FEATURES

Medicine in Captivity: How Internment Shaped Japanese American Health For Generations

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Introduction

Eighty-three years later, the internment of Japanese Americans during World War II (WWII; 1939–1945) remains one of the most egregious violations of civil liberties in the history of the United States. In the wake of the 1941 attack on Pearl Harbor, the U.S. government failed to distinguish between imperial Japan as a foreign power and Japanese Americans (Office of the Historian, n.d.). As a result, widespread xenophobia and wartime hysteria fueled suspicion toward anyone of Japanese ancestry.

Following the signing of Executive Order 9066 in 1942, approximately 120,000 Japanese Americans were forcibly removed from their homes and relocated to internment camps (National Archives, 1942). The conditions in the camps were harsh: remote locations with extreme temperatures, inadequate food supplies, and poor sanitation. Edward J. Ennis, then a Member of the Board of Directors of the American Civil Liberties Union, condemned the ongoing mass incarceration as “the greatest deprivation of liberty since slavery” (Ennis, 1984).

One of the most telling indicators of the quality of life in these camps was the state of healthcare. While healthcare today is recognized as a fundamental human right—formally articulated in the World Health Organization’s 1946 Constitution—U.S. policy had not incorporated such a concept during WWII. Thus, within the camps, patients receiving medical care were also forced to contend with chronic shortages of medicine, equipment, and trained physicians. Although the U.S. government assigned some medical personnel to the camps, these staff were few in number and often inadequately supplied. Interned medical professionals—many of whom had been practicing doctors, nurses, or pharmacists before their incarceration—worked under severe constraints, receiving little to no pay and lacking

the necessary resources to provide adequate care (Nagata & Takeshita, 1998). Although the U.S. government made some efforts to offer medical services, such as sending meager supplies, these attempts were largely insufficient, and often led to preventable illness, suffering, and death (Nakayama & Jensen, 2011).

Overall, these failures of healthcare in the camps were a reflection of racialized policies that determined access to basic human needs. Moreover, the effects of this medical neglect stretch far beyond the closure of the camps; its consequences have lingered for generations, affecting the physical and mental health of Japanese American families in contemporary society.

Healthcare in the Internment Camps

The forced removal of Japanese Americans dismantled entire healthcare networks that had served these communities, particularly in urban areas. Many Japanese American doctors, nurses, and pharmacists lost their practices, and community hospitals were shuttered overnight (Nakayama & Jensen, 2011).

Internees were initially sent to makeshift assembly centers, where living conditions were deplorable (Nagata & Takeshita, 1998). Families were crammed into overcrowded barracks, including converted horse stalls that reeked of manure, while rudimentary sanitation facilities led to frequent outbreaks of disease (Jensen, 2008). Overcrowding and poor ventilation created the perfect conditions for the rapid spread of tuberculosis and influenza. These crude infirmaries lacked essentials such as intravenous needles, tubing, and fluids. Even with emergency supplies, the Japanese medical staff struggled to treat the overwhelming number of patients (Fiset, 2024). Additionally, although medical records are sparse, oral histories frequently describe cases in which treatable physical illnesses such as tuberculosis or the flu were misdiagnosed, and "melancholia" or medical complaints were dismissed as somatic symptoms of psychological distress (Dusselier, 2008). As Dr. Yoshiko "Fred" Fujikawa, an interned Japanese American physician, later recalled from the Santa Anita assembly center in California, "people lined up to go to the latrine and […] some of them fainted in the line" (Nakayama & Jensen, 2011). His recollection exemplifies the exhaustion of the first phase of internment.

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Even upon transfer to the more permanent War Relocation Authority camps, the healthcare situation remained inadequate. These camps often lacked basic resources like ambulances, surgical equipment, and adequate prenatal care. Hospitals, if constructed at all, took months to open. Japanese American physicians and nurses received as little as $19 per month and, despite their professional training, were routinely overruled by White supervisors, who often abused their authority (Fiset, 2024).

The racial hierarchy within healthcare systems at the camps added to the stress for both patients and providers. White medical directors often discounted the expertise of more experienced Japanese American doctors. For instance, Dr. Reece Pedicord, the White medical director at the Tule Lake internment camp in Northern California, grew suspicious that Japanese American physicians were performing an excessive number of surgeries (Nakayama & Jensen, 2011). Dr. Shigeru Hara, an interned Japanese physician, remembered that "he [Pedicord] used to say, 'Any case that has to be operated [on], you've got to see me first.' Some of those were acute appendicitis. By the time he got to see them, he had made it pretty late and made it much worse. So that's why a lot of people were against him" (Nakayama & Jensen, 2011). This dynamic reveals how deeply anti-Japanese prejudice was woven into the structure of American medicine: the hierarchy at the camps mirrored the broader racialized exclusion of minorities within American healthcare, which ultimately exacerbated in patient suffering.

Long-Term Health Consequences of Internment

The health consequences of Japanese American internment went far beyond the years spent in the camps. The deprivation of basic necessities and systemic neglect that the internees faced in the camps created a lasting imprint on the health of survivors.

In the camps, the widespread malnutrition and overcrowding created an environment in which both infectious and chronic illnesses flourished. Chronic conditions such as diabetes, ulcers, and cardiovascular disease were often poorly managed in the camps, due to a lack of medications, specialized care, and consistent monitoring, leaving some with irreversible complications

that continued into adulthood (Jensen, 2005). In some cases, previously mild illnesses worsened irreversibly due to neglect or stress-induced flare-ups. For example, tuberculosis, which thrived in the overcrowded and poorly ventilated barracks, could cause permanent lung damage (Jensen, 2005). The spread of coccidioidomycosis (also known as Valley fever) was also exacerbated by the dusty, arid locations of many of the camps (Fiset, 2024). The lack of prenatal care for pregnant internees added further risks: Miscarriages, preterm births, and birth complications were more frequent, and mothers often lacked access to trained medical staff during labor.

These physical consequences were compounded by severe psychological trauma. Internment involved not only the loss of homes, but also communities, autonomy, and dignity—all of which generated widespread symptoms consistent with those of post-traumatic stress disorder (Cai & Lee, 2022). Depression and anxiety were especially common among older internees who had lived stable lives before the war.

Intergenerational Effects of Internment

While survivors endured significant trauma during the internment, its impact also affected the mental and emotional health of later generations. Research indicates that third-generation Japanese Americans, or Sansei, whose parents experienced incarceration during their own childhoods, exhibited higher levels of distress and lower subjective well-being later in life compared to non-interned Japanese Americans (Nagata et al., 1999). These effects echo the findings from intergenerational trauma studies across multiple populations, such as the descendants of Holocaust survivors, Cambodian genocide survivors, and Indigenous boarding school attendees (Isobel et al., 2021).

Moreover, the internment experience often disrupted traditional family structure and caregiving roles. Children of internment survivors who witnessed their parents lose control over daily life were found to be at higher risk of developing a fractured sense of identity and intergenerational detachment (Spiel et al., 2023). Broader studies suggest that such environments can lead to insecure attachment styles, which correlate with long-term relational and psychological challenges, such as anxiety, depression, or emotional dysregulation.

The legacy of this internment has also played a crucial role in how trauma was passed down. Many second-generation (Nisei) parents remained silent about their experiences in the camps, often out of shame, a desire to assimilate, or a fear of re-experiencing the trauma. This silence created what scholars call "emotional gaps" between generations, in which children felt the presence of unspoken trauma without being able to name or process it (Isobel et al., 2021). Children often interpreted their parents' abnormal behavior as personal or emotional withdrawal, which compounded their own struggles with identity, anxiety, and belonging.

Research on intergenerational communication in Asian American families supports this dynamic (Hesse & Main, 2000). When parents fail to discuss past trauma, children are left to make sense of it on their own, sometimes internalizing it in ways that harm their mental health, such as self-blame or emotional suppression (Isobel et al., 2021). This process is described by Isobel et al. (2021) as a major mechanism for the transmission of trauma's cross-generational effects.

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In this way, the effects of internment were transmitted through generations. The internalized cultural expectation among Japanese Americans to suppress grief and 'move on' after the war likely intensifies the psychological strain carried by their children (Cai & Lee, 2022). Without space for communal mourning or storytelling, trauma became embedded in their memories and family dynamics. Recognizing this intergenerational trauma is essential not only for an accurate historical understanding but also for informing contemporary approaches to mental health care.

Conclusion

The internment of Japanese Americans during WWII was a clear violation of civil liberties, with the consequences extending across generations. The incarceration camps created an environment of deprivation: overcrowded living quarters, insufficient food, inadequate medical care, and the psychological burden of forced displacement and racial scapegoating. These conditions inflicted immediate harm, and their consequences persisted long after the camps closed.

Attempts to understand the history of Japanese American internment is necessary, not only for Japanese

American communities, but for how we understand the lingering health effects of social injustice wherever it may pervade. The same patterns of systemic neglect and medical mistrust seen in the internment camps persist today in marginalized communities. Black Americans still face unequal treatment in hospitals, Indigenous communities suffer from chronically underfunded health systems, and immigrants in ICE detention experience the same deprivation once normalized in internment camps. The echoes of internment are not just metaphorical; they reveal a recurring national failure to protect the health and dignity of those deemed "other." Recognizing these parallels reminds us that history's injustices will continue to shape who receives healthcare and who is unjustly denied it.

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