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## The Jesuit Hospital in the Religious Context of Sixteenth-Century Japan

In 1555, just six years after arriving in Japan, missionaries from the Society of Jesus founded a small medical clinic in the city of Funai (modern-day Ōita). This was the first European hospital in all of East Asia, and historians have often regarded it as the beginning of a scientific revolution, a revolution which would eventually see the official adoption of Western medicine in Japan along with the marginalization of Eastern techniques. This article seeks an alternative perspective. It argues that there is some misunderstanding as to the nature of the Jesuit hospital. The historical sources in fact indicate that it was largely designed by, directed by, and staffed by the local Japanese Christians. Because of this, it functioned much like a Buddhist temple sanatorium. It had buildings of a similar architectural style, and its patients were treated in a similar way, receiving both Chinese medicine and Western surgery. The primary goal of the Jesuit hospital was not to introduce exotic medical techniques, but rather to offer appropriate social and spiritual support to the community.

KEYWORDS: hospitals—medicine—Muromachi period—Confraternity of Mercy—*hijiri*—Jesuits

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THE STEREOTYPICAL view holds that Western medicine is advanced and scientific, while traditional Japanese medicine is old fashioned and vaguely superstitious. This view was largely established during the early Meiji era, when modernization was often associated with westernization. The young government brought in European doctors to teach in Japanese medical schools and sent Japanese pupils to study in European universities (SUGAYA 1978, 6–20; NUMATA 1996, 243–45). It required all aspiring practitioners to pass an exam based on Western methods, a system which essentially shut Eastern medicine out of hospitals (SHINMURA 2006, 235–37; MARCON 2015, 148–51). In short, it completely reformed the medical system, abandoning traditional medicine in favor of a European model.

This contrasted view of East and West impacted the historiography of Japanese medicine. Historians of the twentieth century, in particular, often equated scientific progress with the West. Accordingly, their studies tended to focus on the arrival of European doctors in Japan: the Jesuit missionaries of the sixteenth and seventeenth centuries, the Dutch doctors of the Edo period, the English and German doctors of the early Meiji era, and so on. These moments of contact with Europe were treated as moments of scientific advancement (GARDNER NAKAMURA 2005, 14–15). Meanwhile, doctors of traditional Japanese medicine were often portrayed as opponents to progress (PARAMORE 2017, 243–46).

Today, scholars continue to struggle with this legacy. There is general agreement that a new way of thinking about the relationship between Western and Eastern medicine is needed. However, what that relationship should look like is not entirely clear. Some scholars reverse the hierarchy, noting that in many ways Eastern medicine was superior to Western. It was only the specific political and ideological conditions of the nineteenth century that temporarily created an appearance of European superiority (ELMAN 2015, 17). Other scholars have proposed that Japan was not simply a disciple, but rather a full partner and collaborator in scientific advancement (KIM 2014). Finally, a third tendency is to criticize the emphasis on scientific progress altogether, questioning the assumption that technological prowess determines a civilization's value (ADAS and CHAN 2014, 129–89; HART 2013, 33–49).

For the purposes of this study, the third path noted above is particularly important. After all, medical care is not simply a matter of science. It also includes a vast range of nonscientific aspects. For example, it depends on communities, on groups of people who gather together in order to help the sick:

doctors, nurses, family members, and so on. It depends on culture and tradition: the collective values and goals that determine how to handle the human body, disease, or death. Occasionally, historians have noted these other aspects of medical care. For example, Susan Burns has examined the different meanings that Meiji-era Japanese attached to Western hospitals, from pride over being cared for in such an exotic institution to fear of being confined in one due to mandatory quarantines (BURNS 1997). Another example is the debate that Numata Jirō launched over the political implications of Western medicine, regarding whether Dutch medicine (*rangaku* 蘭学), ultimately strengthened or weakened the late Edo *bakufu* 幕府 (NUMATA 1982, 89–96; 1996, 234–45). What makes this sociocultural approach notable is that the success of medical care is not judged solely by scientific standards. Instead, attention is turned towards how the care responded to the broader needs of the community and the people within it.

This article focuses on a key moment in the history of the relationship between Eastern and Western medicine: the founding of the Jesuit hospital of Funai 府内. To give some context, let us briefly review Euro-Japanese relations prior to this event. The year 1543 is considered the first contact, when a handful of Portuguese merchants came ashore at Tanegashima (LIDIN 2004, 24–27; NAKAJIMA 2005). The Jesuits then followed. In 1549, Father Francis Xavier arrived in Satsuma, accompanied by Father Cosme de Torres and Brother Juan Fernandez (SCHURHAMMER 1982, 53–58; BOURDON 1993, 123–28; ASAMI 2011, 39–42). Xavier founded the first permanent church in 1551, in Yamaguchi (MATSUDA 1970, 30–31). Soon after, however, he departed for India, leaving Father Torres in charge of the mission (SCHURHAMMER 1982, 290–98; BOURDON 1993, 229–39; ASAMI 2011, 60–66). A second church was founded in Funai by the newly arrived Father Baltasar Gago, in September 1552, under the patronage of Lord Ōtomo Yoshishige 大友義鎮 (BOURDON 1993, 249–55; GONOI 1990, 53–55). Funai Hospital was established three years later, in 1555.

Scholars often see the hospital as part of a huge influx of Western knowledge and culture that characterized the celebrated “Christian century.” The Jesuit missions were hotbeds of westernization, introducing European food, music, clothes, astronomy, and, of course, religion (see, for example, BOXER 1951, 188–209). At Funai Hospital, Brother Luis de Almeida showed off hitherto unknown techniques, such as cauterization and the use of alcohol and olive oil on wounds (MICHEL 2001, 3–5). Accordingly, many historians have hailed this as the beginning of a scientific revolution in Japan, as a first small step leading towards the medical reforms of the Meiji era (ŌTORI 1964; OGAWA 1964, 59–60; TSUGE 1968, 33–34).<sup>1</sup>

1. It is worth noting that historians now point out that Jesuit medicine from the Christian century probably did not have wide dissemination among Japanese practitioners. See, for example, MICHEL (2001, 5–7). That is to say, it probably did not start a medical revolution.

This article seeks an alternative to such views of the Jesuit hospital. It does not examine it from a scientific perspective, but rather from a sociocultural one. That is to say, the goal is not to determine how the hospital spurred technological innovation, but rather to see how it fit into Muromachi society and contributed to community life. Indeed, we will see that the Jesuits constantly sought to adapt the hospital to better fit the people of Funai. Thus, over time, the hospital was gradually “japanicized”—perhaps more so than the surrounding society was “westernized.” Eventually, the facility came to act more like a Japanese institution than a Western one.

### *The First Hospital of Funai*

The establishment of the hospital was not a one-time event, but rather a series of steps. Initially, the Jesuits set up the hospital according to European tradition. It seems that it was Father Baltasar Gago who conceived of the project in Funai. In 1555, he wrote to his superiors of a new project; he wanted to build an orphanage for abandoned children, which could also serve as a shelter for the poor (MHSI 137: 549). Gago reported that, with permission from Lord Ōtomo Yoshishige, he had bought a new plot of land (MHSI 137: 549–50, 567). On this land, he proceeded to construct a new, larger chapel. On the old plot, he remodeled the former chapel to become the shelter (MHSI 148: 183).

In these early letters, Gago referred to this orphanage as a “hospital” (MHSI 137: 549), but it was hardly a hospital in the contemporary, medical sense of the word. As was common in early modern Europe, the term “hospital” had a broad use and could refer to any charitable facility offering hospitality and shelter (RISSE 1999, 154–56; CARLIN 1989, 21–26). Certainly, there was a former ship’s surgeon working there, a recently ordained priest named Luis de Almeida. However, it seems that his labor was not medical in nature—at least not yet. In 1556, Luis Froís wrote that “[Almeida] made a hospital at his own cost, where he receives the poor and takes care of them with much love and charity” (MHSI 137: 645). The fact that Almeida was reportedly receiving the “poor” (rather than the sick) suggests that the institution was functioning more as a shelter than as a medical facility. For his part, in his letters of 1555, Father Gago never mentioned any medicine being offered in the hospital (MHSI 137: 549, 566, 572).

It seems that Gago originally designed the shelter/hospital with a European-style layout. This is suggested by his decision to construct it out of an old chapel, that is to say, out of an assembly hall. The orphanage probably had one large, open chamber, where all the children would be housed together. This was the typical structure of Western facilities, which emphasized communal patient care, featuring wide hallways with numerous beds (CARLIN 1989, 28; HENDERSON 1989, 75). The Jesuits proposing a European-style shelter to help the Japanese was

the beginning of the intercultural dialogue. In response to the Jesuit proposal, it seems that the Japanese Christians had a less than enthusiastic response. It quickly became clear that the hospital/orphanage, in its original form, did not respond to the wishes of the local population. Instead of orphan care, the Christians were asking for medical services.

During the Muromachi period, professional doctors in Chinese medicine did exist, such as the famous Tanba 丹波 and Wake 和気 clans of Kyoto (FUKUNAGA 2014, 29). However, such specialists were expensive, and they primarily served the elite. Taku Shinmura has shown that the most common medical practitioners were the Buddhist priests. Some sects (most notably Shingon, Tendai, and Jishū) incorporated medical studies into their regular temple education. Their temples often had medical specialists (SHINMURA 2013, 58–69; 1985, 347–49).<sup>2</sup> For the sick folk who could not travel to a temple, itinerant priests, such as *hijiri* 聖, often visited homes in the countryside (SHINMURA 2013, 47–48). In general, people looked to priests for medical advice. It seems that many priests had some knowledge of the art of medicine, even if they were not necessarily specialists (HATTORI 1971, 93).

Just as they had previously sought medical help from Buddhist priests, the sick Japanese Christians began asking for similar help from the Jesuits (ABÉ 2010, 172–75). The Jesuits had mixed experiences in dealing with the sick. Sometimes the requests were simple. For example, it was commonly believed that ritual impurity caused sickness, and the Jishū offered water purification rituals to cleanse the diseased (SHINMURA 2013, 126–29). Accordingly, many sick Christians came to the Jesuits asking for baptism, apparently seeing it as a form of therapy (HIGASHIBABA 2001, 103–109). The missionaries, of course, were happy to offer this (MHSI 137: 418, 527, 529; MHSI 148: 93–94; SCHILLING 1992, 97; EBISAWA 1944, 72–77). Similarly, it was commonly believed that demons (*oni* 鬼) and fox spirits caused sickness (HATTORI 1971, 48–51), and Tendai and Shingon priests healed their patients by purging these dark forces (SHINMURA 2013, 47–57). Accordingly, many ill Japanese came to the Jesuits asking for exorcisms (MHSI 137: 527–28, 560; ABÉ 2010, 55–57). Faced with such requests, Father Gago did not hesitate to cast out demons in the “name of Jesus and Saint Michael” (MHSI 137: 528).

However, occasionally, the Japanese Christians came with requests that Gago could not satisfy. They sometimes asked him to give them Chinese medicine:

Another Christian at that time had not made his two sons Christians. When one of them was sick, he came to Father [Gago], asking him for medicine. And

2. It is true that such temple hospitals had become less common during the chaotic Sengoku period (SCHILLING 1992, 98; EBISAWA 1944, 75). Nonetheless, they were present, and they continued to function as best they could (SHINMURA 1985, 23–42; YOSHIDA 2001, 61–96).

when the father told him that he had no medicine, except for the soul, and that he would give that to him if he wanted, [the Christian] returned to his house without saying anything to his son, and without his son asking for it. And although he had already heard of the things of God, he did not want to accept them. And thus he died without them. (MHSI 137: 417)

Disappointed that the Jesuits could not give them medicine, some Christians returned to the Buddhist temples. Brother Pedro Alcaçova reported the following story, which occurred in Yamaguchi around 1554:

Another Christian, when he had a fever, came to Father [Torres] to get medicine for this sickness. And the Father told him to bless himself a certain number of times in the name of the Father, and of the Son, and of the Holy Spirit. And when he had finished doing so, the fevers left him. And when the Christian left our place, he went to recommend himself to a Pagoda so that they might help him and those fevers never return. And when he arrived at his home, a very great fever came that tormented him much. On a later day, he came to the father to ask forgiveness for what he had done. And the father ordered him to bless himself as many times again, and when he had finished doing so, the fevers left him, and never returned to him again. (MHSI 137: 424)

This particular story has a happy ending (at least for Father Torres), but there must have been other stories—ones with very different endings—that the Jesuits chose not to report. They clearly felt pressure to offer Chinese medicine like the rival temples. Thus, the Jesuit missionaries soon realized that they had to adapt the hospital.

#### *The New Hospital Management: The Confraternity of Funai*

In 1556, the hospital/orphanage underwent a change in management to the Confraternity of Mercy (*Confraria da Misericórdia*). In May 1556, the Jesuit Superior of Japan, Cosme de Torres, arrived in Funai (MHSI 137: 733). He had previously been in Yamaguchi, but had fled when the city fell to Mōri Motonari 毛利元就 (1497–1571). Soon after arriving, Torres gathered the most devoted Japanese Christians together and formed them into the Confraternity. He placed the hospital under its care (MHSI 148: 421). At that point, Father Gago handed over management duties to the local Christians.

At first glance, there was nothing unusual about Torres's actions. Confraternities were common throughout southern Europe and Portuguese Asia. Indeed, the Funai Confraternity adopted the rules of the Goa Confraternity, which had itself adopted the rules of the Lisbon Confraternity (WICKI 1974, 216; COSTA 2007, 76; RUIZ DE MEDINA 1995, 667). Consequently, the Funai Confraternity took on many traditional European religious practices. For example, community

banquets and Holy Week processions were popular in Italy, Spain, and Portugal (FLYNN 1989, 42–43, 126–32; BLACK 1989, 91–92). The Funai Confraternity began holding similar events (see, for example, MHSI 148: 418, 426). Similarly, the Lisbon Confraternity had the explicit mission to “cure the sick and visit the prisoners” (SILVA GRACIAS 2000, 16), and many Iberian confraternities managed hospitals (FLYNN 1989, 44–74). From this perspective, Torres was simply following European tradition when he entrusted the Jesuit hospital to the Confraternity.

A closer examination, however, shows that Torres’s decision was more complex. In fact, the Funai Confraternity differed from the Goa Confraternity in significant ways. They had very different memberships as the Goa Confraternity only admitted white men over thirty years of age as members. No native Goans or converted Jews were allowed (SILVA GRACIAS 2000, 17–18). That is to say, it consisted of Portuguese colonists. In contrast, the Funai Confraternity took the opposite approach. It consisted almost entirely of Japanese, with perhaps just one European male member.<sup>3</sup> It seems to have excluded the European priests from membership.<sup>4</sup> It also strayed from the Goan rules in that it admitted people who were under thirty,<sup>5</sup> and perhaps also admitted women, as will be discussed below. It had about thirty members during the period of this study.<sup>6</sup>

The Funai Confraternity members were also quite un-European in regards to their professions. First of all, one portion of the group was made up of former Buddhist priests or acolytes (*dōjuku* 同宿). There were about five such men who lived in the same residences as the Jesuits. They maintained the same sacerdotal lifestyle as their European counterparts: preaching and evangelizing, following the daily rhythm of the canonical hours, and upholding vows of poverty and chastity (GONOI 1994, 352–56; HIGASHIBABA 2001, 20–29). Nonetheless, they were not officially priests, because no Japanese could be ordained during this time.<sup>7</sup>

3. Other than the priests, there was only one reported white male resident in Funai during this period: a retired Portuguese merchant named Estevão Martinez, who had married a Japanese Christian from Yamaguchi (MHSI 148: 414).

4. None of the Jesuit priests are ever mentioned as members of the Confraternity. Juan Fernandez’s letter of 1561 suggests that the priests were treated as honored outsiders. For example, he says that he was sometimes invited to come preach at the gatherings of the Confraternity on Sundays (MHSI 148: 421).

5. We will see that the young Paulo (to be discussed later) was one of the majordomos of the Confraternity even though he was a young man, perhaps twenty-four years old (MHSI 137: 688).

6. There are no precise numbers on the membership of the Confraternity. The figure given here is based on the number of Christians who were allowed to take Communion during Holy Week: in 1557, thirty Japanese Christians were allowed (MHSI 137: 724). In any case, there must have been relatively few members, for in 1561, Juan Fernandez reported that each Sunday, they would all meet in one house (MHSI 148: 421).

7. No Japanese would be ordained until 1580, and even then the decision provoked significant controversy (HIGASHIBABA 2001, 20–29).

Another portion of the Confraternity was made up of Japanese nuns.<sup>8</sup> At the heart of this group was a woman baptized as Clara, about sixty years old. Father Gago reported that she “had run across the greater part of this Japan, and she had the duty of gathering alms from the lords to rebuild and fund pagodas, since she was from them” (MHSI 148: 187). In other words, she must have been a *hijiri*. Certainly such activities of traveling and fundraising were typical of the profession (MATSUO 2007, 44–47), and women were not excluded from it (NISHIGUCHI 2006, 6–13). By 1559, two other widows of martyred Christians had joined Clara (MHSI 148: 187, 413–14). Gago reported that they observed “the rule of convents” (MHSI 148: 187).

Still another portion of the Confraternity was made up of family elders. They were reportedly artisans such as carpenters and blacksmiths (MHSI 148: 413). However, these elders were not precisely secular laymen either. In 1557, some of them asked permission from Father Torres to take a vow of chastity. Torres refused to ordain them, but he nonetheless recommended that they maintain “a perfect life” (MHSI 137: 693). That is to say, he asked them to live like priests without the title. Consequently, by 1559, twelve families had come to live on the church campus (MHSI 148: 379; EBISAWA 1944, 90; HATTORI 1971, 370). About six of these men were counted as unofficial “brothers,” even though they were still married, and even though they continued to maintain their businesses.<sup>9</sup> In other words, they had become lay priests.

By now it should be clear that Father Torres’s decision to entrust the hospital to the Confraternity was in fact quite unusual. He was not giving it to a group of Catholic-raised Portuguese colonists, but rather to Buddhist-raised Japanese lay priests. He could not expect them to run the hospital like those in Lisbon (which were completely unknown to them). Most likely, he did not know exactly what to expect.

8. The Jesuit correspondence contains no explicit statement that the Japanese nuns belonged to the Confraternity, but it seems likely. They took part in many activities associated with the Confraternity. For example, they were allowed to practice self-flagellation (MHSI 148: 187) and take Communion (MHSI 148: 413). Admitting women would not have been a violation of religious tradition. Although the Lisbon Confraternity did not admit women, many other Iberian confraternities did (FLYNN 1989, 23–24).

9. This would seem to be the only way to explain Luis de Almeida’s statement in MHSI 148: 237–38: “There are twelve brothers in this house, Japanese ones. Those who serve this year are Pedro and Paulo.” Almeida states that there are twelve Japanese brothers, even though, as noted, there were only about five celibate men living with the Jesuits. The explanation would seem to be that some of the family elders are included in the number. The confirmation of this is that Almeida explicitly mentions Pedro as one of these brothers. Later, we will see that Pedro was a blacksmith, married with children. The businesses of the twelve families were apparently still active. For example, Juan Fernandez said that Pedro “lives off of his work, because he is a blacksmith” (MHSI 148: 416).

This unprecedented situation may explain why Father Torres, ever cautious, also broke with the Goa and Lisbon confraternities in another way. Those confraternities were truly lay organizations. Their leaders were not appointed by Rome, but rather elected by the members themselves (SILVA GRACIAS 2000, 16–21). In contrast, at least during the period of this study, the Funai Confraternity was partially controlled by the Jesuits. Father Torres handpicked the two leaders of the group, and these two leaders had to report to him for all major decisions. The missionaries were aware that this was a violation of the Goa rules. However, they felt it was necessary:

Although the *Book of Mercy* mandates that [the majordomos] be elected by lots, up to now, because it is a new project, the father has chosen those who seem best to him for this. Because, although they may be good men, they have need of more. That is to say, that they be diligent and have a good understanding of the things of God, not only for themselves but also to teach others. And that they be unoccupied and know something about medicine.

(MHSI 148: 417)

In other words, Torres was aware of the risk. If he did not keep watch, the Confraternity could potentially start doing some very unorthodox activities, and he wanted to be careful.

### *The Remodeled Hospital of Funai: Medical Care*

The Confraternity took over the hospital around late 1556. At that point, the institution began undergoing major changes. It changed from being a European-style orphanage to a Japanese-style medical clinic. Let us go through these changes one at a time.

The first aspect concerns medical services. The Jesuit letters from 1557 are the first to describe Western surgery and Chinese medicine in the hospital. The chief of surgery was, of course, Luis de Almeida (MHSI 137: 689). As noted in the introduction, he has already been well studied. In contrast, the specialists in Chinese medicine are much less understood.

The chief doctor of Chinese medicine was one of the two leaders (majordomos) of the Confraternity. His baptismal name was Paulo.<sup>10</sup> He was among the group of single men that lived in the Jesuit residences (MHSI 148: 183). The European missionaries held him in the highest regard: “This is one of the men

10. There were many Paulos in Funai, and this has caused much confusion. In addition to Paulo of Tōnomine 多武峰, there was also Paulo of Bungo 豊後, a secular townsman who Ruiz de Medina has identified (MHSI 137: 541, note 8). In his *Historia de Japam*, Luis Frois unfortunately did not realize this, and attributed all the activities of both Paulos to Paulo of Tōnomine (see, for example, FROIS 1976, 87). Numerous historians have followed Frois’s mixed biography (CRASSET 1715, 200; EBISAWA 1944, 98–99; HATTORI 1971, 364–67).

through whom God our lord does works of great wonder in Japan,” wrote Luis Froís in a letter from 1556 (MHSI 137: 647). Father Torres almost considered him to be a full priest, saying that he was “like a brother with vows” (MHSI 137: 737). The more forward Father Vilela did not hesitate to say that he was “ordained” (MHSI 137: 688).

It seems likely that Paulo practiced Chinese medicine in the manner of *hijiri*. He traveled through the small towns in the hills surrounding Funai, distributing alms and healing the sick (MHSI 137: 688; SCHILLING 1992, 102). Father Vilela said that Paulo cared for Christians “in the manner of the land, with herbs and many other medicines that he would make from herbs” (MHSI 137: 688). He used prescriptions from Chinese books (EBISAWA 1944, 105, 116). The Jesuits described these books as being “easy” (*faceis*) (MHSI 148: 183), which suggests that they were formula books or practical reference guides (GOBLE 2011, 33–36).

If Paulo acted like a *hijiri*, it is probably because he used to be one. Luis Froís reported that Paulo was a former Buddhist priest, whose name had been Quiogen (probably pronounced “Kyōzen”), and who had studied at a “very famous monastery by the name of Tonomine” (FROÍS 1976, 81). This was presumably the celebrated Myōrakuji 妙楽寺 (now known as Tanzan Jinja 談山神社) in the town of Tōnomine 多武峰. This means that Paulo had been trained in the Tendai sect, which, as noted, actively promoted medicine. Gago said that Paulo “lived and grew up with priests and pagodas” and that he was “a physician” (MHSI 148: 185). Luis Froís said that Paulo was well versed in natural science (MHSI 137: 647).

In late 1557, only a year after the hospital opened, Paulo suddenly passed away (MHSI 137: 712). The Jesuits struggled to find a replacement. Historians have often suggested that a refugee who had fled from Yamaguchi named Tomé Uchida took his place, but this is mistaken.<sup>11</sup> In fact, the Jesuits never found a completely satisfactory successor. Father Gago reported that they first recruited a man baptized as Miguel, but that he too soon passed away (MHSI 148: 185; SCHILLING 1992, 102). In this vexing situation, Father Torres himself considered the practice (MHSI 148: 185; SCHILLING 1992, 108; EBISAWA 1944, 115). He certainly had the religious and social stature to fill the role, but the challenge may have been beyond him. Father Gago’s 1559 letter is the first mention of Torres trying to learn medicine, and it is also the last mention of it.

11. Many scholars say that Tomé Uchida became the chief doctor after the death of Paulo of Tōnomine (SCHILLING 1992, 102; EBISAWA 1944, 99–100; HATTORI 1971, 366). The idea has become somewhat popular (see, for example, YASUTAKA 2010, 38). Unfortunately, it is not true. The key source, a 1557 letter from Luis de Almeida, states that Tomé Uchida’s son worked in the hospital, not Tomé Uchida himself (MHSI 137: 720–21). (This son, also baptized Paulo, will be discussed later.) The source of the error is Luis Froís, who Schilling explicitly cites, and who, in his *Historia de Japam*, summarized Almeida’s letter in an ambiguous fashion (FROÍS 1976, 108).

Finally, the Jesuits settled on a compromise. Gago's 1559 letter also reported that a Japanese doctor occasionally visited the hospital, stopping by when it was convenient for him (MHSI 148: 183). One of the hospital's buildings was reserved for his use (MHSI 148: 183). The Jesuit letters do not describe this doctor in detail, and consequently, information must be gleaned piecemeal. He is never described as a Christian, and his name is never mentioned—perhaps because he had no baptismal name. Juan Fernandez said that he was an “old physician” from “outside the church” (MHSI 148: 411). He was probably well trained, for the Jesuits reported that, when examining his patients, he took their pulse (MHSI 148: 411); that is to say, he followed the traditional method of diagnosis, the *shishin* 四診 (WISEMAN and YE 1998, 470–72). All of this suggests that the mission had resorted to hiring a professional doctor.

In addition to a chief doctor of Chinese medicine, Funai Hospital also had a medical assistant. It was probably typical in medieval Japanese society to pair an experienced doctor with a pupil, a master with an apprentice. Certainly, stories of the great doctors always describe them followed by apprentices (see, for example, SHINMURA 2013, 67–68).

Confusingly, the medical assistant's name was Paulo. His biography has also been subject to confusion. He was in fact the son of Tomé Uchida (MHSI 137: 720–21).<sup>12</sup> Paulo must have been a former *dōjuku* in a Buddhist temple. Certainly, his demographic profile suggests this: he was a young man, perhaps twenty-four years old, educated, unmarried, and apparently without property.<sup>13</sup> As soon as he arrived in Funai, in late 1557, he expressed his intention to become a priest.

12. No source explicitly says that the young Paulo was Tomé Uchida's son, but it seems highly likely because their stories match up. The first mention of young Paulo is in the letter of Father Gaspar Vilela from October 1557 (MHSI 137: 688). Luis de Almeida describes the arrival of Tomé Uchida's son in a letter from November 1557 (quoted in the previous note). The Almeida's description of Uchida's son fits everything that is known about the young Paulo: he was a young man who knew medicine, came to live with the Jesuits, and inherited the roles of the deceased Paulo of Tōnomine, and so on.

13. As to the status of Paulo, it has been mentioned that he was one of the five Japanese men living in the Jesuit quarters (MHSI 148: 411). This means that he was celibate and apparently did not have his own personal residence. As for his age, we cannot be completely certain, for it comes from a passage that seems to contain an error (MHSI 137: 688).

There is something strange about this passage regarding Paulo. It immediately follows a passage describing Paulo of Tōnomine (MHSI 137: 688). And indeed, Vilela goes on to state that Paulo died (MHSI 137: 712). However, as noted, all sources agree that Paulo of Tōnomine was a veteran priest, not a twenty-four-year-old young man. In other words, Vilela must have suddenly switched topics, from the elder Paulo to the younger one, without warning the reader. Was Vilela writing in a confused way, or is there a copyist's error here? It should also be noted that Vilela was in Hirado when he wrote this letter. He was reporting events in Funai secondhand, and he probably had not yet met the young Paulo in person.

However, Father Torres told him that he would have to wait (MHSI 137: 720). Thus he came to stay at the church as another lay priest.

The young Paulo became the successor to Paulo of Tōnomine. This probably explains why he was baptized with the same name as the deceased. Perhaps from his experience as a temple acolyte, the young Paulo already knew the art of Chinese medicine. The Jesuits thus set him to work in the hospital. Luis de Almeida reported this in 1559: “He now remains in place of Paulo [of Tōnomine], who we had at the church as a physician of the hospital and who had already died. This young man is very eager to serve God and a friend of virtue. He is very necessary to the church” (MHSI 137: 720). Like the elder Paulo, he traveled around the city and out in the neighboring villages. When he encountered the sick, he brought them to the hospital (MHSI 148: 416–17; SCHILLING 1992, 101; EBISAWA 1944, 100, 112; HATTORI 1971, 172). Paulo also distributed medicine to patients. Finally, it is worth noting that he took the deceased Paulo’s place as one of the two majordomos of the Confraternity (MHSI 148: 411, 237).

However, while the young Paulo could fill some of the old Paulo’s roles, he could not fill all of them. He had been a *dōjuku*, not an elder priest. Juan Fernandez reported this in 1561: “Because this Japanese man is very young, although he knows the art of medicine quite well, the Father does not let him do anything on his own.” Paulo thus worked under the supervision of the unnamed doctor of Chinese medicine. Fernandez described the teamwork of the two, saying that the young man gave medicine “through the counsel” of the elder (MHSI 148: 411). In other words, the doctor diagnosed patients and made prescriptions, and then Paulo prepared the medicine and administered it in an adaptation of the master-apprentice structure. The introduction of medicine, and more specifically Chinese medicine, was a change that the Confraternity made to the hospital and one way that they adapted it to Japanese tradition.

### *The Remodeled Hospital of Funai: Architecture*

Let us now look at a second change that the Confraternity made to the hospital: architectural changes. It should be remembered that some of the members were carpenters and blacksmiths who probably did the construction. “In the making of this church,” wrote Cosme de Torres in 1559, “the Christians helped us with their work” (MHSI 148: 735).

Gago had probably designed the original hospital/orphanage building with a European-style layout. The building had previously been a chapel (MHSI 148: 183). In other words, it probably resembled an assembly hall, with one large, open chamber, where all the children were housed together. This was the typical structure of facilities in Europe, which emphasized communal life, featuring wide

hallways with numerous beds (CARLIN 1989, 28; HENDERSON 1989, 75; RISSE 1999, 181). It was probably also the format of hospitals in Portuguese India.<sup>14</sup>

As soon as the Confraternity took over, remodeling began. The first round of construction was completed around January 1557 (EBISAWA 1944, 85; HATTORI 1971, 364–67). The carpenters divided the original single chamber into two in order to better meet standards of ritual purity. In his 1557 letter, Father Gaspar Vilela wrote that it is “a large place with two compartments, that is to say, one for injuries and sicknesses that can be cured easily, and another compartment behind this one for lepers” (MHSI 137: 688; EBISAWA 1944, 87–88; HATTORI 1971, 364).

The Confraternity was still not satisfied, for within two years they started remodeling again. The second renovation was completed around November 1559 (MHSI 148: 183; EBISAWA 1944, 88–89; HATTORI 1971, 366–67). The hospital now featured four different buildings, each with a different function. Father Gago’s letter of 1559 describes them. First, there was a residence for patients with leprosy; this was the old hospital building/orphanage, now reconverted again. Second, there was the new hospital, a residence for those with ritually clean conditions, such as injuries. Third, there was a small building used by the chief Japanese physician: a place for Chinese medicine. Fourth and finally, there was a “veranda” where Luis de Almeida performed operations: a place for Western medicine (MHSI 148: 183–84).

Looking at the general evolution, it is clear that the hospital underwent a steady process of fission. The original single chamber split into two subcompartments, which then split into four completely separate buildings. This was in fact a shift from the style of European hospitals (which featured one large building) towards the style of Buddhist temple hospitals (which had a multitude of small buildings). For example, the largest hospital of the medieval period, Gokurakuji 極樂寺, featured about eight different facilities (GOBLE 2011, 15–20; FUKUNAGA 2014, 32–34; HOSOKAWA 2004; YOSHIDA and HASEGAWA 2001, 89–91). Probably more to the scale of the Jesuit hospital was the facility of Shitennōji 四天王寺, which, according to tradition, was founded by Shōtoku Taishi 聖德太子. This was the model for subsequent temple hospitals. It had four structures (*shika’in* 四箇院): the main temple facility itself (*kyōden’in* 敬田院), a shelter for the destitute and impure (*hiden’in* 悲田院), a general hospital (*ryōbyōin* 療病院), and a building for cultivating and preparing Chinese medicine (*seyakuin* 施薬院) (FUKUNAGA 2014, 26–28; SHINMURA 2013, 26). The Jesuit hospital may have vaguely followed this model with its main chapel, residence for

14. There are scattered details on the various hospitals of Goa, which all tend to suggest that they were all built in a European style with one, central building (PEARSON 2005, 405–12; D’COSTA 1965, 140–43; SILVA GRACIAS 2000, 66–78). The only division within these hospitals was the typical separation of male and female patients (D’COSTA 1965, 141; SILVA GRACIAS 2000, 69).

lepers (unclean patients), residence for clean patients, and building for Chinese medicine.

The new patient residence hall of Funai Hospital was also more like Buddhist temple residence halls. The latter emphasized privacy. For example, the famous leper shelter of the Risshū 律宗, the Kitayama Jūhachi Kenko 北山十八間戸, gave each patient an individual room. It had a long row of eighteen small chambers, each with its own door (FUKUNAGA 2014, 31–32). The new residence hall seems to have followed a similar format. It was a long building, with single rooms, each with its own door—Almeida calls them “cubicles” (MHSI 148: 225)—arranged in two rows of eight, for a total of sixteen (MHSI 148: 183).

Still, the architects of the hospital made one clear concession to European style: they placed an altar in the residence’s central hallway, between the two rows of rooms (MHSI 148: 183). The Jesuits sometimes called this space an “oratory” (MHSI 148: 413). Thus, from their beds, patients could watch the priest perform the Mass. Father Gago reported that “when they are in the hospital, they enjoy learning prayers” (MHSI 148: 185). Juan Fernandez reported that many Japanese Christians would go to the hospital oratory to pray and would leave offerings of silk and Chinese paper (MHSI 148: 413). However, the Jesuits realized that many patients did this because they thought it would bring better physical healing. Because of this, Father Torres forbid them to be baptized until after they had fully recovered (MHSI 148: 185, 238). Thus, making buildings that were in the style of temple hospitals was a second change that the Confraternity made, and a second way that they adapted Jesuit facilities to Japanese tradition.

### *The Remodeled Hospital of Funai: Patient Care*

Finally, let us consider a third change that the Confraternity members made to the hospital: they adjusted the general system of patient hospitality. In this case, they mixed together both European and Japanese styles of patient care. On the one hand, the hospital maintained a Portuguese model of hospital management. The Confraternity Hospital of Goa, for example, had a hospital scribe (*escrivão*) who was “required to maintain strict checks on the admission to see that only the sick were admitted in the hospital” (SILVA GRACIAS 2000, 68). At Funai Hospital, the Jesuits gave this duty to the second majordomo of the Confraternity (the first being Paulo). This was an older Japanese man named Pedro. He must have been one of the family elders who had made a vow of chastity, for Almeida counts him among the “twelve Japanese brothers” of the mission (MHSI 148: 237–38). He apparently had a fiery personality, ready to defend the faith against any and all (MHSI 137: 418).

Juan Fernandez wrote that Pedro “takes care of the sick who are there, takes care to notify Father [Torres] of all necessities, and the people who come to be

cared for” (MHSI 148: 416). He screened applicants, deciding whether to admit them into the hospital or turn them away. “Nobody is accepted,” reported Fernandez, “unless they are brought by their fathers or lords, or known individuals, who give proof that they are not vagabonds” (MHSI 148: 416). As one of the majordomos, Pedro had access to the church funds and could provide for the patients as necessary (MHSI 137: 688; 148: 183). However, he had to approve his spending decisions with Father Torres (MHSI 148: 237). That is to say, Pedro acted like a hospital scribe, keeping track of general hospital affairs and patient reception.

At the same time, the hospital also cared for patients in a clearly Japanese fashion. Again, some context is necessary. It should be noted that Buddhist temple hospitals were not the primary centers of medical care. In medieval Japan, the most typical medical facility was simply the house. People who were sick stayed in their own homes or in those of friends or relatives, and doctors did house calls (GOBLE 2016, 51–52; SHINMURA 2013, 69). Religious medical care flowed out of this private tradition. There are stories of priests taking sick friends into their own residences (TSUJI 2014, 1216). There are also stories of temples, even ones without medical facilities, hosting ill guests while they recuperated (SHINMURA 2013, 69). This is all to say that in medieval Japan it was rare to strictly distinguish between public and private medical care. There was no clear line between the notion of “patient” and that of “guest.”

Pedro and the other Confraternity members probably had a similar attitude towards Funai Hospital, and they formed a veritable community around it. The church campus was divided in two during this period. The “upper campus” had the chapel, the residence of the missionaries, and the five celibate Japanese brothers. The “lower campus” had the hospital, the residences of Clara, and the nuns, the twelve families, and the servants (EBISAWA 1944, 89–90; MHSI 148: 183–87; 413). In many ways, the lower campus was like the temple towns (*jinaichō* 寺内町) of the Jōdo Shinshū: it had lay priests, active businesses, and residences, bound together as a faith community (GOBLE 2016, 51). In other words, Funai Hospital was not an isolated public building. On the contrary, it was embedded within a “private” community, right next door to the homes of the Confraternity members themselves.

Accordingly, the Confraternity members often treated hospital patients like guests in their own homes. The aforementioned majordomo, Pedro, was head of one of the twelve families on the lower campus. Juan Fernandez reported that he was “in the hospital with his children and servants” (MHSI 148: 416). In other words, he ran it as an extension of his own household. Clara and the nuns acted as hostesses. Although the servants were already cooking meals for the patients (as will be seen below), Clara was reportedly also making soups and other “consolations” for the sick (MHSI 148: 187). Fernandez also reported that Damían

(another lay priest) takes care “to always keep a pot of water boiling, and to give tea to all those who come from outside and are in the house who want it, a thing that is customary in the land” (MHSI 148: 412).<sup>15</sup>

In this world of Japanese private hospitality, the Jesuits themselves sometimes felt out of place. The Japanese often treated the sick like cloistered priests, withdrawn from the world (SHINMURA 2013, 162–64; HATTORI 1971, 76). As noted, this meant an emphasis on privacy. The Europeans, in contrast, tended to treat the sick as fellow monks (see, for example, RISSE 1999, 184–90). This meant an emphasis on commonality: shared housing, shared meals, shared daily schedules. The Jesuits were somewhat perplexed by the seclusion of the hospital guests. Torres just sent Brother Duarte da Sylva (or sometimes Juan Fernandez) to do visitations and preaching once a day for two hours.<sup>16</sup> It should be noted that they were chaplains, without any medical role.<sup>17</sup> Perhaps feeling some embarrassment at the limited visitation time, Fernandez noted that “with the sick also we have no further interaction, because the Japanese are cared for much differently than the Portuguese” (MHSI 148: 415).

### *Servants and Slaves*

Servants and slaves were the primary workforce of the hospital. However, their identities are often unknown, and the mystery is further deepened by confusion in the scholarship.<sup>18</sup> There were nine of them initially, reduced to six in 1559 (MHSI 148: 239, 440). One was a Bengali slave baptized Francisco, whom the merchant Duarte da Gama had “donated” to the mission around 1553 (MHSI 137:

15. The information summarized in this paragraph is reconstructed from various scattered references. First of all, Luis de Almeida says that the two majordomos of the Confraternity were named Paulo and Pedro (MHSI 148: 237). Without giving names, Juan Fernandez says that one of the majordomos was from Funai (MHSI 148: 413) and was a blacksmith (MHSI 148: 416). (We have seen that the first majordomo, the young Paulo, fits neither of these descriptions.) Finally, in a passage describing the leaders of the Funai church, Melchior Diaz mentions that one of the elders is a “blacksmith Pedro... from Bungo” (MHSI 148: 324).

16. Juan Fernandez says that the time frame was from one hour before noon till one hour after noon, and Duarte da Silva (or Fernandez himself) would go to preach to the sick (MHSI 148: 438).

17. There is considerable confusion in the scholarship surrounding the roles of Fernandez and da Sylva in the hospital. SCHILLING (1992, 101–102) mistakenly thought that they were practicing medicine in the hospital. EBISAWA (1944, 106) followed Schilling, and HATTORI (1971, 371–72) followed Ebisawa. However, this is a mistake. In addition to Fernandez’s letter describing Duarte da Sylva preaching in the hospital (cited in the text), Father Gago’s letter of 1559 makes it clear that there was a division of roles between Luis de Almeida (the surgeon) and Duarte da Sylva (the chaplain) (MHSI 148: 184).

18. SCHILLING (1992, 104–105) and EBISAWA (1944, 103) thought that Almeida’s “helpers” were just members of the Confraternity. They did not realize that some of them were servants. HATTORI (1971, 369–70) realized that they were servants, but he thought that they were all Japanese, and he did not realize that they were of different cultures.

543, note 19). Another was a young Javanese man baptized Luis, the freed slave of Luis de Almeida, who had arrived in 1555 (MHSI 148: 413).<sup>19</sup> Two were orphans from Goa, who Father Belchior Nunes Barreto had brought with him to Japan in 1556 (MHSI 111: 21). There must have been a few Japanese servants as well, for in 1559, Almeida said that his helpers were “Japanese as well as from India” (MHSI 148: 226). Were these Japanese local folk, recruited from Funai? Were they refugees who had fled from other cities? Or were they simply the servants of Pedro, mentioned above? The sources do not give enough information to offer a decisive answer.

The servants had hard lives. In the morning, they joined the missionaries for the morning service, Matins (MHSI 148: 237). After that, they went to the hospital with Luis de Almeida, who supervised them (MHSI 148: 177). Juan Fernandez said that they were given “the duties of purchaser, steward, cook, and gardener” (MHSI 148: 440). This is probably just a partial list, but it gives a clear enough idea of their tasks: they handled the gritty work of running the facility. They labored throughout the day, apparently until Vespers, that is to say, sunset (MHSI 148: 440). It was a tiring, thankless life, and the priests were not always sympathetic to their plight. It seems that some—perhaps the young orphans—were very unhappy. “Among them, there are some troublemakers who need a spur and a restraint,” wrote Juan Fernandez. “The Father sent three of them to India in the year 1559” (MHSI 148: 440).

In using bonded labor, the hospital was following Portuguese custom. The setup was modeled after the Jesuit Seminary of Saint Paul, in Goa, which also depended on slaves (CONSTITUTIONES 1948, 123). That said, the Japanese patients were probably not surprised to see such workers within the facility. In Buddhist temples of the time, sharp class distinctions existed as well. Studies on Tōdaiji 東大寺 and Mt. Kōya 高野, for example, have noted the presence of low-class laborers charged with similarly menial tasks (INABA 1997, 56–57; HIRASE 1988, 112–26). Rather, what seems to have shocked the Japanese patients was when the servants transgressed the hierarchy. For example, the young Luis helped his former master, Almeida, to perform surgeries. He gained so much experience that eventually he became the chief surgeon himself (MHSI 148: 415–16). However, Almeida reported that the patients did not like this, for they did not “have regard” for the servants (MHSI 148: 226).

19. This is probably because he bore the same name as Luis de Almeida, and so the young Javanese man baptized Luis has often been misidentified. Schilling and Hattori thought that Almeida was training Japanese apprentices (SCHILLING 1992, 99–100; HATTORI 1971, 371–72). EBISAWA (1944, 104) thought that Almeida was training a Japanese apprentice named “João,” that is to say, he misread the word for “Javanese” (Jão). At the same time, from a separate source, he was aware that there was a Javanese apprentice as well (for the passage in question, see MHSI 148: 415).

*Conclusion*

This article has examined the Funai Hospital from a sociocultural perspective, and, viewed from this perspective, Jesuit medicine takes on a different meaning. Certainly, the scientific aspects were important. The missionaries were proud of their achievements, boasting that word of the hospital had spread even to Kyoto (MHSI 148: 183). “The Japanese Christians and Pagans say that there is no medicine other than that of the fathers of Jesus!” (MHSI 148: 412). However, while such scientific distinctions were certainly gratifying, they were only of secondary importance. We have seen that from beginning to end, the primary goal of the hospital was not therapy, but rather charity. It was one way, among others, that the Confraternity of Mercy tried to respond to problems of poverty and suffering in Funai.

In this development of charitable activities, the Jesuits and the Japanese never had a one-way relationship. The Japanese Christians did look up to Cosme de Torres as a guide, but clearly they also felt that he was wrong at times. Cosme de Torres saw himself as the detainer of spiritual truth, but he was humble enough to recognize his limitations and allow the Japanese Christians to manage the hospital as they saw fit. Actually, the Christians had to take more of a leadership role because only they had the cultural knowledge necessary to adapt the hospital to Muromachi society. In short, the Meiji-era narrative of Western doctors coming to educate Japan does not fit well with the experience of the Jesuits in Funai.

The sociocultural perspective gives a broader understanding of what was happening in Funai Hospital. It highlights aspects that the scientific approach tends to neglect: its religious, cultural, and societal implications. Those aspects must not be forgotten, for they were perhaps most important to all those involved.

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