). In a second, "uniformitis" infected "silly girls" by turning them into "vamps" who preyed on the servicemen coming into Los Angeles (Image 1.2) much like the way the disease afflicted servicemen and the general population. The article compared the influenza pandemic to solider crazy young girls. The article explains that the new "disease" of uniformitis afflicted women especially, who waited for the men in uniform to come off duty. The Times expressed no qualms in their observations of the various types of women these camps attracted, from earnest lookers and husband-seekers to "Jezebels" looking to ply their trade. According to the article, "Most of the unattached, would-be-attached chits had all the look of truant schoolgirls, gigglers, amateurish flirts, not-very-near vampires- one and all victims of aggravated forms of the new "epidemic.""[36]

These illustrations were meant to raise support for the war bonds parade and arouse patriotism. This article also appealed to men by insinuating that women flocked to men in uniform. One of the cartoons contains an older man begging for entrance in the draft stating, "For Gawd-sake [sic], gimme a gun. A woman hasn't looked at me since Pershing sailed for France." (Image 1.3) The appeal of "uniformitis" utilized medical language (itis) to describe the appeal of patriotism and downplayed the severity of the pandemic.

[35] "Uniformitis, Our New Epidemic: Everybody's Got it, More or Less, or…," *Los Angeles Times* October 6, 1918.
[36] Ibid.

Image 1.1 "Nearly as Prevalent as the Spanish Influenza"

Image 1.2 "The Not-Very-Near Vamp"

Image 1.3 "Uniformitis"

Common sense prevailed, for a while. October celebrations including the Liberty Day parade, the grand opening of the Liberty Fair, and the launching of the harbor plant were cancelled due to the orders of Los Angeles city public heath commissioner, Luther M. Powers.[37] The Los Angeles Times claimed these measures were merely preventative and "Los Angeles emphatically has not an epidemic of Spanish influenza. It has not an epidemic of anything."[38] The article argued that influenza could not be found in the city, but concluded with the simple of advice, "the more thoroughly and cheerfully the present precautionary regulations are observed, the sooner they will be rescinded."

World War I obscures the history of the pandemic by pairing the narrative within the national epoch. Indeed, the "Great War" adds a layer of complication to influenza's history in southern California. Public health offices were schizophrenic agencies all throughout the United

[37] *Los Angeles Times*, October 11, 1918. Luther M. Powers cancelled these celebrations despite earlier denial of the importance of influenza just one week earlier.
[38] *Los Angeles Times*, October 13, 1918.

States, at once exasperated by the health exigencies of quarantine and containment but also recognizing that the war required participation from the general public.[39] The coupling of the war and the disease pushed influenza to prominence as an "American Experience." Influenza became a Los Angeles experience.[40] Historian John Mckiernan-González argued that medical language helped shape the discourse of disease and public health into concerns of diplomacy also during a time of war.[41] Patriotism, rather than public health concerns, emerged as the driving force. Remembrances of the pandemic have placed this period in U.S. history as something very American because of the sacrifices made on the home front as well as on the battlefield.[42] Disease and war become a dual war of attrition with the American spirit triumphing at the end of both battles.

The Global Pandemic Hits Home

The influenza pandemic killed approximately 21-50 million people worldwide, more than the combined civilian and soldier casualties of World War I. According to scientist Jeffrey Taubenberger, approximately a third of the world was infected with the disease.[43] From large cities such as Los Angeles to the remote corners of Pacific islands, no community remained unscathed. This total morbidity (those that were sick) resulted in mortality (those that died) totaling 2.5% in the overall national populations to micro effects of over 50% death rate in some

[39] Alfred W. Crosby, *America's Forgotten Pandemic: The Influenza of 1918*, 2nd ed. (Cambridge: Cambridge University Press, 2003). Alfred connects the two histories of disease and the war to examine influenza's history across cities in the United States.
[40] Robert Kenner, "American Experience: Influenza 1918" (PBS, 1998). I further explore the way that the pandemic becomes prominent as the "American" experience later on in this chapter.
[41] John Mckiernan-González, *Fevered Measures: Public Health and Race at the Texas-Mexico Border, 1848-1942* (Durham: Duke University Press, 2012).
[42] See Roger Cooter, "Of War and Epidemics: Unnatural Couplings, Problematic Conceptions," *Social History of Medicine* 16, no. 2 (August, 2003): 283 -302. Cooter interrogates the pairing of war and disease and urges scholars for an overall understanding of disease outside the context of geopolitics.
[43] Taubenberger, J.K., et al. "The Origin and the Virulence of the 1918 "Spanish" Influenza Virus" Proceedings of the American Philosophical Society 150, no. 1 (March, 2006): 86-112. Dr. Jeffrey Taubenberger, the man who sequenced the H1N1 virus, states that most people died of secondary bacterial infections such as pneumonia. Because the infection made lungs weak, ordinary bacteria contained such as pneumococcus further compromised weakened immune systems causing a disruption in pulmonary functions that led to mortality.

local native communities in the Alaskan wilderness.[44] The New York Times reported, "Nearly 1,000 Dead on Seward Peninsula from Influenza…Cape Prince of Wales Village, the second largest of this district, reports about 25 adults and 100 children left of an Eskimo population formerly numbering 300."[45] Some researchers have estimated conservative numbers of mortality such as 15 million while others have cited figures upwards of 100 million. This number includes an estimate due to inaccurate reports from Asia and Africa.[46] According to scholars, Niall Johnson and Juergen Mueller, if China's statistics were taken into account, the estimate would be closer to 50-100 million people worldwide, a number that doubles the current statistical accounts of influenza's effect (Table 1.4).[47]

[44] In comparison to the staggering number of 2.5% of the population, previous influenza epidemics affected 0.1% of the population.

[45] "Malady Sweeps Eskimos," *New York Times* December 21, 1918: 21. Another article in July 13, 1919 cited that an epidemic of influenza killed 95% of the native population. In native communities, death tolls were about four times as high as that of American cities. See Crosby, *America's Forgotten Pandemic*, 228; "Influenza Among American Indians," *Public Health Reports*, 34 (May 1919). There is still a great deal of work needed to document the affect of the pandemic on native populations in the United States. For studies on the Maori population in New Zealand, see Geoffrey Rice, *Black November: The 1918 Influenza Pandemic in New Zealand* (Wellington, N.Z.: Allen & Unwin, 1988).

[46] The estimates of deaths from the disease remain debated today. See David K. Patterson and Gerald F. Pyle, "The Geography and Mortality of the 1918 Influenza Pandemic," *Bulletin of the History of Medicine* 65, no.1 (Spring, 1991): 19. Patterson's number is between the lowest estimates of 15 million and the highest estimate of 100 million. I believe that the higher estimates are more in colonized Africa and Asia.

[47] Niall P.A.S. Johnson and Juergen Mueller, "Updating the Account: Global Morality of the 1918-1920 "Spanish" Influenza Pandemic," *Bulletin of the History of Medicine* 76 (2002): 105-115. In other parts of the world such as Australia, there was a fourth crest of the illness that scientists have yet to discern whether this was another wave of the same disease or a completely different strain of the virus. Johnson and Mueller's estimate is between 50 to 100 million because of the lack of evidence for China's death toll. This approximation is an aggregate of research about the pandemic by various scholars.

Place	Estimated Deaths
Africa	2.1 – 2.4 million
Asia	26 – 36 million
Europe	2.3 million
South America	766,000 – 966,000
North America	725,000
Pacific (Oceania)	85,000
Total	50 – 100 million

Table 1.4 Global Estimates of Influenza Mortalities

Not until Spain (a country that did not censor its newspapers during the war) reported the disease did contemporaries take note of its importance. Sometimes labeled as the "Spanish flu," the disease had no connection to Spain.[48] This name implied that Spaniards were responsible for the disease and its spread.[49] In fact, Spain represented one of the first few European countries to report on the high rates of people falling ill. Contemporary and modern writers of the pandemic often reproduce this inaccuracy by taking the "Spanish flu" at face value.[50] For example, Richard Collier's monograph on influenza in 1974 assembled an assortment of stories of the pandemic and described the disease as the "Spanish Lady" despite acknowledging, "In truth, Spain bore no real blame."[51] The engendering of the disease as a "Spanish lady" for Collier implied a deadly woman that "called" upon households.

The flu arrived as a surprise, occurring in three waves throughout the world. It started in late spring/early summer of 1918, crested in the fall of 1918, and continued in some parts of the

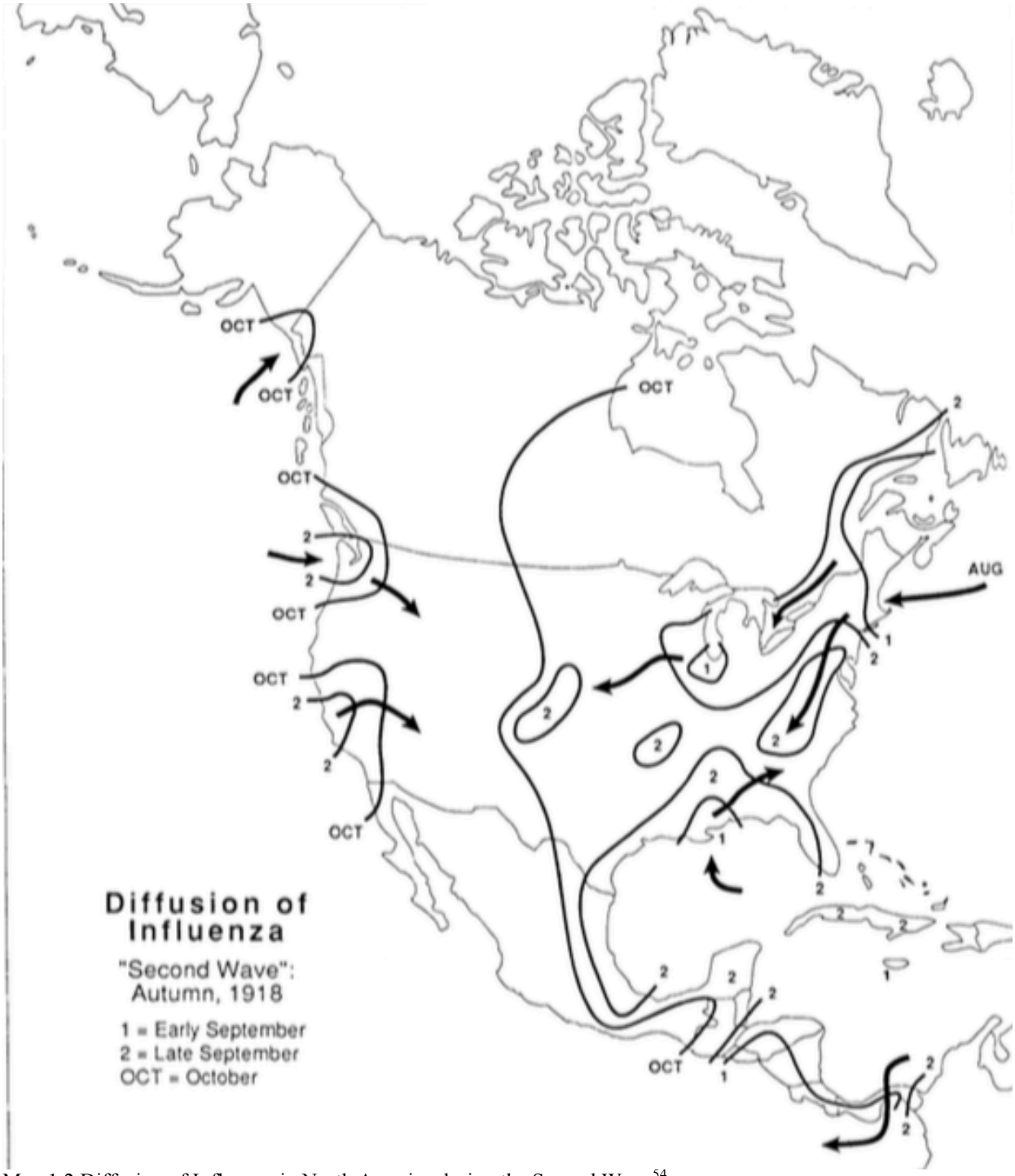
[48] Andrew Noymer and Michel Garenne, "The 1918 Influenza Epidemic's Effects on Sex Differentials in Mortality in the United States," *Population and Development Review* 26, no. 3 (September, 2000): 566. See also Alfred Crosby, *America's Forgotten Pandemic: The Influenza of 1918* (New York: Cambridge University Press, 1989).
[49] "Spanish Influenza," *Journal of the American Medical Association* 71, no. 8 (August 24, 1918): 660. The article conjectures that the disease might have started in Spain.
[50] Richard Collier, *The Plague of the Spanish Lady* (London: Allison & Busby Ltd, 1974). Collier's examination of the flu is within a global scale, utilizing stories from across the world to demonstrate its affect on civilian and military persons.
[51] Collier, 9.

word, into the early part of 1919. For most localities the first and third waves appeared relatively mild while the second wave of the pandemic (in the fall of 1918) produced the largest of the mortality totals in the United States and around the world. At the time, these waves of attacks seemed to move in no discernible pattern or timetable. The earliest documented cases occurred in the Midwest but by the autumn, the deadliest strains of the flu strains hit cities such as Boston and New York, killing in the hundreds (see Table 1.5).[52]

Major Cities in the United States	Estimated Deaths
Atlanta	578
Boston	1,909
Chicago	5,122
Detroit	2,347
Los Angeles (city)	1,055
New Orleans	1,284
New York (city)	14,822
Philadelphia	4,034
San Francisco (including Oakland)	1,929 (1,422 and 507)
Washington D.C.	976

Table 1.5 Estimated Reported Mortalities of Major U.S. Cities in 1919 (influenza and pneumonia)[53]

[52] William H. Davis, "The Influenza Epidemic as Shown in the Weekly Health Index," *American Journal of Public Health* 9, no.1 (January, 1919): 52.
[53] Reproduced and edited from Crosby, *America's Forgotten* Pandemic, 208-209.



Map 1.2 Diffusion of Influenza in North America during the Second Wave[54]

[54] Reproduced from David K. Patterson, "The Geography and Mortality of the 1918 Influenza Pandemic," *Bulletin of the History of Medicine* 65, no.1 (Spring, 1991): 11.

A New York Times headline proclaimed, "6,000,000 Died of Influenza: Regarded as the World's Greatest Plague Since the Black Death."[55] While impossible to know the exact numbers of those affected, estimates ranged between 650,000 to upwards of one million died from influenza in the United States. The estimated deaths represents anywhere from half a percent to one percent a population of over 103,000,000 Americans.[56] Documentation of the mortality rates reflects these discrepancies. For example, in 1920 the California State Journal of Medicine stated that of the 1,471,367 reported deaths reported in 1918, the Census Bureau attributed 477,467 or 32% of those deaths to influenza and pneumonia.[57] The University of Michigan Center for the History of Medicine's website cite an estimated 650,000 deaths while Stanford University's website cite 675,000. Scientist Jeffrey Taubenberger claims this number as closer to 700,000. Since influenza was not a reportable disease, these figures remain contested and often miscategorized in global, federal, state, and local statistics.[58] However, the pandemic did depress the average life expectancy by ten years.[59]

Researchers and doctors in 1918 had little to offer in terms of reliable knowledge about the causes of influenza. They hoped for solutions in the form of the development of a vaccine that would decrease the severity of the illness. A vaccine, however, proved difficult to create and even harder to convince the general populace that vaccination was a possible solution. Doctors

[55] "6,000,000 Died of Influenza: Regarded as the World's Greatest Plague Since the Black Death," *New York Times* December 20, 1918, 24. The article stated, "Influenza has proved itself five times deadlier than war, because in the same period at its epidemic rate, influenza would have killed 100,000,000." The latter estimate is closer to current scientific enumerations of mortality.

[56] U.S. Census Bureau, *Historical National Population Estimates: July 1,1900 to July 1, 1999* https://www.census.gov/population/estimates/nation/popclockest.txt (December 12, 2014). The following are the estimates surrounding the years of the pandemic; 1919:105,063,000; 1918: 104,550,000; 1917: 103,414,000.

[57] "Review of 1918 Census of Causes of Death," *California State Journal of Medicine* 18, no. 4 (1920): 121. The journal claimed that of the influenza related deaths, 380,996 occurred in the last four months of the year.

[58] Jefferey K. Taubenberger, "Symposium Keynote Address: Fixed and Frozen Flu: The 1918 Influenza and Lessons for the Future," *Avian Diseases* 47, Special Issue. Proceedings of the Fifth International Symposium on Avian Influenza (2003): 789-791.

[59] Taubenberger, "The Origin and Virulence of the "Spanish" Influenza Virus," 4. See also Robert D. Grove and Alice M. Hetzel, "Vital Statistics rates in the United States: 1940-1960" (Washington D.C.: US Government Printing Office, 1968).

themselves seemed unsure of the vaccine without trial runs. "It is well to emphasize to the public that the vaccination is experimental, and is not compulsory; otherwise, in the event of its ultimate failure, the whole system of vaccination may be discredited by the public, including that against smallpox, typhoid, etc."[60] Despite these warnings, doctors across the United States emphasized the possibility of immunizing oneself against influenza. While the causes remain debated, most experts agreed that people who gathered in large areas seemed much more likely to get sick due to exposure to the disease.

Because influenza was a virus, public health practitioners could only treat symptoms and make their patients more comfortable. Dorothy Deming, a nurse in New York and general director of the National Organization for Public Health Nursing of New York recalled, "We knew of the efforts to develop a vaccine to immunize people against the influenza virus, but never saw its results in our wards. Over and over again we heard the doctors say, after writing a long list of orders which we came to know almost by heart, "Now everything depends on good nursing.""[61] In short, most doctors recognized that they could do little in this emergency because of the nature of the disease and the limitations of medical knowledge. Though scientists and doctors had entered the new age of bacteriology, the promises of a cure or vaccine appeared beyond their reach. Bolstered by the germ theory of medicine, researchers looked for a bacterium that caused influenza.[62] After the pandemic passed, scientists remained stumped by its causes

[60] "Weapons against Influenza," *American Journal of Public Health* 8:10 (1918): 788.
[61] Dorothy Deming, "Influenza 1918: Reliving the Great Epidemic," *The American Journal of Nursing* 57, no. 10 (October, 1957): 1309.
[62] The germ theory explained that microorganisms caused illness. See Linda Nash *Inescapable Ecologies: A History of Environment, Disease, and Knowledge* (Berkeley: University of California Press, 2006). Nash makes a strong argument for a model of medicine that combines both germ and miasma theory in her examination of pesticides and its affect on rural community health. Moreover, she charts the inconsistencies in health access, especially in farming communities made up of primarily Mexicano workers. Her work is a cutting edge examination on the ways health, humans, and the environment interacted.

noting, "the best way not to get it is to avoid it."[63] The best pathologists in the United States noted "a rather confusing lack of agreement as to the effects of preventative measures, and modes of treatment upon the form of the epidemic wave and as to the kinds and character of statistical data available."[64] Doctors assumed the transmission of bacteria caused the flu. Based on this knowledge, they attempted to search for vaccines that would cure the disease outright or act as a preventative measure against future outbreaks.

Scientists optimistically believed at various times that they had found vaccines that would halt its transmission. They took small strains of the bacteria through blood or other body fluids and injected this as a vaccine, resulting in "nearly as much failure as success."[65] The Journal of the American Medicine Association created a special committee for the investigation on the efficacy of vaccines but concluded that, "The evidence at hand affords no trustworthy basis for regarding prophylactic vaccination against influenza as of value in preventing the spread of the disease, or of reducing its severity."[66] A second investigative board, the "Special Board of Statistical Investigation" concluded that despite the fact that the vaccines they investigated had no therapeutic benefit, they nonetheless recommended, "That the state encourage the distribution of influenza vaccine…The use of such vaccine is to be regarded as experimental. That the state shall neither furnish nor endorse any vaccine at present in use for the treatment of influenza."[67]

While scientists and physicians continued to work on a cure, the disease completely surprised local public health agencies in terms of its magnitude and scope. The *Journal of Public Health* noted, "When you get back home, hunt up your wood-workers and cabinet-makers and

[63] Watson Davis, "Medical Science in New Conquests of Disease," *Current History* 24, no.1 (April, 1926): 94.
[64] Charles C. Grove, "Meeting of the Subcommittee of Pathometry of the Influenza Epidemic of the Public Health Association," *Science Magazine* 50, no 1290 (September 19, 1919): 271-272.
[65] Watson, *Current History*: 94.
[66] "Current Comment: Vaccines in Influenza," *Journal of the American Medical Association* 71, no. 16 (October 19, 1918): 1317.
[67] Ibid.

set them to making coffins. Then take your street laborers and set them to digging graves. If you do this you will not have your dead accumulating faster than you can dispose of them."[68] Such was the state of emergency during the 1918 pandemic that very few local, state, or federal agencies could handle such large fatalities in this emergency. Ordinary people coping with the disease knew this firsthand. Carmen Trujillo Portillo whose mother was a midwife at the Trujillo Ranch in New Mexico echoed the same sentiment when she described as a child, "One thing that stayed in my mind because I used to hear it even later, was the pounding of the, nailing of boards together. Making, I called, boxes, coffins for the people."[69] As a young child, she knew what public health officials observed, that people died at rates faster than the living could cope.

As the daughter of a midwife, Carmen Trujillo Portillo would have seen her mother treating pregnant women, who were especially vulnerable. Deaths that may have been triggered by influenza such as tuberculosis, encephalitis, pneumonia, and maternal mortality during childbirth, or stillbirth may not have been named "influenza" as the chief cause of death. A critical discrepancy concerns the omission of stillbirths that may have resulted from the pandemic. While doctors acknowledged that the pandemic influenced pregnant women in disproportionate way, they excluded infant deaths from the final numbers of influenza and influenza-related deaths.

A study of the affect of influenza on pregnant women conducted in Cook County Hospital in Illinois revealed that about one hundred and one pregnant women were admitted and treated between September 15 and November 5, 1918.[70] Of these cases, fifty-two died, a

[68] "Weapons against Influenza," *American Journal of Public Health* 8, no. 11 (1918): 787.
[69] Carmen Trujillo Portillo Interview by Lisa Laden, narrated by S. Epatha Merkerson. "We Heard the Bells: The Influenza of 1918" (2008).
[70] M.W.Ball, "Abortion as a Sequela of Influenza," Correspondence to the Editor *JAMA* 71, no. 16 (October, 1918): 1336. M.W. Ball cited from Ziemssen's Encyclopedia, a book written by a nineteenth century German physician and researcher.

mortality of 51.4%. Of the forty-nine women who survived the disease, a little less than half experienced early cessation of labor. This rate was much higher among women who died of influenza: 75 percent had spontaneous abortions, premature labor, or labor within or around term. Described in clinical terms, the researchers of these cases believed that "the most prominent feature noted during the clinical course of the disease was the apparent ease of abortion or premature labor, its rapidity and the apparent lack of pain incident to it… Abortion occurs with relative ease and lack of pain. In the majority of cases, death follows within twenty-four hours after emptying of the uterus. The percentage of recoveries after interruption of pregnancy is small."[71]

The clinical nature of the studies of influenza on pregnant women belies perhaps the actual mental and physical trauma experienced by these women. Not only did women deal with the possibility of losing an unborn child, they continued to experience difficulty in continuing their menstruation after the disease, which indicated possible interruption or complication to their future fertility.[72] As previously noted, the pandemic changed life expectancy in the United States by ten years. However, this does not account for the gender differentials. Women's life expectancy, which generally had an advantage of 5.6 years over their male counterparts, dropped to a one-year advantage. Moreover, "females would not regain their pre-epidemic mortality advantage over males until the mid-1930s."[73]

Influenza in Los Angeles

[71] Wesley J. Woolston and D.O. Conley, "Epidemic Pneumonia (Spanish Influenza) in Pregnancy," JAMA 71, no. 23 (December 7, 1918):1898-1899. See also Walter V. Brem, George E. Bolling, and Ervin J. Casper, "Pandemic "influenza" and Secondary Pneumonia at Camp Fremont, Calif" JAMA 71, no. 26 (December 28, 1918): 2138.
[72] "Notes on the Present Epidemic of Respiratory Disease," JAMA 71, no. 19 (November 9, 1918): 1569-1570.
[73] Andrew Noymer and Michel Garenne, "The 1918 Influenza Epidemic's Effects on Sex Differentials in Mortality in the United States," *Population and Development* Review, 26, no. 3 (September 2000): 568-569.

While doctors attempted to treat pandemic patients all across the United States, the city of Los Angeles had different ideas about how to handle their citizenry. To ensure the safety and security of its citizens during the global influenza epidemic, Los Angeles attempted to quarantine their residents. In October of 1918, officials suspended "all public gatherings, both indoor and outdoor, suspended and have ordered all churches, schools and theaters closed during the period considered necessary by the Health Commissioner and his Advisory Board."[74] Those that went against the sanctions faced arrest and possible fines if found congregating in churches, theaters, or small groups.[75] These signs, written only in English, stated that it was "unlawful for any person, firm or corporation to keep open, or to cause or permit to be kept open, for the purpose of permitting the public to congregate therein, any theater, motion picture theater, concert hall, show, or amusement place, church, school, dance hall, fair, exhibitions, and in addition thereto, any place of public resort."[76] Failure meant "any person, firm or corporation violating any of the provisions of this ordinance shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine of not more than five hundred dollars ($500), or by imprisonment in the city jail for a period of not more than six (6) months, or by both such fine and imprisonment."[77] These hefty fines were designed for maximum enforcement of their decrees.

[74] Los Angeles City Council, *Minutes*, (Los Angeles, October 18, 1918), volume 112, 470.
[75] Natalia Molina argues county services and initiatives segregated through language In her study of the Belvedere and Maravilla county health clinics, the services offered for distinctly white or Mexican patrons were separated by Spanish or English as well as explicit notices that classified "Mexican" and "American" services in distinctive parts of Los Angeles, with clinics sometimes in close proximity to each other. While these language separate signs were meant to ensure that services were culturally and linguistically distinct, signs prohibiting gatherings generated the same kind of disciplinary role because of the fact that they were English only. See Molina, *Fit To Be Citizens?*, 90.
[76] *Minutes* (Los Angeles, October 11, 1918) vol. 112, 433-434. Ordinance No. 38522 was read in front of the LACC and enacted immediately to be sent to the major Los Angeles English newspapers. I did not find any ordinances at the city, state, or federal level that was printed in a language other than English.
[77] *Minutes* (Los Angeles, October 11, 1918) vol. 112, 433-434. The minutes refer to Los Angeles City Ordinance No. 38522.

In eliminating contact, public health and city officials hoped to control vectors of disease contamination but also limited the options people took to care for themselves and for others. Quarantining proved both beneficial and detrimental.[78] Because officials sought ways to control the spread of disease, they ignored the most important aspects of illness; care. The uneven support of religious institutions illustrates this point. The Church Federation of the City of Los Angeles enthusiastically agreed with Health Department officials, "we will second anything you may do to bring pressure to bear upon the proper forces to stop the gathering there which certainly must be a distributing center for the disease. Hoping that something definite may be done about this matter."[79] Conversely, the First Church of Christ Scientists did not support the city's desire to close church doors and asked to resume services on and after October 16th, 1918.

Petitioners from the First Church of Christ Scientists wanted the "dissemination of the universal understanding of omnipotent divine power, reliance upon which eventually aids in destroying the dread of contagion, and that the comfort and support of such services are much needed at this time."[80] Moreover, H.P. Hitchcock, along with four other members of the Christian Science Church insisted that the law to restrict religious gatherings were unlawful and an overreach of the public health department. They asserted that the Church, rather than the state, provided their source of comfort. Moreover, in asserting restrictions on their religious practice, they argued that the city council had acted unconstitutionally. The Los Angeles City Council summarily dismissed their request five days after their first petition.[81] Christian Scientists

[78] There was one sensational headline in San Francisco that a public health official shot a man for refusal to comply with the city's mask ordinance. Robert Kenner, "American Experience: Influenza 1918" (PBS, 1998). See also "Three Shot in Struggle with Mask Slacker," *San Francisco Chronicle,* October 29, 1918; University of Michigan Center for the History of Medicine, *Influenza Encyclopedia* (accessed July 12, 2013). Defiance of quarantining and mask ordinances did not just mean a fine and possible jail time but possibly getting shot.
[79] Letter to the City of Los Angeles from the Church Federation of the City of Los Angeles: 2085, Los Angeles City Council, *Minutes* (Los Angeles, October 18, 1918), vol. 112, 497.
[80] "Scientists Would Lift Church Ban," *Los Angeles Times*, October 17, 1918.
[81] *Minutes* (Los Angeles, October 16, 1918), vol. 112, 458. *Minutes*, (Los Angeles, October 21, 1918), vol. 112, 477.

decided to ignore the edicts, opening church doors for nearly five hundred people waiting outside the Ninth Church of Christ Scientists in Los Angeles (see illustration 1.5).[82] Four members agreed to represent the Christian Scientists: chairman of the board R.C. McClay, R.L. Craig, former member of the Board of Education and business woman, Miss Clare Germain, and H.P. Hitchcock. These four members were arrested, booked, and charged for violating a health ordinance but released on their own recognizance. This act of defiance by the board of directors challenged the constitutionality of the ordinance and the "extraordinary authority placed upon health officers." Their actions were meant to obtain a court ruling on public health measures by intentionally calling the police department to make the arrests. According to Judge Robert M. Clarke, the attorney representing the church, "the opportunity to make the arrests was presented to the police… so that he may have the chance to transfer the case to the Superior Court on a writ attacking the constitutionality of the ordinance."[83] Police Judge White indicted the four arrested, but according to The Los Angeles Times, "Justice White said yesterday he is convinced that the law is discriminatory and therefore invalid. He says he is not convinced that the emergency measure is constitutional and he believes it calls for unjust exercise of police power." [84] While the original intent challenged public health and city council power, the protests of the Church Scientists did not result in further appeals to California's Supreme Court nor to changes in the

[82] "Will Test 'Flu Closing Order: Christian Science Churches to Reopen Tomorrow; Arrests will Follow, Says the Health Commissioner; Court will then Pass Upon Habeas Corpus Pleas," *Los Angeles Times*, November 2, 1918; "Defy "Flu" Rule; Arrested: Christian Scientists to Make Test of City Health Body's Closing Order. Four "Submit" as Defendants by Agreement with Police," *Los Angeles Times*, November 4, 1918. Christian Scientists in San Gabriel did not attempt the same defiance as their Los Angeles counterparts. See "No Service Held: San Gabriel Christian Scientists Make no Attempt to Test County Regulation," *Los Angeles Times*, November 11, 1918.
[83] "Defy "Flu" Rule; Arrested: Christian Scientists to Make Test of City Health Body's Closing Order. Four "Submit" as Defendants by Agreement with Police," *Los Angeles Times*, November 4, 1918.
[84] "Calls Flu Law Invalid: Justice Trying Scientists Indicates Anti-Closing Decisions," *Los Angeles Times*, November 29, 1918.

authority of health officials. The four had charges dismissed and the health ordinance upheld as an "emergency measure."[85]

[85] "No Relaxation in Flu Fight; Cases Fewer, but Vigilance is Still Public Duty; Health Commissioner Tells of Progress Made; Arrested Christian Scientists Formally Discharged," *Los Angeles Times,* December 22, 1918.

At Ninth Church of Christ, Scientist, yesterday.

Image 1.4 Arrests at the Church of Christ[86]

[86] *Times*, November 4, 1918.

The city of Vernon, an adjoining city south of Los Angeles, also provoked the ire of public health officials with its "saloons and dancehalls" "operating in defiance of public opinion, and public safety, and nullifying to a large degree the strict quarantine being enforced by the City of Los Angeles."[87] Vernon's defiance of Los Angeles city's ordinances echoed George A. Soper's lament on the handling of the pandemic in Los Angeles. A member of the Sanitary Corps of the United States, he exclaimed,

> Three main factors stand in the way of prevention: First, public indifference. People do not appreciate the risks they run…The second factor which stands in the way of prevention is the personal character of the measure which must be employed. The enteric infections can be controlled by procedures of a general sort which impose no great restriction upon the conduct of the individual, but this is not true of the respiratory infections…Third, the highly infectious nature of the respiratory infections adds to the difficulty of their control.[88]

Officials such as Soper railed against individual disregard for the spread of the disease. The exasperated Los Angeles Public Heath agency appealed to the State Board of Health to compel the city of Vernon to comply with the quarantine. Dr. Wilfred H. Kellogg, of the California State Board of Health, along with L.J. Williams, Vernon's health officer, convinced Vernon City Trustees to "halt the sale of liquor in saloons, which was reported to be attracting larger and larger crowds."[89]

There arose a tension between the act of care and carelessness. On one hand, for the city and health officers, care meant the expansion of services to contain disease.[90] On the other hand, local and state public health agencies demanded the populaces' obedience to health regulations

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[87] Los Angeles City Council, *Minutes*, (Los Angeles, October 18, 1918), volume 112, 470.
[88] George A. Soper, "The Lessons of the Pandemic," *Science* 49, no. 1274 (May 30, 1919): 501-502.
[89] ""Flu" Closes Vernon Bars," *Los Angeles Times*, October 20, 1918.
[90] *Minutes* (Los Angeles, October 23, 1918 and October 21, 1918), vol. 112, 494. Health Commissioner Luther M. Powers wrote to Mayor Woodman regarding the reclassification of employees with the addition of more half time employees for work in San Pedro. In a previous report on October 22, 1918, Powers asked for additional appropriations of $10,000 for equipment, beds, and expansion of facilities. See also pages 467, 479, 480.

despite uneven application of quarantine measures. For example, while the city of Vernon closed dance halls and saloons, strangely, wholesale liquor houses remained open. Los Angeles and Vernon city trustees allowed policeman stationed at the doors of liquor houses to keep crowds of men away, while allowing the resumption of business. While the "saloons" and "dancehalls," working-class spaces, reinforced the coupling of disease and individual responsibility. Quarantine measures were not applied evenly across class. Vernon's Country Club also closed its entertainment rooms and service bars but kept their main dining room open.[91]

The influenza pandemic knew no borders. Officials believed this illness should be reported, isolated, and quarantined to check its spread but remained silent on how the department dealt with the sickness and conveyed care. Thus, influenza in Los Angeles and in southern California, viewed through the lens of public health officials and reports, explains as much as it obfuscates the disease landscape of southern California. Medicine in southern California encompassed a diverse cast of characters who attempted to insert their views about health, medicine, and public health. Couched in terms of the worldwide pandemic or "American Experience," this continued trope ignores how influenza and other diseases affected communities of color.

The influenza pandemic became part of the "racial script" in southern California.[92] Historian Natalia Molina compellingly describes the spectrum of choices available to communities of color were based on relational racial hierarchies within California. Her model contends the "lives of racialized groups are linked across time and space and thereby affect one

[91] See Linda Nash, *Inescapable Ecologies: A History of Environment, Disease, and Knowledge*. (Berkeley: University of California Press, 2006). Nash writes about the ecology of disease as part of the defining feature of rural Mexican workers in the use of pesticides. Similar to Nash's work, this dissertation contends that disease was also part of the southern California landscape even as officials used it as a political ax to either deem populations fit or unfit to receive services.

[92] I borrow this term from Natalia Molina's recent article. See Natalia Molina, "The power of racial scripts: What the history of Mexican immigration to the United States teaches us about relational notions of race," *Latino Studies* 8, 2 (2010): 156-175.

another, even when they do not directly cross paths."[93] Moreover, "racialized groups put forth their own scripts, *counterscripts* that offer alternatives or directly challenge dominant racial scripts." Current historiographies of influenza in the United States do not racialize the disease, in sharp contrast to studies involving tuberculosis or even the plague. While influenza was not ascribed to one group of people, the treatment of influenza as well as the care people sought and received; occurred within the racial landscape or "scripts" that inform the history of Los Angeles and southern California.[94] Previous outbreaks of the flu however, evoked racial and class propensities. For example, city doctors and public health officials claimed that lobar pneumonia, a result of the grippe epidemic in 1916, appeared especially "prevalent among colored people than among white persons- mortality higher among males than among females."[95] Health officials also emphasized that this disease did not seem especially harmful to children or the elderly; but rather men of a healthful age. Public health officials prior to and after the pandemic took note on the disproportionate affect of the disease following the "racial script."

A 1920, health report noted the prevalence and persistence of influenza in Los Angeles despite the fact that the largest waves of the pandemic had already passed. Health officers noted, "this disease continued to exist in the city, diminished in numbers and milder in form than when it first appeared in the Fall of 1919. After January 1st, 1920, a marked recrudescence occurred,

[93] See also Natalia Molina, *How Race is Made in America: Immigration, Citizenship, and the Historical Power of Racial Scripts* (Berkeley: University of California Press, 2014), 6-7.

[94] International historians such as the work of Matthew Heaton and Toyin Falola do account for the racial disparities of influenza. They implicate colonization as a main factor in the higher death rates of Africans versus their European counterparts. See Matthew Heaton and Toyin Falola, "Global Explanations versus Local Interpretations: The Historiography of the Influenza Pandemic of 1918-19 in Africa," *History in Africa* 33 (January 1, 2006): 205-230. African historians Heaton and Falola raise the need to bridge the gap between two trends of the historiography: isolating influenza as a localized and isolated phenomenon or an overarching cross-regional or global comparisons without examining the local dimensions of the disease. See also Geoffrey Rice, *Black November: The 1918 Influenza Epidemic in New Zealand* (Wellington, N.Z: Allen & Unwin, 1988). Rice offers a social history of the pandemic in New Zealand and its affect to the Anglo and Maori population.

[95] Los Angeles City Health Department, *Monthly Bulletin*, published under Luther M. Powers, ed. Arthur J. Messier. Vol. 4 November 1917, No. 12. "October Health Report" (page 2). The original contains this quote in bold and offset from the rest of the script.

and for a time we feared that we would have a recurrence of a severe epidemic, because many new residents had located in the city, and a large number of the population had escaped the disease in the previous epidemic."[96] The health officer made a connection between migration and persistence

The relational racial hierarchy better explains influenza and its relation to tuberculosis in southern California when we look at the long-range impact, outside of the pandemic in 1918.[97] Southern California emerged as the preeminent destination for those seeking wellness and "once billed itself as a health resort, especially for people with "lung troubles.""[98] Tuberculosis seemed especially ubiquitous in the land of salubrious sunshine. While boosters promised better health to easterners, there existed an enormous gap between wealthy health seekers and those who did not get well. While boosters encouraged wealthier health patrons, they proved intolerant to other classes of people seeking the same health retreat. There emerged a tension and hostility between the health seekers and immigrants, the latter whom public health and city officials condemned as parasites on city coffers. Public health officials worked alongside border control to surveil first "white, single men labeled "tramps" during the 1890s and early 1900s."[99] At the beginning of the twentieth century, nativist sentiments drove state and city health officials to bar entry to possibly sick Mexican migrants and then by the 1930s to expel them through deportation and repatriation drives. "Migrants with TB who applied for financial assistance or medical care received only train fare out of the metropolis."[100]

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[96] Los Angeles City Health Department, *Weekly Reports*, June 30, 1920, 3-4.
[97] See also Tomás Almaguer, *Racial Fault Lines: The Historical Origins of White Supremacy in California*. (Berkeley: University of California Press, 1994). Almaguer theorizes that there was a creation of racial and ethnic hierarchy that cut across class lines in the development of California's history
[98] Emily K. Abel, *Tuberculosis and the Politics of Exclusion: A History of Public Health and Migration to Los Angeles* (New Brunswick, NJ: Rutgers University Press, 2007), 1.
[99] Abel, 2.
[100] Abel, 4.

Andrew Noymer's compelling study of the mortality of tuberculosis patients notes the relationship of these two diseases; making the total numbers or mortality attributed to influenza throughout the United States much higher than previously noted. He argues that influenza actually reduced the number of tubercular patients in the twentieth century.[101] This seems especially relevant to Southern California because of newcomers who migrated to Los Angeles for treatment. Despite the end of the pandemic across the globe, there occurred over 9,000 cases of influenza with a death toll of 239 in Los Angeles alone according to the 1920 health report.

The various dictates, ordinances, sanctions, and reports were filled with contradictions. While municipalities warned individuals of public gatherings, they also recognized that the responsibility of care fell primarily on individuals and on the communities themselves. Yet, in this acknowledgment that family members needed to take care of loved ones, sanctions continued to warn people not congregate in specific areas. Furthermore, the state of California issued warnings. In a special session of the California State Board of Health, state public health officers declared that "discourage unnecessary public gatherings, especially in small and rural communities, and see that all forms of social intercourse is restricted to the absolute minimum."[102] Enforcement, of course, depended upon the availability of personnel to ensure compliance.

There were few physicians to attend to all those who fell ill and not enough officials to enforce the labyrinth of health and city codes during the pandemic. Instead, families dealt with the pandemic as best as they could. The oral history of Antonia Moñatones reveals the desperate measures to understand and cope with the sickness of her sisters and brother when they

[101] Noymer's contemporary research indicates there is need for further research that pairs influenza and tuberculosis as a continuum of disease treatment, especially to update the accounts of influenza related deaths, especially relevant in southern California. Andrew Noymer and Michel Garenne, "The 1918 Influenza Epidemic's Effects on Sex Differentials in Mortality in the United States," *Population and Development* Review, 26, no. 3 (September 2000).
[102] California State Board of Health, *Special Meeting in Annual Reports* (Sacramento, January 30, 1920), 529.

contracted tuberculosis in Los Angeles.[103] In an interview at her Monterey Park (a suburb approximately ten miles east of Los Angeles city), she narrated her experience with the pandemic and tuberculosis. Her family migrated to Los Angeles from from Lerdo, Mexico because they were fleeing from the Mexican Revolution. Her father first worked as a railhand, as an agricultural worker, and foreman for the Diamond Coal Company before earning enough money to open his own business as a candy maker; creating Mexican confections at La Victoria Dulcería, a factory he owned. Her father cared for her younger sister through a mixture of private doctors and public tuberculosis clinics but she succumbed to the illness in 1920. When her brother also contracted tuberculosis and needed to go to Olive View (a tubercular hospital), they had to sign over their home in order to pay for his treatment. She stated,

> "I know that a lot of times when a person has TB, they just take him to the hospital because he is spreading the disease around. This is what they have the hospitals for, for all the TB people. I don't know whether it's still the same, but like I say, they made us sign a lien to have my brother sent up there. Of course they told us that it was foolish of us to do this, but we knew nothing at the time… So when my brother was in the hospital he thought that all this would eat up our savings – that we wouldn't have anything left when we even sold it, that we'd be paying the County for all this. So he was worrying about our losing our property. He didn't want to say too long in the hospital because of this."[104]

Antonia's father and family made a good living from the candy factory; yet, despite having done well financially, the cost of caring for his child proved more than he could bear financially. Her father had to sell their property to pay back the county.

Perhaps, the closeness of Antonia's sister's death to that of the pandemic suggests the relationship of tuberculosis and influenza. As noted in Noymer's study, tubercular patients appeared especially vulnerable to influenza during the pandemic and continued to be susceptible

[103] Antonia Muñatones, interview by Christine Valenciana, March 24, 1972, Mexican American Community History Project, California State University, Fullerton.
[104] Ibid., 9-10.

to other pulmonary infections after its passing. In its wake, families, such as the Moñatones, cared for their sick in face of threats of possible deportation. Antonia's oral history seemed to suggest that many families around her were repatriated. According to Antonia, "Those people were having a hard time, because there were mostly poor people in the area. They probably were on some kind of welfare at the time or not. But I suppose that they had some kind of help from the County, I don't really know." Her oral history suggests that any reliance on the County for aid meant undue attention by the state.[105] Her father was "too proud" to ask for assistance, and instead relied on his own hard work to care for his sick children. In doing so, they themselves suffered long-term financial instability and emotional tolls long after the passing of the influenza pandemic.

""We tried our best": Health and Wellness in Los Angeles"[106]

Individual experiences and memories during and after the pandemic centered on issues of wellness and care rather than public health and city ordinances, decrees, and restrictions. Like Antonia Moñatones' oral history of the pandemic, Clarence Nishizu's recollections centered on the aid of a family friend, Mr. Goya. Described by Clarence as the family's guardian during the crisis, Goya came "to our rescue at the risk of his own exposure." Even as Clarence's mother warned him against visiting, Mr. Goya "utterly refused to go" and continued to nurse the Nishizus back to health. An elderly man, Mr. Goya belonged to the Kasuya Gun Jin Kai, an organization created by Issei who migrated from the same area of Fukuoka, Japan as the Nishizu

[105] Francisco E. Balderrama and Raymond Rodriguez, *Decade of Betrayal: Mexican Repatriation in the 1930s, revised* (Albuquerque: University of New Mexico Press, 2006). See also George J. Sanchez, *Becoming Mexican America: Ethnicity, Culture, and Identity in Chicano Los Angeles, 1900-1945* (New York: Oxford University Press, 1993) and David G. Gutiérrez, *Walls and Mirrors: Mexican Americans, Mexican immigrants, and the Politics of Ethnicities* (Berkeley: University of California Press, 1995).

[106] Dorothy Deming, 1309. This quote centers the heart of this section, which is the caring of nurse practitioners and ordinary people during the pandemic. Deming and doctors she worked with recognized the inefficacies of medicine in coping with the pandemic. Rather than medical solutions, nurses like her tried to ameliorate the affects of the disease by nursing the sick back to health.

family. Indeed, Clarence likened his altruism to that of Father Damien but also revealed he also loved to tell "funny, sexy stories." [107] A farmer in Watts, Mr. Goya did more than tell jokes, he risked his health to take care of the Nishizu family and perhaps others in nearby areas who had migrated from the same region. Against the family's cautions and public health sanctions, he drove an old Model T forty miles, often on unpaved roads, to the Nishizu farm in Garden Grove to deliver care and provisions.[108]

Mr. Goya defied public health agencies that warned him to "avoid coughing, sneezing, or sniffling persons."[109] By making the trek from Los Angeles to Garden Grove, he defined the terms by which he dealt with illness, unbound by geographic barriers or official mandates.[110] That Mr. Goya risked his health and ignored city sanctions raises questions about how communities of color dealt with the influenza pandemic and health in the interwar period.[111] In doing so, Goya navigated through "racial borderhoods" of belonging and exclusion in the southern California landscape: a literal and figurative map of segregation.[112]

James (Jim) Goto narrates his experience with the pandemic and later medical career. Clarence's neighbors, the Goto family also fell ill. Jim Goto was also the only person in his

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[107] Father Damien was a Catholic priest that worked among lepers in Hawaii on the island of Molokai. In the traditional rendering of the story, Father Damien also risked his life to live and work among the sick. Most biographies of Father Damien still render this person as near mythical and saintly. See Richard Stewart, *Leper Priest of Moloka'i: The Father Damien Story* (Honolulu: University of Hawaii Press, 2000).

[108] Clarence Nishizhu interview. And *LAT* Oct 11, 1918.

[109] L.L. Lumsden, *Public Health Reports*: 1731.

[110] Vicki L. Ruíz, *From Out of the Shadows: Mexican Women in Twentieth Century America* (New York: Oxford University Press, 1998). Chicana historian Vicki L. Ruíz noted the importance of mutual assistance especially in coping with the pandemic. Ruíz recounts the oral history of Eusebia Vásquez who recalled her father's assistance to sick neighbors in 1918. Eusebia Vásquez's oral history, though in Chicago, demonstrates the importance of networks and family care. Distance aside, Ruíz's history is one of the few that mentions the community care and its importance during the Influenza Pandemic.

[111] I end the story of the narrative of public health and healthcare in the 1940s because of the development of penicillin. The discovery of penicillin changes the scope of medicine. Not only does the relationship between doctors and patients change after the war but also the rise of drug companies as an actor in public health, medicine, and healthcare altered many relationships. See Charles Rosen, *The History of Public Health* (Baltimore: The Johns Hopkins University Press, 1993).

[112] Albert M. Camarillo, "Navigating Segregated Life in America's Racial Borderhoods, 1910s – 1950s," *The Journal of American History* 100, no. 3, December 2013: 646.

family who did not catch the flu. The son of sugar beet and chile farmers in Garden Grove, Jim shared his memories with Clarence at a banquet several decades later. Like his friend Clarence, he assumed all the family chores on the farm while everyone recovered though he was only eight years old. Years later, perhaps affected by his experience during the pandemic or perhaps because of the shortage of Japanese American doctors, Jim Goto attended medical school. Jim Goto graduated from the University of California, Los Angeles in 1929 and graduated first in his class at the University of Southern California's medical school in 1932. World War II interrupted his studies when he was interned with over 110,000 Japanese 1942.[113] Jim Goto stayed in the camps until the war's end in 1945. Dr. Goto joined other Japanese doctors upon their return to California to help reorganize and open the Japanese Hospital in Boyle Heights.[114] He later became the chief surgeon at Los Angeles General Hospital and developed a practice in Honda Plaza in Little Tokyo near downtown.

Like other Americans, Clarence and Jim experienced a shortage of medical attention. It was difficult enough to find enough doctors to care for the sick in metropolitan areas, never mind the resources needed to provide for people in rural communities. There emerged the "widespread perception that immigrants threatened the health of the nation in both a real and metaphorical

[113] U.S., Final Accountability Rosters of Evacuees at Relocation Centers, 1942-1946. Records of the War Relocation Authority, RG 210. His name is listed on the rosters along with his wife in Manzanar. Roger Daniels, *Concentration Camps USA: Japanese Americans and World War II* (New York: Holt, Rinehart and Winston, 1972); Stephen Fugita, *Altered Lives, Enduring Community: Japanese Americans remember their World War II Incarceration* (Seattle: University of Washington Press, 2004); Jeanne Wakatsuki Houston, *Farewell to Manzanar: a true story of Japanese American experience during and after the World War II Internment* (Boston: Houghton Mifflin, 1973); Daisuke Kitagawa, *Issei and Nisei: The Internment Years* (New York: Seabury Press, 1974); Gary Okihiro, *Encyclopedia of Japanese American Internment* (Santa Barbara: Greenwood, 2013); Ronald Takaki, *Strangers from a Different Shore* (New York: Little, Brown, 1989); Ronald Takaki, *A Different Mirror: A History of Multicultural America* (New York: Little, Brown, 1993).

[114] Harry K. Honda, interview with REgenerations Oral History Project, Japanese American National Museum, Los Angeles, 2000. According to Mr. Honda's interview, many Japanese Americans were reluctant to return to Los Angeles. However, of the Nissei doctors that returned were Dr. James Goto and Dr. Masako Kusayanagi. The Issei doctors that returned were Dr. Kikuwo Tashiro, Dr. D. Kuroiwa, Dr. Ichioka, Dr. Paul Ito, Dr. M. Murase, Dr. Isami Sekiyama, and Dr. Kyoichi Isawa. This generational cooperation was needed to service the Japanese Americans along with having the necessary English skills to maneuver administrative processes involved with organizing a community hospital.

sense" it remains unclear if the Japanese could utilize the services in either Los Angeles or Orange County.[115]

Public health agencies were not the sole purveyors of health in southern California. Because Japanese Americans, like other communities of color, needed reliable, trustworthy doctors to treat their sick. Issei and Nisei doctors opened their own hospital as well as established their own community of health practitioners of doctors, nurses, and midwives. The next chapter reveals the work of doctors such as Jim Goto, who transformed the landscape of medicine in southern California by establishing their own institutions. Navigating through arbitrary applications of professional laws that governed the licensing of doctors and state laws for the incorporation of community spaces such as the Japanese Hospital, Japanese Americans cut across public health and medicine to establish their own avenues for providing health and wellness to their community. In doings so, they provided a different benchmark for "care" within communities of color.

[115] Molina, *How Race is Made in America*, 4.

CHAPTER TWO

The Right to Practice: Japanese Doctors and the Quest for Professionalization

Sensational headlines claimed, "influenza has been more fatal to the foreign-born population than to native Californians" but with the caveat that "the death rate among the Chinese and Japanese has remained about normal." All communities struggled with the lack of access to proper care.[1] Historian Alfred Crosby asserted that this claim of "normal" death rates were "a patent impossibility. The flu and pneumonia deaths of these two groups were not reported as such or, possibly, were not reported at all."[2] Envisioning care as an immediate need and long-range strategy, the Japanese American medical community in southern California took action, given the need to create medical services for Japanese Americans beyond the emergency period of the pandemic.

For example, The Los Angeles Times reported that O. Muraguchi sued Dr. M.L. Moore and Pierce Brothers and Company for $10,000 in 1910.[3] After his wife passed away, he accused the undertaker and the doctor of removing his dead wife's kidneys. According to the article, "Drs. Moore and White mutilated and dissected the body, removing the kidneys, and it is asserted that Pierce Bros. consented to the act." According to Buddhist customs, the desecration of her body caused "disgrace and severe mental and spiritual suffering and torture." While not known if he won, this case underscored cultural misunderstandings of European American practitioners.[4] The desecration represented a physical and cultural violation but in the United States at the time, "dissection was seen to be a necessary, even exemplary, part of nineteenth

[1] "Influenza Shows Drop in Cases Recorded for Day: Officials Get Fighting Grip on Epidemic Deaths Number 91; Total of 19,656 Cases Thus Far Reported in City," *San Francisco Chronicle* November 1, 1918: 9.
[2] Alfred W. Crosby, *America's Forgotten Pandemic: The Influenza of 1918*, 2nd ed. (Cambridge: Cambridge University Press, 2003), 99.
[3] "Asks Damages for Kidneys: Japanese Sues Doctors and Undertakers," *Los Angeles Times*, June 12, 1910.
[4] I was not able to locate any Los Angeles court records regarding O. Muraguchi against the undertakers or the doctors.

century Western medical practice."[5] This particular case brought out in stark relief the importance of having co-ethnic practitioners familiar with the customs and practices of the Japanese community.[6] Perhaps due to restrictions of access experienced by Japanese as patients and as doctors in various hospitals, there was not an ethnic practitioner to attend to her death and burial rites.

Japanese doctors, nurses, and midwives, however, were part of the landscape of medicine in southern California. At the turn of the century in Los Angeles, Japanese practitioners offered a network of private healthcare, albeit limited by their numbers, and at a time when mutual aid represented sometimes the only line of care. Doctors such as Dr. James Goto (chapter one), worked within the professional and legal system by applying to the state medical board for licenses to practice in California as formally recognized health professionals. Later generations of Japanese Americans, schooled and trained in the United States, did not, like their predecessors, have to apply for bilateral agreements between their medical institutions in Japan and the state medical board. Instead, they negotiated a different set of racial politics as American born Japanese.

Japanese doctors needed their own hospitals to care for their sick because of uneven policies that at times denied them access to white hospitals. Interestingly, their inability to access to white hospitals complicated the ways social theorists have understood notions of power within the clinic. While theoreticians such as Foucault depicted the clinic as a site of state power, Japanese doctors negotiated this space as an alternative to state power and discourses about bodies of color. Japanese doctors complicate this notion because their access and relationship to

[5] David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley: University of California Press, 1993), 5.
[6] The original article stated Muraguchi was originally under the care of Dr. Furusawa. The only Dr. Furusawa noted in the California State Archives obtained his license in 1917. See Appendix A.

power was uneven. This differing levels of access happened on a case-by-case basis. For example, Dr. James Hara, an Issei doctor in the Los Angeles region, had access to White Memorial Hospital because he was an Adventist. In contrast, his non-Adventist contemporaries, such as Kikuwo Tashiro were refused access to surgical units there. As ethnic healthcare professionals, Japanese practitioners faced myriad obstacles to practice medicine entrée to white spaces proved inconsistent, at best.

Dominating the medical profession, Anglos doctors that set the standards for entry, with the American Medical Association as primary gatekeepers for their profession.[7] At its inception, the AMA, as a voluntary professional organization, staked its claims through black subordination. Historian Douglas Haynes writes, "racial discourses of difference and practices of exclusion have simultaneously privileged whiteness and marginalized blackness and perpetuated this dichotomy within and without professional cultures as normal…As in the case of blacks, gendered discourses about expertise together with sexist practices of female exclusion, helped fashion the very image of the modern professional as white and *male*."[8] Given rural and ethnic stratification, a Japanese physician stood at the apex of his community with the first Issei doctors in Los Angeles served as community leaders. Early pioneers established the Los Angeles Japanese Council in 1905, and among the council's permanent members were three Japanese physicians. The included Ikeuchi Kiyomitsu who established a clinic at 204 South Main Street along with Tanaka Jyuhei and Ito Takejiro who started medical practices in Little Tokyo. Regarded as the "life of the community," a year later, they formed the Association of Japanese

[7] George Rosen, *A History of Public Health* (Baltimore: Johns Hopkins University Press, 1993); John Duff, *The Sanitarians: A History of American Public Health* (Chicago: University of Illinois Press, 1992). A notable exception to the profession of medicine is Doctor Margaret Chung, "Mom Chung," a Chinese-American physician who defied race, gender, and sexuality. See Judy Wu, *Doctor Mom Chung and the Fair-Haired Bastards: The Life of a Wartime Celebrity* (Berkeley: University of California Press, 2005); Douglas M. Haynes, "Policing the Social Boundaries of the American Medical Association, 1847-70," *Journal of the History of Medicine and Allied Sciences* 60, no. 2 (April 2005): 170-195.

[8] Haynes, "Social Boundaries of the AMA,"172-173.

Physicians in Los Angeles.[9] At the time, the Los Angeles Japanese population stood close to 5,000. According to southern Californian George Abe,

> manual labor was about the only thing that was open for us, the Japanese Americans and other minorities. Working in a produce store, a wholesale market, or on a farm, they were about the only things that were open to us. So, unless you had a great vision, schooling didn't mean anything. Why go to school when you see people with degrees—bachelor's degrees, master's degrees—doing menial labor? The only degree that helped at that time was an MD. Now if you were an MD, you had to start your own little practice even then. You didn't work with anybody. I never knew of a (Japanese American) MD in a hospital; they all just had little offices on their own.[10]

In describing the challenges that most Japanese faced in the labor market, working as doctors accorded prestige even with limitations to their professional independence.[11] Abe's observation that he had no knowledge of Japanese doctors working in hospitals seems an accurate assessment and motivated them to create the Japanese Hospital.

Importantly, some white doctors did treat Japanese Americans with care and concern.[12] In Garden Grove, Reverend Kenji Kakuchi recalls a kindly German doctor, Dr. Charles Connley

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[9] Its membership comprised of Ikeuchi Kiyomitsu, Ito Takejiro, Nishikata Tomozo, and Tanaka Jyuhei. See Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 37-38. Tanaka Jyuhei, according to historian Susan Smith, established the Southern California Japanese Hospital on Turner Street.

[10] George Jiro Abe Oral History 1763, interview by Martha Bode, February 20, 1984, Nisei Experience in Orange County, California, California Oral History Project, California State University, Fullerton. According to George Abe, his father was one of the founders and original developers of Los Angeles' City Market on San Pedro Street, a popular center for produce and commerce. With his help, his eldest brother Frank attended medical school until he had to drop out due to the Depression.

[11] Kazuo Kawai, "All Roads, and None Easy: American-Born Japanese Looks at Life" 1926-1927 Conference file. Includes correspondence, proceedings, and related materials. Ninth Conference on the California-Japanese problem, San Francisco, California, 1922 October 11, Survey of Race Relations record, Box 4-3, Hoover Institution Archives. Kawai examines of the labor stratification of American born Japanese in the United States. For example, one of the people he examines is an anonymous American born Japanese that graduated with an engineering degree. He states, "this one Japanese, simply because of his race, could not get a position. He had drifted to Los Angeles, still seeking work, and the last I hear of him was that he had finally secured a minor position in a little third-rate electrical shop in Honolulu, which offered practically no chance for advancement," 164.

[12] According to the Japanese biographer who documented Dr. Tashiro Kikuwo's life, there were several more that had received medical training but did not pass their licensing degrees and therefore could not practice medicine. See Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 38.

Violette who cared for the sick and delivered babies at minimum or no charge.[13] Because he seemed to genuinely care for the Japanese in Garden Grove, he "gained the trust and respect of the people in the community." The Reverend could not recall of any Japanese doctors in Orange County but related how others who wanted a Japanese doctor traveled to Long Beach or Los Angeles to seek care. By 1915, there were seven Japanese physicians available: Tanaka Jyuhei, Ikeuchi Kiyomitsu, Karaki Yasuzo, Iseri Kaoru, Miyata Yuhiro, Ito Takejiro, and Nakagi Kiyohide.

Maki Kanno, a woman who migrated to Orange County to join her husband to farm leased land in Fountain Valley, recalls that for the birth of her children, she received help from a local white doctor.[14] Aided by lamplight, the doctor delivered her children at home, in the middle of the night. Knowing no English, she relied on her husband as a translator to get through labor. Trained as a midwife's assistant in Japan, she stated that she knew what to do even without the doctor's help and was not afraid. She recalled, "Not many doctors liked to come to Japanese communities, but this doctor (Dr. Jesse Burlew) was an exception. Now, of course, the Japanese don't have any problems, since there are Japanese hospitals and doctors." Mrs. Kanno's later rosy assessment of access to healthcare belies the ordeal faced by many Japanese in securing quality care in southern California and the experience of Japanese doctors. In fact, Maki Kanno did not seem to have specific recollections of her experiences with doctors. Because they lived in a rural area with little access to the outside world, she stated, "When there was some illness in the family, they used the telephone at the landowner's… She didn't go to the doctor too often."

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[13] Kenji Kakuchi Oral History 1758, interview by Arthur A. Hansen, August 26, 1981, Honorable Stephen K. Tamura Orange County Japanese American Oral History Project, California Oral History Project, California State University, Fullerton. Reverend Kakuchi immigrated to the United States in 1924 and did not remember services readily available for the Japanese community.

[14] Maki Kanno Oral History 1761, interview by Toni Rimei and Masako Hanada, November 30, 1983, Honorable Stephen K. Tamura Orange County Japanese American Oral History Project, California Oral History Project, California State University, Fullerton.

Care was a two-pronged intervention. First, Japanese doctors, nurses, and midwives had to fight for professional recognition.[15] For practitioners who received their licenses from Japan, they had to establish the validity of their degrees. For second generation Japanese Americans, they had to contend with a difficult racial environment that restricted their admissions to medical school, internships, and residencies. Secondly, as ethnic medical professionals, they mediated between their communities and the state to create a space in which to practice their healing arts. Mary Akita, an Issei nurse, turned her home into a maternity hospital in the 1910s.[16] Some years later, the maternity hospital would be converted into the makeshift Southern California Japanese Hospital (Nanka Nihojin Byoin) as a response to the influenza pandemic.[17] According to Japanese historian Hasegawa Shin, "when an influenza epidemic hit the Los Angeles area, the Japanese community was faced with an acute crisis situation since its members were not accepted as patients by the hospitals serving primarily the white population."[18] With the help of Dr. Jyuhei Tanaka, this facility, also known as the Turner Street Hospital, served the community during the pandemic and remained open until 1935 when it merged with the Japanese Hospital on Fickett Street in Boyle Heights. This makeshift hospital occupied a liminal position of legal medical practice and illegal space because it remains unclear whether or not the State Medical Board or the California Secretary of State approved the creation of the original maternity hospital.[19] What does the history of the Japanese Hospital reveal about race and the medical

[15] Naomi Hirahara and Gwenn Jensen, *Silent Scars of Healing Hands: Oral Histories of Japanese American Doctors in World War II Detention Camps* (Fullerton: Center for Oral and Public History, California State University, 2004).
[16] Susan L. Smith, *Japanese American Midwives: Culture, Community, and Health Politics, 1880-1950* (Chicago: University of Illinois Press, 2005), 89.
[17] This chapter will later document the conflicting stories and evidence about the establishment of these hospitals.
[18] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 38-40.
[19] Smith, *Japanese American Midwives*, 88-89. Smith cites there were actually two Japanese hospitals. One was began by Issei nurse, Mary Akita in her home and expanded into the Southern California Japanese Hospital by Dr. Jyuhei Tanaka and a second hospital formally organized under Dr. Kikuwo Tashiro on Fickett Street. It was not until

practice in the United States? How did the state of California respond to the growth of Japanese healthcare practitioners?[20]

Attempts to open up a hospital challenged federal and state restrictions, as California Secretary of State Frank C. Jordon threw obstacles in their path.[21] Jordon gridlocked the doctors' attempts under the guise of the Alien Land Laws. Because the Japanese were "aliens ineligible for citizenship," he claimed that restrictions of land use extended to corporations, stalling the incorporation of the Japanese Hospital and extending to the city, the same prohibitive measures of land ownership placed on Japanese farmers. The creation of the Japanese Hospital and the multiple networks doctors navigated to practice medicine forms the heart of this chapter. Again, the racial politics of healthcare and wellness forms a pivotal axis of care within the medical geography of southern California.

The Landscape of Care

The history of Japanese physicians begins with the migration of Japanese in the United States at the end of the nineteenth century. Unlike the first migration of Asian Americans, the Chinese, who were predominantly laborers either during the Gold Rush or western railroads, Japanese migration represented a mixture of professionals and laborers into Hawaii and the West Coast after the 1868 Meiji Restoration in Japan.[22] While many Japanese men came to the United

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1935 that the two merged into one. See also Troy Tashiro Kaji, "City View Hospital and the Japanese Hospitals of California," discovernikkei.org, June 10, 2010, http://www.discovernikkei.org/en/journal/2010/6/25/3471/.

[20] Douglas M. Haynes asks a similar question about the role of "peripheral" medicine to the growth of national medicine. His study of Patrick Manson, the scientist important for documenting mosquitoes as the vector for malaria, documents the study of medicine as not a national endeavor but one that relied on the empire. See Douglas M. Haynes, *Imperial Medicine: Patrick Manson and the Conquest of Tropical Disease* (Philadelphia: University of Pennsylvania Press, 2001), 2. Rather than peripheral to the growth of medicine, Japanese doctors were instrumental to the medical geography on a personal, state, and federal level.

[21] Frank C. Jordon served as California's State Secretary from 1911-1940.

[22] Ronald Takaki, *Strangers from a Different Shore: A History of Asian Americans* (Boston: Little, Brown and Company, 1989); Ronald Takaki, *A Different Mirror* (New York: Back Bay Books, 2008); Gary Okihiro, *Margins and Mainstreams: Asians in American History and Culture* (Seattle: University of Washington Press, 2014); Roger Daniels, *The Politics of Prejudice: The Anti-Japanese Movement in California and the Struggle for Japanese Exclusion* (Berkeley, University of California Press, 1962); Paul Spickard, *Japanese Americans: The Formation and*

State as workers in the sugar cane fields of Hawaii or on western farms, some also migrated as university students, professionals, and adventurers.[23]

Los Angeles City/County Japanese Population				
Year	City	Total City Pop	County	Total County Pop.
1900	150	102,479	204	170,298
1910	4,238	319,198	8,461	504,131
1920	11,618	576,673	19,911	936,455
1930	21,081	1,238,048	35,390	2,208,492
1940	23,321	1,504,277	36,866	2,785,543

Table 2.1 Japanese Population in Los Angeles City and County, 1900 – 1940[24]

The career of Dr. Kyoske Uyeda's story illustrates these patterns of overlapping migration. Christened as "George" by the American family that employed him as a cook and servant in Los Angeles, Uyeda saved his money to attend the University of Chicago. Within ten years, he received his education through correspondence and applied to work with the Japanese government to visit countries where Japanese students attended colleges.[25] The migration of Japanese resulted from changing geopolitical alignments in the Pacific as Japan modernized during the Meiji Period (1868-1912). In the quest for empire and modernity, Japan encouraged western learning especially in the sciences.[26] Japanese doctors trained in Japan were educated in western scientific methods, especially through the German models of education. As a result, the

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Transformations of an Ethnic Group (New York: Twayne, 1996). See also Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 2, 1.

[23] Moon-Ho Jung, *Coolies and Cane: Race, Labor, and Sugar in the Age of Emancipation* (Baltimore, Johns Hopkins University Press, 2006). See also "Japanese in Hawaii Pack," *Los Angeles Times*, March 13, 1907. The article details the needs for Japanese doctors by Japanese laborers in sugar plantations. The article states there are, "only six practicing physicians in this city, where there are nearly 30,000 Japanese. The native Hawaiians often employ the Japanese doctors, because their fees are lower than those of the white doctors."

[24] Table reproduced from Natalia Molina, *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939* (Berkeley: University of California Press, 2006), 7.

[25] "Uyeda Now Censors All: Used to be Cook for Family in Los Angeles," *Los Angeles Times*, June 12, 1904.

[26] Ardath W. Burks, ed., *The Modernizers: Overseas Students, Foreign Employees and Meiji Japan* (Boulder: Westview Press, 1985). In 1885, Japan reversed its previous emigration policies and encouraged migration to also alleviate the economic and population problems. The Japanese government allowed the migration of students and professionals to western nations such as the United States, Germany, and the United Kingdom to obtain professional experience and education. The Japanese government also encouraged the education of women in the sciences. Women were trained as *sanba*, or modern, licensed midwives. See Susan L. Smith, *Japanese American Midwives: Culture, Community, and Health Politics, 1880-1950* (Urbana and Chicago: University of Illinois Press, 2005).

first Japanese doctor licensed in California, Tey Watanabe, appears in the state archives as early as 1888.[27]

Despite, anti-Asian immigrant sentiment in the West Coast as well as throughout the United States, most Japanese migrated into the United States between 1890 and 1924.[28] Japanese Americans migrated after the passage of the Chinese Exclusion Act in 1882.[29] By 1907, The Gentleman's Agreement restricted the emigration of Japanese laborers. Much like the Chinese Exclusion Act, this legislation created a two-tiered system for entry that resulted in the restriction of Japanese laborers to America even as it allowed entry of Japanese professionals as well as women migrating as picture brides to the United States.[30] By 1913, California passed the Alien Land Law that banned ownership of agricultural land by Japanese and by 1922, they were banned as persons ineligible for citizenship.[31] Japanese immigration to the United States steadily increased despite regulations until the passage of the 1924 National Origins Act or Johnson-Reed Act, which further barred Japanese immigration and "cast Japanese and Asian Indians with Chinese as unassimilable aliens and helped constitute the racial category "Asian.""[32] Amidst a

[27] See Appendix A. I have compiled a list of all Japanese doctors licensed by the State of California until 1941. Register of Physicians and Surgeons of the State of California 1876-1967, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760: Series 13, Boxes 91 and 103-143, California State Archives, Office of the Secretary of State, Sacramento, California. I end with this period because World War II changes the landscape of medicine in the United States and in California. This list is a compilation of my own work along with the work of Dr. Troy Tashiro Kaji. In contrast to this particular archival information, the work of Hasegawa Shin cites the first Japanese doctor practicing in Los Angeles was Ikeuchi Kiyomitsu in 1901. See Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 37.

[28] Valerie J. Matsumoto, *Farming the Home Place: A Japanese Community in California, 1919-1982* (New York, Cornell University Press, 1993), 2-3. Most Japanese residents at the turn of the century were Issei (first generation). The Gentlemen's Agreement in 1908 eliminated laborers from entering the United States but allowed for the entry of family members. The 1920s witnessed an increase in women and according to Matsumoto, "with the arrival of women, Japanese American communities- and the population of second-generation youth- grew faster than those of other early Asian immigrants groups in the West Coast." See also Roger Daniels, *Asian America: The Chinese and the Japanese in the United States since 1850* (Seattle: University of Washington Press, 1988).

[29] Sucheng Chan, *Entry Denied: Exclusion and the Chinese Community in America, 1882-1943* (Philadelphia: Temple University Press, 1991).

[30] Mae M. Ngai, *Impossible Subjects: Illegal Aliens and the Making of Modern America* (New Jersey: Princeton University Press, 2014).

[31] See *Takao Ozawa v. United States*, 160 U.D. 178 (1922).

[32] Ngai, *Impossible Subjects*, 38.

climate of restrictive immigration policies, the Japanese American population grew and with it, medical professionals who would serve their community.[33]

As noted in the previous chapter, healthcare among Asians in southern California often involved only mutual assistance among friends, neighbors, and loved ones.[34] For example, when Japanese women had children in the United States, they relied on Japanese midwives or older women in the community. Clarence Nishizu recalled, "from 1918 to the mid-twenties, many Japanese mothers went to Los Angeles to have babies delivered by a midwife. In later years, the local doctors seemed to take over."[35] A midwife delivered all the children in his family. Despite the fact that California limited the issuing of professional certificates to Japanese midwives or that many in rural areas did not acquire professional licenses, many still practiced. Instead of formal centers or clinics, they traveled to the aid of neighboring women, especially in rural areas.[36]

There even occurred instances of cross-cultural aid. For example, Kimi Yamaguchi delivered Mexican and Japanese babies in her community, many of her neighbors could pay little for Yamaguchi's services if anything at all. Instead, she often received gifts of homemade

[33] Sucheng Chan, *Entry Denied: Exclusion and the Chinese Community in America, 1882-1943* (Philadelphia: Temple University Press, 1991). Despite immigration policies that banned entry, the Chinese were able to continue migration into the United States through various channels and loopholes. Similarly, the Japanese were able to continue to migrate into the United States despite the 1924 Johnson-Reed Act. See also Roger Daniels, *Guarding the Golden Door: American Immigration Policy and Immigrants since 1882* (New York: Hill and Wang, 2004); Rogers Daniels, *The Politics of Prejudice: The Anti-Japanese Movement in California and the Struggle for Japanese Exclusion* (Berkeley: University of California Press, 1962).

[34] Fumiko Fukuoka, "Mutual Life and Aid Among the Japanese in Southern California with Special Reference to Los Angeles," (MA thesis, University of Southern California, 1937).

[35] Clarence Iwao Nishizu, interview by Arthur A. Hansen, June 14, 1982, Honorable Stephen K. Tamura Orange County Japanese American Oral History Project, California Oral History Project, California State University, Fullerton.

[36] Susan L. Smith, *Japanese American Midwives*, 42. See Julie Harmon, "Statutory Regulations of Midwives: A Study of California Law," *William & Mary Journal of Women and the Law* 8, issue 6 (2001): 115-132. These certificates were effectively licenses to practice medicine, surgery, podiatry, and midwifery in the state of California. See also Jennifer Lisa Koslow, *Cultivating Health: Los Angeles Women and Public Health Reform* (New Brunswick: Rutgers University Press, 2009): 104-131.

tortillas and beans.[37] While midwifery played a subordinate professional role in medicine, Japanese midwives were instrumental in the care of women in Los Angeles as a form of mutual aid. Until a change in California statutes in 1949 that prohibited the issuing of certificates of practice to midwives, a requirement to practice midwifery in the state, Japanese midwives obtained certificates of professional parity in California. While midwifery played a subordinate professional role in medicine, Japanese midwives were instrumental in the care of Japanese women in Los Angeles. Historian Susan Smith noted that in the United States, midwives delivered half of all babies in 1910. By 1930, this number was reduced to fifteen percent. Eighty percent of midwives in the 1930s were African Americans (many practicing in the south) and the remaining twenty percent were from the West. Of these midwives in the west, many were women of color and notably, Japanese. According to Smith, "In the first half of the twentieth century, American midwifery did not disappear – it was racialized."

Southern California Japanese did rely on a few Japanese practitioners and sympathetic whites but for more serious medical issues, they could depend on few medical clinics and hospitals that allowed them entry in the early part of the twentieth century. There were notable exceptions, as religious charities throughout southern California offered low cost healthcare. For example, historian Kristine Gunnell argues that religious organizations such as the Daughters of Charity played an instrumental role in providing hospital care, especially for indigent or poor patients, in the American West and in Los Angeles. In 1858, the Daughters of Charity "opened a separate hospital to care for the county's indigent patients."[38] The Los Angeles Infirmary, County Hospital, or Sisters' Hospital cared for indigent sick regardless of religious affiliation or their ability to pay. The hospital took in native-born Americans, Mexicans, Europeans, and a few

[37] Susan Smith, *Japanese American Midwives*, 47 and 58.
[38] Kristine Ashton Gunnell, *Daughters of Charity: Women, Religious Mission, and Hospital Care in Los Angeles, 1856-1927* (Chicago: DePaul University Vincentian Studies Institute, 2013), 32-33.

Chinese. As Japanese migrants started to arrive in California, the Sisters' Hospital also took in Japanese railroad workers.[39] At the turn of the century, Japanese patients comprised five percent of the Sisters' Hospital's medical services. At this hospital, Mexican, Chinese, and Japanese patients were cared for in wards that cost $8 a week, half the cost of private rooms. Despite the work of the Sisters of Charity, there remained limited possibilities for care. Alongside the difficulties of affordable treatment, there were no native-speaking doctors in these low cost hospitals and clinics.

Japanese doctors migrating with a respectable degree in medicine did not ensure equal standing in the United States. They had to overcome California state professional requirements and educational hurdles to allow them to practice, appealing to the California Board of Medical Examiners to recognize their education abroad, even though their education was based on either a western model of medicine.[40] Moreover, they had to take a medical examination in English. In 1917, the state of California allowed foreign language examinations in Japanese and Spanish; however, the examinations vexed the state board. State officials seemed wary of both Japanese doctors and their translators, whom they feared aided and abetted fraudulent claims of degrees from Japan and so proved reluctant to issue certificates of professional parity to Japanese doctors. Surprisingly in the earlier part of the century, demonstrating the contradictory and inconsistent positions they held about the Japanese, they issued certificates for Japanese nurses and midwives to practice without much opposition.[41] If Japanese Americans, they faced great

[39] Gunnell, *Daughters of Charity*, 154-155, 159-160, 204, 207.
[40] Ann Jannetta, *The Vaccinators: Smallpox, Medical Knowledge, and the 'Opening' of Japan* (Palo Alto: Stanford University Press, 2012); William Johnston, *The Modern Epidemic: A History of Tuberculosis in Japan* (Cambridge: Harvard University Asia Center, 1995).
[41] Natalia Molina, *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939* (Berkeley: University of California Press, 2006). Natalia Molina notes the same kind of discrepancy in her work in dealing with public health in Los Angeles. For her, public health officials in Los Angeles were concerned with the high infant mortality rates (IMR) among the Japanese and Mexican population in relation to labor. Professionals such as midwives and doctors evaded the scrutiny of local officials because they simply did not deem them "threats." While local officials did not

difficulties in navigating through the educational system in the United States in obtaining their medical degrees. Chicana historian Vicki Ruiz contends that educational segregation posed a serious blockade and "felt most keenly at the level of personal aspiration."[42] Ruiz's documentation of restrictive school boundaries experienced by Mexican American children meant that the route to personal aspiration proved a labyrinth undertaking. Japanese Americans faced similar challenges to their personal aspirations as they attempted to gain entry into medical school as caretakers of their community's health.[43] Moreover, upon finishing medical school, they faced racial restrictions in applying to hospitals where they could intern and do their residencies. These set of negotiations, by Japanese American students, shaped the contour care in southern California.

"The Nacayama Conspiracy"

Questions about professional efficacy, standing, and legitimacy were not an aberrant occurrence faced by physicians of color.[44] In 1917, perhaps because of the shortage of medical doctors due to the war, the California State Medical Board allowed foreign nationals to take the medical entrance examinations in Japanese and Spanish.[45] Ohyama Ujiro, the Japanese Consul in Los Angeles, had also appealed to the California Department of Hygiene to obtain special

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pay much heed to the professionalization of midwives, the state of California kept close tabulations of the licensing of ethnic practitioners and by 1949, the ease of certification ended with state restrictions on issuing licenses to midwives.

[42] Vicki L. Ruíz, "South by Southwest: Mexican Americans and Segregated Schooling, 1900-1950," *OAH Magazine of History* 15, no. 2 (Winter, 2001): 23-27. Ruíz, "South by Southwest," 25.

[43] For an overview of American medical schools, see Joseph Kett, *The Formation of the American Medical Profession* (Westport, CT: Greenwood Press, 1980); William Rothstein, *American Medical Schools and the Practice of Medicine: A History* (New York: Oxford University Press, 1987);

[44] Haynes, "Social Boundaries of the AMA." See also Thomas Ward, *Black Physicians in the Jim Crow South* (Fayetteville: University of Arkansas Press, 2003); Darlene Clark Hine, *Black Women in White: Racial Conflict and Cooperation in the Nursing Professor, 1890-1950* (Bloomington: University of Indiana Press, 1989).

[45] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 39. 1917 Minutes, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760:6, Series 1, California State Archives, Office of the Secretary of State, Sacramento, California: 989-991. The Board of Medical Examiners held a special meeting from June 11-13, 1917 to discuss the exact specifications of the statute. It was filled under Chapter 81, Statutes of 1917, and effective July 27, 1917. The Board did not detail the exact reasons for foreign language examinations.

consideration for Japanese doctors. Sixteen Japanese doctors took the first of these tests.[46] Shortly after allowing these examinations, problems arose.[47] The Board of Medical Examiners noted that there existed notable discrepancies between the translations. The archival records did not reveal how these discrepancies were discovered, but officials claimed there were "inaccuracies."[48] The following year, the Board of Medical examiners leveled accusations of fraud against Japanese doctors and midwives. The Board stated,

> Certain of the Japanese applicants thereafter entered into a conspiracy with the translator, Mr. Thomas Nacayama, appointed by the Board on the recommendation of the Japanese Consul, whereby Nacayama, for a specific sum of money, was to receive from the applicants in the plot of supplemental set of answers to the questions propounded to the examination. The co-conspirators had arranged to write the supplemental answers at their leisure at a time subsequent to the regular examination, after reference to text books[sic] on the subject. The supplemental answers then forwarded by the co-conspirators to Nacayama, then presumably engaged in the translating of the answers as written in the examination rooms.[49]

The State Board accused the Japanese Consul and the translators of misconduct. Despite previous assurances that using laymen would create fairness, the board faulted translators for conspiring with their countrymen for the purpose of acquiring licenses to practice. According to the Board, a special agent investigated the matter and arrested Nacayama and named six other

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[46] According to *The Los Angeles Times*, "The Japanese seem to have been the most progressive in accepting this offer from the State government." "State Board Ready to Hatch Doctors," *Los Angeles Times*, October 11, 1917. The Board of Medical Examiners cites 14, rather than the 16 applicants cited by *The Los Angeles Times*.

[47] 1918 Minutes, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760:7, Series 1, California State Archives, Office of the Secretary of State, Sacramento, California: 1098. Japanese translators could not complete the work of translating papers into English in a timely manner. The examinations were placed with the Japanese Consulate and after forty-three days, the final translations were submitted for correction in the first of the foreign language examinations.

[48] 1918 Minutes, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760:7, Series 1, California State Archives, Office of the Secretary of State, Sacramento, California: 1321-1322. As a result of these translational discrepancies, the board motioned to reject the examination of Ai Otani and motioned to pursue legal action. The board declared, "any inaccuracy in any translation is a deliberate attempt to obtain or deprive any applicant from obtaining a certificate as designated by the medical practice set, that such committee is herby empowered to instruct the legal department to take such steps as may be proper to meet the means of justice."

[49] Minutes 1919, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760:8, Series 1, California State Archives, Office of the Secretary of State, Sacramento, California: 1369-1370.

co-conspirators: Rinhei Maruki (Sacramento), Tetsu Hayashi (Berkeley), Buichi Nakahara (Los Angeles), Masao Ochisi (San Francisco), Matsua Suzuki (Vacaville), and Etsuzo Watanable (Sacramento). According to the report, this resulted in the subsequent confession by Thomas Nacayama. As further evidence of their presumed guilt, the Board detailed the unfolding of events with this scandal. Dr. Suzuki, one of the physicians accused in the case, died suddenly and Nakahara, another accomplice, committed suicide in Los Angeles.[50] The Board further sensationalized the case by stating that this resulted in a feud within the Japanese community. Nacayama served as an "informant" and he was shot at twice and required a bodyguard. As a result of this "feud" among the Japanese, the Board declared that the Japanese Consul could not provide any further competent translators. This dramatization of events by the accused and the ensuing spectacle within their own community provided fodder that reinforced their convictions about the foreign language examination and the incompetence of Japanese doctors.

Convinced of fraud, the Board stated that only white translators could give the examination solely in English. Citing the University of California's department of Oriental Languages, the Board insisted that only three such reliable translators existed in the whole of the United States because native translators were undependable at best. Beyond the "Nacayama Conspiracy," the Board condemned all foreign language applications stating,

> nor are our difficulties solely confine to the Japanese language for the applicants writing in the Spanish language in the June meeting contend that the translation was not written to their satisfaction. The Board of Medical Examiners are unanimous in their conviction that the examination written in other than the English language are impractical and strongly urge that this particular provision be stricken from the act.[51]

[50] I have found no further archival records confirming the suicide was linked to the conspiracy.
[51] Minutes 1919, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760:8, Series 1 California State Archives, Office of the Secretary of State, Sacramento, California: 1370.

The irksome question of foreign medical examinations brought to the forefront questions about how to handle foreign nationals and their bid for professional recognition at a time when anti-Asian sentiment checkered state and national debates about their belonging. After the years of debate about Asian exclusion, California's medical profession still struggled with Japanese professionals who, unlike the Chinese, had the backing of a powerful government and an active Consul. White doctors proved successful in limiting professional access but ultimately ineffective at barring Japanese claims to the American medical profession. The "Nacayama Conspiracy" proved unfounded in the federal courts in San Francisco. Thomas Nacayama was found innocent of the Board's charges of fraud.[52] However, due to the discrepancies of the examinations, they required retranslation by Ko Murai.[53] Attorney Encell, the legal consultant on the case, declared, "it lies entirely within the discretion of the Board whether they do or do not give examinations in a foreign language."[54] At the closing of the case and the Board's own verdict, the secretary, Dr. C. B. Pinkham discussed with the translator, K.O. Murai, whether or not American physicians were permitted the same foreign language examination in Japan.

K.O. Murai, the Japanese translator for the Board of Medical Examiners explained,

Honorable Secretary: -

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[52] Minutes 1919, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760:8, Series 1, California State Archives, Office of the Secretary of State, Sacramento, California: 1527, 1623, 1639. Despite the verdict of not guilty in the "Nacayama Conspiracy," there were two doctors that were still denied the ability to take a subsequent examination: Rinhei Haruki and Tetsu Hayashi. The minutes to the Board of Medical Examiners cited the case as "not guilty" by California courts. I was unable to retrieve any cases involving Nacayama. It seemed as though the "conspiracy" that the Medical Examiners used was mail fraud.

[53] Even K.O. Murai's translations were in question. In another case involving Dr. Shiba in Sacramento, the Board extensively questioned Shiba about his relationship with K.O. Murai. His licensing and practice were under question by a letter claiming the fraudulence of his education in Japan and the United States. Dr. Shiba was a translator for a practicing Anglo doctor in the Sacramento region. He took the physicians examination and passed in 1920 (see index). See Minutes 1920, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760:9, Series 1, California State Archives, Office of the Secretary of State, Sacramento, California: 1930-1935. See also Register of Physicians and Surgeons of the State of California 1876-1967, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760: Series 13, Box 122, California State Archives, Office of the Secretary of State, Sacramento, California.

[54] Minutes 1920, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760:9, Series 1, California State Archives, Office of the Secretary of State, Sacramento, California: 1726.

> "In regard to the present practice of Japanese authority in medical examination of American doctors in Japan and her territories…
>
> Many of American applicants now practicing medicine under Japanese license in Japan and other oriental countries, have obtained the license by verbal examination when they have American education and American medical license.
>
> Japanese and Chinese students studies medical sciences in American institutions, however, can not enjoy this privilege, but, instead they are subjected to usual strict examination with some questions and clinical practices with Japanese co-applicants…
>
> American doctors of medicine and as many as four at one occasion including Phillipinos[sic], … none of them were ever denied the license applied, when the worst record of Japanese own applicants in same duration was as low as nine per cent. pass…
>
> Hoping above information may have some value to your board,
>
> I remain,
>
> Yours very sincerely,
> (Signed) K.O. Murai
> Official Japanese Translator of Examination Answers.[55]

While not outright condemning the practices of California's Board of Medical Examiners, Murai equated American medical colleges as equal to Japanese education. Regardless of claims of commensurable quality in education, California's Board of Medical Examiners disregarded Murai's testimony. By June 1920, the Board banned all further foreign language examinations.

"In a hurry": Japanese Doctors and the Politics of Professionalization in California[56]

Amidst debates about the legitimacy of licensing Japanese doctors in California, some did pass the licensing exams in English. The Nacayama Conspiracy demonstrated racialized access to professionalization. The following section examines the profiles of Japanese doctors in Los Angeles in their quest for legitimacy. Each generation of doctors negotiated a different set of

[55] Minutes 1920, Dept. of Consumer Affairs - Board of Medical Examiners Records, RG F3760:9, Series 1, California State Archives, Office of the Secretary of State, Sacramento, California: 1832-1833.

[56] Yoriyuki Kikuchi, Oral History 1340, interview by Arthur A. Hansen, July 29, 1974, Honorable Stephen K. Tamura Orange County Japanese American Oral History Project, California Oral History Project, California State University, Fullerton.

challenges. Issei doctors encountered the state very early on in their attempts to acquire professional licenses despite their status as "aliens" while Nisei doctors contested racial and gender barriers to medical school, internships, and residencies. Lastly, World War II and the subsequent internment of almost 120,000 Japanese Americans leveled generational experiences. The work they did as private practitioners and community leaders were stripped away in the barracks of internment.

In 1906 Yoriyuki Kikuchi, migrated from the countryside of Kyoto to America to avoid conscription, seek an education, and support his family back home.[57] Born into a family that owned land, a successful farm, mill, and merchandise store, Kikuchi grew up in very comfortable circumstances. As a samurai family, they enjoyed a full attendant of maids and servants.[58] As the eldest son of seven, he inherited the responsibilities of the farm at sixteen because of his father's failing health. Unbeknownst to him, his father had already mortgaged most of the family's patrimony. He realized he needed to venture to the United States to make money and pay off the considerable debt that had accrued. Despite the lack of options available, Yoriyuki's father still did not support his decision to leave because he needed him to run the farm and business.

Dr. Kikuchi initially planned on attending Stanford University for electrical engineering but made his way first to southern California, working as an orange picker in Riverside. This sudden fall of status proved quite difficult given his privileged background. He states, "I never did serve other people before. You understand why. Tears came down incessantly, I couldn't serve at all, the cook did the job the first time because I couldn't stand it. In Japan I was never raised that way; I was always served and not the servant." Dr. Kikuchi saved his money first to

[57] Yoriyuki Kikuchi, Oral History 1340.
[58] Samurai were the prestigious military class of Japan. Often of the nobility, they comprised less than10% of the population and were often noted by their family name, lineage, and clan. See Brett L. Walker, *A Concise History of Japan (Cambridge Concise Histories)*, (Cambridge: Cambridge University Press, 2015).

get a business degree, because, "In a hurry, I had to. I'm hungry, very hungry. And I worked at the post office a little while and at all kinds of stores just for mere existence." His memories of hunger served a poignant reminder throughout his life.

Yoriyuki Kikuchi decided to take up dentistry because according to him, "you don't have to lie, you can practice dentistry without a lie." After his work with business associates in San Diego who practiced unsavory systems of fraud and fabrication in selling their goods, Yoriyuki felt that the practice of dentistry and medicine offered an honest way of making a living; by helping people. He then spoke to Dean Ford at USC School of Dentistry, and took an examination that very evening. He did well in his exams except in Latin and English. After spending a month studying medical Latin and English, he attended dentistry school with four other Japanese students, receiving top marks in his courses. When he graduated, he received the Ford Medal. He remembered,

> I hate to tell you this story, but at the time discrimination was so strong. Every year they give one scholarship medal and one for the best technological student, so two medals were issued. At my graduation, two Japanese were awarded the medals, and no white students. So they manufactured two more medals, and four medals were given that time… and next year it was back to two medals.

Like other Japanese student doctors, Kikuchi could not practice at most of the hospitals in southern California prior to World War II. He remembered, "They have a Japanese hospital, City View Hospital.[59] I used to be the director of a Japanese hospital a long time ago and I thought it was the best organization." Dr. Kikuchi graduated in 1914 and immediately took his licensing exam to open a practice in Little Tokyo. People came from as far as San Francisco for care, one even as far as Texas. He built a good business in Little Tokyo and returned to Japan to choose a

[59] This was the name later used by the Japanese Hospital when it changed to a geriatric care unit in the 1980s.

wife, a common practice among Issei men. Upon their return to the United States, his wife contracted tuberculosis. Kikuchi simply said, "my first wife was not strong."[60]

Los Angeles had smaller clinics that provided some medical services prior to the creation of the Japanese Hospital. Dr. Tanaka Jyuhei, an Issei pioneer and physician had a small clinic called "Eisei-in" (hygiene institute), a small facility in Los Angeles.[61] Perhaps seeing a need for care amongst the Japanese community in 1918, Dr. Hatsuji Hara also operated a clinic in Moneta, then a small rural town, now the city of Gardena.[62] An immigrant from Japan, Hatsuji Hara graduated from high school and college in the state of Washington at the age of seventeen in 1905. At thirty, he received his medical degree from Loma Linda University, a Seventh Day Adventist institution. Dr. Hara opened a clinic in Moneta, which boasted a small but poor Japanese farming community of over three hundred, people who primarily cultivated strawberries and small-scale vegetables. Because the cultivation of strawberries required frequent rotation of fields, many Japanese farmers lived in small temporary, make-shift shacks called a "Jap House" that enabled them to move around every three years.[63] Dr. Hara worked within this mobile working-class community. He probably also served Long Beach/Terminal Island Japanese community.

Dr. James Hatsuji Hara's life proved fairly controversial. Despite miscegenation laws that prohibited the marriage between "orientals" and white women, he married Dr. Margaret Farr, a European American physician.[64] According to a Los Angeles Times article, she married him

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[60] His first wife eventually succumbed to pulmonary complications in 1933.
[61] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 38.
[62] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 42-43.
[63] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 44.
[64] See Jennifer Lisa Koslow, *Cultivating Health: Los Angeles Women and Public Health Reform* (New Brunswick: Rutgers University Press, 2009). Koslow contends that in the early part of the twentieth century, women were at the

secretly because her parents would not approve and even claimed to have "made inquiries about the legality of marriage between an oriental and an American citizens." The article contended that the couple not only married secretly, but did so three miles off the coast of California by a sea captain because of anti-miscegenation laws on the mainland. Dr. Margaret Farr, a county health officer who worked with children and in 1918, was part of the cadre of reformers sent to canvas the birth rates in the county by Dr. Pomeroy, the Los Angeles County Health Supervisor and head of public health in the county. She met Dr. Hara when investigating high infant birth rates among the Japanese population. According to the article, upon realizing their illicit marriage, Dr. Pomeroy asked for her resignation. Indeed, she lost her citizenship because of her marriage and was asked to resign from her post as American women lost citizenship when they married men ineligible for citizenship. As historian Peggy Pascoe argues, "marriage links individual desire to social respectability and financial responsibility; it also links citizens and their dependents to the state."[65]

Dr. Farr denied claims that she was asked to resign her job. Rather, she quit her post with the County health offices to assist Dr. Hara with his medical clinic. She stated, "I am now helping my husband in his practice. Three weeks ago I found I could not assist him and remain with the health office at the same time, so I submitted my resignation." The marriage of a white woman to a Japanese man was unusual for the time. Most interracial marriages, when they did occur, were often between white men and Asian women. Perhaps their similarity in faith, education, and profession helped them navigate through a racial terrain that deemed their union

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forefront of public health and its expansion. Ironically, they used maternalism as a way to expand their role in public policy and especially in public health reforms. Although an exception to the racialized impulses of white women reformers, Dr. Farr also represents one of the many white women that were part of this landscape of changing public health.

[65] For an account of exogamous marriage, see Peggy Pascoe, *What Comes Naturally: Miscegenation Law and the Making of Race in America* (New York: Oxford University Press, 2009), 2.

"unnatural." Despite this controversy, Dr. Hara along with his wife, Dr. Margaret Farr operated the clinic and conducted surgeries for this community.[66] Perhaps due to his education at a Seventh Day Adventist university and his own religious conversion, he served as a liaison between the Japanese and white community.[67] Dr. Hara had affiliations with White Memorial Hospital and crossed multiple racial barriers to practice surgery.[68] This however, proved not to be the case for most Japanese Americans.

A Place of Our Own: The Creation of the Japanese Hospital

The creation of the hospital points to important questions about the nature and role of the clinic. Michel Foucault articulates, "The clinic – constantly praised for its empiricism, the modesty of its attention, and the care with which it silently lets things surface owes its real importance to the fact that it is a reorganization in depth, not only of medical discourse, but of the very possibility of a discourse about disease."[69] Foucault examines the creation of "birth" of the clinic as part of a historical process that creates systems or processes in which the body becomes a floating signifier and the clinic the space in which to posit what is "empirical" with the observing gaze.[70] While this is true of western medical practices where people went to clinics

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[66] See also "Woman Physician Weds Japanese; Job Forfeit," *Los Angeles Times*, July 29, 1921. Hatsuji Hara was also known as James Hatsuji Hara. This article relates contradictory evidence to that of Hasegawa Shin's documentation of Dr. Hara and Dr. Farr's life. According to Shin, Dr. Margaret Farr's father was a notable doctor, not minister. In Shin's account, Dr. Farr's family supported their marriage and professional careers.

[67] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 49-50.

[68] In 1926, Dr. Hara and Dr. Farr left Moneta to pursue medical research at the University of Pennsylvania and later at Harvard University. See Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 78.

[69] Michel Foucault, A.M. Sheridan Smith, trans., *The Birth of the Clinic: An Archaeology of Medical Perception,* (New York: Vintage Books, 1994), xix.

[70] Stuart Hall, "Race, the Floating Signifier," *The Media Education Foundation*, 1997. I use Hall's idea of race as a set of "discursive constructs" in addition to Foucault's work on the clinic. Foucault never directly dealt with the issue of race. See Michel Foucault, *The History of Sexuality Volume 1-3* (New York: Vintage Press, 1988). Sex is the site for the production and reproduction of state power. It is also the aggregate of disciplinary practices. While scholars have used this in the extension of colonial power, see Ann Stoler, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things* (North Carolina: Duke University Press, 1995), I find this interpretation limiting because it lacks interpretation on how race is understand, not from the standpoint of white officials and agencies, but through communities of color themselves. Later scholars have amended his work

for observation and treatment, Foucault theories remains silent about people of color and the ways in which bodies were understood as manifesting difference. These set of "signifiers" is much more complex in communities of color because bodies of color were already marked as different before entrance into a clinical space. The creation of the Japanese Hospital represents a negation and renegotiation of the gaze within a bound space. It was health officers, traveling the racial terrain of Los Angeles that created these floating markers of race and body. In fact, the clinic, run by Japanese doctors and primarily for the treatment of Japanese bodies, can both render bodies of color inaccessible for the western gaze.[71]

The Japanese Hospital presents a conundrum. While Foucault's theory helps scholars understand the ways in which the state operates, normalizes, and reproduces power, it does not offer a way to understand the textures of power negotiated within communities of color, outside the purview of the state. The Japanese American community and the creation of the hospital was part of the "*counterscipts* that offer alternatives or directly challenge dominant racial scripts" to the ways in which elite white medical profession practiced medicine.[72] Rather than a hegemonic process of power within the medical profession, in service to the state, Japanese doctors put forth this "alternative." While certainly true that most white doctors and hospitals did not regularly admit and treat Japanese patients; the creation of a hospital, specific to a community of color, posits that these bodies are no longer available. For example, white surgeons were often invited to perform complicated surgeries in the Southern California Japanese Hospital, as there were no available Japanese surgeons. With the arrival of Dr. Tashiro Kikuwo, "he would defy this

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on biopower to include notions of race and citizenship. See Natalia Molina, *How Race is Made in America: Immigration, Citizenship, and the Historical Power of Racial Scripts* (Berkeley: University of California Press, 2014). The notion of "racial scripts" is a powerful way of understanding the ways in which race becomes characterizations. From there power flows and changes in relation to ongoing discussions of racial policy.

[71] This also renders Japanese bodies unintelligible to white doctors because they no longer have access to Japanese bodies.

[72] I use Molina's notion of "counterscript." See Molina, *How Race is Made*, 7.

practice and he performed even the most difficult of operations by himself without the aid of outsiders."[73]

The history of the establishment of the Japanese Hospital in California illustrates the divergent ways in which the medical professional treated ethnic practitioners. Moreover, it reveals a "counterscript" or narrative to the ways in which power was diffused through the clinic. Unsurprisingly, the history of California's response to the creation of the French Hospital in San Francisco and the Japanese Hospital in Los Angeles contrasted significantly.[74] There was never a dispute about the legality of the French Hospital.

Few state documents exist in relation to the Turner Street Hospital.[75] Closer to a small-scale clinic, it eventually reached a thirty-three bed unit with one operating room and one laboratory.[76] According to historian Susan Smith, the maternity clinic was later expanded in 1918 to serve the Japanese during the influenza pandemic under Dr. Jyuhei Tanaka.[77] A founding member of the Los Angeles Japanese Council, Dr. Tanaka also established the Association of Japanese Physicians in Los Angeles in 1906.[78] Perhaps given its genesis as a clinic first for

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[73] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 42.

[74] Gary Libman, "L.A.'s French Hospital Grew From Settler's Hiring of a Doctor," *Los Angeles Times*, September 20, 1985.

[75] "Japanese Hospital," *Los Angeles Conservancy*, access date June 22, 2012, https://www.laconservancy.org/locations/japanese-hospital. This website states the Japanese Hospital had its roots in Mary Akita's maternity center on Turner Street in 1915 and was later joined by Kikuwo Tashiro in 1922. Again, there is no mention of Dr. Jyuhei Tanaka. There is also no mention of the fact this hospital was turned into an emergency unit during the influenza pandemic.

[76] *ibid*.

[77] Susan Smith, *Japanese American Midwives*, 88-89. Smith also cites smaller Japanese hospitals located in San Francisco, Stockton, Fresno, San Jose, and Sacramento. Smith's claim that the hospital was started under Tanaka Jyuhei may be from Dr. Tashiro's biography. However, there is no mention of Mary Akita as operating the clinic first as a maternity unit except by the Los Angeles Conservancy. She is cited as being the head nurse. See also Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 40.

[78] The membership of the Association of Japanese Physicians in Los Angeles was composed of Ikeuchi Kiyomitsu, Ito Takejiro, Nishikata Tomozo, and Tanaka Jyunhei. Tanaka Jyunhei was the vice-president of the Los Angeles Japanese Council in 1906. By 1915, the membership of the Association of Japanese Physicians included also Karaki Yasuzo, Iseri Kaoru, Miyata Yujiro, and Nakagi Kiyohide. See Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 38.

maternal care and then as an emergency hospital during the pandemic, the hospital faced few obstacles. Its articles of incorporation contain two dates, 1918 and 1935.[79] Although Mary Akita and Jyunhei Tanaka are often cited as the founders of the Turner Street Hospital, the officers listed under the articles of incorporation with the state of California included the following: Geo. Y. Hirai, S. Hirose, G. N. Tayama, S. Ansai, M. Tanimoto, N. Tamosa, G. Yuasa, J. Masuno, Geo. S. Masuda. Each of these members held one share of $10.00 for the hospital. Neither Mary Akita nor Jyuhei Tanaka appears on the state records for the board or having any shares of the hospital. Surprisingly, the 1918 articles of incorporation was filed and endorsed by the Secretary of State, Frank C. Jordon. By the time that that the 1935 incorporation was filed, the Turner Street Hospital (Southern California Japanese Hospital) had merged with the Japanese Hospital. It remains unclear why the State did not challenge the existence of the Turner Street Hospital but disputed the creation of the later Japanese Hospital.[80]

There is also conflicting evidence about the exact history surrounding the establishment of the Japanese Hospital.[81] Filed in the state archives, the Japanese Hospital, in contrast to the Southern California Japanese Hospital (the first record of incorporation), suggests that Japanese doctors attempted to create a space for surgical practices and patient care earlier than its predecessors. Sho Inouye, P.M. Suski, and T. Furusawa first applied as trustees or directors for

[79] Southern California Japanese Hospital, File No. 87423, Secretary of State Records, Part I, R206, California State Archives, Office of the Secretary of State, Sacramento, California.

[80] By the time the merger with the Japanese Hospital with the Turner Street Hospital occurred in 1935, legal disputes by the state had already been settled in favor of Japanese doctors.

[81] On Los Angeles hospitals and doctors in Los Angeles, see Item #348, "Classified Japanese Institutions in Los Angeles, CA," Box 36 Minor Documents, 1907-1934, Survey of Race Relations Records, Hoover Institution Archives. This document lists there are 12 doctors and hospitals (this totals are not detailed), 11 dentists, and 18 midwives. The actual year for these total is unknown. In another listing, there are listed7 hospitals and infirmaries, 3 dental clinics, and 9 midwives. There is one doctor's and dentist's office in 1915. See William M. Mason and John A. McKinstry, "The Japanese of Los Angeles," *Contributions in History* (Los Angeles County Museum of Natural History), no. 1 (1969): 1-39. There is a detailed list for San Francisco in 1918. See Item #350, "Classified Japanese Institutions (Japanese American Directory, 1918)," Box 36 Minor Documents, 1907-1934, Survey of Race Relations Records, Hoover Institution Archives. It lists the following hospitals: Nippon Hospital, Hashimoto Hospital, Imperial Hospital, North American Hospital, Hayaishi Hospital, and San Francisco Hospital. These hospitals represent those that were created by and utilized by the Japanese community.

Articles of Incorporation to the state of California in February 1913.[82] Two hundred members of the Japanese American community held shares of the corporation with capitalized at $10,000. However, it appears that the Japanese Hospital of 1913 was forfeited on March 1916 for unknown reasons.[83] With the closure of the Japanese Hospital, there still remained a need for a larger facility for surgical procedures to service the Japanese community.

The eventual establishment of the modern Japanese Hospital began with Kikuwo Tashiro, a Japanese immigrant from an educated family. In 1907, the year before the Gentleman's Agreement between Japan and the United States, his father, Tashiro Saburo migrated to the United States to earn money so that he could send his sons to medical school. He left behind his wife, four children and two wards. Thirteen when his father left, he learned English and kept an English diary while preparing for his entrance exams at Nagasaki Medical School. Kukuwo's close friend stated, "he calculated that the more quickly he completed his schooling, the sooner he would be able to join his father in America."[84] In 1914, his mother Mono journeyed to the United States to join her husband, leaving behind her children under the care of the Shimokawa family. The Tashiro family's history demonstrates the chain migration of immigrants.

[82] Japanese Hospital, File No. 72184, Secretary of State Records, Part I, R206, California State Archives, Office of the Secretary of State, Sacramento, California.
[83] I found no other records about the original Japanese Hospital established by Inouye, Suski, and Furusawa in secondary sources or in other primary sources. There is no address to corroborate whether these hospitals were in the same locality as the Turner Street Hospital. It is unclear whether this facility was associated with Mary Akita's maternity unit or independent of the Southern California Japanese Hospital. Hasegawa Shin's history also suggests that the Southern California Japanese Hospital was a clinic operated by Tanaka Jyuhei, rather than a maternity unit.
[84] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 3, 14. Dr. Kikuwo Tashiro also appears as Kikuo Tashiro.

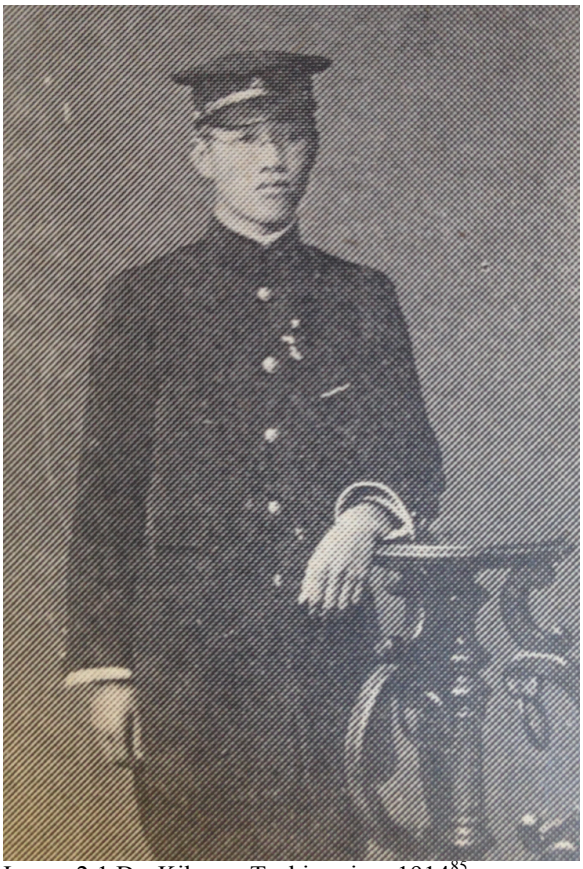

Image 2.1 Dr. Kikuwo Tashiro circa 1914[85]

Kikuwo Tashiro graduated and received his license in 1918 in Japan. His father wanted to him to immigrate, open a medical practice, and, of course, to take care of his parents. He remained in Japan for a few years as a researcher at Asada Hospital, working with prestigious surgeons in Japan. There he met his future wife, Mori Moto whom he married in 1920. Perhaps at the behest of his parents, Kikuwo arrived in California on September 7, 1921, leaving his pregnant wife behind at her parent's home in Nagasaki. His brother, Tanenori, a student at Stanford University, met him at the port in San Francisco for the train ride to Los Angeles and the family farm in nearby San Gabriel.[86] Due to notions of *kini kikyo* (return home in the glory of success), Dr. Kikuwo Tashiro had to abandon his dream of studying at a prestigious research

[85] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), 129.
[86] Troy Tashiro Kaji, interview by author, July 11, 2015, Berkeley, California.

university and perhaps attending a German university to practice as a physician. In 1922, his wife Moto and his first child, Akiko, joined him. As a sign of his new wealth, he picked up his family in a new Ford coupe.

By the time Moto and Kikuwo Tashiro settled in San Gabriel with his parents, there were over twenty licensed Japanese physicians in Los Angeles for a Japanese population of approximately 20,000 or only one doctor per 1,000 people. After the arrival of his family, he took his examination for medical practice after the suspension of foreign language exams; he failed in the first attempt but passing in 1923.[87] Dr. Tashiro opened up a clinic in Little Tokyo on First Street and San Pedro Street and another in his Gardena home, close to the practice of Dr. Hara, a friend and colleague (seem image 2.1 and 2.2).[88] In the mornings, he saw patients at his home practice and also make house calls on Terminal Island where there was a Japanese community employed as fishermen and in the canneries. Mrs. Tashiro sometimes accompanied her husband.[89] Matsutsuyu Ichitaro, an elderly fisherman remembered, "Dr. Tashiro was indeed a dedicated physician who generously extended his helping hand to the poor, such as the fisherman residents of Terminal Island. He always said, "pay when got some cash on hand." He would refuse payment from those known to be in poverty."[90] He then drove to see his patients in downtown Los Angeles. There, he would perform surgeries on patients in the afternoon at the Southern California Japanese Hospital on Turner Street. The demand on his time was great but

[87] Dr. Tashiro was trained in German in Japan. According to Hasegawa Shin, the biographer of Dr. Kikuwo Tashiro, he passed his examination in 1923. However, according to the Official Register of Physicians and Surgeons in the State of California Who Hold the Certificate from the Board of Examiners of the Medical Society of the State of California, Dr. Tashiro did not obtain his license until 1925. There is another document for his license in 1929.

[88] Historic Resources Survey Team, "Historical Resources Survey Report: Historic Resources Inventory," (City of Gardena, 1981). The Gardena Historical Society lists Dr. Tashiro's as 749 W. Gardena Boulevard in Gardena. His house and ranch in Coachella was purchased through his trusted Nisei chauffeur, Kazuo "Bob" Matsuishi. The Tashiro family was forced to evacuate this home in 1942 at the outbreak of World War II and did not return. Dr. Masako Yamauchi, an optometrist, utilized this residence/clinic after the war.

[89] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 46.

[90] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 74.

he earned the admiration of his patients and larger community. Mr. Iwaoka Masamitsu remembered Dr. Tashiro,

> Any family with an ailing member was particularly hard hit, without being able to afford any hospitalization or treatment of any consequence. Dr. Tashiro was a real savior at such a crisis, offering to help the sick without any realistic promise of payment… Perhaps seventy percent of all Japanese patients requiring surgery must have been the beneficiaries of Dr. Tashiro's benevolent ways during those hardships.[91]

Image 2.2 Tashiro Residence/Clinic *date unknown*

[91] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 58.

Image 2.3 Tashiro Former Residence/Clinic 749 W. Gardena Boulevard, City of Gardena, CA, 1981[92]

Prior to the creation of the larger Japanese Hospital, Dr. Tashiro would house Japanese medical students in his home in Gardena and teach them surgical skills at his clinic or at the Southern California Japanese Hospital.[93] In 1927, Dr. Kikuwo Tashiro along with Dr. Isami Sekiyama, Dr. Paul K. Ito, Dr. Y. Karaki, and Dr. F.T. Nakaya applied for a license to incorporate a larger facility called simply, the Japanese Hospital.[94] California Secretary of State, Frank C. Jordon denied their application to incorporate. Dr. Tashiro and his attorney Marion Wright filed a suit against the state.[95] Frank Jordon argued that the "petitioners are prohibited by

[92] The house still stands today but no longer serves as a clinic. It is a private residence. Troy Tashiro Kaji, interview by author, July 11, 2015, Berkeley, California.

[93] Students such as Dr. Lee M. Watanabe received his medical training under Dr. Tashiro. Dr. Watanabe then opened a practice in San Jose. Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 81.

[94] Japanese Hospital, File No. 72184, Secretary of State Records, Part I, R206, California State Archives, Office of the Secretary of State, Sacramento, California. This application is for the 1929 articles of incorporation. I could not find the original 1927 article.

[95] *K. Tashiro et al. v. Jordon, Secretary of State, et al.* 201 Cal. 236, 256 p. 545 (1927). His biographer, Hasegawa Shin stated that this endeavor was unsupported by the Japanese Consul in Los Angeles. See also "Japanese Hospital:

the laws of this state, and particularly by the provisions of the Alien Land Law, from forming any corporation, one of the purposes of which is to possess, use, or occupy real property situated in this state."[96] However, the Supreme Court of California interpreted the 1911 treaty between the United States and Japan as granting permission "the right to carry on trade, wholesale and retail, to lease land for commercial purposes and generally do anything incident to or necessary for trade upon the same terms as native citizens or subjects."[97]

Tashiro v. Jordon (1927) did not strike down the Alien Land Laws but stated that the provisions under the Alien Land Law "were framed and intended for general application and to limit the privileges of all ineligible aliens in respect of agricultural lands."[98] Interestingly, though this case allowed for the incorporation of the Japanese Hospital, it upheld the constitutionality of agricultural land restrictions. In allowing "trade and commerce" to Japanese physicians, the California Supreme Court did not interpret this as granting the same privilege for those of lower professional standing such as farmers. Rather than a radical interpretation of the law, the California Supreme Court maintained the privileges of the professional class of migrants

Frank C. Jordon and the state of California appealed to the Supreme Court of the United States their case.[99] Jordon used a different tactic in the federal courts, citing that the treaty did not include a hospital as falling under the terms of "trade" and "commerce." The U.S. Supreme Court heard their case and upheld Dr. Tashiro's bid for the Japanese Hospital. The U.S. Supreme

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Caring for the Pre-war Nikkei Community," YouTube video, posted by DiscoverNikkei at the Japanese American National Museum, May 11, 2010, https://www.youtube.com/watch?v=VEjxyuszpkI.

[96] *K. Tashiro et al. v. Jordon, Secretary of State, et al.* 201 Cal. 236, 256 p. 545 (1927). For the creation of "Asian" in the United States, See Mae M. Ngai, *Impossible Subjects*, 38-39; See also *Takao Ozawa v. United States*, 160 U.D. 178 (1922) and *United States v. Bhagat Singh Thind*, 261 U.S. 204 (1923).

[97] *K. Tashiro et al. v. Jordon, Secretary of State, et al.* 201 Cal. 236, 256 p. 545 (1927).

[98] *ibid*. The California Alien Land Laws were not repealed until 1956 on a ballot measure (Proposition 13) voted by California citizens. It was voters, rather than the state legislature that repealed this discriminatory practice. See Xiaojian Zhao and Edward J.W. Park, eds., *Asian Americans: An Encyclopedia of Social, Cultural, Economic, and Political History* (Santa Barbara: Greenwood, 2014), 37. See also Mae M. Ngai, *Impossible Subjects: Illegal Aliens and the Making of Modern America* (New Jersey: Princeton University Press, 2014).

[99] *Jordon, Secretary of State, et al. v. K. Tashiro et al.* 278 U.S. 123, 49 S. Ct. 47 (1928).

Court concluded the legality of the hospital with a "liberal construction" of the treaties and under the provision that stated, "to do anything generally incident to or necessary for trade upon the same terms as native citizens or subjects, submitting themselves to the laws and regulations there established."[100] After an almost two year battle between Dr. Kikuwo Tashiro and the state of California, the Japanese Hospital became a legal entity in the state of California and set the precedence for further establishments of ethnic hospitals. Interestingly, similar to the California courts, the U.S. Supreme Court also kept intact the restrictive principles of the Alien Lands Law by upholding the principles of the 1911 Treaty that allowed for recognition of the professional classes from Japan but denied rights to farmers and workers.

The archives remain silent on why Frank C. Jordon denied the creation of this Japanese hospital under Dr. Kikuwo Tashiro. Upon the success of their case, the Japanese Los Angeles Physicians Association held a party at the Biltmore Hotel honoring their efforts and promising to invest in the projected facility.[101] Despite his victory, Dr. Tashiro could not purchase the land to build the Japanese Hospital. Instead, the new site was purchased in the name of Nisei doctor Yogoro Takeyama in Boyle Heights, along East First and Fickett Street.[102] In 1929, with the help of the Japanese Physicians Association, Kuroiwa Daishiro (internal medicine), Tashiro Kikuwo (surgery), Nakaya Fusataro (internal medicine, surgery), Kozasa Toru (obstetrics), and Takahashi Shota (otorhinolaryngology), (dubbed the "Big Five") began hospital construction plans. They contributed to the hospital's development with their own funds but also used the mutual self-help system called *tanomoshi-ko* to finance the construction of the new hospital.[103] Dr. Tashiro and

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[100] *ibid*.
[101] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 92.
[102] I was not able to locate records from Los Angeles County Registrar-Recorder/County Clerk or from Los Angeles City and County Assessors to confirm or refute this claim about land ownership by Nisei doctor Yogoro Takeyama.
[103] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 95-96.

fellow doctors solicited widely throughout the Japanese community in southern California and raised the sum of $129,000 for the construction of the new hospital despite the onset of the Great Depression. Once finished, the building boasted a two-story structure equipped with a forty-two beds, three operating rooms, an X-ray room, and a research lab.[104] The new hospital staff communicated with patients in Japanese and even served traditional Japanese dishes during their convalescence. Dr. Tashiro served as the president of the new, modern hospital until 1931.

Image 2.4 Construction the new Japanese Hospital[105]

The new Japanese Hospital also served Asian, white, Mexican, and other patients.[106] Dr. Ichioka Toshio explained,

> Today, no institution can be allowed to monopolize. The construction of a new hospital in our community is a positive

[104] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. V, 98.
[105] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), 228.
[106] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. V, 98.

> development… It ultimately helps our patients… We will emphasize our principle of serving the community, with or without financial gains for our service.[107]

The Japanese Hospital expanded the medical geography of southern California to become a much more inclusive space. It remained in service until 1942, when the compulsory evacuation of Japanese and Japanese Americans forced doctors to close the hospital. As a corporation, the doctors leased its facilities to White Memorial Hospital, which used it as a maternity hospital until 1946 when Dr. Tashiro returned to Los Angeles and reopened the Boyle Heights facility.[108] The Japanese Hospital remained open to all community members and in 1961, merged with City View Hospital and became a nursing facility in 1985.[109]

Dr. Tashiro's work paved the way for second-generation Japanese doctors in multiple ways. First, the creation of the Japanese Hospital allowed subsequent Japanese physicians to avoid a racialized medical landscape that alternately denied them access or granted them entry to treat their patients. Secondly, Dr. Tashiro left behind a legacy of care upon the Japanese medical profession by acting as a mentor to second generation doctors. Mr. Kameichi Kuida, a Gardena residents and acquaintance of Dr. Tashiro recalled,

> Dr. Tashiro always attempted to encourage the young Nisei physicians to continue on with their study and, along with them, he diligently carried out various researches. He tried to demonstrate to these young physicians the way of a serious-minded physician by living what he preached… Perhaps because of Dr. Tashiro's diligent leadership many of these Nisei physicians have tuned out to be outstanding medical professionals themselves and making much contribution to the development of medical profession.

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[107] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 100.

[108] In 1936, the Los Angeles Seventh Day Adventist Church established a Japanese chapter of the White Memorial Church, thus solidifying the relationship between Japanese doctors such as Hara who were converts to the faith.

[109] "Japanese Hospital," *Los Angeles Conservancy*, access date June 22, 2012, https://www.laconservancy.org/locations/japanese-hospital.

Dr. Tashiro changed the landscape of medicine in southern California by offering a "counterscript" to the regime of physicians in a traditional white, male profession.

A Nisei Experience

Despite the inroads of the first generation of Japanese doctors, second generation, or Nisei doctors, still contended with a difficult racial environment in their endeavors to break into a white profession. Even when Nisei physicians could get into medical schools, it proved difficult for many to secure positions at hospitals or research centers for their internships. The Tashiro clinic offered an important training ground for young Nisei men with an American education. Students such as Lee Watanbe, Norman Kobayashi, Howard Suenaga, George Wada, Sam Tokuyama, Tadashi Fujimoto benefited from the close mentorship of Dr. Tashiro.[110] However, the resources for Nisei women who wanted to become physicians, rather than nurses, remained quite limited.

Dr. Sakaye Shigekawa faced gender and economic constraints as a Nisei woman from a working-class background.[111] She recalls that her father was first a gardener and then later went into the hog business and "after all those years, they only got $10,000 for 30 years of work." Born in South Pasadena in 1913, she was the eldest daughter.[112] As a translator for her critically ill father to white nurses and doctors, she became inspired to pursue a career in medicine with her parents' encouragement. She attended Jefferson High School in Huntington Park and was

[110] Hasegawa Shin, *Nippon Dasshutsuki: Los Angeles no Tashiro Doctor*, trans. Itsuki Charles Igawa (Tokyo: Seiji-sha, 1978), vol. 4, 114.
[111] Mei Nakano, *Japanese American Women: Three Generations, 1890-1990* (Berkeley: Mina Press, 1990). Issei Japanese women, before World War II, typically worked in agriculture and domestic work. See also Valerie J. Matsumoto, *Farming the Home Place: A Japanese Community in California, 1919-1982* (New York, Cornell University Press, 1993); Valerie J. Matsumoto, *City Girls: The Nisei Social World in Los Angeles, 1920-1950* (New York: Oxford University Press, 2014). See Matsumoto, *City Girls*, 145, 147, 149, 173, 182, 185, 198, 203.
[112] Sakaye Shigekawa, interview with REgenerations Oral History Project, Japanese American National Museum, Los Angeles, 2000. She was also a twin. At the time of her interview, her twin sister had passed.

accepted into the University of Southern California upon graduation.[113] She did her medical training at Loyola Medical School in Westchester and was one of four women admitted. She started her doctor's residency at Los Angeles County Hospital when World War II broke out and all staff members of Japanese ancestry were summarily dismissed from their positions. From there, she secured employment at the Seaside Memorial Hospital in Long Beach (a Naval Hospital). She left April 3, 1942 to Santa Anita Assembly Center to report to an internment camp.

Image 2.5 Sakaye Shigekawa[114]

At the Santa Anita Racetracks she, along with six other doctors, cared for the 17,000 detainees. Shigekawa sent letters to Washington D.C. stating that she would go to the camp (Heart Mountain in northwestern Wyoming) but she refused to work as a physician. Before she her schedule departure, official visitors told her, "Oh, we thought you were a man, (chuckles) keeping you out of the army" in which she boldly replied to the officials, ""Yeah. That's a big deal. I would have liked to have gone to the army, [rather] than being incarcerated." So they let

[113] The University of Southern California seemed to have been an institution that accepted many students of color. There is more research needed to document the role of USC as an institutional access point for students of color.
[114] "Pioneering Nisei Doctor Sakaye Shigekawa Dies at 100," *Rafu Shimpo*, October 28, 2013. Sakaye Shigekawa was known for her colorful hats.

me go." Interestingly, she received permission to go to Chicago for her residency rather than spend her time at the camps.[115] Though she only remained in Chicago for a few short months, she hit it off with Irish patients and was even nicknamed "O'Shige." In Chicago, despite few Asians there, she stated that she did not feel the racial climate as contentious,

> I was never concerned because I had gone to school there in Chicago, and there were no Orientals there. [It was] really sparse at the various schools – probably they had one or two, maybe. There were really no Orientals that you could even meet. There was one Japanese restaurant, and gift shop. So, I think, people treated me good (chuckles), because I was a curiosity to them not having seen Orientals.
> Her tenure in Chicago proved short lived in part because
> "in the first place – I wasn't what they expected. And second place, they didn't pay me what they promised to pay me. So I just walked out on them. And as I'm walking out, they reminded me there's a war on. And I told them, "Yes, I know, but I didn't start it." And I just walked right out."

Shigekawa asserted her worth as a doctor by refusing her services to the hospital rather than getting unfair payment and treatment. She then went on to work with another doctor in private practice and moved to Mercy Hospital in Bay City, Michigan stating, "At first when I was at Bay City, Michigan, as an intern, there were little things I hear that I might be a spy, but nothing came of it. People were good to me there, too. I had no problems."

Shigekawa's attitude was an uncommonly brave. As a Japanese woman, she had negotiated her way through a profession difficult for Japanese Americans and women alike.

> See there were a lot of hospitals that did not take women. The excuse was they didn't have facilities for women who are interns. So most of us took what we could get. And they were pretty picky about the interns that they picked at the various hospitals because they would naturally prefer men in those day[s]. But now, I think, I was the second woman in Bay City, Michigan to be a woman intern.

[115] Sakaye Shigekawa's family was interned in Amache, Colorado and in Utah.

After the war, she opened her own practice in Los Angeles treating patients of various backgrounds, though as many as fifty percent were Japanese and Japanese Americans. The patients she served all came by referral. Mary Nakahara, her nurse, remembers, "Her prestige as a doctor was of no importance of her. Her attention was on the comfort of her patient."[116] Nakahara further elaborated that Dr. Shigekawa's work spoke for itself: "Nobleness is only made in real *service.*"[117]

Though a successful doctor, Sakaye Shigekawa was not immune to the postwar racial climate. There were meetings held in her neighborhood to remove her parents from living in Hollywood even though she served as a doctor there due to restrictive racial covenants. She remembered, "in spite of the fact that they tried to get my folks out of there, they became my patients. As a matter of fact, I took care of most all of them until they died." Moreover, Shigekawa faced challenges to her professional ethics. A Caucasian woman doctor reported her to the County Medical Board for advertising her services, illegal at the time. Shigekawa remembered the incident,

> I think when I delivered triplets one time, she reported it to Los Angeles County Medical Board. At first, I was cited on that, because you were not supposed to advertise. It was in the papers. It wasn't my picture. It was a nurse holding the three children… So I had to prove I wasn't even in there. So, anyway, the staff at the hospital and all, they knew I wasn't in the picture.

Dr. Shigekawa believed that the reason she faced questions about her professional standing was because she was had more patients than the other doctor despite believing "most women doctors will at least encourage women to start practice." In face of perhaps racism and envy, Dr. Shigekawa continued to do well in her practice.

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[116] Quoted from John Howard, *Concentration Camps on the Home Front: Japanese Americans in the House of Jim Crow* (Chicago: University of Chicago Press): 120.
[117] Howard, *Concentration Camps on the Home Front*, 121.

Dr. Shigekawa delivered from 20,000 to 30,000 babies in her practice as a general practitioner in a career spanning over five decades. According to her oral history, Sakaye Shigekawa practiced general medicine though most of her patients were women who utilized her for maternity and obstetric care. She stated, "More and ore as the years went by, I did more deliveries [of] babies because I was a woman." She gave up obstetrics and gynecology when the laws changed to require expensive insurance policies for practice in the delivering of babies in the 1980s. She remained as a general practitioner throughout the rest of her career. Dr. Shigekawa never married; instead, she dedicated her life to medicine, contesting the traditional roles of women and the many restrictions placed on Japanese Americans.

Uprooted[118]

Uprooted,
thrown in a pile, side of the road.
But remember,
rise again and full bloom once again

World War II colored Sakaye Shigekawa's professional experiences. [119] Media outlets and the U.S. government featured stories about Japanese spies. Notions that the Japanese doctors were spies were not a new accusation. As early as 1896, The Los Angeles Times reported a Japanese doctor, under the aegis of checking on the sanitary conditions of Cuba was reportedly a spy for the Japanese government to check on the Cuban Revolution. The Japanese doctor, cited as Esquiel Murata, was discovered to have sent correspondence on military conditions of the island but these correspondences were intercepted. The doctor had initially traveled to America before heading to Cuba. Luckily, Dr. Shegekawa evaded accusations as a woman doctor. While she was never interned in Heart Mountain like her sister and parents, her oral history is framed

[118] This is the beginning of poem written by Dr. Kikuchi. See Yoriyuki Kikuchi, Oral History 1340, interview by Arthur A. Hansen, July 29, 1974, Honorable Stephen K. Tamura Orange County Japanese American Oral History Project, California Oral History Project, California State University, Fullerton.
[119] A "Japanese Spy," *Los Angeles Times*, September 19, 1896.

around "time divided into "before the war" and "after the war.""[120] Writer and documentarian Karen Ishizuka stated that internment represente a "shared experience, no matter how unjust the circumstances, creates an intimate and kindred universe for those who share it."[121] For many, this shared experience included an environment that taxed even those in the best of health. At the very early days of internment, bad sanitation in the camps resulted in diseases like dysentery and substandard food rations exacerbated the humiliation.[122] Just as ethnic practitioners were needed outside the barbed wires of internment, the Japanese community again needed medical services of doctors. The internment of Japanese Americans during World War II leveled the field of experiences between Nisei and Issei doctors, as many continued to treat patients at the camps.

Despite their education and prestige within their own communities, their distinction did not prevent them from being from incarceration, seventy percent of whom were native-born U.S. citizens.[123] For example, Dr. Kikuchi, interned at Manzanar, stated, "I am a doctor and didn't belong to the Japanese Association or have connections with the Japanese school…We volunteered instead of being dragged to camp." Even as the chief of the dental clinic in the internment camp, he worked under the supervision of white medical staff members. He recalls that he received a mere $19 a month to work as a dentist. His wife, worked in the social welfare department and also received $19 a month. This was a considerable cut from the $300-500 he made as a private dentist in Los Angeles. According to Dr. Kikuchi, he served over forty to sixty patients a day, in comparison to the dozen he would treat in private practice.

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[120] Karen L. Ishizuka, *Lost and Found: Reclaiming the Japanese American Incarceration* (Chicago: University of Illinois Press, 2006), 5.
[121] Karen L. Ishizuka, *Lost and Found*, 126.
[122] Yoriyuki Kikuchi, Oral History 1340, interview by Arthur A. Hansen, July 29, 1974, Honorable Stephen K. Tamura Orange County Japanese American Oral History Project, California Oral History Project, California State University, Fullerton.
[123] Karen L. Ishizuka, *Lost and Found*.

In one instance, Dr. James Goto witnessed the unfolding of the Manzanar riots in 1942 which two of the internees were killed and ten wounded by gunshots after rising tensions over the mistreatment of the detainees.[124] Dr. Goto claimed that James Ito, one of the internees, was shot in the back. However, the "administration put so much pressure on Goto to sign otherwise… Goto thought it was the guard's mistake, but it was wartime. Mistake or no mistake, you can't argue, especially in a camp like that; anything goes. Anything the administration does is right and the prisoner's conduct is wrong."[125] Despite his standing in the community, Dr. Goto's testimony was dismissed.

Doctors in the camps continued to treat patients in their wartime experience amid racial tensions and limited resources. At Manzanar, Dr. Kikuchi recalled ten doctors that treated the 10,000 detainees, often with very little tools. Many of their belongings were left behind or in the case of Dr. Tashiro, White Memorial Hospital took stewardship of his medical journals and belongings until the end of the war. In other camps such as Jerome, Arkansas, there were just seven doctors (Kawamoto, Ikuta, Taira, Abe, Tanaka, Fujikawa, and Kuroiwa) that treated close to 9,000 detainees. Dr. Kikuchi stated, "we couldn't carry anything with us so I went there barehanded. I picked up nails on the street and burned them up so I could treat teeth." While he made do with the little that he had, he convinced an officer at the camp to bring back some of his dental equipment. He joked, "I am guilty of smuggling equipment and medicine into the camp and that's how the dental clinic got started." Despite the subordination of those of Japanese decent, he treated everyone, including the guards. Dentists and doctors at times treated patients

[124] Arthur A. Hansen and Betty E. Mitson, eds., *Voices Long Silent: AN Oral Inquiry into the Japanese American Evacuation* (Fullerton: California State University at Fullerton Oral History Program, 1974), 41-79. See also Jeanne Houston and James D. Houston, *Farewell to Manzanar* (New York: Ember Press, 1973), 72-80.
[125] ibid.

who lived close to the camps. For example, another Japanese dentist in Poston, Arizona, treated Native Americans suffering from periodontal diseases.[126]

Wartime internment colored reminisces of Japanese Americans. After the war, many Japanese Americans attempted to piece together their lives. Dr. Kikuchi moved as far away from Manzanar as possible, settling first in New York before deciding to return to Los Angeles to reestablish his dental clinic. Along with other compatriots that scattered across the United States, they rebuilt the lives they had lost during the internment. Sometimes, welcoming friends greeted them and other times, they were greeted with "Japs are returning."[127] The Tashiros moved to Los Angeles instead of resettling in Gardena, they lived in Boyle Heights in 1945 to be closer to the hospital and his downtown practice. There, they rebuilt a new community. In doing so, Dr. Tashiro took on the task of reestablishing the Japanese Hospital, an undertaking that took close to a year to resolve.

The end of the war changed the landscape of care within the Japanese American community. In 1947, the first Japanese Physicians Association (renamed Southern California Japanese American Physicians Association) met and elected a new generation of doctors. For example, while Nagaki Kiyohide, an Issei was elected as new president, the following year, Dr. Hara Hatsuji, a Nisei physician, took the reins. In the years that followed, and as the Nisei population increased, the Japanese medical community reflected this generational shift within their rank and file.[128] The war served as a marker for their shared experience of loss and reconstruction.

[126] Hasegawa Shin, *Nippon Dasshutsuki*, vol. 5, 234.
[127] Hasegawa Shin, *Nippon Dasshutsuki*, vol. 7, 12.
[128] Hasegawa Shin, *Nippon Dasshutsuki*, vol. 7, 34-35.

We will meet again[129]

Japanese physicians, in their individual practice, each and every day, contributed to geography of care despite racial segregation, punitive laws, and regulations that deemed them "aliens." In spite of individual hostility, a restrictive medical profession, the state of California, and the United States government, Japanese physicians claimed a space to care for their community. Before the war, the "Nacayama Conspiracy" can be considered a small victory even as it denied claims of educational equivalence by banning the foreign language examination. These physicians were vindicated as innocent even as their ability to practice medicine was challenged by the State Medical Examiners who eliminated the Japanese language examination. Japanese Issei took their exams in English to open medical practices that would treat the growing numbers of the Japanese community.

The California Supreme Court and the United States Supreme Court decision to allow the creation of the Japanese Hospital leveled the medical geography of southern California by carving out an alternative space for ethnic practitioners. In doing so, Japanese physicians defended their right to provide medical care to their community. The Japanese Hospital stood as a monument of their efforts. As pillars of their community, Japanese physicians approached care as a community effort and raised fund needed to establish a space that remained an important feature of the Japanese community. Even as World War II disrupted their efforts, Japanese physicians returned to Los Angeles to reestablish their homes, their practices, their hospital, and their community.

The Japanese Hospital disrupts the notion of the clinic and hospital as a site for the state. Michel Foucault claims that as political systems become centralized, the body, disease, and

[129] Hasegawa Shin, *Nippon Dasshutsuki*, vol. 5, 219. This was the message by *Rafu Shimpo*, the widely circulated and read Japanese newspaper, in their final issue on April 2, 1942.

spaces become analogues of the state. Whereas the hospital and clinic become sites of understanding, containing, and dealing with disease, bodies act as receptacles for their knowledge and knowing gaze. Often Foucault becomes an important way to understand tendons of power, especially in modernity. However, because the United States never developed a state system of medicine, as did Western Europe or even their colonies, Foucault obfuscates, rather than explains the role of ethnic practitioners. Japanese physicians were not agents of the state, in Foucault's rendering. They were abhorrent to the state.[130] The "counterscript" created by the presence of Japanese physicians as well as the space they carved for themselves as practitioners and leaders of their community meant they formed a cross cut to the racial configuration created by the state. Japanese physicians such as Dr.Tashiro Kikuwo challenged the California Secretary of State Jordan by the terms of diplomacy but also as an American. These doctors, as racialized Americans, were still "aliens" to America. They negotiated an American system in tandem to the cultural practices they brought with them or learned at home. In weighing the considerable prejudice and discrimination they faced, they continually navigated through the medical profession and the state to create a system of care. In doing so, they disrupted familiar tropes about medicine and health as the sole site for power and discourses of the body. The Japanese Hospital rendered Japanese community, as a citizens and subjects of the United States, as their own purveyors of medical knowledge.

[130] Ironically, even as Dr. Hara worked for Los Angeles Health Department, his story disrupts Foucault's theorization of physicians as arms of the state. His marriage to Dr. Farr further undermines claims of this association.

CHAPTER THREE

Merchants of Health: Chinese Herbal Doctors in southern California

Photographed in front of his herbal shop at 703 E. 9th Street in downtown Los Angeles. Paul Chin proudly stood in front of the sign, "For Five Thousand Years Chinese Herbs Have Given Miraculous Relief of Many Ailments."[1] In 1976, he had operated the Bow Yuen Tong Company for thirty-one years, inheriting the trade from his father Joe Chin. Traditionally, the trade of the Chinese herbal doctor was a profession passed on from father to son. Chin explained, "My ancestors were all herbalists. Often in Chinese families, the sons do what fathers did." Advertised as "Famous Chinese Herbs," Paul Chin grew, collected, and specialized in the use of over 1,000 different medicinal herbs. However, Paul Chin offered a disclaimer about his business, "We are herbalists, not doctors. We never diagnose, examine, or give prescriptions. We are specialists in herbs and at your request suggest herbs that may possibly be helpful to your health." He further explained,

> In China a herbalist is doctor but not in America… Americans don't understand about herbs. It's nothing new, but most people in West don't know about this stuff. Herbs are in Bible. Shakespeare wrote about herbs. Ancient Greeks and Romans had herbs. And Chinese have always had herbs.

Chin insisted that, far from a tradition unique to the "east," herbs were a recognized and respected part of medical expertise from the time of antiquity. While recognized as medical professionals abroad, herbalists did not have the same professional standing in the United States. According to historian Haiming Liu, "herbal medicine is not a folk practice… Chinese medicine developed into a systematic body of medical knowledge."[2] However, the state of California,

[1] Charles Hillinger, "Son Carries on Father's Herb Tradition," *Los Angeles Times*, December 6, 1979.
[2] Haiming Liu, *The Transnational History of a Chinese Family* (New Brunswick: Rutgers University Press, 2005), 50.

along with other states, deemed them below American medical standards.[3] At the end of the interview, Chin reasserted, "remember I am not a doctor, just old-time Chinese herbalist with dried roots, bark, and leaves from plants used by Chinese 5,000 years for better health." Paul Chin's repeated assertion that he was "not a doctor" strongly suggests that he knew the penalties of practicing medicine, specifically, diagnosing illness, without a physician's license. He deliberately maintained his status as an herbalist who dealt with the trade of goods.[4]

Image 3.1 Paul Chin in front of his store

This chapter argues that Chinese herbal doctors played a pivotal role in the landscape of medicine in southern California. They served as merchant of health. Chinese herbalists, though not sanctioned as medical doctors, provided affordable healthcare and low-cost treatments to their patients.[5] They were early ethnic brokers that traded in health, rather than goods. In doing

[3] Laurel Thatcher Ulrich, *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812* (New York: Vintage Books, 1990). Ulrich explains that midwives in the colonial era had intimate knowledge of the usage of herbal remedies. This was a trusted form of doctoring before the professionalization of medicine.
[4] Linda A. McCready and Billie Harris, "From Quackery to Quality Assurance: The First Twelve Decades of the Medical Board of California" (Sacramento: California State Medical Board, 2004).
[5] See Todd Stevens, "Brokers Between Worlds: Chinese Merchants and Legal Culture in the Pacific Northwest, 1865-1925" (Ph.D. diss, Princeton University, 2003). Stevens argues that Chinese merchants served as "brokers" between American society and their communities.

so, they offered viable options for many. This chapter examines the ways in which herbalists operated within medical discourses and their function as a crosscut of discourses about bodies of color and the state.[6] As a result, Chinese herbalists challenged western doctors as the sole purveyors of health and wellness.

Chinese herbalists circumvented medical professionalization even as they became entrenched in the economy of health from their first migrations.[7] Although accused as medical quacks by the California Medical Board, Chinese doctors had a long tradition in California, beginning with the first arrival of migrants onto the shores of "Gold Mountain."[8] For example, the Son Loy Company of San Francisco held three subbasements full of personal luggage that had belonged to Chinese pioneers who had left them for safekeeping at the turn of the twentieth century. In almost all trunks and boxes, medicinal herbs of various sorts were found.[9] The Chinese proved unwilling to use American doctors for their ailments given the language barriers, higher fees, and strange medication, and understandably, relied on traditional practices to get well and stay well. Regardless of literacy, people shared and transmitted collective ideas about the health effects of the most basic herbs as a sort of lay knowledge.[10]

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[6] Haiming Liu, *The Transnational History of a Chinese Family: Immigrant Letters, Family Business and Reverse Migration* (New Brunswick: Rutgers University Press, 2005).

[7] Liu, *The Transnational History of a Chinese Family*, 45-69. Liu examines herbal medicine as a transplanted culture in the United States.

[8] In almost all of the thirty five oral histories I have examined, the interviewees claimed that their parents, in particular their mothers, made Chinese herbal soups and remedies as part of their routines. Moreover, one of the questions asked by the Chinese Historical Society was about their familiarity with herbs. While not all corroborated the efficacy of their usage, almost all of their parents believed in using herbs and herbal doctors for health and wellness as well as sickness. I surveyed 165 of the oral histories available from the Chinese Historical Society and UCLA Oral History Project. Every single one of these oral histories indicated the usage of herbal remedies by families.

[9] Thomas W. Chinn, H. Mark Lai, Phillip P. Choy, eds. *A History of the Chinese in California: A Syllabus* (San Francisco: Chinese Historical Society of America, 1969), 78. See also Haiming Liu, "Chinese Herbalists in the United States." In *Chinese American Transnationalism: The Flow of People, Resources, and Ideas between China and America during the Exclusion Era* (Philadelphia: Temple University Press, 2006), 138.

[10] Haiming Liu, "Chinese Herbalists in the United States," 140.

The first Chinese arrived as early as 1820, but many more migrated to *Gum San*, Gold Mountain during the 1840s and 1850s for the chance of riches in northern California.[11] Primarily poor men from the farming communities of Guangdong province, the Chinese left a world in the midst of British colonization and European encroachment after the Opium Wars. Coupled with peasant rebellions, civil strife, and environmental disasters such as floods and famines, one of the few options left for Chinese men in the southern region was to migrate to the United States. Mostly illiterate men, they planned on working abroad for just a short period of time before returning to China. "The Chinese who returned to their villages with money they had made in Hawaii and American reinforced the excitement of emigration."[12] News traveled back to China that those who had braved the migration east had indeed made money. In comparison to the limited options in China, California seemed a worthwhile adventure.

While the notion of the "coolie" became the steadfast image of Chinese migration, many came voluntarily by either paying their own way, borrowing money from family, or relying on a credit-ticket system from brokers whom they repaid once they arrived.[13] By 1870, there were 63,000 Chinese in the United States, seventy-seven percent residing in California.[14] Initially, very few Chinese women migrated with men because of Confucian beliefs that restricted their

[11] Mark Him Lai, *Becoming Chinese American: A History of Communities and Institutions* (Walnut Creek, CA: AltaMira Press, 2004); Iris Chang, *The Chinese in America: A Narrative History* (New York: Penguin Books, 2003); Yong Chen, *Chinese San Francisco: A Trans-Pacific Community, 1850-1943* (Stanford: Stanford University Press, 2000); Ronald Takaki, *A Different Mirror: A History of Multicultural America* (New York: Little Brown and Company, 1993); Ronald Takaki, *Strangers from a Different Shore: A History of Asian Americans* (New York: Little Brown and Company, 1989);

[12] Ronald Takaki, *A Different Mirror*, 193.

[13] See Moon-Ho Jung, *Coolies and Cane: Race, Labor, and Sugar in the Age of Emancipation* (Baltimore: Johns Hopkins University Press, 2006), 5. See also Najia Aarim-Heriot, *Chinese Immigrants, African Americans, and Racial Anxiety in the United States, 1848-82* (Urbana: University of Illinois Press, 2003); Alexander Saxton, *The Indispensable Enemy: Labor and the Anti-Chinese Movement in California* (Berkeley: University of California Press, 1975).

[14] Ronald Takaki, *A Different Mirror*, 194.

movement.[15] By the turn of the century, these numbers changed, resulting in the growing number of Chinese families throughout California.[16]

As the gold mines became untenable sources of revenue, many turned to the railroads as a steady form of labor. Moreover, many Chinese worked in agriculture between 1860s and 1880s as tenant farmers who helped to change the landscape of California's agriculture.[17] Fears about the "Chinese Problem" elicited the specter of a menacing figure threatening white labor and society.[18] In Los Angeles, animosity towards the Chinese resulted in the Chinese Massacre of 1871 whereby some twenty Chinese were lynched by a mob at Calle de los Negro.[19] From his base in San Francisco, Denis Kearney's Workingmen's Party of California continued to rail against the Chinese, considering them responsible for the workingman's woes. This virulent nativism led to the legislation that excluded Chinese from American shores. While the Chinese made up only .002 per cent of the total U.S. population, Congress pushed through legislation that made it illegal for Chinese to immigrate for the next ten years and denied naturalized citizenship

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[15] Sucheng Chan, ed. *Chinese American Transnationalism: The Flow of People, Resources, and Ideas between China and America during the Exclusion Era* (Philadelphia: Temple University Press, 2005); Erika Lee, *At America's Gates: Chinese Immigration during the Exclusion Era, 1882-1943* (Chapel Hill: University of North Carolina Press, 2003); Erika Lee, *The Making of Asian America: A History* (New York: Simon & Schuster, 2015).

[16] For work on Chinese women in the United States, see Madeleine Hsu, *Dreaming of Gold, Dreaming of Home: Transnationalism and Migration Between the United States and South China, 1882-1943* (Palo Alto, CA: Stanford University Press, 2000); Judy Yung, *Unbound Feet: A Social History of Chinese Women in San Francisco* (Berkeley, University of California Press, 1995); Peggy Pascoe, *Relations of Rescue: The Search for Female Moral Authority in the American West, 1876-1939* (New York: University of Oxford Press, 1993). See also Susan Lee Johnson, *Roaring Camp: The Social World of the California Gold Rush* (New York: W.W. Norton & Company, 2000).

[17] Sucheng Chan, "Chinese Livelihood in Rural California: The Impact of Economic Change, 1860-1880, *Pacific Historical Review* vol. 53, no. 3 (August, 1984): 273-307.

[18] Alexander Saxton, *The Indispensible Enemy: Labor and the Anti-Chinese Movement in California* (Berkeley: University of California Press, 1975). See also Tomás Almaguer, *Racial Fault Lines: The Historical Origins of White Supremacy in California* (Berkeley: University of California Press, 1994); Michael Omi and Howard Winant, *Racial Formation in the United States: From the 1960s to the 1980s* (New York: Routledge, 1986).

[19] Isabella Seong-Leong Quintana, "National Borders, Neighborhood Boundaries: Gender, Space and Border Formation in Chinese and Mexican Los Angeles, 1871-1938" (Ph.D. diss., University of Michigan, 2010) and "Making Do, Making Home: Borders and the Worlds of Chinatown and Sonoratown in Early Twentieth-Century Los Angeles." *Journal of Urban History* (2014). See also Cesar Lopez, "El Descanso: A Comparative History of the Los Angeles Plaza Area and the Shared Racialized Space of the Mexican and Chinese Communities, 1853-1933" (Ph.D. diss., University of California, Berkeley, 2002); 83-95. For a novelistic account of the massacre, see Alejandro Morales, *The Brick People* (Houston: Arte Public Press, 1992).

for existing Chinese.[20] Renewed every ten years, the Exclusion Act was not repealed until 1943.[21]

Despite a hostile racial environment, the Chinese continued to arrive into the United States and with them, their traditional medicines. As noted in the previous chapter, white, male doctors served as gatekeepers for state sanctioned professional medicine.[22] In doing so, the state proclaimed those who practiced any form of healing arts outside of professionalized medicine were "quacks."[23] In its crusade to quash unlicensed practitioners, the Medical Board arrested and prosecuted those practicing medicine without a proper certificate or license.[24] In 1876, California established the first Medical Practice Act, creating the Board of Examiners. This legislation ensured that physicians held diplomas or licenses with affidavits confirming authenticity. Those who did not graduate from qualified universities were required to present themselves to the Board for an examination. In 1901, the Board also required a fee for their tests and subsequent renewals. The Board served as the sole governing agent until 1922 when osteopaths and chiropractors, through a voter initiative, created their own Board of Osteopathic Examiners and a Board of Chiropractic Examiners.[25]

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[20] Sucheng Chan, ed. *Entry Denied: Exclusion and the Chinese Community in America, 1882-1943* (Philadelphia: Temple University Press, 1994).

[21] Mae M. Ngai, *Impossible Subjects: Illegal Aliens and the Making of Modern America* (New Jersey: Princeton University Press, 2014). Ngai argues that the Exclusion Act actually created and reified the racial category of "Asian" in American legal and cultural tradition.

[22] Douglas M. Haynes, "Policing the Social Boundaries of the American Medical Association, 1847-70," *Journal of the History of Medicine and Allied Sciences* 60, no. 2 (April 2005): 170-195. See also "Chinese Medicine," *California State Journal of Medicine* 11, no. 3 (March 1913), 98.

[23] McCready and Harris, "From Quackery to Quality Assurance." See also "Raids on Quacks," *The California State Journal of Medicine* 13, no. 9 (September 1915), 334. The special agent of the Board of Medical Examiners raided two Japanese doctors and eight Chinese "Doctors."

[24] "More Arrests by State Medical Board" *Oakland Tribune* September 30, 1912. See also "Eight Quacks in Federal Toils: Stand Charged with Using the United States Mails to Defraud Public," *Oakland Tribune* July 13, 1914. This citation is also listed in the "Charge Misuse of Mails," *Los Angeles Times* July 15, 1914.

[25] McCready and Harris, "From Quackery to Quality Assurance," 9.

Chinese herbal doctors contested the changing terrain of professionalized medicine in California.[26] Frustrating to the Board, when Chinese doctors were accused of medical fraud, few juries would convict them, if they even came to trial.[27] For example, at the turn of the century, the Los Angeles Times ongoing coverage of Chinese medical "quacks" revealed the tension between their critics and the larger population that supported them.[28] Doctors Tom She Bing, Wong H. Young, and G.S. Chang were arraigned on practicing without a license. The following week, Dr. Tom Leung and Dr. Tom Moy were also issued arrest warrants.[29] Using the investigations of Bessie Hall, a local Los Angeles woman who posed as a patient, police directed by Dr. Luther M. Powers, Los Angeles city public health commissioner, investigated herbal businesses and arrested those practicing without a medical license. The doctors requested a jury for their charges, however, one of the cases proved "the most peculiar in the history of the local police court" as the prosecution, after examining three hundred jurors, could only find three who were not biased.[30] Much to the chagrin of prosecuting attorney, the doctors had a smart lawyer who said the Chinese could not get a fair trial. Grant R. Bennett, the doctors' lawyers, dismissed jurors for their anti-Chinese attitudes. Ironically, then, Judge Rose had to dismiss the case. The prosecution also struggled to find a jury for G.S. Chan, one of the five doctors arrested.[31] In an

[26] "Chinese Doctor Arraigned," *Los Angeles Times*, February 9, 1907. Toy Kee was accused of practicing without a license. The article cited that he intended to fight the case in court by attacking the statute. There is no other coverage on the outcome of his case.
[27] C.B. Pinkham, "The Chinese Herbalist and the Medical Practice Act" *California and Western Medicine* 23, no. 6 (June 1925), 738. For an early account of court dismissals, see "Wong Goes Free for Lack of Jury: Police Court Crippled Because Nobody Will Serve," *Los Angeles Times*, January 24, 1902.
[28] "Herb Quacks in Law Net: Medical Examiners on Trail of Chinese Fakers," *Los Angeles Times*, June 4, 1907; "Rich Chinamen are Indignant: Head of Herb Concerns are Arraigned in Court," *Los Angeles Times*, June 5, 1907.
[29] "Net Drags in Rich Chinese: War on Oriental Doctors Reaches Many," *Los Angeles Times*, June 9, 1907. Interestingly, a white herb doctor was not arrested but fined a few days later, see "Herb Doctor Fines," *Los Angeles Times*, June 14, 1907.
[30] "Chinese Grin in Sleeves: Impossible to Get Jury for Doctor's Trials," *Los Angeles Times*, July 18, 1907.
[31] "Doctor Chan Talks Fight: Police Court Convicts in Remarkable Case," *Los Angeles Times*, July 31, 1907. Dr. Tom She Bing was released with three other pending cases, see "Chinese Physician Free," *Los Angeles Times*, February 8, 1908. Interestingly, in the case of Dr. Tom Leung, the prosecution attempted to secure women's

interesting turn of events, the testimony astounded the courts. Though G.S. Chan was convicted of practicing without a license, Mrs. Emma Sperling of Monrovia, the prosecution's main witness, revealed that Dr. Chan was indeed a legitimate healer. The sixty-five year old Mrs. Sperling declared, "let me tell you, young man, he was the best physician I ever had… Chinese or no Chinese, he did me more good than all the white physicians I ever paid money for." In response to his indictment, Dr. Chan replied, "I intend to fight this case through to the Supreme Court if necessary."[32]

California's Medical Examiners power to hunt those who practiced without a formal license became enhanced by the Medical Law Act that gave them legislative power. Its annual reports revealed violations of Chinese practitioners who did not fit its requirements. The Medical Board's attorney stated the arrests and prosecution served, "to protect the public from "quacks" and "charlatans."[33] Multiple offenders included T. Foo Yuen ($200 fine, paid), Cheung Hong (150 days jail, probation), T. Leung ($100 paid, probation), Tom She Bin ($100 paid and 60 days jail, probation), G.S. Chan, H. Ching ($100 paid, 180 days jail, probation), Henry Ching, and M.J. Yem.[34] Rather than single cases, the Board gave multiple citations and charges against these herbalists throughout the year perhaps hoping to drive them out of practice through

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testimonies against him, see "In Frock and High Hat: Millionaire Chinese Doctor in Police Court," *Los Angeles Times*, March 10, 1908.

[32] Ibid.

[33] Charles B. Pinkham, "Annual Report of the California Board of Medical Examiners (Sacramento: State of California, 1915), 9. The 1914 Annual Report lists only the northern California violators. They are listed as Wong Him ($100 fine), Ah Fong ($300 fine and 90 days jail), Tom J. Chong ($400 fine), Wong Shue Nin (2 year probation), Jang Kwai (2 year probation), B.B. Lee (2 year probation), C.W. Wong, Chow Juyan ($600 and 6 months jail), Tom J. Chong ($600 and 6 months jail), Chow Juyan ($600 and 6 months jail), Chow Let ($600 and 6 months jail), Yak Q. Gine ($600 and 6 months jail). Some practitioners were arrested for practicing without a license multiple times throughout the year. These offenders only represent a small sample as some were fined and released without appearance on the annual reports.

[34] See also "Illegals Prosecuted" *California State Journal of Medicine* 12, no 10 (October 1914), 432. The journal lists Chow Juyan, Chow Let, Yak Q. Gine, and Tom J. Chong. Federal indictments included C.M. Fong, Lee K. Chinn, T. Wah Hing, Ah Fong, Charles Low, Jang Kwai, T. Shue Wing, and T. Foo Yuen.

imprisonment, probation, and fines.[35] Charles Pinkham, the secretary of the Board, charged these men on multiple occasions.

Rather than quiet resignation, the multiple offenders of the Medical Practice Act decided to bring the Board to court. In 1915, according to The Los Angeles Times, three Chinese doctors filed a suit in San Francisco claiming that they should have the right to practice as doctors.[36] The very same doctors who had been convicted multiple times, fined, and sometimes jailed in 1914 attempted to redefine the meaning of the legislation to include their presence in the growing field of medicine. Though tried under the California Medical Act of 1913 for practicing without a license, they challenged the law based on its discriminatory nature. Chow Juyan, Tom J. Chong, Chow Juyan, Chow Let, and Yak Q. Gine asserted that the State Medical Board refused to give them the examination because they were "herbalists." According to the coverage of the Los Angeles Times article, the doctors claimed they were accredited practicing physicians from China and did not need the examination of license because the treaty with China and as a "favored nation" should have guaranteed them equal rights.[37] The doctors further elaborated that the Board acted unconstitutionally because the new law "gave the board power to arbitrarily favor certain schools of medicine, to set arbitrary standards for medical schools" and dismiss Chinese medical training. Chow Juyan, Tom J. Chong, Chow Juyan, Chow Let, and Yak Q. Gine filed their case with the District Court of Appeals. However, their case was denied in the lower courts and they decided to appeal to the Supreme Court of the state of California.

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[35] It may have been difficult for the State Medical Board to get actual convictions from juries. See "Editorial Comments," *California State Journal of Medicine* 18, no. 2 (February 1920), 39. The article notes the difficulty in obtaining convictions for Chinese doctors on trial.

[36] "Medical Act is Attacked.: Three Chinese Doctors File Suit in San Francisco; Protection Under the Treaty is also sought by them; Oriental Herbalists Insist on State Recognition," *Los Angeles Times*, October 20, 1915: I4.

[37] Under the Burlingame-Seward Treaty in 1868, the United States proclaimed they upheld Chinese sovereignty and independence along with placing Chinese in America with equal footing to other immigrants. See John Schrecker, "For the Equality of Men – For the Equality of Nations": Anson Burlingame and China's First Embassy to the United States, 1868" *Journal of American-East Asian Relations* 17, no. 1 (2010): 9-34.

The defendants opposed the 1913 Act, insisting that it encroached on their practice of medicine by limiting the definition of medicine through western learning. Furthermore, besides the law's basis, they testified, "the act interfered with interstate commerce because it prohibits or unduly burdens the sale of imported herbs."[38] District Judge Dooling denied their appeal and upheld the constitutionality of the 1913 Medical Act. In his words,

> But it does not prohibit the sale of such herbs, and, if it burdens such sale, it is only because the seller, in addition to selling the herbs, acts also as a physician in prescribing their use, and the prescribing is burdened to the extent that the prescriber must have the medical certificate required. It is not Chinese herbalists alone who must secure such certificate, but all herbalists.

The new law gave legal weight to the California Medical Board. Prior to the Medical Acts, health officers surveyed the practices of Chinese doctors but without much recourse.[39] In upholding the 1913 Medical Act, Judge Dooling maintained the supremacy of western medicine. In doing so, he also made an important distinction about the herbalists' second claim: the trade of the herbs was not illegal but an herbalist acting as a physician violated the law. In making this kind of division between acting as a licensed medical professional and as a merchant, Judge Dooling set a legal precedent, placing Chinese herbalists in a liminal space of legality. While free to sell herbs, they could not *act* as physicians.

Long before Judge Dooling's ruling, Chinese herbal doctors created a space for themselves in the United States by establishing a business for their trade in medicinal herbs. For example, the Dr. Wong Company incorporated their business for the purposes of selling drugs, herbs, and medicines but with the notable exception that they also wanted to "manage and conduct hotels, restaurants, lodging houses, sanitariums, and hospitals." It listed among their directors Wong You Ting, Wong Ting Cheung, Dong Soon, S. White, and John T. Jones of Los

[38] Ex parte Chow Juyan, 235 F. 1014 (1916)
[39] See "Chinese Doctors," *Los Angeles Times*, September 16, 1885.

Angeles. Perhaps to circumvent prosecution, herbalists forged a professional line of business recognizable to the Chinese community though they could not legally act as doctors in the United States. Community historian Him Mark Lai stated, "Early in the twentieth century, herb shops and herb doctors were the subject of close scrutiny for possible violations of California medical laws and practice, but successfully survived the ordeal."[40] Rather than apply for professional parity, as was the case with Japanese doctors, Chinese doctors used a circuitous route to treat their patients. They applied for licenses to exist as corporate entities. For example, the Foo and Wing Herb Company filed articles of incorporation through the state of California as a trade,

> to dispense and deal in Chinese herbs, remedies, medicines, and general Chinese merchandise, and to acquire all kinds of real, mixed, and personal property necessary for carrying on and conducting the same. To translate, write, and copyright, print and publish medical pamphlets, lectures, books, and other literature in the Chinese and English language[41]

This corporation held a capital stock of $10,000 divided into one thousand shares at a value of $10 each directed by Tom Foo Yuen, Li Wing, and Jee Tak in Los Angeles. Wu Yung Chaw and Tom Leung of Canton, China were also listed as corporate directors suggesting herbs were a

[40] Thomas W. Chinn, H. Mark Lai, Phillip P. Choy, eds. *A History of the Chinese in California: A Syllabus* (San Francisco: Chinese Historical Society of America, 1969), 78.

[41] "New Incorporations," *Los Angeles Herald*, April 16, 1897: 10. See Articles of Incorporation of the Foo and Wing Herb Company, Secretary of State Records, Part I, R206, California State Archives, Office of the Secretary of State, Sacramento, California, April 30, 1909. This document lists the shareholders as Tom Foo Yuen, Tom Leung, Tom Shue Wing, Tom Shue Foo, Quan Guey, Gee Sin Lock, Li Hong, Li Hing, Leung Carn, Chun Sang, Tom Shee, Chow Jop, Tom How Wing, Ung Yuen, Gee Dock, Yaw Kee, Woo Fook, Li Foo Yuen, Tom Wing, Tom Now Foo, Tom Sone, Wong Yok Lin, and Woo Quay. See also Articles of Incorporation of the Foo and Wing Herb Company, Secretary of State Records, File no. 57365 Part I, R206, California State Archives, Office of the Secretary of State, Sacramento, California, March 4, 1916. This document is a reinstatement of previous articles of incorporation. See also Articles of Incorporation of the Dr. Wong Him Herb Co, Secretary of State Records, File no. 47639, R206, California State Archives, Office of the Secretary of State, Sacramento, California, July 26, 1913. See also Dr. Jung Hong, "New Incorporations," *Los Angeles Times*, December 18, 1901 and Dr. Chan Company, "New Incorporations," *Los Angeles Herald*, July 20, 1906.

transnational enterprise.[42] Some Chinese herbalists also used white sponsors to establish their businesses and to avoid the scrutiny of the state.[43] Indeed, the trade of herbs proved lucrative. European Americans also formed their own companies to sell herbs, such as the deceptively named Chinese Herb Company formed by A. Z. Holmes, Julia Holmes, J. B. Earley, J. R. Weller and J. E. White of Los Angeles.[44]

White merchants who established their own herbal companies used Chinese men, some who were actually herbalists and sometimes lay people, to operate as a front for their businesses.[45] For example, in 1912, J.W. Myers, head of a company deceptively called the Oriental Medicine Company was arrested by the State Board of Pharmacy and charged with selling drugs without a license. Myers stated, "he knew that he had been doing wrong, but that the American people were "easy marks."" He sold the equivalent of $11 of Chinese herbs for $1.[46] The news coverage indicated that, "So great was the demand for the herbs that the officers experienced considerable difficulty in pushing their way through the crowd." Perhaps noting the ubiquity and usage of Chinese herbs, some of these "quacks" utilized Chinese names and

[42] Haiming Liu, "Chinese Herbalists in the United States." In *Chinese American Transnationalism: The Flow of People, Resources, and Ideas between China and America during the Exclusion Era* (Philadelphia: Temple University Press, 2006), 136-155; Haiming Liu, *The Transnational History of a Chinese Family: Immigrant Letters, Family Business and Reverse Migration* (New Brunswick: Rutgers University Press, 2005), 45-69. Liu closely examines the trade of goods and herbalists as a thriving merchant class.

[43] For the Dr. Wong Company see "New Incorporations," *Los Angeles Times*, July 19, 1901; Articles of Incorporation of the Dr. Wong Co, Secretary of State Records, File no. 3801, R206, California State Archives, Office of the Secretary of State, Sacramento, California, July 18, 1901. For the Toy Kee Herb Company see "New Incorporations," *Los Angeles Herald*, September 14, 1906. This articles lists Toy Kee, Williams Waller, Phoebe Lankersley, O.M. Walter, and F.F. Pratt as the directors of a new stock company with a capital stock of $1,000.

[44] "New Incorporations," *Los Angeles Times*, June 26, 1904. A.Z. Holmes may have been the same sponsor of Y.H. Chung, father of Dr. Arthur W. Chung. Mr. Holmes spoke "understandable" Chinese and helped Y.H. Chun establish the herb business in white neighborhoods. They even rented a home under Mr. Holmes' name. See Dr. Arthur W. Chung Oral History 9, interview by Bernice Sam and Suellen Cheng, October 23, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

[45] Patt Morrison, "Reviving the Chinese Ghosts of Gold Rush California" *Los Angeles Times*, March 7, 1999. In this article, Yee Fung Chung's name is Romanized as Cheung. Chinese herbs were familiar and a lucrative practice.

[46] "May Plead Guilty," *Los Angeles Times*, April 7, 1912.

herbalists as a façade for their medicine show.[47] It remains unknown how many businesses under white owners even Chinese shareholders were earnest businessmen and healers or merely as fronts for medical charlatans.[48]

Amid protestations of "quackery," Chinese herbalists did fill in a vacuum of medical need. Iconic California commentator and lawyer, Carey McWilliams noted upon his arrival in Los Angeles in 1922, "the vacuum created in the medical art was filled by Chinese herb doctors, faith-healers, quacks, and a miscellaneous assortment of practitioners."[49] Despite McWilliams' lumping of Chinese herbal doctors with other dubious medical practices, he befriended a family of Chinese herbalists, perhaps utilizing their services.[50] Herbal doctors proved pivotal in providing alternative treatments. In contrast to the Japanese American community, the Chinese did not undergo a similar "modernizing" period that looked to western science or medicine to transform their country as a way to compete with western powers.[51] Moreover, few Chinese neither came to the United States seeking a medical education nor obtained a western education back in China.[52] Unlike Japanese Americans who sought to establish a formal Japanese Hospital for western medical practices, the Chinese could not establish the same kind of community

[47] See "Doctor Gun Wa," *Daily Alta California* 82 no. 174 (June 23, 1890). This story detailed the story of a manager of a gambling house owned and operated the Gun Wa Herbal Company which started in Pueblo, Colorado. Public officials in various cities accused him of operating a false business using a Chinese laundryman, gambler, and laymen to act as Chinese physicians to front his operations that sold a concoction of sage, sugar, and water. He went on to Milwaukee, Pittsburgh, St. Louis, and Indianapolis, and Salt Lake City to create the same false business.

[48] See George Rosen, *A History of Public Health* (Baltimore: Johns Hopkins University Press, 1993); Stephen Barrett et al, *The Health Robbers: A Close Look at Quackery in America* (Buffalo, NY: Prometheus Books, 1993).

[49] Carey McWilliams, "*Southern California: An Island on the Land* (Salt Lake City: Gibbs M. Smith, 1983), 258.

[50] Liu, *The Transnational History of a Chinese Family*, 56.

[51] "Pitable Cases," *Los Angeles Times*, April 23, 1889; ""Hospital" a Menace: Official Attention Called to the Filthy Chinese "Hospital" by a Death Occurring Yesterday, *Los Angeles Times*, September 13, 1900; "A Chinese Hospital in Los Angeles and Some of Its Weird and Wasted Denizens: Everybody for Himself," *Los Angeles Times*, August 18, 1901; "Horrors of Dead House," *Los Angeles Times*, July 13, 1902. These articles illustrate the menace of bachelors living in close quarters attending to themselves. See also Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001).

[52] See Teresa Brawner Bevis, *A History of Higher Education Exchange: China and America* (New York: Routledge, 2014). She documents the life of Dr. Yung Wing who was the first Chinese American to receive a degree from Yale in 1854. He convinced the Qing Dynasty to send a delegation of students to learn about western sciences as part of the Chinese Educational Mission in 1872. However, this mission was abandoned in 1881.

support. In Los Angeles, a Chinese "hospital" was informally established to treat the very sick. A scintillating report showed a small, dedicated space run by bachelors. The report elaborated that this hospital was provided by funds from local Chinese merchants. The Los Angeles Times contained pictures of a dilapidated space with makeshift buildings comprised of mud and wood showing Chinese men left to fend for themselves. This space lacked professional medical doctors and nurses given the shortage of licensed Chinese medical professionals.

The Lee family was a notable exception to Chinese medical professions. Alfred E. Lee, his brother David, and father were the first dentists in Chinatown.[53] Born in Los Angeles in 1910, he was the son of Chinese dental technician who survived the 1906 San Francisco earthquake.[54] His father found work under Dr. Alfred E. Blake, Alfred Lee's namesake, who proved "instrumental in giving his father a place in dentistry." According to Alfred Lee, "everything was done by apprenticeship, not schooling." Alfred Lee's father work as a dental technician allowed him a profession that served primarily Chinatown. Allen Mock remembered, "there were very few doctors. Dr. Ed Lee right now, his father was the only dentist that we used to have in Chinatown, the only dentist."[55]

Alfred Lee followed in the footsteps of his father. He attended Los Angeles High School and attended USC in 1932 for dentistry. At that time, he remembered, no other Chinese attending

[53] Alfred E. Lee Oral History 46, interview by Beverly Chan, January 16, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles. Alfred does not state his father's name. Oral histories about the Lee family also do not mention his name. See also Allen Mock Oral history 140, interview by Jean Wong, December 13, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles. Allen Mock recalls that Alfred Lee's father was the only dentist in Chinatown and later Alfred or "Ed" Lee and his brother were the only ones to serve to Chinatown. He states, "They were the first family of dentists that I knew of."

[54] The 1906 earthquake and fire also allowed many Chinese to claim that they were born in the United States. See Sucheng Chan, ed. *Entry Denied: Exclusion and the Chinese Community in America, 1882-1943* (Philadelphia: Temple University Press, 1994).

[55] Allen Mock Oral History 140, interview by Jean Wong.

the school.[56] Alfred Lee opened his own practice in 1933 alongside his father and brother in the plaza area of Los Angeles until World War II when he enlisted in the medical corps. They advertised by word of mouth and gained a popular following not only among the Chinese but also among the Mexican population. In his words:

> How would an oriental people go down to an American part of town and explain what he wanted or wanted one done unless the doctor had an interpreter or translator? I have experienced quite a bit because I worked an awful lot with Mexican people since my graduation. In fact, I took over the Methodist church clinic in 1934. It was opened to the public. In other words, the poor people would go to the church and ask for help and the church would accept them and take them and charge them $.50 for every appointment. But we did everything. In other words, we did extractions, we did cleanings, and did some fillings… I gave them three hours a day that's on a Wednesday morning, volunteered. There was no pay. The church supplied the materials, we supplied the service but I did supply my office because the church eventually ran out of space for office space so we donated our space. So every Wednesday, I'd turn my office into a clinic for the poor

Historian George Sánchez noted the growing presence of women physicians and ethnic physicians like Dr. Lee in the Plaza area.[57] Though Dr. Lee understood the limits of his practice, he considered himself close to the communities he served, "you got to, you living and working with it. You take their money, you don't think you don't know some of their problems?" There exist few testimonies to the presence of a professionalized class of Chinese doctors in Los Angeles. Many Chinese relied on non-traditional forms of healing because of discriminatory practices that limited their options. According to Dr. Lee there was a need for physicians,

[56] A notable exception was Dr. "Mom" Chung. However, she attended medical school and worked in San Francisco rather than Los Angeles. See Judy Tzu-Chun Wu, *Doctor Mom Chung of the Fair-Haired Bastards: The Life of a Wartime Celebrity* (Berkley: University of California Press, 2005).

[57] George Sánchez, *Becoming Mexican American: Ethnicity, Culture, and Identity in Chicano Los Angeles, 1900-1945* (New York: Oxford University Press, 1995), 175.

"whether they packaged herbs or anything else… you looked for somebody who knows how to help you."[58]

Chinese herbalists provided an indispensible need: affordable healthcare. They carved out a space for health and wellness in southern California.[59] Representing a small middle class, Chinese herbal doctors were medical brokers. They navigated the terrain between ethnic medicine and western medicine. Some Chinese physicians became so successful that they were the targets of crime. For example, the Los Angeles Herald described the death of a Chinese physician, Lin Moon Chuck. "It is supposed that he was decoyed to that place by a fictitious call to attend a sick person and then killed and robbed. He was known to carry considerable money and also had some valuable diamonds and jewelry."[60] Moreover, some health inspector extorted money from Chinese herbal doctors. The Los Angeles Times reported that Nick Harris, a health inspector, reportedly accepted protection money form Tom She Bin.[61]

Historians Kenneth H. Marcus and Yong Chen contend they represented the elite of the Chinese community who, in contrast to laborers, were able to "cross racial, geographic, and even gender boundaries at a time when segregation, discrimination, and race hatred remained the norm in relations between Asians and European Americans."[62] Indeed, Chinese herbalists represented a large swath; some did quite well while others barely eked out a living. Herbalists in Los Angeles had a diverse clientele: some catered only the Chinese population, while others

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[58] Alfred E. Lee Oral History 46, interview by Beverly Chan, January 16, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

[59] See Mae M. Ngai, *The Lucky Ones: One Family and the Extraordinary Invention of Chinese America* (New York: Houghton Mifflin Harcourt, 2010). Historian Mae Ngai's extraordinary documentation of the Tape family reveals the ways that a middle class Chinese family negotiated race, immigration, and discrimination as "brokers" of America culture.

[60] "Chinese Physician: Strangled to Death," *The Los Angeles Herald*, July 10, 1905.

[61] "Drops Ax on Nick Harris: Health Inspector Indiscreetly Took Gifts," *Los Angeles Times*, December 5, 1908.

[62] Kenneth H. Marcus and Yong Chen, "Inside and Outside Chinatown: Chinese Elites in Exclusion Era California" *Pacific Historical Review* 80, no. 3 (August 2011), 370.

welcomed white and Mexicans, with little overlap between the English-speaking and Spanish-speaking advertisements.

Medical Tourism in Chinatown[63]

Los Angeles City/County Chinese Population				
Year	No. in City	Total City Pop	No. in County	Total County Pop.
1900	2,111	102,479	3,209	170,298
1910	1,954	319,198	2,602	504,131
1920	2,064	576,673	2,591	936,455
1930	3,009	1,238,048	3,572	2,208,492
1940	4,736	1,504,277	997	2,785,543

Table 3.1 Chinese Population in Los Angeles City and County, 1900 – 1940[64]

Chinese herbal doctors performed an important function in the Chinese community, which at the turn of the twentieth century totaled a little over two thousand in the city and over three thousand throughout Los Angeles County (see Table 3.1). As most California facilities denied medical services to the Chinese, the need was urgent.[65] Allen Mock remembered that there were little services for the Chinese. He stated,

> There's no way to protect yourself, you can't call for police in Chinese… you would like to at least run out and talk to another Chinese and they can help you. Whether it's somebody getting hurt, or somebody getting a heart attack. Somebody can speak to you about your ills. Go to a dentist who's Chinese, go to a doctor who's Chinese, go to a lawyer whose Chinese…. It's a safety factor and I think that's why it's important.[66]

[63] Judy Wu also uses the term medical tourism but this is specifically in reference to those that visited Dr. Mom Chung in San Francisco. I use the term medical tourism to describe the prevalence of white health seekers that utilized Chinese herbalists. See Judy Tzu-Chun Wu, "The Ministering Angel of Chinatown," in *Asian/ Pacific Islander American Women: A Historical Anthology*, eds. Shirley Hune and Gail M. Nomura (New York: New York University Press, 2003); Judy Tzu-Chun Wu, *Doctor Mom Chung of the Fair-Haired Bastards: The Life of a Wartime Celebrity* (Berkley: University of California Press, 2005).

[64] Table reproduced from Natalia Molina, *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939* (Berkeley: University of California Press, 2006), 7.

[65] Joan B. Trauner, "The Chinese as Medical Scapegoats in San Francisco, 1870-1905," *California History* 57, no. 1 (Spring, 1978): 82. Trauner documents the city and county bans on Chinese to hospitals.

[66] Allen Mock oral history 140, interview by Jean Wong, December 13, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

Public health officers rationalized the inability of Chinatown's occupants to acquire medical care as an indictment of Chinese sanitation and culture, rather than as a failure of public health reforms. The lack of medical services left Chinese vulnerable to epidemic diseases. However, health officers cited Chinatown and the Chinese people as the source for disease outbreaks. Historian Natalia Molina's work documented public health as a site of racialization in Los Angeles, using the lack sanitary services as a means to couple disease and Chinese. Similarly, historian Nayan Shah's illustrated that health agents "depicted Chinese immigrants as a filthy diseased "race" who incubated such incurable afflictions as smallpox, syphilis, and bubonic plague and infected white Americans."[67]

Nayan Shah's work on San Francisco's Chinatown theorized that the disciplinary role of the state produced what he dubs as the "subject-citizen." Reform-minded state agencies such public health and housing were gatekeepers for citizenship.[68] While Shah's assessment of the state's production of a modern "subject-citizen" helped categorize the levels of admission to the body politic, this concept as it relates to health remains limited because the state alone does not account for the creation of medical discourses. Individuals did negotiate their wellness options within a marketplace of health. Chinese herbalists, as a crosscut of discourses on public health, created what I term *sovereign consumers*. The *sovereign consumer* negotiated health practices within bounded options of the state and the availability of practitioners. Thus, while Shah addresses individuals in relation to the state, I am much more interested in individuals within the *marketplace* of health.

In highlighting the work of Chinese herbalists, the theoretical template for understanding health in California becomes much more complicated than a straight relationship between

[67] Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown,* (Berkeley: University of California Press, 2001), 2.
[68] Nayan Shah, *Contagious Divides*, 7.

individuals and the state. That is, more than a state production of discourses about bodies of color, the individual's relation to medicine was early on based on demand. Chinese herbalists took the risk of coming to the attention of authorities by contesting the new medical regime, carving out a liminal place for practice as merchant intermediaries. There existed a tension between avoiding the appearance of practicing medicine and actually practicing medicine by pursuing traditional methods. That Judge Dooling denied Chinese herbalists a place among the medical profession but emphasized their ability to sell herbs as a business highlights the role of the market.

In order to avoid "practicing" medicine, they did not charge for diagnoses but rather for herbs.[69] A typical herb shop would carry more than three thousand herbs. Herbalists began by taking the pulse of their patients, asking questions related to gender, age, class, and diet.[70] An herbalist would form an opinion about the condition of the patient based on his or her overall health rather than disease as a solitary condition. That is, a person's bodily and mental conditions caused disease rather than disease as a problem in and of itself. They then prescribed the necessary herbs, brewing them into a tea. Sometimes, to offset the bitterness, raisins were offered as sweeteners within the tea or upon drinking the bitter concoction. Patients would return daily or weekly for follow-up examinations. If the results proved effective, patients continued to see the same herbalist. Patients utilized herbalists to treat various ailments from the common cold to

[69] "New Remedy for Dysentery," *Pacific Rural Press*, September 5, 1874.
[70] Garding Lui, *Secrets of Chinese Physicians* (Los Angeles: B.N. Robertson, 1943). Garding Lui was also an herbal doctor. An assortment of literature by the herb companies highlighted their function as health practitioners. See Tan Fuyuan, *The Science of Oriental Medicine: Its Principles and Methods* (Los Angeles, 1897); Fong Wan, *Herbal Lore* (Oakland, 1933).

rheumatoid arthritis.[71] By the late nineteenth century, patrons of herbalists were not just Chinese.[72]

Rather than looking at the body as the sole site for disease and ill health, Chinese herbalists situated health as a holistic practice rooted in every day practices of the individual person. People of many nationalities traveled to Chinatown and various herbal shops scattered through the city to obtain low-cost health care. As early as 1887, the American Journal of Pharmacy noted the usage and growing number of Chinese drug stores in America.[73] The notion of medical tourism begins in the streets and alleyways of Chinatown in the early part of the twentieth century.[74] Medical tourism offered for white patrons in the Los Angeles area, care coupled with the exotic and dangerous.[75] The Chinese physician was "star actor among the odd

[71] Thomas W. Chinn, H. Mark Lai, Phillip P. Choy, eds. *A History of the Chinese in California: A Syllabus* (San Francisco: Chinese Historical Society of America, 1969), 78.

[72] For an understanding of interethnic relationships in Los Angeles see Isabella Seong-Leong Quintana, "National Borders, Neighborhood Boundaries: Gender, Space and Border Formation in Chinese and Mexican Los Angeles, 1871-1938 (Ph.D. diss., University of Michigan, 2010) and "Making Do, Making Home: Borders and the Worlds of Chinatown and Sonoratown in Early Twentieth-Century Los Angeles." *Journal of Urban History* (2014).

[73] Stewart Culin, "Chinese Drug Stores in America" *American Journal of Pharmacy* 59, no. 12 (December, 1887).

[74] For medical tourism see Sean Brotherton, "Fueling la Revolucion: Itinerant Physicians, Transactional Humanitarianism, and Shifting Moral Economies" in Nancy Burke, ed. *Health Travels: Cuban Health(Care) on the Island and Around the World* (Berkeley: University of California, 2013), 127-151. There is a special issue in *Medical Anthropology* about medical tourism. See Andrea Whittaker, Lenore Manderson, and Elizabeth Carthwright, "Patients without Borders: Understanding Medical Travel," *Medical Anthropology* 29, no. 4 (2010): 336-343; Beth Kangas, "Traveling for Medical Care in a Global World," *Medical Anthropology* 29, no. 4 (2010): 344-362; Sara L. Ackerman, "Plastic Paradise: Transforming Bodies and Selves in Costa Rica's Cosmetic Surgery Tourism Industry," *Medical Anthropology* 29, no. 4 (2010): 403-423; and Aren Z. Aizura, "Feminine Transformations: Gender Reassignment Surgical Tourism in Thailand," *Medical Anthropology* 29, no. 4 (2010): 424-443. These articles detail the transformative nature of medical tourism as a modern global phenomenon. However, I contend that this phenomenon existed at the turn of the century within the medical offices of Chinese herbal doctors in and outside of Chinatowns.

[75] Medical anthropologists have documented the contemporary phenomenon of visiting foreign countries for low cost medical treatments, especially for North Americans who visit developing nations whereby "poorer countries offer visitors from wealthier countries an appealing package of state-of-the-art clinical services, hospitable locals, and exotic sightseeing." Sara L. Ackerman, "Plastic Paradise," 404. Anthropologist Sara Ackerman described the journeys of white American women who traveled to Costa Rica for plastic surgery and subsequently care among the local population. Far from just seeking medical attention, women ventured to places such as Costa Rica for the anonymity of their procedures and their foreign caregivers. See also Carolyn Smith-Morris and Menore Manderson, "The Baggage of Health Travelers," *Medical Anthropology* 29, no. 4 (2010): 333. This article documented the desperation of some health seekers stating that some "health-related travel is emergent, desperate, and unplanned."

and curious scenes of Chinatown, that foreign city within the limits of an American municipality."[76]

As the historical forerunners for medical tourism and medical consumerism, Chinese herbal doctors offered a form of consumable orientalism coupled with medical care for white tourists.[77] Moreover, as representatives, they served as an "approachable role model for the community" by offering medical services by an ethnic body.[78] Similarly, Yong Chen and Kenneth H. Marcus argued that Chinese herbalists "functioned as representatives of Chinese culture, and they did not seek to shed their Chinese traditions in interacting with whites."[79] While not far from their own communities in southern California, Chinatown was indeed a foreign country to most white patrons.[80] In the United States, travel writing and tourism served as the basis for constructing what Marguerite Shaffer claimed as "a new national consciousness," one that included visiting American landmarks "amid God's mountains and plains; with Indians, and Mexicans, and Chinese, and coloured[sic] people." Here in the United States, one could visit the "Orient" and the United States in one trolley, train, or car ride.

Chinese herbal doctors deployed "orientalism" to their advantage. In doing so, they created a medical economy that reinforced and disrupted popular discourses of the "orient." Historian Barbara Berglund argued that "among the white middle-class men and women who made up the bulk of Chinatown's tourists, its appeal combined a number of overlapping impulses – the desire to see the exotic the pull of an encounter with a different culture; the draw of

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[76] William M. Tisdale, "Chinese Physicians in California," *Lippincott's Monthly Magazine* 63 (January-June 1899): 411.
[77] Edward Said, *Orientalism* (New York: Vintage Books, 1979).
[78] Matt Garcia, *A World of Its Own: Race, Labor, and Citrus in the Making of Greater Los Angeles, 1900-1970* (Chapel Hill, The University of North Carolina Press, 2002), 193
[79] Kenneth H. Marcus and Yong Chen, "Inside and Outside Chinatown: Chinese Elites in Exclusion Era California" *Pacific Historical Review* 80, no. 3 (August 2011), 399. Marcus and Chen argue that herbalists and missionaries represented the elite class to examine the class contours of the Chinese community during the era of exclusion.
[80] Marguerite Shaffer, *See American First: Tourism and National Identity, 1880-1940* (Washington: Smithsonian Institutional Press, 2001), 16 and 24.

slumming; and the attraction of experiencing, from a safe distance or with a police guide, racially charged urban dangers."[81] Making a trip to Chinatown served as a way to racialize the Chinese and in doing so, confirmed their own whiteness. White interest in Chinatown also helped create an economic niche for the Chinese living in Chinatown. The opportunity to create "real" Chinese in an authentic Chinatown led to the creation of architecture, theatre, curios, and cuisine designed for tourists.[82]

In Los Angeles, after the destruction of the original Chinatown for Union Station in 1933, two Chinatowns emerged.[83] Brainchild of Christine Sterling, chief architect of the Mexican-themed Olvera Street, China City was meant to replace the original Chinatown with a clean, new, and safe version. Indeed the city itself seemed a confusing racial matrix for many white Midwesterners who migrated to Los Angeles with "Mexican, Italian, and Chinese immigrants who dominated Plaza life."[84] Much like Sterling's romantic "Spanish" California, the creation of China City presented an opportunity to create a sanitized form of Chinatown, without the opium dens.[85] Coupled with Hollywood sets and "Chinese" curios, China City opened its gates to "ten thousand Southern Californians bid a smiling hello."[86] However, Chinese families could not live

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[81] Barbara Berglund, "Chinatown's Tourist Terrain: Representation and Racialization in Nineteenth-Century San Francisco," *American Studies* 46, no. 2 (Summer, 2005), 5-6; Barbara Berglund, *Making San Francisco American: Cultural Frontiers in the Urban West, 1846-1906* (Lawrence: Kansas University Press, 2007), 95-136; Will Irwin and Arnold Genthe, *Old Chinatown: A Book of Pictures* (Norwood, MA: The Plimpton Press, 1908).

[82] Raymond W. Rast, "The Cultural Politics of Tourism in San Francisco's Chinatown," *Pacific Historical Review* 76, no. 1 (February 2007), 29-60.

[83] John Kuo Wei Tchen, *New York Before Chinatown: Orientalism and the Shaping of American Culture, 1776-1882* (Baltimore, Johns Hopkins University Press, 1999); Anthony Lee, *Picturing Chinatown: Art and Orientalism in San Francisco* (Berkeley: University of California Press, 2001).

[84] William D. Estrada, *The Los Angeles Plaza: Sacred and Contested Space* (Austin: University of Texas Press, 2008), 109.

[85] See also Cesar Lopez, "El Descanso: A Comparative History of the Los Angeles Plaza Area and the Shared Racialized Space of the Mexican and Chinese Communities, 1853-1933" (Ph.D. diss., University of California, Berkeley, 2002).

[86] "China City Lures Crowd: Ten Thousand Attend Opening," *Los Angeles Times*, June 8, 1938; "Leaders to See New China City: Preview Arranged by Mrs. Sterling, Project's Founder," *Los Angeles Times*, June 4, 1938. Harry Chandler, one of Sterling's ardent supporters and owner of the Times, attended the opening gala along with Louis B. Mayer, a studio executive. See also "Los Angeles "China City" Given Oriental Film Set," *Los Angeles Times*, March 27, 1938; "Plans for Los Angeles New China City Completed," *Los Angeles Times*, January 18, 1939.

in China City itself. The project had little backing from the Chinese American community.[87] In fact, "many who found work in China City were those who, for whatever reason, fell outside of the traditional networks of Los Angeles' Old Chinatown."[88]

There were two Chinatowns. In 1938, Chinese American businessmen created another Chinatown, led by Peter SooHoo. SooHoo hoped "to erase once and for all the erroneous idea that a Chinatown is necessarily a part of the underworld."[89] This Chinatown was not bound by walls but integrated into the city itself. Christine Sterling's "Great Wall" in China City served as an important metaphor: both to enclose the Chinese within a bounded area and create a safe space for patrons to consume the "orient" with its shopping center, rickshaw rides, fake temples, and lotus ponds. Sterling even recreated the set from the popular movie, *The Good Earth*.

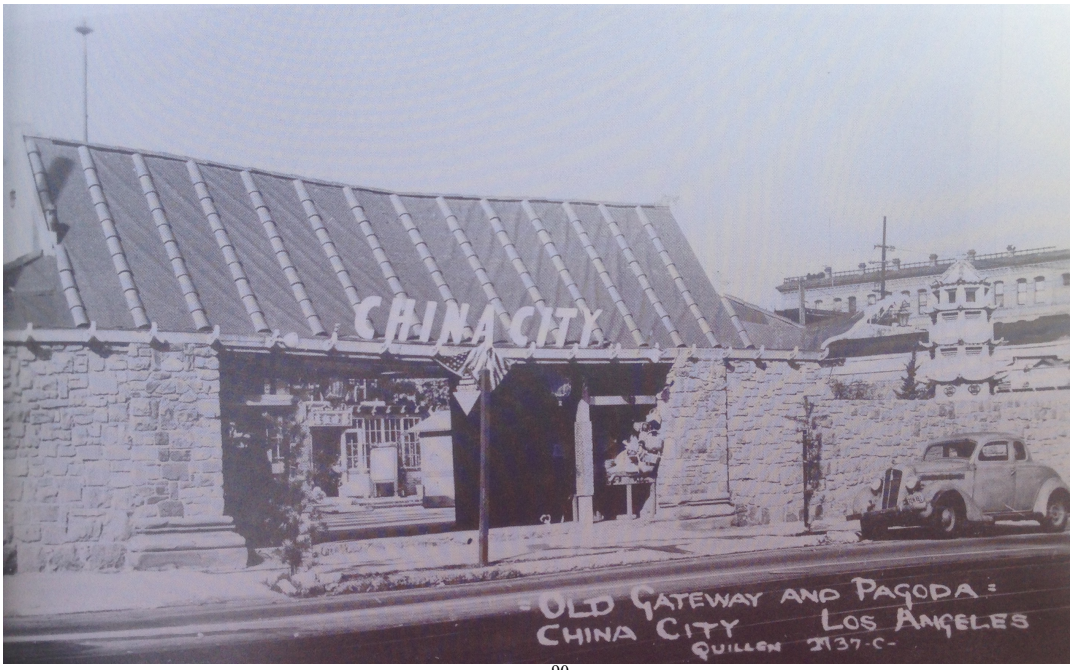

Image 3.2 Entrance to China City from Main Street[90]

[87] A mysterious fire burned down China City in 1939, a year after its opening. Sterling rebuilt China City again. However, another mysterious fire led to the destruction of China City in 1948.
[88] William Gow, "Building a Chinese Village in Los Angeles: Christine Sterling and the Residents of China City," *Gum Saan Journal* 32, no. 1 (2010), 2.
[89] Edwin R. Bingham, "The Saga of the Los Angeles Chinese," Masters' Thesis (Occidental College, 1942): 155.
[90] Reproduced from Jenny Cho and the Chinese Historical Society of Southern California, *Chinatown and China City in Los Angeles* (South Carolina: Arcadia Publishing, 2011), 39.

Image 3.3 Chinese Herb Store in China City[91]

Garding Lui, a well-known herbalist in Los Angeles, wrote a book about his version of Los Angeles' China City, introducing the English speaking public to an alternative to the Chinese community, one that highlighted the imaginative role of the space for white patrons. While describing China City as a beautiful and interesting place he explained, "The Chinese regard it as a beach resort, without water, or sea" indicating that though there was a nice lacquer to the site, it was a place of artifice with businesses that sold primarily "oriental curios." In describing the glamour of China City he also noted the Chinese that worked, "China City may well be called the Chinese Movie Land, for most of the Oriental actors and actresses are from China City."[92] While not explicitly stating the pretext of China City was a conjuration of

[91] Reproduced from Garding Lui, *Inside Los Angeles Chinatown* (Los Angeles: B.N. Robertson Publishing, 1948), 203.
[92] Ibid, 29.

Sterling's Hollywood dreamscape, his descriptions served to highlight that the existence of two Chinatowns served two impulses: the creation of China City as a white imaginary and a new Chinatown that was an actual home.

The Chinese whose homes were in Chinatown narrate different stories about the meaning and differences of Chinatown. For example, Allen Mock's grandfather came here as a young man in the 1800s to work in the railroads. [93] He sent back for Mock's father when he turned eighteen. In China, his father learned herbal medicine and came to America to open up his own business on the U.S.-Mexican border.[94] Mock stated, "Literally they had to go to Vancouver or Tijuana or Mexicali and try to sneak across into the United States." His father eventually settled in Los Angeles' old Chinatown and started multiple businesses in order to support his growing family in the United States, China, and Mexico. Mock remembered old Chinatown businesses as bifurcated: the ones that served whites and "stores that catered to Chinese."[95] Mock recalls incidences in his neighborhood where Chinese business owners utterly refused the patronage of whites,

> You go into an all Chinese-speaking store, they got no time to speak to you in English. It's strictly a Chinese for the Chinese. You go to an herb store, they don't speak English. There was an herb store in there, that was also from our village, and you go in, they're always playing mah jong and they're always drinking tea. Nobody even gets up off their chair to say to the American, what do you want. You could stand there until it freezes over… They'll pass you on, they don't really try to be helpful. In the old days, Caucasians weren't very friendly to the Chinese and in return the Chinese were not very friendly to the outside market. Only the stores, gift shops, they were real nice because that's the only way

[93] Allen Mock oral history 140, interview by Jean Wong, December 13, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

[94] For work on the multinational migrations of the Chinese see Robert Chao Romero, *Chinese in Mexico, 1882-1940* (Tucson, University of Arizona Press, 2011); Grace Delgado, *Making the Chinese Mexican: Global Migration, Localism, and Exclusion in the U.S.-Mexico Borderlands* (Stanford: Stanford University Press, 2012).

[95] See Homi K. Bhabha, *The Location of Culture* (New York: Routledge Press, 1994). Here I am thinking of the "third space" that allows for transgressive behavior.

> they could do business. In the Chinese strictly for Chinese, no, they didn't. They didn't have to bend over backwards to serve you.

As Mock detailed, the Chinese herbal store was a place that could refuse the favor of white patronage.[96]

Indeed, herbal doctors deliberately chose their clientele. They were deliberate in the choices they made in order to cater to a specific community. In contrast to the herbal shop that Mock described with men playing mah jong, the herb shop in China City catered to whites in a clean and organized space with "one room for reception, one for consultation, one in which to keep his two or three hundred different kinds of herbs, and other necessary rooms" (see image 3.3)[97] In presenting such a space, they marketed both "Chinese" and "medicine" within a racialized space in and outside of Chinatown, a sterilized and clean version for white consumers.[98] In line with Christine Sterling's vision of the "orient" in a bound and safe place, they offered to their white patrons, a *medical* experience of the body within a safe ethnic space.

Covering Health

Though there does not exist exact records to indicate who utilized Chinese herbal medicine.[99] However, press coverage, advertisements, publications, and word of mouth advertisers pointed to the importance of herbal doctors as "transmitter of specialized knowledge."[100] Regardless of whether the reporting hailed the practices of Chinese herbal

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[96] I borrow the term "refusing the favor" from Deena J. Gonzalez. I believe this is an apt term for the ways in which Chinese businesses literally refused to cater to whites. See Deena J. Gonzalez, *Refusing the Favor: The Spanish-Mexican Women of Santa Fe, 1820-1880* (New York: Oxford university Press, 2001).

[97] Lui, *Inside Los Angeles Chinatown*, 202. There were some herbalists that even had a separate room for men and women.

[98] See Sharla M. Fett, *Working Cures: Healing, Health, and Power on Southern Slave Plantations* (North Carolina: University of North Carolina Press, 2002); Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (North Carolina: University of North Carolina Press, 2001).

[99] Some famous white patrons such as Jane Stanford, was documented as using herbal doctors to cure her disease. See William Burg, *Sacramento's K Street: Where Out City was Born* (Sacramento: The History Press, 2012), 37-38. See also Patt Morrison, "Reviving the Chinese Ghosts of Gold Rush California," *Los Angeles Times*, March 7, 1999. See also "Medical News" *Journal of the American Medical Association* 74, no. 1 (January 3, 1920): 37.

[100] Kenneth H. Marcus and Yong Chen, "Inside and Outside Chinatown," 374.

medicine or condemned them, the press served underscored the ambiguous position of Chinese herbal medicine. For example, press coverage about Li Po Tai, a famous herbal doctor who began in San Francisco but established another business in Los Angeles, illustrated the conflicting opinions surrounding Chinese herbal doctors.[101]

Li Po Tai first started his practice in San Francisco and was considered one of the first Chinese doctors to work with white patrons before establishing another business in Los Angeles. An immigrant from Canton, Li Po Tai established his herbal business during the gold rush era. He and his predecessors seemingly took up this call and were among the first to set up a system of medical tourism in and outside of Chinatown, utilizing their position as ethnic Chinese practitioners and capitalizing on a form of medicine at variance to western medicine. Moreover, they utilized the word of mouth advertisements of white patrons such as George Hazard, brother of Los Angeles mayor Henry Hazard.[102]

According to William M. Tisdale of Lippincott Magazine, Chinese physicians were the only acceptable kind for Chinese in the United States. Li Po Tai was one of the "genuine Chinese physicians and impose upon the credulity of their fellow-countrymen and tourists."[103] Moreover, the treatment of white patients, according to Tisdale, contrasted significantly to the treatment of their Chinese patients. In treating white patients, doctors such as Li Po Tai, "observe[d] the utmost neatness and cleanliness, and adhere strictly to their rule of employing only non-

[101] Li Po Tai may have also had offices in other states. See "Advertisement," *The Sunday Oregonian*, October 1, 1901: 6. The romanization of the name is different in English but the Chinese name is the same. However, Li Po Tai died in 1893, thus this advertisement may have utilized his well-recognized name for their practice.
[102] Yong Chen and Kenneth H. Marcus, "Inside and Outside Chinatown," 378-379. Historian Vicki Ruiz calls these patrons "angels." Conversation with Vicki L. Ruiz, December 31, 2014.
[103] William M. Tisdale, "Chinese Physicians in California," *Lippincott's Monthly Magazine* 63 (January-June 1899): 411-416

poisonous herbs."[104] Intentionally or not, his article served as advertising to help other white patrons distinguish between clean and sanitized healthcare and "quacks."

In contrast to this recognition, Chinese herbal doctors continued to raise the ire of those who wanted nothing more than to rid the city of "curious customs of the yellow man."[105] While writers such as Tisdale hailed the medical cures of Li Po Tai, the doctor was in fact, a thorn on the side of California's white medical establishment and continued to haunt the medical field well after his death in 1893. The California State Journal of Medicine tried to discredit Li Po Tai by pointing to the fact that he was not a doctor but merely a front for "two white men wanting to make money conceived the idea of employing a shrewd Chinaman (he subsequently proved shrewd all right!) to play doctor at a salary of $100 per month.."[106] According to the article, once Li Po Tai realized the lucrativeness of the business, he got rid of his white associates and continued to sell nostrums for the kidney and liver and that most businesses of Chinese doctors were run by white men. The author, J.F. Gibbon further stated, "Other shrewd Chinamen, learning of Li Po Tai's success, tried their hand at the game, and it worked so well that Chinese doctors sprang up all over the coast and into the adjoining states and territories."

Yet despite citing the questionable cures of "dried powdered snakes and lizards, wasps' nests, scrapings of deer's horns, herbs teas," the author recognized the lucrative market for these "strange" herbal remedies. The author lamented that many "fancy white sick men and women going to a Chinese sanitarium to drink herb tea with a pinch of powdered died snake or lizard thrown into it!"[107] Their irritation at the success of herbalists were coupled with frustration over

[104] Ibid, 415.
[105] "Chinese Medicos," *Los Angeles Times*, September 27, 1900.
[106] J.F. Gibbon, "The Advent of Chinese Doctors into California," *California State Journal of Medicine* 13, no. 2 (February 1915), 74-75.
[107] According to Gibbon, when Li Po Tai died he had over "300 carriages, two hearses, four horses, each covered with white flynets, two white bands of music, 40 pieces of each, together with several Chinese bands."

their claims of being "doctors," a moniker they felt were reserved for the white medical establishment.[108] The Board of Medical Examiners expressed their frustration, arguing that herbalists "absolutely knowing nothing of anatomy or the circulation of the blood."[109] They were similar to "palmists, seers, the spooks, the astrologers, and the rest of the fraternity, if catering to superstition pays!"


THE GUARDS AT LI PO TAI'S COFFIN.
[From a photograph.]

Image 3.4 Funeral of Li Po Tai in San Francisco[110]

[108] C.B. Pinkham, "The Chinese Herbalist and the Medical Practice Act," *California and Western Medicine* 23, no. 6 (June 1925), 737-738.
[109] J.F. Gibbon, "The Advent of Chinese Doctors into California," *California State Journal of Medicine* 13, no. 2 (February 1915), 75. See also "The Pacific Coast Trade in Chinese Medicines and How a Celestial Pharmacist Makes Drugs out of Horned Toads," *San Francisco Chronicle*, March 29, 1903.
[110] "Lined with Gems: The Dead Chinese Doctor's Last Bed," *The Morning Call, San Francisco*, March 23, 1893, 8.

Herbalists created their own press coverage and circulated literature about their role in American medicine.[111] Garding Lui's *Secrets of Chinese Physicians* served as a means to familiarize English speakers to Chinese medicine. Garding Lui even conducted an interview with Los Angeles Times Sunday Magazine.[112] In this article, he persuasively described the history of Chinese medical practices. While asserting the long tradition of herbs, he adds a note of exoticism, "the Chinese healer employs romance and tradition with every actual medicinal benefit." Despite frequently using "doctor" and "physician" as part of his descriptions, he was also careful to also describe and make the distinction between medical professionals and "herb specialists" by stating "what he is called depends upon his credentials and the designation given him by patients."[113] This kind of discrepancy suggested that Lui, though recognizing the limitations set by California's Medical Board, defended the work of herbalists. His books functioned as a medical history, a medical handbook, and advertising.

Advertising Health

Some Chinese herbal doctors established successful businesses (see Appendix C).[114] The Los Angeles City Directory listed three practitioners as early as the turn of the century with a city population a little over two thousand people. However, these numbers reveal as much as they obfuscate as this does not represent a full list of herbalists in southern California. Some herbal doctors did not list their business for fear of reprisal from the California Medical Board.

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[111] Garding Lui, *Inside Los Angeles Chinatown* (Los Angeles: B.N. Robertson Publishing, 1948); Garding Lui, *Secrets of Chinese Physicians* (Los Angeles: B.N. Robertson Publishing, 1943). There were many circulars, books, and pamphlets created by Chinese herbalists. Garding Lui is one of the most popular though very few scholars have examined his work in depth and within the context of medical discourses. For Oakland, see Fong Wan, *Herb Lore* (Oakland, 1936). According to Fong Wan, in 1925 there was an anti-herb bill introduced in the State Assembly. Due to his testimony, the bill was withdrawn. See also Haiming Liu, "Chinese Herbal Medicine," in *Asian Americans: An Encyclopedia of Social, Cultural, Economic, and Political History*, eds. Xiaojian Zhao and Edward Park (Santa Barbara, CA: Greenwood Press, 2013), 271-272.

[112] Elsie Madison, "Herbs for the Ills of China," *Los Angeles Times Sunday Magazine*, February 9, 1936, 8 and 27.

[113] Garding Lui, *Inside Los Angeles Chinatown*, 200.

[114] Los Angeles City Directory, 1900-1941. Special thanks to Gilbert Hom at the Chinese Historical Society of Southern California for helping to compile the list.

This list also does not contain the numbers of herbalists practicing in the county of Los Angeles or surrounding unincorporated areas. Indeed, historian Yong Chen indicated, the vast majority of Chinese in Los Angeles lived outside of the city and Chinatown.[115] Despite the small number living in Los Angeles city itself, there was a growing trade in the herb business, especially by the 1920s and 1930s.[116] The city directory also provided a means to advertise their presence for patrons.

Advertising proved effective but herbalists were selective in their campaigns for patrons. According to Garding Lui, "The herbalist likes to get in a prosperous residence district. He likes to be near the end of a street, and near a settlement composed chiefly of Germans, Italians, Mexicans, Scandinavians, Irish, English, and Scotch descendants."[117] Li Po Tai's son (Li Wing) and nephew (Tom Foo Yuen) inherited his medical practice and used his reputation to open their own herbal practices beyond the streets of Chinatown.[118] Southern California became the perfect place, given its salubrious reputation. Touted as a health mecca for ailing and well-heeled eastern tourist, Los Angeles attracted travelers who came to improve their health.[119] Chinese herbal doctors rearticulated these discourses of a salubrious space in advertisements.[120] Alongside city boosters, Chinese herbal doctors such as Li Wing and Tom Foo Yuen situated themselves within

[115] Yong Chen and Kenneth H. Marcus, "Inside and Outside Chinatown," 372.
[116] This study ends in the 1940s. Moreover, by the 1940s, the trade of herbs was difficult because of the war. Many herbalists were unable to get imported herbs from China.
[117] Lui, *Inside Los Angeles Chinatown*, 202.
[118] I use the original romanization of their names rather than the modern Mandarin translation as they were originally Cantonese speakers.
[119] William Deverell, *Whitewashed Adobe: The Rise of Los Angeles and the Remaking of Its Mexican Past* (Berkeley: University of California Press, 2004).
[120] Liu, *Transnational History of a Chinese Family*, 4. Haiming Liu wrote, "The herbalists' history reveals a little-known aspect of cultural relations between mainstream American and Asian Americans. Chinese herbalists did not become less Chinese in developing roots in America, but white Americans adapted themselves to an Asian therapy. The interaction thus became an interesting instance of reverse assimilation." In my own work, I did not find reverse-assimilation, rather Chinese herbal doctors marketed themselves within mainstream conversations of health.

utopian tropes of wellness.[121] In a quarter page ad in the Los Angeles Herald, the Foo and Wing Herb Company proclaimed, "Southern California for Health Seekers – People Who Desire the Benefits of Our Incomparable Climate – Advantages Often Overestimated."[122] Instead, they insisted that there was a "popular misconception of the value both of climate and of medicine… climate, in itself, has very little influence for healing." Furthermore, they claimed the fault lay with "ignorant doctors in the east who have patients that they can not cure and don't know what to do with. They send them to Southern California to get them out of the way." Moreover, "Patients themselves have blind faith in the powers of medicine… medicine is a hidden science to the average man." Their claims created a cross-cut to medical discourses that envisioned western doctors as the sole agents of well-being by highlighting the alternatives of traditional medicine.

Chinese herbal doctors appealed to consumers by suggesting that their knowledge was generationally acquired, rather than learned through books theirs were "family secrets." The advertisement, obviously meant to appeal to white patients, elided race as a means to gain customers.[123] On the one hand, they insisted that white patrons overlook their ethnic identities, yet they sold their identities as exotic Chinese with their herbs as a racialized commodity. They declared,

> do not be deterred from doing this by mere race prejudice, which is unworthy of a reasoning human being. You will be astonished to find how thoroughly these physicians have adapted themselves to the ways and manners of thought of Americans.

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[121] For a history of advertising see Roland Marchand, *Advertising the American Dream: Making Way for Modernity, 1920-1940* (Berkeley: University of California Press, 1985).
[122] "The Invalid Tourist," *The Los Angeles Herald*, March 4, 1900.
[123] Hiram Perez, "How to Rehabilitate a Mulatto: The Iconography of Tiger Woods" in *East Main Street: Asian American Popular Culture*, eds. Shilpa Davé, LeiLani Nishime, and Tasha Oren (New York: New York University Press, 2005), 222-245. I use Perez's argument about racial elision to examine the ways in which race is both highlighted and ignored.

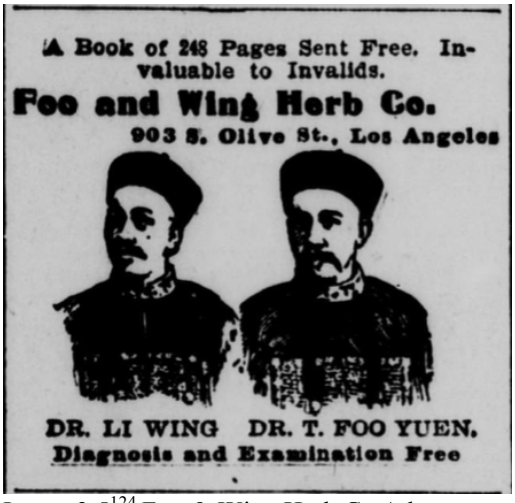

Image 3.5[124] Foo & Wing Herb Co Ad

Image 3.6 Business Card[125]

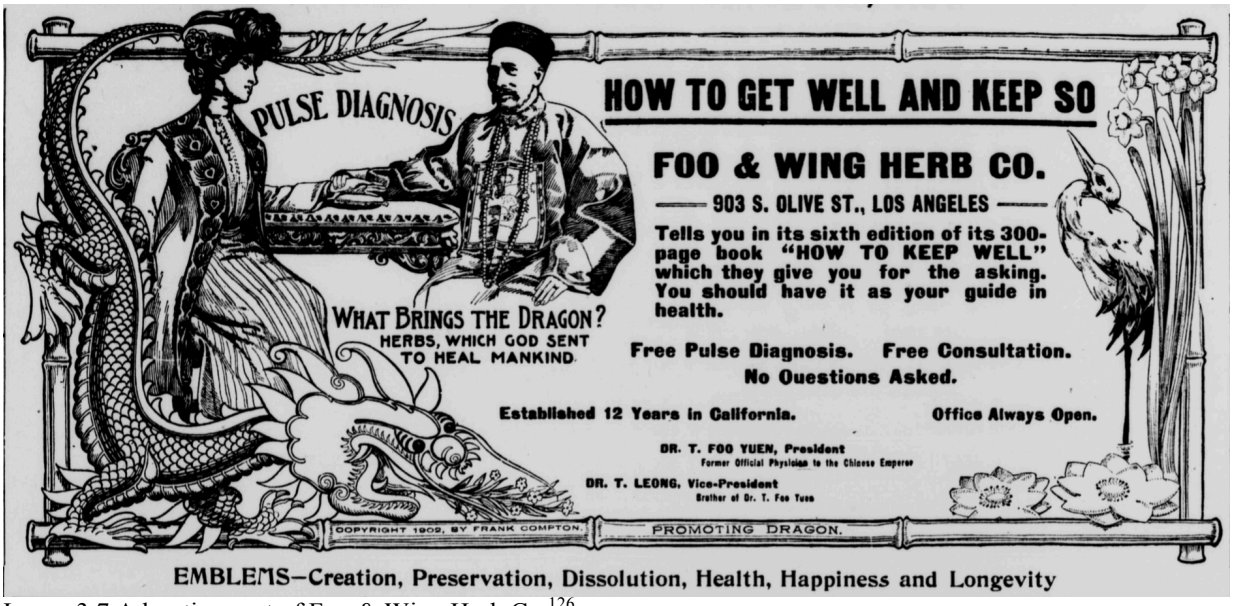

Image 3.7 Advertisement of Foo & Wing Herb Co.[126]

[124] "Ad," *The Los Angeles Herald*, March 4, 1900.
[125] Special thanks to Gilbert Hom of the Chinese Historical Society of Southern California for allowing me to utilize his vast collection of images and sources on Chinese herbal doctors.
[126] "How the Promoting Dragon Brings Health, Happiness, and Longevity," *Los Angeles Herald*, May 1, 1902. Interestingly, even as second generation Chinese Americans, they wore these traditional vestments. According to Gilbert Hom, Tom Foo Yuen's attire was a joke among his family members. He wore them at all times.

Image 3.8 Foo & Wing Herb Company with white patrons[127]

While asking potential white patrons to set aside their "race prejudice," their advertisements belie this request. Donning traditional Chinese outfits, sometimes in gold embroidery and silk, Chinese medical doctors utilized ethnically charged imagery to appeal to their clientele. Many places were also beautifully and extravagantly furnished for white purveyors with "oriental draperies, teak wood furniture, Chinese porcelains and other fittings calculated to create an impression of culture and wealth in an environment advertised as an ethnic space."[128] In their

[127] Foo & Wing Herb Company, *The Science of Oriental Medicine: It's Principles and Methods Comprising Biographical Sketches of Its Leading Practitioners, Its Treatment of Various Prevalent Diseases, Useful Information on Matters of Diet, Exercise and Hygiene* (Los Angeles: W.A. Hallowell, Jr., 1902), 112-113. The photo lists the following patrons in the front of their Broadway establishment: C.R. Wheeler, Mrs. J.C. Rhoades, A.A. Dexter Jr., Mrs. and Mrs. Magga Motherspaw, E.R. Van Deursen, W.M. Wright, J.T. Burrows, E.P. Lane, Henry B. Ruggles, John Scealey, A.J. Hendrickson, J.R. Campbell, Mrs. Mattie Reeder, E.C. Warren, Mrs. Fannie Van Leuven, Miss B.M. Cox, Mrs. C. Ellis, J.B. Courtney, Mrs. J.A. Jones, P.J. Brannen, and Mrs. T.G. Kelty.
[128] "Herb Quacks in Law Net," *Los Angeles Times*, June 4, 1907.

advertisements for health, the Foo & Wing Herb Company created the Chinese imaginary of space with dragons, cranes, lotus, and bamboo as a testimony to their racial heritage. The picture of a Chinese doctor simply touching the pulse of a Victorian era, middle-class white woman offered a form of care that seemed safe, exotic, and confidential.

White women patronized these shops, considering their sojourns with Chinese doctors "romantic" as they walked into rooms filled with incense or "joss sticks."[129] This seems especially important in an era where public health officials stressed that Chinese men were both medical and sexual menaces.[130] But perhaps there were other reasons Chinese herbalists appealed to white women other than an exotic adventure. In 1911, T. Wah Hing was indicted for the crime of abortion and charged with

> willfully, unlawfully and feloniously use and employ upon one Mrs. Lottie Phillips, who was then there a pregnant woman, certain instruments, to wit, a long tongue-shape instrument made of a hard and nonflexible substance… with intent then and there and thereby to procure the miscarriage of the said Mrs. Lottie Phillips.[131]

Mrs. Lottie Phillips testified that she was married for one month and appeared to be three months pregnant. She had originally created a witness statement but withdrew it from testimony stating, "it would ruin her and cause trouble with her husband."[132] In the original trial, T. Wah Hing was convicted of malpractice and sentenced to three years of prison.[133] However, he appealed the case. During cross-examination, Lottie Phillips' husband claimed that he had procured pills from the Chinese herbalist that would grant his wife a miscarriage after she had procured an abortion elsewhere with her mother. Much confusion surrounded the case with witness discrepancies,

[129] "Herb Quacks in Law Net," *Los Angeles Times*, June 4, 1907. This article notes that most patrons of Chinese herb shops were women.
[130] See Nayan Shah, *Contagious Divides.*
[131] *People v. T. Wah Hing* 114 p.416 (Cal. App. 1911). It is uncertain if this is the same T. Wah Hing or his predecessors that treated Mrs. Leland Stanford. See also "Juggled," *San Francisco Call*, November 11, 1909.
[132] "Counter Charges Fly in Hing Cage: Chinese Physician Accuses Prosecution of Trying to Trap him into Bribery," *Sacramento Union*, December 10, 1909.
[133] "Chinese Doctor Gets Three Years in Prison," *San Francisco Call*, December 15, 1909.

police bias, and lack of evidence. In 1911, due to erroneous records that were "highly prejudicial," the court of appeals overturned the original conviction.[134]

In 1926, T. Wah Hing again appealed to the courts in two later cases on charges of practicing without a medical license. His patient, Mrs. McBride "complained of being bloated." While this does not directly indicate that Mrs. McBride sought an abortion, one could make a reasonable speculation. Professionally licensed physicians, midwives, and nurses were mandated to report abortions to the state. Chinese herbalists, who fell outside the purview of the state, may have provided a safe option to avoid prosecution. While little evidence suggests widespread use of Chinese herbs as aborticides, the case of T. Wah Hing illustrates the possibility of that herbs sold were used as a form of birth control.[135] Historian Haiming Lui underscores the importance of Chinese herbalists for white women as offering a form of non-invasive treatment for women's health.[136] While unclear how many women utilized the services of Chinese herbalists for reproductive issues, certainly a market existed. In an environment that guaranteed anonymity, Chinese herbal shops provided an alternative for women who dared not approach traditional doctors.[137]

Some herbalists built very prosperous and expansive businesses.[138] Press coverage of Tom Foo Yuen's trial suggested that he had made millions because of his herb trade. The Foo

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[134] Though it is uncertain if it was the same T. Wah Hing, there was press coverage on a doctor who gave a woman an herbal remedy for an abortion and died. See "Took Chinese Medicine," *San Francisco Chronicle*, August 28, 1891. There was another woman who died after taking medication from T. Wah Hing, see "Released from Jail," *Sacramento Union*, August 15, 1909, 56.

[135] While not an herbalist, Betty Wong Lem's mother also helped women with their reproductive health in Chinatown. Married to an herbalist, she seemed to have learned the trade from her husband. I discuss this further in the next chapter. See Betty Wong Lem Oral History 18, interview by Jean Wong, April 5, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

[136] Haiming Liu, *Transnational History of a Chinese Family*, 53.

[137] See also *People v. T. Wah Hing* 190 p. 662 (Cal. App. 1920) and *People v. T. Wah Hing* 249, p. 229 (Cal. App. 1926). See also Charles D. Ball, "Criminal Abortions and the Medical Profession," *California State Journal of Medicine* 14, no. 2 (February 1916), 64-66.

[138] "In Frock Coat and High Hat: Millionaire Chinese Doctor in Police Court," *Los Angeles Times*, March 10, 1908.

and Wing Herb Company had offices in Boston, Denver, Los Angeles, San Jose, and Oakland.[139] They utilized "American" attendants as part of their business practices to appeal to white patrons. In their advertisements, Foo and Wing also used enthusiastic testimonials from white patrons to proclaim the efficacy of their treatments.[140] For example, in the same ad, a man identified as the Reverend James Bracewell of Ontario, California boldly described, "All those cases were chronic, difficult, and unyielding, where the ordinary means as employed with our American doctors had utterly failed to effect a cure."

While one cannot take stock in testimonials, they were common tropes in advertisements for medicinal remedies at the turn of the century.[141] Testimonials by white patrons possess common themes: the long suffering nature of their ailments, the failure of western medicine and the surprising and successful outcomes of their treatment. Of course, advertisements provided a disclaimer:

> All consultations and pulse diagnosis is free. No fee is charged as Dr. Foo, not being a citizen, cannot receive a license which any young graduate of a Medical College here can get for $1.50 and so is prohibited by law from charging a fee. What profits the company makes is from the sale of the simple herb remedies, which have proved such a blessing to thousands in California.[142]

Chinese herbal doctors also marketed to non-English speaking immigrants.[143] Unlike English language newspapers, Chinese herbalists did not highlight their "oriental" status to their

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[139] "Return of T. Foo Yuen," *San Francisco Chronicle*, March 31, 1912.
[140] "How the Promoting Dragon Brings Health, Happiness, and Longevity," *Los Angeles Herald*, May 1, 1902.
[141] While herbal doctors had many detractors, there were also many who supported their work. For example, M. J. McGinnis responded to press coverage on Chinese doctors and objected to the raids by the police and public health officials. The author recounted the 2 a.m. raid on Dr. H.T. Chan's home on Main Street as "cannibalistic" as the raid occurred with his wife and two small children in attendance. McGinnis stated, "the business of these doctors practically ruined" by these "barbarous treatment of the Chinese doctors of our city." The author further objected to the treatment of Dr. Chan as, "many can testify to the almost miraculous cures by Chinese physicians." See M.J. McGinnis, "Unfair Treatment of Chinese," *Los Angeles Times*, March 19, 1913.
[142] "How the Promoting Dragon Brings Health, Happiness, and Longevity," *Los Angeles Herald*, May 1, 1902.
[143] There were also ads in other ethnic vernaculars though it is beyond the scope of this chapter. See "Advertisement," *La Opiñion*, July 17, 1931. See Raymond Lou, "The Chinese American Community of Los Angeles, 1870-1900: A Case of Resistance, Organization, and Participation" (Ph.D. diss., University of California,

Spanish speaking clientele. To be sure, they noted their status as Chinese but did not "orientalize" their advertisements in the same ways they did to attract Anglo patrons. In doing so, there were even instances of cross-cultural medical partnerships, such as a botanical called "Builtone," that claimed it was the Mexican and Chinese Pharmacy on 437. N. Los Angeles Street. This may have been the small pharmacy established by a group of Chinese, Dr. Loo Chee, Dr. Samuel Ng, Dr. Si Chun, and Paul Gómez in old Chinatown, the first of its kind. Paul Tom described his internship at the pharmacy in the 1930s as a great experience as he and Gómez got along well and "he taught me a lot of things."[144] Patrons of the pharmacy included, "orientals, Chinese, and Mexican." The pharmacy also had a soda fountain that became a meeting place for young Chinese kids.

Historian George Sánchez documented the presence of Chinese herbalists within the Mexican American community,

> Asian physicians, however, were the largest group of non-Mexican professionals to appeal to Mexican immigrants, largely stressing their training in herbal medicine, an area not unfamiliar to rural Mexicans. Among them was Dr. Chee, who characterized himself as "Doctor Chino" in 1920, and Dr. Y. Kim, who boasted the combination of a Yale degree and a specialty in Oriental herbal treatments.[145]

Responding to a need, Chinese herbalists advertised to the growing Mexican immigrant community. They advertised their practices and herbs within the prominent and largest Spanish-

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Irvine, 1982). Lou briefly mentions the presence of Chinese herbalists in Spanish newspapers but does not cite or give specific examples.

[144] Paul Tom Oral History 101, interview by Bernice Sam, April 28, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles. I am uncertain of the Romanization of the Chinese names. It is very likely that the same Dr. Lew Chee who opened this pharmacy, was the same herbalists that advertised to the Mexican community.

[145] George Sánchez, *Becoming Mexican American: Ethnicity, Culture, and Identity in Chicano Los Angeles, 1900-1945* (New York: Oxford University Press, 1995), 176.

language newspaper, La Opiñion.[146] For example, in 1927, an advertisement showed Dr. Chee, wearing glasses and clad in a western style suit. The advertisement asked, "Do you suffer from any illness?"

Image 3.9 Advertisement of Dr. G. Lew Chee from La Opiñion[147]

> Thousands of Mexicans suffering from different diseases have been cured by this famous Chinese doctor and his wonderful treatments in Chinese herbs. Consult Today: It may be that tomorrow will be too late. Consultations in Spanish, French, English, Chinese

[146] The first advertisements of Chinese herbalists show up in the second year of *La Opiñion*. I found no advertisements in 1926, the first year the newspaper was established.
[147] Advertisement, *La Opiñion*, January 16, 1927. Translation my own. See also Advertisement of Hung Took Tong Herb and Tea Company, *La Opiñion*, February 8, 1930.

In a later advertisement, Dr. G. Lew Chee claimed that he was the only certified Chinese doctor in this city.

Image 3.10 Advertisement of Dr. G. Lew Chee from La Opiñion[148]

> To All My Old Patients, To All my Customers and Friends: I take this occasion to reiterate my most expressive thanks for the trust they have accorded me and I assure you that all my efforts will always be worth it.

Perhaps to gain more Spanish-speaking clients, Dr. Chee reiterated his continued work among his faithful as patients, rather than customers. Dr. G. Lew Chee, a licensed physician in the state of California, earned his medical degree from the University Medical College of Missouri

[148] Advertisement, *La Opiñion*, January 1, 1928. Translation my own. By 1932, Dr. G. Lew Chee slowed his advertisements in *La Opiñion*. Perhaps having built a lucrative business among the Mexican immigrant community, he no longer needed the ads.

1911.[149] He found that the white community did not want treatment from a Chinese doctor and Chinese patients did not want to be treated by western methods.[150] After a few years, he moved to Butte, Montana where he began advertising as an herb doctor who also western methods. He continued to practice in Butte as an herbalist but he moved his wife and growing family to Los Angeles for a better climate. After a few years, he moved his practice to Los Angeles and established an office that utilized both western and eastern medicine to Anglos, Chinese, and Mexican patients.[151]

Similarly, D.K. Tuey advertised he was a "friend of the Mexicans." These advertisement emphasized acquaintance and affinity with the Mexican community. This stands in contrast to English-speaking advertisements that emphasized professionalism.[152] In a later advertisement, D.K. Tuey included the testimonials of his Spanish-speaking patients. Similar to English-languge advertisements, D.K. Tuey marketed to women. For example, one patient, identified as Arcadia Campos declared, "It is my pleasure to send my picture as proof that their drugs have healed me of all of my diseases… I already feel better and I thank God."[153] Advertisements neatly captured the anxiety of would-be patients and urgency to find a cure that worked. Noting the many

[149] *Directory of Physicians and Surgeons, Osteopaths, Drugless Practitioners, Chiropodists, Midwives 1918*, Department of Consumer Affairs – Board of Medical Examiners Records, F3760: Series 13, California State Archives, Office of the Secretary of State, Sacramento, California. Dr. Chee was given the license number C-1099. He was licensed in Los Angeles county by the state on November 7, 1918.

[150] Gilbert Hom stated that Dr. Chee shared a similar experience as Wah Jean Lamb, the first Chinese who received a medical degree from USC in 1898. Special thanks to Gilbert Hom who shared these family histories with me. Conversation with Gilbert Hom of the Chinese Historical Society of Southern California, December 21, 2015. See also "100 Years of Trojan Spirit," *Then & Now* (Summer 1998).

[151] Conversation with Gilbert Hom of the Chinese Historical Society of Southern California, December 21, 2015.

[152] Garding Lui's book about Chinese doctors was meant to familiarize English-speaking patrons to the practice of herbal remedies. I know of no such treatise in Spanish. See Garding Lui, *Secrets of Chinese Physicians* (Los Angeles: B.N. Robertson Publisher, 1943).

[153] Advertisement by Chinese herbalists to Mexican immigrants also appealed to women. An advertisement by D.E. Chong claimed, "These herbs are good for secret diseases of both sexes and all kinds of chronic diseases in general." See Advertisement, *La Opiñion*, October 24, 1927. Translation my own.

diseases, advertisers utilized "scare copy" and their ability to resolve individual requests for health.[154]

¿Esta Ud. Enfermo?

¡LA SALUD ES MEJOR QUE EL ORO!

OBTENGALA SIN EL USO DE DROGAS VENENOSAS

D. K. Tuey, famoso herbolario chino ha probado ser uno de los mejores y de más confianza en los Estados Unidos. Ha tenido más de 20 años de experiencia. Durante ese tiempo millares de clientes han obtenido alivio permanente. ¿Por qué no lo conseguirá usted también? No importa qué enfermedad tenga. Las yerbas chinas son eficaces para los desórdenes del Estómago, Reumatismo, Catarro, Enfermedades del Hígado y los Riñones, Sangre impura, Desórdenes de la Sangre, Cáncer, Dolores de las Piernas, Dolencias de las Señoras, Ataques, Fístulas y muchas diferentes clases de enfermedades. Consultas gratis. Venga a verme o escríbame hoy mismo. Se habla español.

"Señor D. K. Tuey.—Mi apreciable señor: Es de todo mi gusto enviarle mi fotografía para que sea una prueba de que sus medicinas me han sanado de todas mis enfermedades. Después de estar padeciendo más de 23 años de Reumatismo, Dolores del Vientre, Agitación del Corazón, Dolor en el Cerebro, Neuralgias, un cansancio que no podía ni respirar, Inflamación del Vientre, ya me encuentro buena y doy gracias a Dios y después de Dios a sus medicinas que esas fueron las que me sanaron, sin más su servidora.—Arcadia Campos. (firmado).—Box 632.—Brownsville, Texas".

"Deming, N. Mex., Mayo 26 de 1930.—D. K. Tuey.—Muy señor mío: La presente sirve para noticiarle que con las últimas medicinas que me mandó estoy tan aliviado que ahora me siento curado por completo, pues mis intestinos funcionan bien y mi estómago anda bien, es decir, en una palabra, nada me duele, estoy bueno y sano y este favor se lo debo a las buenas medicinas y a usted principalmente, pues me parece que no necesito más medicinas, me queda un paquete el cual me reservo para cuando se me ofrezca. Por lo tanto le doy a usted las más expresivas gracias porque me sanó. Sin otro asunto, su S. S.—José Caballero".

NO SE CONFUNDA. --- NO TENGO SUCURSALES

D. K. TUEY

HORAS DE OFICINA: 9 A. M. a 5 P. M. y de 6 a 7:30 P. M.
DOMINGOS: de 10 A. M. a 2 P. M.

150½ S. MAIN ST. LOS ANGELES, CALIF.

Image 3.11 Advertisement of D.K. Tuey from La Opiñion[155]

Of course, rural Mexicans had a long tradition of folk medicine that involved herbal remedies.[156] In his work on the Chinese in northern Medixo, historian Robert Chao Romero's work on the Chinese in northern Mexico mentions merchants who sold dried goods and

[154] Marchand, *Advertising the American Dream*, 14. Marchand documented the use of this kind of scare tactic or "negative appeal" in advertising.
[155] Advertisement, *La Opiñion*, July 5, 1931. Translation my own
[156] Lui, *Inside Los Angeles Chinatown*, 204. There is much more work needed on the history of Chinese herbs and herbalists in Mexico. While the use of *curanderos* was a familiar trade, it would be interesting to see the links and departures between these two systems of medicine. See also Grace Delgado, *Making the Chinese Mexican: Global Migration, Localism, and Exclusion in the U.S.-Mexico Borderlands* (Stanford: Stanford University Press, 2012); Veronica Castillo-Munoz, "Divided Communities: Agrarian Struggles, Transnational Migration and Families in Northern Mexico, 1910-1952 (Ph.D. diss., University of California, Irvine, 2009); Jason Oliver Chang, "Outsider Crossings: History, Culture, and Geography of Mexicali's Chinese Community" (Ph.D. diss., University of California, Berkeley, 2010).

merchandise to both the Chinese and Mexican community, including herbal medicine.[157] Quite possible, the herbal trade was a transnational enterprise among the Chinese who settled in Mexico, Canada, and the United States.[158] Even those herbalists who did not have fluency in Spanish or knowledge of Mexican culture still catered to Mexican clients by relying on interpreters. Garding Lui noted the presence of Chinese herbal doctors in the Mexican community. He wrote,

> Here in Southern California, in cases where the business warrants it, a young woman is often employed as secretary and nurse. Generally a Mexican girl is preferred, because she can speak Spanish. Where there is a large patronage of Spanish or Mexican people, a Mexican girl is needed who can write and interpret Spanish.[159]

The advertisements in La Opinion stand in contrast to those in the English-language newspapers. Rather than a consumable form of orientalism, Chinese herbalists associated their trade with modernism. Their images often featured men wearing western suits. In discarding their robes of orientalism, advertisers did not appeal to the exotic but familiar. Chinese herbal practitioners carefully crafted their image as modern professionals rather than exotic emissaries.

Chinese herbalists did more than hawk herbs in their advertisements; they also offered hope and solutions. As mentioned previously, "the herb specialist is not supposed to diagnose cases, but he gives free consultation to the sick before selling them the herbs they need."[160] In doing so, they elevated their status as mere merchants of goods to an actual medical occupation.

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[157] See Robert Chao Romero, *Chinese in Mexico, 1882-1940* (Tucson: University of Arizona Press, 2011), 148. Romero only mentions Chinese medicine in passing but notes the merchant class in Mexico.
[158] Ling Liu, *The Chinese in North America: A Guide to their Life and Progress* (Los Angeles: East-West Culture Publishing Association, 1949). Primarily a pictorial history, Liu documents the presence of Chinese in Canada, Mexico, Cuba, Jamaica, Haiti, Dominican Republic, Puerto Rico, Trinidad, Venezuela, Colombia, Panama, Costa Rica, Nicaragua, Honduras, El Salvador, Guatemala. These pictures reveal government buildings and businesses in these countries that sold "dried goods" which probably also included herbs.
[159] Lui, *Inside Los Angeles Chinatown*, 204.
[160] Lui, *Inside Los Angeles Chinatown*, 200.

Even those doctors who did not claim familiarity relied on translators for their clientele.[161] Their Spanish-speaking secretaries acted as cultural brokers for doctors who were themselves, medical brokers within the marketplace of health.

Chinese herbalists sold herbs in Los Angeles created an alternative space in which to practice medicine, providing affordable healthcare for patients as consumers, not only in white neighborhoods but in Spanish-speaking communities as well.[162] According to Gilbert Hom of the Chinese Historical Society of Southern California, those that served the Chinese and Mexican immigrant community, herbalists who served the Chinese community, were not wealthy but barely eking out a living. However, herbal doctors who catered primarily to whites charged much higher prices.[163] Chinese herbalists, their advertisements, and their place within medical geography of southern California offer a glimpse into the multiple conversations that occurred outside of the range of public health departments.

Chinese herbal medicine created a different route to success in a racially and economically stratified society. As shown in the next chapter, the success of the herbal shop depended on the whole family. Medicine was not just an enterprise that relied on the male herbalist at the front of the store. However, in the backrooms of their stores, wives and children

[161] In an informal conversation with Gilbert Hom of the Chinese Historical Society of Southern California, he recounted the history of T.B. Chew who worked in neighborhoods that had changed into Latino neighborhoods in the 1980s and 1990s. By the 1980s, he was working within a primarily Spanish-speaking neighborhood on 40th and Figueroa in Los Angeles and stopped advertising because he had a stable business with his Mexican clientele. He utilized a Spanish-speaking secretary up until 2000 when he closed his business, even selling his previous business and home to his former secretary, who currently resides in this locale. See T.B. Chew Oral History 4, interview by Suellen Cheng, November 5, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

[162] Conversations with Gilbert Hom from the Chinese Historical Society of Southern California, December 21, 2015.

[163] Ibid. According to Hom, those that served within communities of color charged the similarly low rates due to affordability.

contributed to this medical economy. The next chapter examines the contours of family life, out of the shadow of their fathers' and husbands' herbal businesses.[164]

[164] Here I borrow Vicki Ruiz's term, from out of the shadows. See Vicki L. Ruíz, *From Out of the Shadows: Mexican Women in the Twentieth Century* (New York: Oxford University Press, 2008).

CHAPTER FOUR

The Family Economy of Medicine

In January 1921, Tom Leung traveled to China from San Pedro Harbor. With his family bidding him goodbye, he went to investigate the political situation in China as well as buy merchandise to sell in the United States.[1] He left behind his wife and eight children with just a farewell handshake, though he would be gone for the better part of a year. He spent over $30,000 on this trip, even writing letters to request for more money from his wife so that he could buy more goods. Tom Leung could afford his extravagant spending in his travel to China "on account of treating that flu."[2] Successfully advertising and selling herbs to a largely European American population in Los Angeles, Mr. Leung took a solo trip overseas. In 1918, Leung treated many flu patients and not one person in his family got sick. The neighbor next door did not fare as well; a young couple and their two babies caught the flu and died. His daughter Louise, thirteen at the time, remembered, "We could see and hear the grandmother sobbing over the babies from our second floor bathroom… there was sickness and death everywhere."[3] Her brother Taft also recalled,

> I remember in the World War I, the flu epidemic. At that time, my father had a really good formula and it saved the lives of many many people. And during that period of time, I think he made a great deal of money… Shortly after that, I guess he had enough money to make this trip to China and buy up antiques. He was a great lover of antiques, jewelry, and rugs.

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[1] Louise Leung Larson, *Sweet Bamboo: A Memoir of a Chinese American Family* (Berkeley: University of California Press, 1989), 154-157. Louise Larson recalled her father even had a concubine in China. Her mother gave her father an ultimatum: stay in China with the concubine and send money back or he returned to the United States without her. He returned home alone.

[2] Taft Leong Oral History 65, interview by Bernice Sam, February 11, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles. The family uses Leung as the spelling of their name, though on the oral history he is listed as Leong as misromanization of his Chinese surname.

[3] Louise Larson, *Sweet Bamboo*, 125.

Taft Leung's father turned tragedy into personal success as a medical merchant. Not all practitioners fared the same as the Leung family, nor did they successfully treat their patients with favorable outcomes. Tom Shee Binn, a close family friend of Tom Leung, was sentenced to a fine of "$350 and to imprisonment for 180 days in jail" because he was convicted of charging "J.A. Dunn $780 for herbs to prevent Spanish influenza, and that Dunn, notwithstanding, died from the disease."[4]

In comparison to other Chinese men in Los Angeles who were relegated to "menial labor," Tom Leung established himself as a Chinese herbal doctor, maintaining a practice until his death in 1932. He seemed especially popular among white Angelenos and was welcomed into Caucasian homes, even making house calls in Pasadena. He even had prominent friends like Judge Thomas D. White of Pasadena, who often served as his attorney when he faced arrest for practicing without a medical license. The Judge "used to help my father a great deal because he was harassed by the American Medical Board." His sister recalled that she was "angered and ashamed at these arrests" and sometimes "a whole squad of police would arrive in a patrol car and raid our home."[5] There was even an incident when their father was hauled off in a paddy wagon. In total, their father ended up paying over $5,000 in fines. The harassment stopped when their father stopped using "doctor" in his advertisements.

The son of an exceptionally successful Chinese herbal doctor, Taft Leung was born in 1909 on Olive Street, in back of the May Company, a popular department store.[6] The Chinese population in Los Angeles County was a little over two and a half thousand people.[7] As his

[4] Medical News: California" JAMA 71, no. 22 (November 30, 1918): 1837.
[5] Louise Larson, *Sweet Bamboo*, 77-78.
[6] His name is also romanized Long or Leong.
[7] Chan, Sucheng, ed. *Chinese American Transnationalism: The Flow of People, Resources, and Ideas between China and America during the Exclusion Era*. (Philadelphia: Temple University Press, 2006); Erika Lee, *At America's Gates: Chinese Immigration During the Exclusion Era, 1882-1943* (Chapel Hill: University of North

father catered to a primarily white clientele, he decided not to make the family residence close to Chinatown. At home, however, Taft remembered a Chinese upbringing, "We had all these other health foods. Chinese soups made of herbs."[8] Given his father's business acumen, Taft enrolled in the University of Southern California, a popular and receptive institution for Asian Americans.[9]

Taft and Louise remembered their childhoods fondly despite punctuated incidences where their father was arrested, fined, and sometimes served time for his business as an herbalist. Taft oral history centers on the theme of class and mobility; that his father owned a car and he would drag him around Chinatown because "I think my father was very proud of his boys, his sons…And then when I got a little older, he took us out to moving picture theatres, plays, concerts. That way we broadened our education." At the end of their excursions, the family would go into Chinatown and eat in one of restaurants. His younger brother William wrote about the happy memories of his childhood in his diary,

> Today, we went to the beach (Palisades Park). When we found a place to sit we rested for five or ten minutes and then at our lunch. Mama gave us each 10 cents to buy some cotton candy.[10]

As a well to do herbalist, Tom Leung was conscious of his wealth and status. "He always insisted that he or the children were well dressed when they go anywhere. He said that was important, to give a good impression."[11] His children's memories also reveal the textures of growing up as second generation Chinese-Americans. Chicana historian Vicki Ruiz, theorized

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Carolina Press, 2003); Alexander Saxton, *The Indispensable Enemy; Labor and the Anti-Chinese Movement in California* (Berkeley; University of California Press, 1995).

[8] Taft Leong Oral History 65, interview by Bernice Sam, February 11, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

[9] Henry Yu, *Thinking Orientals: Migration, Contact, and Exoticism in Modern American* (New York: Oxford University Press, 2002).

[10] Louise Larson, *Sweet Bamboo*,

[11] Mae M. Ngai, *The Lucky Ones: One Family and the Extraordinary Invention of Chinese America* (New York: Houghton Mifflin Harcourt, 2010).

that immigrant families like the Leungs went through a process of "cultural coalescence."[12] She argued,

> Immigrants and their children pick, borrow, retain, and create distinctive cultural forms. There is not a single hermetic Mexican or Mexican-American culture, but rather permeable *cultures* rooted in generation, gender, and region, class, and personal experience. People navigate across cultural boundaries and consciously make decisions with regard to the production of culture.

Louise Leung also remembered a very comfortable childhood. As the second eldest, she benefitted from her father "spoiling" her. Adopting the nickname "Mamie," she, along with her older sister Lillie, participated in many Chinese American activities for young women, including dances. She even had her hair "marcelled." Due to her mother's embrace of modernity along with her father's financial standing, their home became a hub of many social activities for their friends, an unusual experience for many young Chinese American women.[13] She herself attended the University of Southern California and graduated in 1926 with a degree in journalism, later becoming the first Asian American woman reporter.

The Leung family enjoyed exceptional cultural and monetary capital.[14] According to Taft, "my father always took care of us." As a child, Taft observed his father while he interviewed patients. He would sit and absorb the ways his father did business with his patients. He was amazed at his father's capability at diagnosing and treating patients. As he got older, he worked in his father's office, "I became a kind of a secretary and helped write letters for my father to answer some queries from patients away from the city." Until he was twenty-three in 1932, when his father passed, Taft and his siblings benefitted from the lucrative herb business.

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[12] Vicki L. Ruíz, *From Out of the Shadows: Mexican Women in the Twentieth Century* (New York: Oxford University Press, 2008), xiv.

[13] Judy Yung, *Unbound Feet: A Social History of Chinese Women in San Francisco* (Berkeley, University of California Press, 1995)

[14] Pierre Bourdieu, *Distinction A Social Critique of the Judgment of Taste* (London: Routledge Classics, 2010). Here I use Bourdieu's notion of social capital, one that is produced and reproduced generationally. The idea of "taste" is inherited through class distinctions.

After his father's death, he left USC to get a job, and support the family. His sister Mamie, in Chicago at the time, sent money home from her work as a journalist. His other brothers took menial jobs to help support the family. With the Depression and death of his father, the Leung's story dovetailed with that of many herbalist families in southern California.

Most Chinese herbal doctors in California were not well connected to notable white patrons in Los Angeles nor did they enjoy the prosperity of a thriving business.[15] Most herbal businesses represented a middling profession whereby success was not guaranteed, and one which required that the family participated in the economy of medicine. [16] Rather than focusing on the male breadwinner, this chapter examines the work of their families: the invisible labor of their children and wives.[17] This chapter contends that the very "patterns of daily life" ensured that their family businesses ran smoothly.[18] Like other women of color, rather than merely supplementing husbands' and fathers' work, wives and daughters supported their families with work inside the herbal business as well as taking outside jobs.[19] Herbal businesses, even as it relied on the father figure as the face of the business, required the labors of their children, wives, and kin. As Taft's oral history demonstrated, family security became at risk with the death of the patriarch.[20]

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[15] Historians Haiming Liu and Yong Chen documented notable exceptions of very wealthy herbalists. See Kenneth H. Marcus and Yong Chen, "Inside and Outside Chinatown: Chinese Elites in Exclusion Era California" *Pacific Historical Review* 80, no. 3 (August 2011) and Haiming Liu, *The Transnational History of a Chinese Family* (New Brunswick: Rutgers University Press, 2005).
[16] Louise A. Tilly and Joan Scott, *Women, Work and Family* (New York: Holt, Rinehart, and Winston, 1978).
[17] Kenneth H. Marcus and Yong Chen, "Inside and Outside Chinatown: Chinese Elites in Exclusion Era California" *Pacific Historical Review* 80, no. 3 (August 2011); Haiming Liu, *The Transnational History of a Chinese Family: Immigrant Letters, Family Business and Reverse Migration* (New Brunswick: Rutgers University Press, 2005); Haiming Liu, "Chinese Herbalists in the United States." In *Chinese American Transnationalism: The Flow of People, Resources, and Ideas between China and America during the Exclusion Era* (Philadelphia: Temple University Press, 2006).
[18] Vicki L. Ruíz, *From Out of the Shadows*, 7.
[19] Vicki L. Ruíz, *Cannery Women, Cannery Lives: Mexican Women, Unionization, and the California Food Processing Industry, 1930-1950* (Albuquerque: University of New Mexico Press, 1987), 16.
[20] "The Physicians Family," *California State Journal of Medicine* 22, no. 1 (January 1922), 1. Indeed, even western medical professionals argued that the physicians' family was vulnerable to financial failure when the physician died.

Herbalist fathers and sons consistently took the labor of their mothers, daughters, and sisters for granted even as they looked to them for support for their businesses. This chapter considers the *filial economy of health*, that is, the economy of the family that enabled the work of Chinese herbalists. Asian American scholar Lisa Park articulates the class standing of children, who became beneficiaries of their parents' financial successes in the United States and in doing so, upward mobility was both a class marker as well as citizenship status.[21] Her work examines the economic structures of power in relation to the larger U.S. society and the racialization process of Asians within U.S. economy. In her assessment, children are recipients of hard working parents.[22] Children, however, contributed to a family economy.

The *filial economy of health* serves as an extension of understanding of the sovereign consumer in the previous chapter. Whereas, the sovereign consumer theorizes individuals entrenched in the marketplace of medicine, the notion of the filial economy articulates the role of children and wives as economic partners in the marketplace for health, rather than as beneficiaries of economic investment. Moreover, whether migrants or native-born, children and wives were dependents economically and socially but in reality, wives and children of herbalists worked inside and outside the home to make ends meet. In doing so, they helped shape the medical geography as much as the herbalist patriarch. The work of wives and their children reveal the textures of the medical economy as a complicated matrix. As health seekers sought alternative remedies to their ails and woes, they were in fact treated by a whole family whose

[21] Lisa Park, *Consuming Citizenship: Children of Asian Immigrant Entrepreneurs* (Palo Alto: Stanford University Press, 2005), 2.

[22] Vicki L. Ruíz, *Cannery Women, Cannery Lives*, xvi. Historian Vicki L. Ruíz's documents the role of Mexican American women in the family wage economy as well as a consumer wage economy in her examination of *Mexicanas* in the food processing industry in California. In doing so, young Mexican women who worked in the canneries were able to supplement family incomes as well participate as consumers.

labors allowed them to obtain relief. Health as a familial enterprise crossed generations and labor markets.

Historians have documented the importance of kinship networks, common among immigrant families.[23] Herbalists also relied on a kinship network for the success of their businesses. Allen Mock remembered that his father's success as an herbal business meant that his family home on Los Angeles Street served as the center for the Mock clan in Mexico, United States, and Canada. As the eldest of the clan, his father assumed responsibility for the financial and medical well being of the family network. He states, "After all, there would be no assistance forthcoming from Caucasians and even a Lee or a Wong wouldn't help a Mock."[24] The family association served several important functions. Making a central family house for members who might fall on hard times; pooling their resources to establish family businesses and combining resources for medical bills and burials. The kinship networks served a means to safeguard success and absorb failures.

Even within large kinship networks, there were nuances to family success. George Tom, Taft Leung's cousin, remembered a difficult childhood when his father passed in 1927.[25] Born in Vancouver, Canada, George and his family had migrated to the United States when he was eighteen, joining his family in the Bay Area and later Los Angeles. His father opened the Peter Lee Herb store, across from the Plaza, following in the footsteps of his grandfather who

[23] Haiming Liu, *The Transnational History of a Chinese Family* (New Brunswick: Rutgers University Press, 2005); Todd Stevens, "Brokers Between Worlds: Chinese Merchants and Legal Culture in the Pacific Northwest, 1865-1925" (Ph.D. diss, Princeton University, 2003; Ronald Takaki, *Strangers from a Different Shore: A History of Asian Americans* (New York: Little Brown and Company, 1989); Sucheng Chan, ed. *Chinese American Transnationalism: The Flow of People, Resources, and Ideas between China and America during the Exclusion Era* (Philadelphia: Temple University Press, 2005); Erika Lee, *At America's Gates: Chinese Immigration during the Exclusion Era, 1882-1943* (Chapel Hill: University of North Carolina Press, 2003); Erika Lee, *The Making of Asian America: A History* (New York: Simon & Schuster, 2015).

[24] Allen Mock Oral History 140, interview by Jean Wong, December 13, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

[25] George Tom Oral History 31, interview by Stanley Lau, April 21, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

established the well-known Foo & Wing Herb Company. As we saw from the previous chapter, Foo & Wing was a lucrative business that primarily advertised to white patrons but was also a "family business, employing friends and their children, family." Unlike his grandfather's business, George Tom remembered his family as "just making it, just getting by. We never had a big savings, living day-to-day. Course we could skimp by making day old bread… day old donuts were fifteen cents a dozen."

"Mother Did All the Hard Work"[26]

Chinese women attended to their family's health even if their husbands were herbalists or medical professionals.[27] As the primary cooks of the household, mothers employed herbs in their daily menus. These herbs, primarily used in soups with bone broth, were meant to *bo sun*. That is, these soups were literally meant to "protect the body." T.B. Chew, an herbalist and son of an herbal doctor, recalled that these soups were an important dietary mainstay because "we believe in whole remedies. In the spring time, we cook some Chinese medicine for the whole family… *ching lerng*."[28] There were foods that were meant to cleanse the body. There were different foods for different seasons. As T.B. Chew continued, the spring signaled a time to clear the body while in the fall and winter, there were herbs to "protect the body" from colds and flus. Oral histories detailed food and culture were intertwined memories, often with their mothers as primary memories.[29]

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[26] Bernice Leung Oral History 137, interview by Jean Wong, December 11, 1980 and January 15, 1981, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

[27] In the 152 interviews, all but a few of the oral history participants recalled their families used herbal remedies in their soups and daily consumption.

[28] Dr. T.B. Chew Oral History 4, interview by Suellen Cheng, November 5, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles. *Ching lerng* literally translates to purify.

[29] For food and culture, see Vicki L. Ruíz, "Citizen Restaurant: American Imaginaries, American Communities" *American Quarterly* 60, no 1 (March, 2008), 1-21; Yong Chen, *Chop Suey, USA: The Story of Chinese Food in*

Women formed the nexus of home life.[30] For those who had herbal businesses in Los Angeles, the family and labor were intrinsically tied to both the domestic space, the American economy, and to the marketplace of health. However, Chinese women were scarce during the first migration of Chinese in the mid-nineteenth century.[31] As husbands, brothers, fathers, and sons sojourned to *Gum San*, many remained in China and awaited their returns. From the 1840s until the 1880s, most who had settled in San Francisco, according to historian Judy Yung, had "bound feet and bound lives."[32] The 1882 Exclusion Act that barred Chinese from entering into the United States also limited the entry of women with the exception of merchant daughters and wives.[33] As seen in chapter three, herbal doctors worked around the medical profession by becoming merchants and in doing so, could bring their families from China.[34] However, the Cable Act of 1922 highlighted the gender restrictions in immigration laws, revoking the citizenship of women who married men "ineligible for citizenship."[35] In addition, the Johnson-

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America (New York: Columbia University Press, 2014); Hasia Diner, *Hungering for America: Italian, Irish, and Jewish Foodways in the Age of Migration* (Cambridge: Harvard University Press, 2001).

[30] Yen Le Espiritu, *Home Bound: Filipino Lives Across Cultures, Communities, and Countries* (Berkeley: University of California Press, 2003), 2. Sociologist Yen Espiritu argues that homes are "simultaneously places of nurturing and sites of conflict between family members who occupy different positions of power." The domestic space of the home is a space to imagine and reimagine a homeland.

[31] John Haddad, "The Chinese Lady and China for the Ladies: Race, Gender, and Public Exhibition in Jacksonian America," *Chinese America: History and Perspectives* (2011), 5-19.

[32] Judy Yung, *Unbound Feet: A Social History of Chinese Women in San Francisco* (Berkeley, University of California Press, 1995), 24.

[33] For an account of Chinese women's lives in the United States, see Peggy Pascoe, *Relations of Rescue: The Search for Female Moral Authority in the American West, 1876-1939* (New York: University of Oxford Press, 1993); Judy Yung, *Unbound Feet: A Social History of Chinese Women in San Francisco* (Berkeley, University of California Press, 1995); Madeleine Hsu, *Dreaming of Gold, Dreaming of Home: Transnationalism and Migration Between the United States and South China, 1882-1943* (Palo Alto, CA: Stanford University Press, 2000); Susan Lee Johnson, *Roaring Camp: The Social World of the California Gold Rush* (New York: W.W. Norton & Company, 2000); Erika Lee, *At America's Gates: Chinese Immigration during the Exclusion Era, 1882-1943* (Chapel Hill: University of North Carolina Press, 2003); Sucheng Chan, ed. *Chinese American Transnationalism: The Flow of People, Resources, and Ideas between China and America during the Exclusion Era* (Philadelphia: Temple University Press, 2005); Erika Lee, *The Making of Asian America: A History* (New York: Simon & Schuster, 2015).

[34] Judy Yung, *Unbound Feet*, 27; Erika Lee, *At America's Gates*.

[35] Peggy Pascoe, *What Comes Naturally: Miscegenation Law and the Making of Race in America* (New York: Oxford University Press, 2010). For example, Alice Mar Wong, a second generation Chinese American lost her citizenship in 1924 when she married a Chinese man and di not regain it again until after 1943 through naturalization. See also Chinese Historical Society of Southern California, *Linking Our Lives: Chinese America Women of Los Angeles* (Los Angeles: CHSSC, 1984), 9-10.

Reed Act of 1924 further exacerbated the ability of Chinese men, even those with citizenship, to bring wives from China.[36] Even as some men brought over their wives, there was great gender disparity in the Chinese community in Los Angeles, a condition that did not change until after World War II. The U.S. Census only recorded a small number of Chinese women at the turn of the century in the United States with close to twenty men for every Chinese woman. Only by 1920 did this number shift considerably with seven men per one woman. In Los Angeles, the ratio of Chinese women was skewed to nearly twenty-six men to every woman at the turn of the twentieth century. In the 1920s, the uneven sex rations declined by half but was still overwhelmingly men. By 1940, the ratio had improved with just two men for every woman in Los Angeles.

Despite U.S. exclusion and political turmoil across the Pacific, steady increase occurred in the number of Chinese women.[37] The presence of more women meant the possibility of family life in the United States. However, due to imbalance in gender ratios, nuclear family units remained relatively small. According to historian Judy Yung, "unlike the nineteenth century, when there were no gainful jobs for them in America, they now had an economic role to play in the urban economy or in their husbands' small businesses."[38] Much like their gender counterparts, the economy played a significant role for their decisions to migrate. However, women's entry into the United States as wives of merchants did not always mean a life of leisure. Rather, as sojourning partners of their husbands, they proved instrumental in their merchant husbands' businesses.

[36] Mae Ngai, *Impossible Subjects: Illegal Aliens and the Making of Modern America* (New Jersey: Princeton University Press, 2014).
[37] Judy Yung, *Unbound Feet*, 56.
[38] Judy Yung, *Unbound Feet*, 57.

Chinese Population in Los Angeles County by Sex, 1900-1940			
Year	Male	Female	Total in Number
1900	3,089	120 (1:26)	3,209
1910	2,455	147 (1:17)	2,602
1920	1,858	338 (1:6)	2,196
1930	2,701	871 (1:3)	3,572
1940	3,751	1,579 (1:2)	5,330

Table 4.1 Chinese Population in Los Angeles by Sex, 1900-1940[39]

The first women that arrived in the United States came as prostitutes and *mui tsai*, or domestic girls for wealthy families, rather than as wives of merchants. The early arrivals of women in the American West elicited images of enslavement but also worry from white detractors who were fearful that Chinese women would threaten white families.[40] In this declension narrative, public health and city officials were fearful that Chinese prostitutes would lure young white boys and men to brothels whereby they would contract diseases like syphilis or leprosy, resulting in the spread of diseases to their wives and daughters.

Mission homes singled out Chinese women for rescue and rehabilitation.[41] For example, Donaldina Cameron's Mission Home for Chinese girls staged elaborate "rescues" of Chinese girls from lives of prostitution. Missionary women such as Cameron helped Chinese prostitutes and in doing so, also carved a place in Victorian society for their own moral authority as educated white women. However, Chinese women also calculated their limited opportunities as prostitutes and *mui tsai* and so utilized the Cameron House as a means to escape their condition of servitude or undesirable marriages. Consequently, some women shaped new conditions of life

[39] 1910 and 1920 table reproduced from CHSSC, *Linking Our Lives*, 2; U.S. Census Office, *Twelfth Census of the United States, 1900 Volume I Population* (Washington DC: Government Printing Office, 1900); U.S. Census Office, *Thirteenth Census of the United States: 1910 Volume 2 Population: Reports by States Alabama-Montana* (Washington DC: Government Printing Office, 1915); U.S. Census Office, *Abstract of the Fourteenth Census of the United States 1920* (Washington DC: Government Printing Office, 1923); U.S. Census Office, *Fifteenth Census of the United States, 1930 Volume III: Population* (Washington DC: Government Printing Office, 1932); U.S. Census Office, *Sixteenth Census of the United States, 1930 Volume II: Characteristics of the Population* (Washington DC: Government Printing Office, 1943).

[40] Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown,* (Berkeley: University of California Press, 2001), 77-104.

[41] Peggy Pascoe, *Relations of Rescue*.

as Chinese American women in marriages and families. For example Bessie Jeong, never a formal resident at the Cameron House, used her sister's betrothal to a much older Chinese man, to ask for the help of the Mission Home.[42] Cameron helped her attend Stanford University, graduating in 1927. She eventually became one of the first Chinese American woman doctors.[43] In her oral history, she stated, "I was the first girl to say hey, we're not going to be homemakers, we're gonna be career girls…We're not having babies, we're gonna go out in the world and contribute."

In Los Angeles, the Women's Home Missionary Society of the Methodist Church also proved an important linkage between Chinese women and American society. Under the leadership of Mrs. J.F. Davis, missionary women such as Emma M. Findlay taught the English language to Chinese women, and formed lifelong friendships with them and their families. Mrs. Findlay even worked to enroll Chinese children to American schools such as the Macy School.[44] Mrs. Findlay became so trusted in the Los Angeles' Chinese community that she often served as a midwife and in the spirit of Americanization, signed Chinese birth certificates and bestowed Chinese children English names.[45] Missionary programs were also successful at recruiting native speakers to further their work.[46] For example, Mrs. Loy Yau Chan proselytized among Chinese women and children. She organized a yearly excursion to Santa Monica beach as part of her

[42] See also Dr. Bessie Jeong Oral History 157, interview by Suellen Cheng and Munson Kwok, December 27, 1981, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles. Dr. Bessie Jeong attended Stanford under the tutelage and recommendation of Donaldina Cameron. She was considered the "dean's pet" because of her connections with Cameron. According to Dr. Jeong, she was never formally part of the Mission Home. See also Iris Chang, *The Chinese in America: A Narrative History* (New York: Penguin Books, 2003), 191-193. Chang documents Jeong as a resident of the Cameron House.

[43] See Judy Tzu-Chun Wu, *Doctor of the Fair-Haired Bastards: The Life of a Wartime Celebrity* (Berkley: University of California Press, 2005).

[44] CHSSC, *Linking Our Lives*, 21.

[45] Louise Leung, "Chinatown's Godmother," *Los Angeles Times*, November 10, 1940.

[46] I am using María Cotera's notion of native speaker. See María Cotera, *Native Speakers: Ella Deloria, Zora Neale Hurston, Jovita Gonzalez, and the Poetics of Culture* (Austin: University of Texas Press, 2008)

program to encourage young women and their families to join the Mission.[47] Missionary societies and church programs proved an important avenue for Chinese women to integrate as Christian Americans and according to historian Judy Yung, "Chinese women's involvement in church activities expanded their gender roles."[48]

As more women migrated, the Chinese community transformed throughout southern California. Betty Wong Lem's mother exemplified the history of migration and familial responsibility as one of the mere fifty families in Los Angeles at the turn of the twentieth century. Like many of the early women who traveled to the United States, there is scant evidence on Mrs. Wong's life, except in the memories recalled of her children.[49] Betty revealed that her father had staked his claim in the herbal business before he went back to China to marry her mother at the age of thirty. A woman born in the late 1860s, she was only fourteen when she married a man sixteen years her senior.[50] Over the course of their marriage, she bore him fourteen children, ran his household, and assisted in the herbal business.

Arriving in Los Angeles at the turn of the century, the Wongs established living quarters on the side of their herbal shop. This common mixed residence allowed them to live and work within the same quarters with just one rent. Moreover, restrictive real estate covenants in Los Angeles prevented many Chinese families from renting outside the confines of Chinatown.[51] "In the early 1920's in Chinatown everybody lived at the back of the store, above the store, or in

[47] CHSSC, *Linking Our Lives*, 22.
[48] Judy Yung, *Unbound Feet*, 94.
[49] CHSSC, *Linking Our Lives*, 9.
[50] CHSSC, *Linking Our Lives*, 7. In 1900, the age difference was 10.3 years and in 1910, the age difference between men and women married was 14.4 years.
[51] Isabella Seong-Leong Quintana, "National Borders, Neighborhood Boundaries: Gender, Space and Border Formation in Chinese and Mexican Los Angeles, 1871-1938" (Ph.D. diss., University of Michigan, 2010) and "Making Do, Making Home: Borders and the Worlds of Chinatown and Sonoratown in Early Twentieth-Century Los Angeles." *Journal of Urban History* (2014). See also Cesar Lopez, "El Descanso: A Comparative History of the Los Angeles Plaza Area and the Shared Racialized Space of the Mexican and Chinese Communities, 1853-1933" (Ph.D. diss., University of California, Berkeley, 2002); Jordon T. Camp, "Blues Geographies and the Security Turn: Interpreting the Housing Crisis in Los Angeles," *American Quarterly* 64, no. 3 (November, 2011): 543-570.

buildings adjacent to other buildings."[52] Like other families, their rooms doubled as business spaces, serving also as bedrooms in the evening if they had extended family members or a large family. In these close quarters, the Wongs reared their children.

Despite traditional Confucian values that confined women in the home as sole caretakers for their family, Mrs. Wong had to work in the family business but her ability to work outside of the house remained limited. Working in the family business, despite antithetical to Confucian gender norms, still allowed Mrs. Wong to maintain her traditional duties and contribute to the family economy of medicine. In the backrooms, filling orders for patients, she learned how to recognize Chinese characters at a time when few Chinese women obtained an education in either English or in Chinese. Moreover, her responsibilities within a very public environment meant that families adapted to new ideas about gender without ever acknowledging these changes. Indeed her work inside the herbal shop allowed her independence as well as dual literacy.[53]

Betty Wong Lem, one of the youngest of the Wong children, recalled her mother as the backbone of her family, working hard day and night. Betty recalled a particularly poignant moment when her younger brother Bruce was born,

> My mother was sitting down, lying down in a corner. I said, I wonder what she's doing back there…I wonder what she's doing there. I know she was groaning. I paid no attention to her and then there was a little brother coming on the way. She just cut the tubes. Got up. Ain't she a brave woman? She just got up and cut the chord and washed it and started working again. Isn't she amazing?

Feminist scholars of immigrant woman such as Vicki Ruíz, Judy Yung, and Valerie Matsumoto have documented the work immigrant women do inside and outside of the home as part of "the

[52] Marge Ong Oral History 41, interview by Beverly Chan, December 11, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.
[53] Betty Wong Lem Oral History 18, interview by Jean Wong, April 5, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

double day."[54] Chinese women literally labored as part of their reproductive duties and labored as unpaid workers, contributing to the family economy.[55] Mrs. Wong's childbearing, childcare duties, household responsibilities, and labor in the herbal shop were all part of her daily duties.[56] She also planted a garden at the back end of the house, close to the railroad tracks to supplement the family's small business and to provide fresh produce for her family.[57]

Because of the absence of another matriarch in the family such as mother-in-laws, "immigrant wives held the reins in the household, maintaining the integrity of their families in an alien and often hostile land…in America, they were also indispensible partners to their husbands in their efforts to establish and sustain family life."[58] Mrs. Wong ran an untraditional household. Betty remembered, "my mother was from China but she treat us different, more Americanized…She don't force us to do anything, you know. She was so different." At the age of fifty-six, when most of her children had already moved out of the house, her husband died. She showed no hesitancy in moving form the back room to the front room of the herbal business which she ran herself.

Mrs. Wong struggled to keep the family business afloat and Betty soon took up various jobs, giving all her income to her mother while retaining a small allowance for lunch. Betty asserted, "No one took care of me. I worked all the time." Though Betty Wong Lem had a great deal of respect for her father, she credited her mother with learning the herbal business, even assisting women in their reproductive health. In her words,

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[54] Vicki L. Ruíz, *From Out of the Shadows*, 17.
[55] Jennifer L. Morgan, *Laboring Women: Reproduction and Gender in New World Slavery* (Philadelphia: University of Pennsylvania Press, 2004). I use Morgan's notion of "laboring women" as representative of the reproductive and productive labor required of women of color.
[56] Vicki L. Ruíz, *From Out of the Shadows*, 15.
[57] Vicki L. Ruíz, *From Out of the Shadows*, 20-21. According to Ruíz, subsistence gardens and raising small livestock "conserved scarce familiar resources within their own households."
[58] Judy Yung, *Unbound Feet*, 79.

> She knew how to deliver babies, she knew how to get the medicine together, the Chinese herbs together… you take the pills now, she can have an abortion with her Chinese herbs. That's really something for a woman who didn't speak a word of English and who knew how to get the herbs together. You look at her, you think she don't know anything. She's quiet, she knows everything.

Mrs. Wong was educated in women's health despite her illiteracy. She learned the art of healing initially by working in her husband's shop, though perhaps she learned the use of herbs for women from her husband. Her mother filled the herbal prescriptions written by her father by memory, "She watch[ed] him put the herbs together and she can do that herself." Betty Wong's oral history strongly suggests her mother knew of medications for women's health and sold them to other Chinese women. She probably also served as a midwife for other Chinese women in the community for which she probably received some compensation. She even provided the means for her own daughters' reproductive health.

> When my sister didn't want a baby, she can give her a dose of herbs that cure her for *good* (emphasis hers). Isn't that amazing. She cured her… just like they take a pill now; she can give her a dose of herbs that she can't have any more children after that. An herb can do that. I don't know how she did it. I really don't know.

Mrs. Wong became the cornerstone of the Chinatown women's network. After her husband's death, women would often drop by, cook and bake, and socialize at the Wong residence, pastimes she could not enjoy while her husband was alive. Betty stated, "All the other older Chinese women come around and gather around my mother." Her work as an herbalist during her husband's life allowed her the opportunity to learn about herbs to serve other Chinese women as well as her own family members. As a widow and herbalist, she opened her home as a central place for other Chinese women seeking medical help and social refuge.

Some women had fewer choices and greater restrictions. Because some husbands opposed labor outside of the home, women picked up small jobs that could be done within the

confines of the home. For example, women often found secondary sources of income to supplement their husband's business by shelling walnuts and sorting strawberries.[59] Alice Joe Young, daughter of an herbalist in Los Angeles, recalled that her mother would shell walnuts at home, sorting numerous bags for pennies a sack. She stated, "for walnuts, they paid by the sack, you would grade the walnuts, the whole ones, and 1, 2, 3 for sizes and put them in boxes." In doing so, Alice noted the importance of these second jobs, "that's one of their way of making extra money for their family. For the women and their children."

Another Pair of Hands

Betty Wong Lem's father also relied on Betty's contributions to the household. Her father opened a Chinese bathhouse to supplement their family income. Even with the help of Betty and her mother at the herbal store, she recalled that her father "wasn't rich but he was proud." Known for his fastidious nature, this bathhouse was "for convenience of his family and the community too because it was another source of income." People paid twenty-five cents to use the bathtubs. The responsibility of maintaining the bathhouse fell on Betty, who was no more than eleven at the time. She attended American school during the day and went directly to Chinese school. After a long day of schooling, she would "run through the dark alley" back to her own house and walked a few doors down to scrub the tubs. She stated, "I was already full grown at eleven because he kinda made me grow up."

Betty remembered that she sometimes received a small payment for her efforts. She recalled, "I'm lucky I got ten cents or maybe five cents. Sometimes if I would ask for my pay and he would spit on your palm. Very strict my father." Alongside her duties, she also had

[59] Alice Young Joe Oral History 139, interview by Jean Wong, December 7, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

household chores. After the family quietly ate their dinner, because speaking was not allowed at the table, she would help her mother stack and wash dishes.

Many of her siblings did not endure this treatment. Betty recalled, "as they get older, they all left home because he was too strict." One of her sisters even ran away. Betty recalled the incident whereby her father arranged a marriage for her older sister Elsie. Unhappy with the decision, she ran away to marry the man she wanted to marry and never returned. Her father had to return all the gifts and money from the failed arranged marriage. This situation underscored the difficult family life that young women navigated. Her father expected his daughters to marry at the age of eighteen, regardless of their desire for an education, independence, or match. After her father's death, Betty's married a man she chose, demonstrating the freedom young women obtained in the absence of a strict patriarch.

Children, like women, also had a place in the orderly Confucian house and provided another pair of hands and another source of wages for the family. Historians such as Ana Rosas have examined the importance of children as part of wage economy, navigating through an economic system that compelled them to enter into the workforce early. In doing so, there were emotional tolls on their childhood caused by the Bracero Program that both overlooked their labor as well as required their presence.[60] Recent scholarship by Asian American scholar erin K. Ninh examines the "political-economic structures of power obtaining between parents and daughters in the immigrant family" that proved emotionally and psychologically taxing for Asian American children.[61] Ninh's work focuses on the micro-textures of power and conflict within the family as an economic exchange, whereby actual investments in children, especially daughters

[60] Ana E. Rosas, *Abrazando El Espíritu: Bracero Families Confront the US-Mexico Border* (Berkeley: University of California Press, 2014), 4.
[61] erin Khuê Ninh, *Ingratitude: The Debt-Bound Daughter in Asian American Literature* (New York: New York University Press, 2011), 6.

"reveal themselves to be profoundly ordered by a capitalist logic and ethos, their violence arranged around the production of the disciplined and profitable docile body." In doing so, she traces a model of subject formation entrenched in quotidien familial investments that are both gendered and racialized.[62]

Daughters served as cultural mediators for their fathers' businesses. Notably, while daughters were often expected to facilitate between their fathers and their customers in public, in private, they rarely had the same independence. Like others, May Wong worked in her father's business in Long Beach,

> All of us, quite of a few of us learned how to *jup yerk* in other words, we filled out the prescriptions. I know I did. And when we were in Los Angeles, and it was a home office, where the office is downstairs and the home was upstairs. Consequently, I know my sister and I helped.[63]

Similarly Ora Yuen described her work with her father, even assisting with the books and acting as a receptionist for him at his herbal shop in downtown Los Angeles. In fact, she became so good at fulfilling orders that she could accurately weigh herbs without a scale. In addition to receiving guests, working as the bookkeeper, and packing herbs, Ora served as her father's chauffeur because "he didn't drive."[64] He drove a buggy with a horse but refused to drive an automobile. She started driving a car at the age of thirteen, taught by the salesman who sold them the car. She vividly remembered, "I was the first Chinese girl that drove an automobile those days. Every time we'd go down to Chinatown, they'd look." She drove him all over Los Angeles

[62] Miroslava Chávez-García, *States of Delinquency: Race and Science in the Making of California's Juvenile Justice System* (Berkeley: University of California Press, 2012).
[63] May Wong Oral History 33, interview by Suellen Cheng and Munson Kwok, October 27, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.
[64] Ora Yuen Oral History 40, interview by Suellen Cheng and Munson Kwok, January 19, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

to deliver herbs. Indeed, she remembered that people called her *nam yun po*, literally translated as a manly woman.[65]

Her familial responsibilities elicited derogatory comments, but as the eldest of nine children, she was expected to take on unconventional responsibilities as part of her filial duty. In her words, "I had more nerve than my brothers and all the rest of the family." She added pointedly, "my parents wanted boys but I was born first." Ora's "manly woman" duties speak to the level of changes possible in the United States. Families often overlooked the sacrifices made on their daughters, expecting absolute obedience to structured gendered ideas of a virtuous Chinese girl while depending on their financial assistance. The strict oversight of girls' duties also served another purpose, parental surveillance over their activities as young women.

Second generation Chinese women's oral histories echoed the experiences of other second-generation young women of color. Japanese American or Nisei girls also experienced the close scrutiny of elders. *Rafu Shimpo*, the Japanese newspaper of Los Angeles, publicly lamented the images of "painted, short-skirted, bow-legged shebas."[66] For young Mexican American women, "close chaperonage was a way of life" especially to regulate women's behavior with young men.[67] Mexican mothers chaperoned school dances as a way to monitor their daughters. One mother just would just "sit and there and take care of our coats and watch is." For others, the possibility of having a chaperone was completely out of the question, as they were not allowed to date. While there were women who found ways to sneak out and enjoy the company of her friends, many were still found that their parents "watched us like a hawk."[68] Despite the small

[65] For gender "benders," see Catherine Ramírez, *The Woman in the Zoot Suit: Gender, Nationalism, and the Cultural Politics of Memory* (Durham: Duke University Press, 2009).
[66] Valerie Matsumoto, *City Girls: The Nisei Social World of Los Angeles, 1920-1950* (New York: Oxford University Press, 2014), 2.
[67] Vicki L. Ruíz, *From Out of the Shadows*, 58.
[68] Judy Yung, *Unbound Feet*, 109.

amount of freedom young girls carved out, work in the filial economy relied on the daughters to work inside their family businesses.

Marge Ong's parents also expected her to work alongside them in their family business and in the household. The daughter of a self-taught herbalist and restaurateur, she remembered her father as really "old fashioned." At an early age her father recognized her adeptness with numbers so she helped him, "When I was about 12 years old my father found out I know how to count so I was recruited to work for him."[69] Alongside Marge's work at the restaurant, she helped obtain the herbs her father needed for his own personal usage and the store.

Because she was from a large family, she acted as a caretaker even though a child herself, "every time my mother has a child, I take over the older one and was sort of a second mother." Because of her many household and childcare duties, Marge explained that she could not go anywhere. While her brothers had extracurricular activities and independence, she was only able to convince her father to let her go to some football games in high school.[70] Marge stated, "I got stuck until I got married."[71]

Outside the Business

Girls also took on secondary jobs in order to supplement their family's income as part of their filial duties. Lilly Mu Lee remembered that she worked in her father's shop along with working odd jobs in Chinatown.[72] The youngest child of an herbalist, Mu Bit Sam, Lilly was born in 1930 in old Chinatown on top of the family's herbal store. Her father's herbal shop

[69] Marge Ong Oral History 41, interview by Beverly Chan, December 11, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.
[70] For an examination of chaperoning see Vicki L. Ruíz, *From Out of the Shadows*, 51-71.
[71] Vicki L. Ruíz, *From Out of the Shadows*, 60. Historian Vicki Ruíz explained, "they exchanged one form of supervision for another in addition to the responsibilities of child-rearing."
[72] Lilly Mu Lee Oral History 162, interview by Suellen Cheng, July 24, 1982, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

served as an important gathering place for many Chinese men and Lilly remembered fondly that she had a lot of fathers growing up, who also watched over her. Because he serviced a primarily Chinese clientele, Lilly remembered they had very limited means,

> They were all Chinese…couple of others thereafter that went into the American community because there was more money to be made. They can charge much higher prices. But my father was dedicated to Chinese people and he felt that he couldn't do that… I remember that if people didn't have the money, he just credit. He always, if they needed medicine, he always gave it to them.

In contrast to herbalists that serviced European Americans patients, Lilly's father worked within the low-income Chinese community, Lilly remembered, "we were the poorest of all Chinese families" and that her "parents were always working hard." She herself watched over the store and customers, cleaned shelves, put out merchandise, and "whatever needed help." She also delivered medicine to the Chinese cooks and waiters in nearby restaurants.

Girls and young women carved out employment even in a restrictive racial environment. Employment opportunities were rare in Chinatown and paid poorly, especially for young women. Yet Lilly carved out a niche by catering to tourists. In the evenings, she, along with some friends would sell flowers in Chinatown. She recalled that she would get the flowers from a friend's mom, "fifteen cents for one gardenia and thirty five cents for double…and eventually on Saturday nights, I used to have my own stand…from six to twelve." While her secondary job offered a measure of independence, the same men who patronized her father's store also served as a network to watch over her as she worked late in the night.

At times, when tourists would ask Lilly to sing. Rather than perform for tourists as part of an attraction in Chinatown, she charged a penny or nickel to sing a rendition of "God Bless America." Judy Wu argued that these kinds of spectacles in Chinatown "balanced tensions within the Chinese American community and with the broader society by depicting their ethnic

identity as a non-threatening blend of Eastern Confucian and modern Western cultures."[73] Because of her work in her father's store and her second jobs, she had little time for herself; however, Lilly fondly detailed the yearly pilgrimages she and her mother made to Lincoln Park. There, they would have a small picnic and spend the day at the park. Lilly recalled it was the only form on entertainment "when you're poor."

The movie industry in Hollywood also provided another avenue for employment, paying higher wages, if one was lucky enough to get work as an extra. While this may seem a glamorous opportunity, Lilly Mu Lee remembered it as a means to make money. Consequently, when the opportunity for Chinese extras arose during the production of *The Good Earth* in 1936, Lilly auditioned and received a role. Family friends helped shuttle her between her home and the movie set, as her father was needed at the herbal shop. She also received small roles in such films as *Too Hot to Handle* with Clark Gable. Lilly remembered it was not glamorous simply, "$25 a day, which was quite a bit for a little girl."

[73] Judy Tzu-Chun Wu, ""The Loveliest Daughter of Our Ancient Cathay!": Representations of Ethnic and Gender Identity in the Miss Chinatown U.S.A. Beauty Pageant" *Journal of Social History* 31, no 1 (Autumn, 1997), 6. Wu argues that pageants were a means to placate the Anglo community and to highlight the Americanization of Chinese-Americans.

Image 4.1 Lilly Mu Lee with Clark Gable[74]

The Great Depression served as an important catalyst for Chinese Americans to find resourceful ways to make a living. Paul Tom, mentioned in the previous chapter, was the eldest of nine children, born in 1908 to an herbal family.[75] With the support and urging of his father, he enrolled at the University of Southern California's Pharmacy School in 1933 because "during Depression it cost too much for medical school… pharmacy was the next best thing." For a time during his schooling, he worked as an intern in the local Chinese and Mexican pharmacy in the Plaza until the business closed. However, due to the Depression and racial restrictions in the

[74] CHSSC, *Linking Our Lives*, 76.
[75] Paul Tom Oral History 101, interview by Bernice Sam, April 28, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

medical field, Paul could not find work as a pharmacist. Instead, he worked with his father in the herbal shop. While his father was alive, he could help him *jup yerk*, gather herbs, but could not continue with the business because he lacked the required proficiency in Chinese.

Paul Tom also looked to Hollywood as a means for a second income. He remembered his work on *The Good Earth* provided him $7.50 for a day's work as an extra.[76] However, he had to shave off his hair for the production. When he received contract work, he received $65.00 a week with no taxes. In his words,

> if you want to cut your hair off, shave it all off, guarantees you about 5 days of work a week… there's a lot of overtime, when its overtime, it comes to about $15 to $20… if you ride a horse, you got $15 more on top of $7.50…During the Depression, that's a lot of money, besides the $7.50.

Hollywood was an attractive field, with the lure of fame and fortune, but few acted professionally in the industry.[77] Benson Fong remembered, "Oriental actors liked to become professionals in acting but could not make a living by just acting. They all were doing something else on the side. There were no more than ten actors who devoted more time to acting than to other jobs."[78] Hollywood did not offer professional security but provided supplemental income source for those who could find work on the sets, which relied on typecast characters. Yet despite the higher pay, Hollywood was not a consistent form of income as most Chinese actors worked on call. Lillie remembered, "There was no warning and each job was different."[79] While the promise of high wages prompted Paul Tom to take up work as an extra, even as he was a trained pharmacist from USC, because of the instability of the job and his mixed feelings about

[76] Paul Tom Oral History 101, interview by Bernice Sam, April 28, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.
[77] Vicki L. Ruíz, *Cannery Women, Cannery Lives*, 11.
[78] Benson Fong Oral History 51, interview by Jean Wong, August 3, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.
[79] Lillie Louie Oral History 135, interview by Suellen Cheng, December 8, 1980 and January 7, 1981, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles. See also CHSSC, *Linking Our Lives*, 78.

the roles he played, Paul Tom eventually left the movie industry in order to find more steady work in a research lab, never as a pharmacist.

Second jobs were especially critical during the Great Depression.[80] Having a second job meant the difference between survival and starvation. Allen Chan remembered, "there were no bread lines for the Chinese."[81] Despite her famous herbalist father, D.R. Wong, Lillian Fong recalled, "in my childhood, jobs were so hard to get. As a kid, we used to break up walnuts, and shell walnuts. There wasn't much money in that."[82] Shelling walnuts was also a seasonal job. They also rented out extra rooms to make ends meet however, Lillian remembered the extra income as meager, only bringing in $26 a month for the three bedrooms they rented out, which included board.

As the youngest and only daughter, she did not recall any memories of her childhood that involved social activities, "we didn't get a chance to play as much." She did not go to any ballgames and rarely remembered a time when she went to the movies. In better times, her father hired a bookkeeper but by the time Lillian was a pre-teen she took on the responsibilities of his letter writing, bookkeeping, and income taxes to save on the cost of another worker. In the evenings, she and her mother would clean the herbal shop and organized it for the following business day. Unlike other herbalists who wanted their sons to inherit their shop, her father never wanted his sons or Lillian to take over the business because "it was not well-paying." Lillian still had to support her family, receiving high school education, an achievement at the time.

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[80] For work on the Great Depression and New Deal, see Devra Weber, *Dark Sweat, White Gold: California Farm Workers, Cotton, and the New Deal* (Berkeley: University of California Press, 1996).

[81] Allen Chan Oral History 77, interview by George Yee, February 22, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles. San Francisco's Chinatown experienced similar conditions. According to Judy Yung, "the depression deepened and the Chinese kin associations and community charities found themselves no longer able to handle the situation, the Chinese discovered a new source of relief in the local, state, and federal, governments." See Judy Yung, *Unbound Feet*, 181-182.

[82] Lillian Fong Oral History 66, interview by Bernice Sam, January 28, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

Daughters who were expected to give up their education to work with the family business, hold outside jobs, and bear household responsibilities. This was true of many women of color and typical for the time period. In the Japanese American community, even as education was stressed, limited resources meant that sons benefitted from educational attainment, rather than daughters. In addition, historian Valerie Matsumoto found that "immigrant parents and their daughters had differing notions about the kind of education most appropriate for young women, with some Issei favoring language and cultural training in Japan intended to groom them for marriage."[83] Similarly, Historian Judy Yung noted that second-generation Chinese women "clashed with their cultural upbringing at home."[84] Moreover, The Great Depression exacerbated the divide between educational aspirations and the economic pressure to work.

Even as Chinese parents encouraged education, young girls keenly felt that domestic duties fell on them. Betty Wong Lem revealed, "all the boys, as soon as they're old enough, they left home. So I'm the one holding the bag to take care of my mother, the youngest one. All the boys, they just left home, that's all."[85] Alice Hum also lamented her lack of freedom in comparison to her brothers.[86] The seventh child of ten, Alice also remembered an impoverished childhood. Her father imported herbs from China and sold them in the United States but as an illiterate man, he did not do very well in the business. While her brothers sometimes worked at the sore, Alice remembered that her parents expected more from her,

> More on me than anybody else in the family because I'm a girl. Boys don't have to do anything, they worked outside… they expect the girls to help more around the house. And they're more likely to compliment the boys not the girls… In those days, girls

[83] Valerie Matsumoto, *City Girls*, 21.
[84] Judy Yung, *Unbound Feet*, 108 and 305. Yung notes that before World War II, college education remained elusive for young women. See Table 10.
[85] Betty Wong Lem Oral History 18.
[86] Alice Hum Oral History 104, interview by Beverly Chan, May 27, 1980, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

> didn't run off or move out, you don't do those things like you do nowadays. They don't. You stayed home till they're married.

Some rebelled against the restrictions placed on their independence.[87] Because herbalists relied on labor from their families, for those who did not have daughters, they reached out to other female relatives to work the front rooms of their shops. For example, Bernice Leung rebeled against her relative's restrictions. When she came to Los Angeles to work in T.B. Chew's herbal shop on Figueroa, she answered phones and helped to package herbs. She recalled that there was a weekend she wanted to go out,

> He (T.B. Chew) said, you can't go out. He said I'm like your older brother and you can't go out. Oh, I said, you're not related to me at all. So I went out anyway.

Rather than negotiate her independence, Bernice denied her kinship with the older man. According to historian Vicki Ruíz, for young women under the close scrutiny of elders, there were only three options: comply, rebel, or compromise.[88] Bernice left the business. However, few other oral histories echo the bold tactics that Bernice took to assert her independence.[89]

A Family Business

Sons represented their fathers' hopes in the filial economy of health. Sons also shouldered great responsibility.[90] As historian Yong Chen states, "The presence of Chinese-born children underscores the conscious efforts to pass on to their offspring what they had achieved in America."[91] As male heirs, they inherited the family name and also expected to also take over

[87] Bernice Leung Oral History 137, interview by Jean Wong, December 11, 1980 and January 15, 1981, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.
[88] Vicki L. Ruíz, *Cannery Women, Cannery Lives*, 11-12.
[89] Kathy Peiss, *Cheap Amusements: Working Women and Leisure in Turn-of-the-Century New York* (Philadelphia: Temple University Press, 1986).
[90] Susan Man and Yu-Yin Cheng, eds., *Under Confucian Eyes: Writings on Gender in Chinese History* (Berkeley: University of California Press, 2001).
[91] Yong Chen, *Chinese San Francisco: A Transpacific Community, 1850-1943* (Stanford: Stanford University Press, 2000), 57.

their fathers' businesses. Unlike daughters, few sons assumed any responsibilities of the household. Instead, they bore filial obligations with the promise of future social mobility. To this end, fathers invested in their son's education. While some daughters also had educational aspirations, parents pinned their hope on sons. For example, Dr. Arthur Chung, son of herbalist Y.H. Chung, was the oldest son of this second marriage.[92] Arthur remembered, "father was partial to me because he felt as a son, I think he gave me more attention. He encouraged me to take medicine, encouraged me to work."[93]

As the eleventh son of a large family, Y.H. Chung ventured to the United States to help provide for extended relations in China. As the dutiful son, he sent money back to support a large village of people. Arthur stated frankly, "people were parasites." Arthur remembered an especially poignant moment during the Depression when they could not pay rent on their business and home. Yet, despite their poverty, his father still had "sympathy to the Chinese in the village, he would always send money." Because of his father's remissions, Arthur stated, "We were always never very well off." The older Chung sent money back to the village in Canton until his death in 1952 and Arthur even assumed some of this financial responsibility when he grew older.

While his half brother toiled as an asparagus farmer, he took on responsibilities for taking appointments for his father and even served as a caretaker for his father's second office. Arthur also took on the preparation of herbs alongside his mother, Nellie. His father pushed Arthur to obtain his medical degree and to be a "credit" to his family lineage. When he showed an interest as a printer, his father exclaimed,

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[92] Yitang Chang was previously married in China and had three other children from his previous marriage. See Haiming Liu, *The Transnational History of a Chinese Family* (New Brunswick: Rutgers University Press, 2005).

[93] Dr. Arthur W. Chung Oral History 9, interview by Suellen Chegn and Beverly Chan, October 23, 1979, Chinese Historical Society of Southern California, Southern California Chinese American Oral History 1978-1991, University of California, Los Angeles.

> No, you won't be doing anything like that. You will either become an engineer or you will become doctor… We Chinese in the United States, its very difficult to get a job because you are Chinese and unless you have a job where you can be entirely independent where you can have your own office.

Like other second-generation Chinese children, Arthur also remembered very little social activities in his childhood aside from attending Cantonese operas, which he did not understand. He simply stated, "father was very strict."

Despite economic hardship, Arthur's father managed to pay for Arthur's education in China. In Hong Kong and Beijing, Arthur studied until Japanese forces invaded China, forcing Arthur to return to the United States to continue his education. Her returned a few months before the bombing of Pearl Harbor. Because his lungs were scarred from tuberculosis, he could not enlist. Instead, he spent a year at Harvard University, worked in Los Angeles' White Memorial Hospital, and later served as a resident in pediatrics for five years. He remarked, "father was really proud of me."

Arthur Chung's family represented the nexus between filial duty, Individual aspiration, and academic success. In contrast, the family history of Thomas W. Wing highlights the limits of familial obligation.[94] Thomas Wing was the son of a very successful herbalist who sold a concoction called FCF (flu, colds, and fever) to white patrons. His father made a fortune on his herbal trade, allowing him to support a second wife in the United States as well as a family in China. Despite most responsibilities of the household falling on young women, William remembered as the youngest son he "did all the rice cooking and washing dishes. I did it because I was at the bottom of the totem pole."[95]

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[94] Thomas W. Wing and Caroline Wing Greenlee, *Son of South Mountain & Dust* (Kelseyville, CA: Earthen Vessel Productions, 2001). See also Carolyn Wing Greenlee, *Eternal River, Volumes I and II* (Kelseyville, CA: Earthen Vessel Productions, 2006).

[95] Thomas W. Wing and Caroline Wing Greenlee, *Son of South Mountain & Dust*, 60.

Thomas shouldered his obligations during the Depression. Attending Southern California College of Chiropractic in Los Angeles, Thomas Wing saw chiropractic school as an alternative to traditional medical training, one that granted a degree in two years.[96] Chiropractic school provided an expedient means to advance his education and to fulfill his familial responsibilities. According to Thomas,

> I wanted to learn Western diagnosis and apply it to my knowledge in Chinese herbs… The license would protect me from arrest and medical harassment and the chiropractic approach to healing would be compatible with Chinese medicine… I decided I would be most successful as a Westernized Traditional Chinese doctor, combining herbs and chiropractic.[97]

Discouraged as a young child by teachers as a child, "you're the worst behaved boy in the whole school. You're so disobedient and disturb all the classes…You're never going to amount to anything,"[98] Thomas' choice was also bound by a racially hostile educational environment.[99] Thomas' choice in chiropractic school reflects this challenge in attending medical school. Personal aspirations were also contingent on familial support and obligations. Even as he attended chiropractic school, his matriculation took more than double the amount of time expected, as he also had to support his extended family. Though he considered his choice as the "right thing to do," Thomas eventually disassociated himself from his family.

After graduation, Thomas changed his surname to Wing. His desire to change his family name from Sue to Wing, underscored the great pressure he felt in assuming the economic burdens of his family. He made the bold choice to separate himself literally through a change of

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[96] J. Stuart Moore, *Chiropractic in America: The History of a Medical Alternative* (Baltimore: Johns Hopkins University Press, 1993); Walter I. Wardwell, *Chiropractic: History and Evolution of a New Profession* (St. Louis: Mosby Year Book, 1992).
[97] Thomas W. Wing and Caroline Wing Greenlee, *Son of South Mountain & Dust*, 134.
[98] Thomas W. Wing and Caroline Wing Greenlee, *Son of South Mountain & Dust*, 60.
[99] Vicki L. Ruiz, "South by Southwest: Mexican Americans and Segregated Schooling, 1900-1950," *OAH Magazine of History* 15, no. 2 (Winter, 2001): 25. Historian Vicki Ruiz documented these keen restrictions on "personal aspirations" placed on students of color due to school segregation.

surnames and isolating himself from his family. He stated, "You own nothing. Everything you earn belongs to the family. The oldest male heads the family and is the dictator."[100] After four years of working, supporting his parents, and brothers and sister, he had no money for his wife, and young child. After serious consideration, he stated, "neither my wife nor myself wanted to continue to be family slaves."[101] According to his daughter, "My dad selected the name "Wing" in honor of their flight to freedom."[102] Thomas Wing, his pregnant wife, and child left the household without a place to live and no job. He eventually established a successful career combining his medical profession with his love of inventions.[103] Thomas went on to invent the electronic non-needle acupuncture device still used in acupuncture as well as sports medicine today.

Though some like Thomas Wing openly rebelled against the family, this very interdependence was also ironically, a means to their future freedom because some children, primarily sons, also benefitted from their hard work as well as their family. The reliance on wives and children represented a form of pragmatism in a racially restrictive labor market and environment but it was often a means of harnessing personal aspirations. Instances of strict familial control faded during World War II, as more economic and education opportunities opened for the Chinese community during and after the war.[104]

Utilizing the lens of the filial economy of health, we can interrogate the ways in which health was not just a province of public health officials. From mutual aid, to formal establishments of professionalization, and to merchants who served as medical intermediaries,

[100] Thomas W. Wing and Caroline Wing Greenlee, *Son of South Mountain & Dust*, 139.
[101] Thomas W. Wing and Caroline Wing Greenlee, *Son of South Mountain & Dust*, 140.
[102] Carolyn Wing Greenlee, *Eternal River*, 60.
[103] See Jeff Jardine, "It's Brain Boggling when Modestan Recalls Inventive Life," *Modesto Bee*, November 10, 2006. He also has a museum dedicated to his various inventions.
[104] Judy Yung, *Unbound Feet*, 253.

these various actors interceded to form another voice in medicine and public health. However, Asian American doctors and merchants experienced heavy restrictions. Subsequently, health was also an institution that relied on pre-existing structures such as the family to allow the work of these medical men. The filial economy of health highlights narratives of families that formed the backbone for those who worked as doctors and traditional practitioners for sovereign consumers of health.[105]

The economy of medicine, far from an ethos of capitalism, served as a means to combat the inequalities within communities of color.[106] In this work, I am much more compelled by Bruno Latour's assessment that we live in a condition of suspended or false modernity created by the rise of science and the scientific method.[107] This is significant as Chinese herbalists, never saw the difference between individuals and nature. In addition, while the medical establishment condemned the backwardness of medical merchants or restricted the entrance of Japanese doctors into the medical field as they defined themselves as custodians to a modern scientific era, medicine and health in southern California relied on Asian American professionals to stay healthy.

The state did not serve as the sole architect in discourses of public health and wellness at the turn of the twentieth century. As its gatekeepers were overwhelmingly white and male, ethnic practitioners worked within and outside its systems. While the marketplace was a source of independence for some, especially successful medical merchants and professional ethnic doctors, their choices were still constrained. As ethnic medical practitioners, their alien status constrained

[105] Andre Arato and Eike Gephardt, eds., *The Essential Frankfurt School Reader* (London: Bloomsbury Academic, 1982).
[106] Perry Anderson, *The Origins of Postmodernity* (London: Verso Press, 1998). 50-53. Cultural Theorist, Perry Anderson claims that postmodernism became a currency of the right because of its aversion of grand narratives and plurality of market choices. However, Anderson never addresses the role of communities of color who were never full participants of these "choices."
[107] Bruno Latour, *We Have Never Been Modern* (Cambridge: Harvard University Press, 1993). Latour questions the authority of scientific knowledge as the defining feature of modernity.

their ability to heal and practice medicine. For Chinese herbalists, lacking professional recognition in medicine meant they had to carve out an alternative space for their healing arts. As this chapter argues, health was not an edifice defined through the state, nor just by individual actors, but relied on the family. However, constraint and agency were contradictory hallmarks of their presence in medicine. In doing so, their formed the contours of care in southern California as intermediaries between individuals and their quest for health. The ways Japanese doctors, Chinese herbal doctors, and their families participated in the medical economy reveals the plurality of medical discourses in the early part of the twentieth century.

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APPENDIX A

Chronological List of Japanese American Doctors until 1941[1]

Doctor Name	Year Licensed
Watanabe, Tey	1888
Uchida, Fusa Haru	1889
Wada, Kennosuke	1890
Asano, Sanya	1890
Kurozawa, K	1890
Mori, Iga	1891
Kobayashi, S	1892
Arita, Hisamatsu	1894
Kobayashi, Sozo	1894
Toki, Masajiro	1894
Kodama, Rimpey	1895
Katsuki, Ichitaro	1896
Tsumaki, M	1896
Kitano, Toyjiro	1897
Soga, Kikujiro	1897
Haida, Katsugora	1898
Hoshino, O	1898
Suzuki, S	1898
Harada, B	1899
Hashimoto, Shiugo	1899
Ichimura, K	1899
Itow, T	1899
Kibbe, Minora	1899
Nagai, Yakichiro	1899
Sakata, Minora	1899
Ugai, Kuigi	1899
Miyabe, Tadataro	1900
Takeshima, K	1900
Abe, Masayuki	1901
Ikenchi, K	1901
Karaki, Y	1901
Matsuda, M	1901
Matsusaki, E	1901
Nakabayashi, M	1901
Nishikata, A	1901
Okonoki, Bunkuro	1901

[1] Register of Physicians and Surgeons of the State of California 1876-1901, Dept of Public Health Records, Record Group F, Series 3760, Boxes 91 and 103-143. California State Archives, Office of the Secretary of State, Sacramento, California.

Takeoka, M	1901
Tateishi, T	1901
Watanabe, J	1901
Watashiki, J	1901
Yanagisawa, Una Yone	1901
Yoshida, Shunzo	1901
Matsumaida, K. (?)	1904
Tanaka, J.	1906
Iseri, Kawor	1912
Aoyagi, Katsuzo	1913
Karatsu, Tokumitsu	1913
Miyata, Yujiro	1913
Murayama, Mitogoro	1913
Fujimori, Naokazu	1914
Hayaishi, Jitsuzo	1916
Izuno, Fusaichi	1916
Kurata, Haruaki	1916
Furusawa, Takashi	1917
Hashiba, George	1917
Murakami, Toshimichi	1917
Naide, Saburo	1917
Ota, Tomooki	1917
Suski, Peter M.	1917
Yamamoto, Yorodzu	1917
Nabeya, Denjiro	1918
Okita, Kusunoshin	1918
Takahashi, Teiji	1918
Hashimoto, Hideharu	1919
Ichioka, Toshio	1919
Okamoto, Henry R.	1919
Otani, Ai	1919
Sekiyama, I.	1919
Tsukahara, M.	1919
Uchida, Kensuke	1920
Akimoto, Kensuke	1920
Furukawa, Hiroshi	1920
Haruki, R.	1920
Ishikawa, E.	1920
Kitagawa, Kay Jiro	1920
Kuroiwa, Daishiro	1920
Oda, Sanji	1920
Shiba, Taro	1920
Shinohara, M.	1920
Suzuki, Kohji	1920
Iki, George S.	1921

Kibata, Tatsuo	1921
Kitsuda, Frank	1921
Kiyasu, Kunisada	1921
Koda, Kichiro	1921
Ozasa, Touoru	1921
Tsuda, Toura	1921
Yoshinaga, Tanzo	1921
Ito, Paul Kiuji	1922
Takahashi, Matsuta	1923
Ochiai, Masao	1924
Amano, Ajika	1925
Harada, Masa	1925
Okami, Shigeichi	1925
Nakano, Y.	1927
Amano, Kageyos W.	1928
Kibbe, Adelaide	1928
Kasamoto, Sadaichi	1929
Matsumura, Kiyoshi	1929
Nakayama, Joseph	1930
Uyeyama, Hajime	1930
Yamaguchi, Fumiko	1930
Tomita, Hiroshi	1931
Watanabe, Lee M.	1931
Yamaguchi, Minosuke	1931
Yamashita, Goonzo	1931
Hara, Saburo Hosoki	1932
Iriki, Walter	1932
Kobayashi, Norman T.	1933
Matsui, Takejiro	1933
Yamaguchi, Makoto	1933
Kimura, Morton	1934
Miyauchi, Yukio	1934
Muramoto, Jiro	1934
Togasaki, Kazue	1934
Tokuyama, Shunichi Sam	1934
Uyeyama, Kahn	1934
Wakatake, Yono	1934
Yamaguchi, Megumi	1934
Fujikawa, Yoshihiko Fred	1935
Hanaoka, Wilfred	1935
Ishikawa, Tokio	1935
Izumi, Homer	1935
Kanagawa, H.	1935
Miyakawa, George	1936

Sasaki, George R.	1936
Tanaka, Paul A.	1936
Tanaka, Roy K.	1936
Togasaki, Toru	1936
Togasaki, Yoshiye	1936
Goto, James M.	1937
Kanda, Mutsukichi	1937
Kawaichi, Geo. K.	1937
Taira, Kikuo	1937
Abe, Tom	1938
Akamatsu, George	1938
Baba, George R.	1938
Ito, Masayoshi	1938
Iwasa, Kyoichi	1938
Kasuga, Kazumi	1938
Suenaga, Howard	1938
Fujita, Eugenia	1939
Ichioka, Tsutayo	1939
Kondo, Benjamin	1939
Kuramoto, Mitsuo	1939
Sumida, Perry	1939
Watanabe, Toshihisa Tom	1939
Higa, Benjamin M.	1940
Kazato, Henry	1940
Takenaga, Robert	1940
Wada, George	1940
Fujimoto, Tadashi	1941
Hata, Herbert	1941
Kambara, George	1941
Kusayanagi, Masako	1941
Ogura, Joseph H.	1941
Seto, Masaharu	1941
Sugiyama, Tetsuo	1941

Unknown Years of License*
Fukuda, Yoshu
Hara, Hatsuji
Hayashi, Tetsuo
Hirata, Tokuji
Honda, Rikita
Ishii, Kanesuke
Ishikawa, K.
Ishikawa, Seijiro
Kanai, Matsukichi
Kato, Katsuji

Kitahara, Kay
Kitsuda, Y.
Kosaka, Reiji
Miyasaki, John H.
Murakami, Kensuke
Murakami, Tsuneo
Murase, M.
Nakaki, Kiyohide
Nakamura, T.
Nakaya, Fusataro
Shinoda, Megumi (Yamaguchi)
Takemura, G
Taketa, T.
Takeyama, George
Tamaki, Kozo
Tanaka, Masaji
Tashiro, K.
Umezawa, Ryokichi
Yamada, S.
Yamaguchi, So
Yamamoto, Kinko
Yamao, Enichi

*These doctors are listed under files before 1941 but the year of the licensed physicians is unclear

APPENDIX B

Alphabetical List of Midwives in the State of California from 1917-1941

Akiyama, Hifumi
Anemiya, Chiya
Ansai, Tsune
Eda, Suzuno
Endo, Tatsuno
Egashira, Chiyo
Enomoto, Osuji
Fujita, Ko
Fukushima, Fujie
Habata, Ihae
Hamada, U.
Hamaguchi, S. E.
Hamano, Kikuye
Hara, Mrs.(HJ)
Hara, Hisayo
Harada, Tsusa
Hashimoto, H.
Hashimoto, Masako
Hashimoto, Yasuna
Hayaishi, Iye (Hayashi)
Hayakawa, Tomi
Hayashi, Hide
Hayashi, I.
Hayashi, K.
Hayata, Tsuru (nee Sonoda)
Higuchi, Fuku
Hiraga, Roku
Hirakawa, Iwaye
Hiraki, I.
Hiraki, Kano
Hirano, Hite
Hirokado, Chise
Honda, Edith K.
Hori, Mito
Hoshizaki, Ume
Hotta, Kosuye (Kosue)
Iida, Tei
Imada, Kizu
Inouye, K.
Inouye, Shizu (see Obata)
Inukai, Ei
Ishinaga, Masayo

Isozaki, Kiyo
Iwai, Kiyo
Iyeki (Iyaki), Hide
Izumi, Hisa (Isumi)
Kai, Jumo
Kai, Kura
Kaniye, Shima
Katow, Toye
Kamada, T.
Kawamura, T.
Kawaguchi, F.
Kawahara, Nobu
Kawakami, Tono
Kawakami, Yone
Kawamura, Ima
Kawamura, T.
Kihara, Michiko
Kihari, M.
Kiriyama, Yaeno
Kitagawa
Kitahara, Yuki
Kitaoka, H
Kitaoka, Yuki
Kiyama, Tomono
Kobayashi, Chika
Kobayashi, Hamae (Yuge)
Kobayashi, Hiro
Koda, Kichiro
Kodani, Ayano
Koike, Y.
Kojima, Kikuno
Komatsu, T.
Kondo, Takiye (Takiyo)
Kono, Chiyo
Kono, T.
Kotake, Sugi
Koyama, Yukine (Yukino)
Kuromi, Naka
Kuse, Tsugeno
Kushida, Sakuye
Kushido, Sakuyo
Matsuoka, Tora
Mayahara, Tomiko
Maeda, Kiyo
Manabe, Hatsuyo
Matsumura, N. (nee Murayama)

Mayeda, Natsu
Mitsunaga, Hatsu
Miyamoto, Tsuru
Miyazaki, Ai
Mori, Tomi
Mukaye, Tsune
Murakami, Matsume
Murakami, Matame
Murayama, Namiye
Nagamine, Yone
Nagai, T. (nee Nishi)
Nagao, Matsuye
Nakagawa, Tsuta
Nakamura, T.
Nakana (Nakano), Ichino
Nakashima, Shimae
Narushima, Kiyo
Niiseki, Etsu
Nishi, Kikuyo Asano
Nishi, Tsuya
Nishida, Taka
Nishimura, Isao
Nishioka, Haruyo
Noguchi,Shizu
Nomura, T.
Nomura, Miyano
Obata, Shizu
Obayashi, Suye
Oda, Senji
Ogo, Toshiye (Uetsuzi)
Okazaki, Tsune
Okonogi, B.
Oshita, Takeko
Otani, Ai
Otsuka, Kimi
Sakakura, Chiyo
Sakamoto, Koto
Sakano, Fusano
Sakayeda, Fusa
Sakayeda, Tsuru
Saruhashi, Kinu
Saruwatari, Tamaki
Sasakura, C.
Sato, Koto
Sawada M.
Seki, Kiri

Seko, Yaeno
Shigetomi, Kiro (Seki, Kiri)
Shiohama, Kinuye
Shinohara, Kaneko
Sonoda, T.
Takahashi, Kamechiyo
Taketa, Katsu
Tajima, Tamayo
Tamaki, K.
Tanaka, K.
Tanaka, Tsuto
Teranishi, Oiye
Tomijawa, Fumi
Toshimichi, M.
Tsumura, Kisayo
Uchida, Kimi
Ui, Hana
Uetsuzi, T.(nee Ogo)
Uyeda, Ume
Uyehara, T.
Yamada, Kama
Yamaguchi, Ai
Yamamoto, K.
Yamasaki, S.
Yamaura, Natsu
Yasuhiro, Sunao(Yasuhira)
Yokohama, Haruwo
Yokoyama, Haruwo
Yonemura, Ume
Yoshida, Katsu
Yuge, H. (nee Kobayashi)

APPENDIX C

List of Los Angeles Herbal Doctors, 1900-1941[1]

PRACTITIONER	BUSINESS	NO.	ADDRESS	YEAR
	Foo & Wing Herb Co	903	S. Olive	1901
Lang		108	S. Los Angeles	1901
Wong DR		713	S. Main	1901
	Foo & Wing Herb Co	903	S. Olive	1902
	Wong DR	713	S. Main	1902
	Foo & Wing Herb Co	903	S. Olive	1903
	Wong DR	713	S. Main	1903
Kwong S N		208	Marchessault	1904
	Wong DR	713	S. Main	1904
Yung Lung		212	Ferguson Alley	1904
Low Luke		638	S. Main	1905
	Foo & Wing Herb Co	903	S. Olive	1905
Yung Lung		212	Ferguson Alley	1905
Chan G S		719	S. Main	1908
Tom Shee Bin		713	S. Main	1908
Chan H Y		1045	S. Main	1911
Chung Gong	Chung Hung Mee Herb Co	1047	S. Grand Ave	1911
Tom Leung	Foo & Wing Herb Co	903	S. Olive	1911
Yem M J	Chinese Medical Co	955	S. Hill	1911
	Pekin Chinese Herb	921	S. Hill	1911
Ching D S		916	S. Broadway	1912
Tom She Bin	Foo Chung Tong	145	W. 22nd St	1912
	Quon Herb Co	504.5	N. Los Angeles	1912
Chin H		930	S. Broadway	1913
	Wong Co Doctor	715	S. Main	1913
Hee TK		724	Maple Ave	1914
	Liu Soo Wo	526	N. Los Angeles	1914
	Chinese Herb Co	917	S. Hill	1915
Chan GS		915	S. Broadway	1915
Ching H		936	S. Broadway	1915
Kwong S N		208	Marchessault	1915
Leung T	T Leung Herb Co	1619	W. Pico	1915
	Oriental Herb Co	955	S. Hill	1915
	Wong DR	713	S. Main	1915
Chan G S		915	S. Broadway	1916
Ching H		936	S. Broadway	1916
Kwong S N		208	Marchessault	1916
Leung T		1619	W. Pico	1916

[1] This is compilation created from the Los Angeles City Directory from 1900-1941. This does not represent a full or exhaustive list, as some herbal doctors did not list their business for fear of reprisal from the California Medical Board. Special thanks to Gilbert Hom of the Chinese Historical Society of Southern California for filling in the gaps.

	Oriental Herb Co	955	S. Hill	1916
	Wong DR	713	S. Main	1916
	Foo & Wing Herb Co	903	S. Olive	1916
	Hang Yang Tang	223	Ferguson Alley	1916
Chan H T		2515	S. Main	1917
Chang J. J.	Asiatic Herb Co	416	N. Los Angeles	1917
Chung Yick Hong	Hung Chun Lum Herb Co	341	Marchessault	1917
Chung Yick Hong	Chinese Herb Co	917	S. Hill	1917
Tom Shee Bin		2117	S. Main	1917
Wong Wing Lee		711.5	N. Alemeda	1917
	Dr Wong Co	713	S. Main	1917
Tom Shee Bin		930	S. Broadway	1918
	Tong Kee	316	Marchessault	1918
	Tai Sang Hing Kee & Co	516	N. Broadway	1918
	Tai Wo Tong Co	516	N. Los Angeles	1918
	Tuey D K Herb Co	244.5	E. First St	1920
Fong Rukiss W.		208	Marchessault	1921
Hong Wing Lee Mrs.		711.5	N. Alemeda	1921
	Quan Quong Co	504.5	N. Los Angeles	1921
	DR Wong Co	713	S. Main	1921
	Foo & Wing Herb Co	903	S. Hill	1923
Chung Yick H		126	W. 14th Pl	1924
Fong Davis R	Wong D R Co	713	S. Main	1924
Fong Kum	Wong D R Co	713	S. Main	1924
Tom S Foo	Chong Shay Herb Co	955	S. Hill	1924
	Dy Chun Tong Co	208	Marchessault	1924
Fong Kum	DR Wong Co	723	S. Main	1928
Chu Chas		6047.5	Hollywood Blvd	1929
	Yet Sing Herb Co	4517.5	S. Central Ave	1929
Tso L P		1805	W. Seventh St	1930
Wong Goat Sun		909	S. Central Ave	1930
	China Herb Co	208	S. San Pedro Ave	1930
Fong Kum	Wong D R	1016	S. Hill & 723 S. Main	1931
Ng Suey Wo		600	S. Figueroa	1931
Wong Goat Sun		900	S. Central Ave	1931
Wong Hey		442	N. Los Angeles	1931
Wong King Ping		118.5	E. Seventh	1931
	Chan & Kong	1304	W. Seventh St	1931
Chew T B		5906	Hollywood Blvd	1932
Kung P. K.		2111	W. Sixth St	1932
	Ng Suey Wo	609	S. Figueroa	1932
Chew & Chew		5126	Hollywood Blvd	1933
Foo Lung		304	Marchessault	1933
King Ung		319	Appablasa	1933
Ng Suey Noo		609	S. Figueroa Ave	1933
Shew Ying Woo		324	Marchessault	1933

Wong D R		1016	S. Hill & 723 S. Main	1933
	Hung Wo Hong	212	Ferguson Alley	1933
	Teang Wo Tong	320	Marchessault	1933
Fung Ching		900	W. Ninth St	1934
Sung Tai		1928	W Seventh St	1934
Quon D R		417	N. Los Angeles	1935
Tong L		1410	S. Grand Ave	1935
Wo N S		811	W. Pico	1935
	Yee & Ko Herb Co	3012	S. Vermont	1935
	China Herb Co	832	W. Eighth St	1935
Thoy Sam		4622	S. Central Ave	1936
	Bork Tow Co	326	N. Hill	1936
	Benson Kwan Herb Co	209	W. Santa Barbara Ave	1936
Chew T B		2030	N. Broadway	1937
Ling Fu		2004	Cooper Ave	1937
	Tow Bork Co	326	California	1937
	Tom & Lui	4416	S. Vermont Ave	1937
Lee K K		623	E. Fifth St	1938
Leong Y C		330	N. Hill	1938
Leung D R		4721	Avalon Blvd	1938
Sun Toy Jr		1236	N. Main	1938
	High Yuen Co	209	Aliso	1938
	Fook Tai Herb Co	1529	E. 33rd St	1938
Fong B C		426	W. First St	1939
Fong K S		330	N. Hill	1939
Fook Sing		1930	S. Central Ave	1939
Gok Yuen L		643	N. Spring	1939
Hom Toy Deg		210	Bellevue Ave	1939
Kung K		903	S. Grand	1939
Lee Do Yim		817	S. Vermont Ave	1939
Lung Sun S		612	W. Ninth St	1939
Sang Jee		724	N. Broadway	1939
Wing Quon		704	N. Spring	1939
Wong D R		829.5	S. Main	1939
	Leong & Son	939	W. Seventh St	1939
Jeong Sik Lee		724	N. Broadway	1940
	Hong Sing Co	620	N. Spring St	1940
	Canton Herb Co	426	W. First St	1940
Kim Jas		6106	S. Broadway	1941
	Kee Tong	755	N. Alameda	1941
	Herbal Tea Co of Cal.	307	S. Hill St Rm 619	1941
	Bork Tow Co	850.5	S. Main	1941