The foundation of social medicine in Indochina: A mirror image of French Governmentality

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From 1887 to 1900, the Indochina Federation was established based on three former countries: Laos, Cambodia, Vietnam, and the territory of Guangzhouwan. To control this Federation, the French utilized medicine as a “tool of the Empire”. This article analyzes the relationship between the Empire and medicine through Foucault’s concept of governmentality. It explains how social medicine has been founded in Indochina under the guise of civilizing missions. Thus, this paper highlights social medicine's establishment through state, urban, and labor force medicine under French colonial domination and its influence on individuals and society in Indochina.

Keywords: Governmentality, social medicine, milieu, vaccination, Indochina, France

Introduction

Social medicine is the study of epidemiology and the medical needs of society. According to Thomas Mckeown, social medicine is “concerned broadly with the appraisal of the medical problems of society and the means at our disposal for solving them” (Cohen, 1968). Likewise, Foucault highlights that for a capitalist society, the society’s control over the individual was accomplished not only through awareness and ideology but also in the body and with the body. The body is a biopolitical reality, whereas medicine is a biopolitical strategy (Foucault 2001, p.137). In fact, medicine has been accepted as a necessary tool to improve the European nation’s strength and the population since the end of the 16th century. Especially when empires expanded overseas, medicine was also recognized as a broader utility in the service of the Empire. Imperial powers have explored medicine not only as a demonstration of their benevolent and paternalistic intentions but also as a way of winning support from a new subject population. Furthermore, medicine can balance out the coercive features of colonial rule and establish a wider imperial hegemony than could be derived from conquest alone (Arnold 1988, p.16). In the same way, upon conquering Indochina, the French colonizers established a social medicine to restructure and “modernize” Indochina colonial individuals as well as society. For the French, colonial medicine was part and parcel of a broader “mission of civilizing” the colonial subject since it tended to health care, built hospitals, and trained medical knowledge for the indigenous. However, treating diseases was not the ultimate intention of these missions. Thus, the colonial medical interventions brought about more benefits for the rulers rather than the ruled. Based on Foucault’s works on governmentality and medicine, this article aims to advance the understanding of the foundation of social medicine in Indochina. It sets out to determine typical techniques of governmentality in the medical field such as the organization of a state medical knowledge, the standardization of the medical profession, the expanding method of

observation, medicine treatment, and public hygiene including compulsory vaccinations as well as the rudimentary medical training for the colonial subjects. This paper will contribute to the study of social medicine in Indochina under French colonialism.

Governmentality, medicine, and the French Empire's civilizing mission

Governmentality is the concept introduced by Foucault, which is also well-known as “governmental rationality” or “the art of government”. It explicates how we think about governing with different rationalities or “mentalities of government” (Dean 2010, p.24). In colonies, governmentality is understood as the state’s techniques and tactics to observe, measure, and control population. More critically, governmentality is not concerned about territories, but populations and populations’ milieus. Since the population is a fundamental element and precondition for all the others, it not only provides manpower for agriculture, manufacturing, and commerce but also an essential component of the state’s power. Thus, the empire governmentality had to expand the welfare of the population, improve its condition, and increase its wealth, longevity, health, and so on (Legg 2005) by applying for medical advances. As a result, the promotion of social medicine in Indochina is a part of the techniques and practices of French governmentality in the colonies.

After establishing the Indochina Union in 1887, the French Empire saw medicine in its direct relation with the political, commercial, and military expansion of imperial powers (Macleod and Lewis, 1988). It was not only a part of the ideology and the accountancy of the Empire (Arnold 1988, p.16) but also a superior form of propaganda for the benefits of Western civilization and capitalism. Mainly, the French usually used the rampancy of diseases to condemn the Asian “backwardness,” and only through the superior knowledge and skill of European medicine was it thought possible to bring them under effective control. Thus medicine became a hallmark of French racial pride (Arnold 1988, p.7), and the relationship between medicine and disease stood for the connection of power and authority between rulers and ruled. In this view, the European medical intervention represented not only progress towards a more “civilized” social and environmental order medicine but also the vector of a new civilization (Macleod and Lewis 1988) that could transform mentalities and tradition by importing a new way of life (Arnold 1988, p.3). Thus, medicine was utilized as “ [a] tool of [the] empire” that enabled or facilitated western penetration and domination of the non-European world. It was this tool that enabled or facilitated Western penetration and domination of the non-European world (Arnold, 1988, p.10; Headrick, 1981). Medicine allowed imperialism to know its subjects and establish its authority over them through the vast quantities of information about diseases and health that were amassed in statistical and scientific form and by the development of medical agencies, themselves often branches of the state structure itself that began to reach out into the countryside as well as the town. In other words, the French colonizers could find an opening to the hearts of the indigenous under the guidance of doctors and teachers.

However, the political goals of medicine did not stop at the Indochina border. Along with preserving the local population and giving them a Western taste, France intended to arouse the admiration of imperial colleagues, especially the tremendous British rival and its Asian neighbors. The establishment of consular health agencies in China and Siam was a clear sign of this recognized need, as well as a means to prevent the spread of threatening illnesses. Also, the fight against traditional medicine manifested the French colonial government’s attempt to erase the Chinese influence in the peninsula, especially in the North.

Establishing a state medicine: administrative organization,medical and doctors standardization

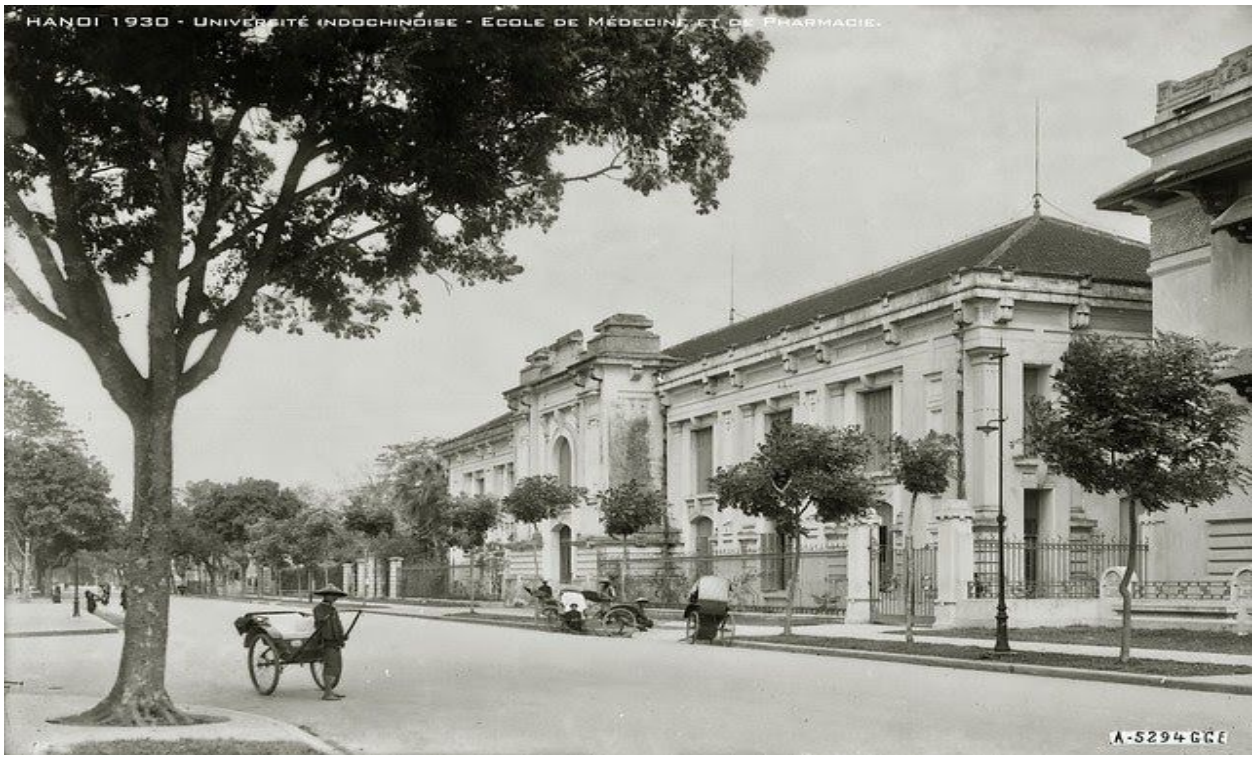
According to Foucault, state medicine is the first step to build a social medicine (Foucault 2001, p.137). It is not only interested in conducting birth rate and mortality censuses but also organizing intervention to “raise” the level of health (Arnold 1988, p.13). Moreover, it builds a system of various disease observations which is based on information gathered from hospitals and doctors in order to record the different epidemic and endemic phenomena in colonies.

Before invading Indochina, the French missionaries and doctors sent many reports about dangerous diseases to the metropole. They soon recognized that Indochina was dominated by a lot of epidemics (plague, smallpox, and cholera), contagious diseases (dysentery, typhoid, dengue fever, intestinal parasite, and malaria) and its social diseases (tuberculosis, venereal disease, and eye disease). Moreover, nowhere could be considered as a safe and healthy area to live. These diseases became a permanent obsession of French soldiers when invading Indochina, and also hindered the invasive process of them.

To overcome these diseases, the French government in both the metropole and Indochina have established administration organizations to run the medical system there. Starting in the 1870s, the colonial administration introduced hygiene and sanitation courses in schools in urban areas. On January 7, 1890, Colonial Health Advisory Council and Colonial Health Corps were founded to guild medicine issues and hygiene. In 1897, Civilian Medical Assistance was established, and under the first medical assistance program, health care directors for each province were also appointed. In 1902, the Governor-General applied the law on urban community health and opened Medical School in Hanoi to establish a broad health protection system and to ensure the loyalty of an assistant doctor, a colonial civil servant like a native administrator or teacher. Primarily, in 1904, the Governor-General built the Indochina General Directorate of Health to control medicine and epidemiological hygiene throughout Indochina through various fields: army medicine, hospitals, medical inspector, epidemiology, and hygiene, personnel, colonial health council. On June 30, 1905, Governor-General Beau established the Medical Assistance Agency, which was responsible for supporting the Indochina General Directorate of Health in epidemiology and medical aid for indigenous people (Rousselot 1999, pp. 57-58). In this same year, the foundation of Indigenous Medical Assistance (AMI) created a turning point in the development of the medical system in Indochina. The central role of this officer was to manage the medical structure, drug store, counseling system, and vaccination. Yet, the lack of financial resources and unfair distribution among these fields prevented the effective operation of this administration system. For example, in 1880, the Colonial Council divided 20 million francs for its activities, but only 100,000 was spent on health care (under 0.5% in the total budget) (Rousselot 1999, p.79) . As a result, the hospital organization linked its funds with the private company and the local budget to operate.

Also, the French were interested in medical officers who would take responsibility from central to the local level, as well as build hospitals and train indigenous doctors. In the beginning, the French colonizers were only concerned about military hospital needs and treated soldiers rather than indigenous. The Navy hospital (200-bed main ambulance) or the Cho Quan maritime ambulance only serviced Western people(Rousselot 1999, p.86). However, the French soon recognized that they had to treat the indigenous peoples to prevent the spread of disease to soldiers. Therefore, in 1864, Cho Quan Hospital was the first reception place for Indochina civilians. After that, the French

extended medical facilities to other territories in the Indochina Union. For instance, a palace and an infirmary were built in Cambodia in 1863. In 1866, a barracks ambulance was installed in Phnom Penh, and the following year began the first rounds of vaccinations. In 1885, an ambulance on the edge of the Tonle Sap was built; then ambulances were posted in Kratie, Kampot, and Takeo (Rousselot 1999, p.86). Also, in Tonkin, the Hanoi and Haiphong barracks were transformed into hospitals in 1883. Medical posts were created in the chief towns of the provinces of Hai Duong and Quang Yen. In the early 20th century, the French continued to build hospitals, infirmaries, clinics, and first–aid posts. Particularly, the legislation of 1914 -1915 also reflected a hierarchy in which the top was the construction of hospitals, then maternity wards, the essential clinics and finally the consultation rooms. Besides, central pharmacies, leprosy houses, lazarets, laboratories, and infirmaries were established. However, most of the crucial hospitals were located in Tonkin and Cochinchina, rather than Laos and Cambodia. Therefore, any severe cases in Laos and Cambodia had to transfer to hospitals in Cochinchina and Tonkin.



"HANOI 1930 - Université indochinoise - Ecole de Médecine et de Pharmacie" by manhhai is licensed under CC BY-NC-ND.

In addition, to standardize the auxiliary doctors, the French government was also concerned with the development of an education program for native medical personnel. Nevertheless, indigenous people only worked as auxiliaries for the French doctors rather than independent working. They would join courses from 6 months to 1 year and then work with the French doctors or in the first-aid of villages. If they wanted to become native doctors, they needed to study at School of Medicine in Hanoi for a long time until they obtained a certificate. In January 1913, the French colonizers determined that the role of the indigenous doctors was subordinate as the assistant of the French

doctor. The native doctors and midwives, for their part, are responsible for the service of dispensaries and maternity wards, under the control of the mobile colonial practitioner.

In 1916, 93 public and military assistance doctors were stationed throughout Indochina. Later, with the expansion of the medical school, the number of doctors and nurses of Indochina increased. In 1937, 117 doctors were recruited at AMI, and the local staff included five medical doctors, 199 auxiliary doctors, 35 pharmacists, and 418 midwives, and four contracted doctors. Besides, there were still 122 European nurses in operation and especially 3,133 Indochinese nurses (Rousselot 1999, p. 96). However, native doctors were authorized to treat only the native population and promote hygienic practices among the native communities rather than the French.

Urban medicine and labor forced medicalization

In Foucault's works in social medicine, urban medicine was understood as the expansion of urban structures, the change of the surrounding environment, and new tactics and mechanisms to either prevent diseases or to remote diseases. In another way, urban medicine is a medicine of things such as air, water, decompositions, and fermentations rather than medicine of man, the body, and the organism. It is the process of improving the health of people through prevention and vaccination. Thus, the French not only accumulated knowledge on the causes of illnesses in the urban space or places that generated and propagated epidemic or endemic phenomena but also analyzed the zones of congestion, disorder, and danger within the urban precincts. Moreover, when building urban infrastructure, the French were very concerned about urban sanitation, the management of clean water, and waste systems.

Principally, it was necessary to separate between the European hospital and the indigenous patient. In addition, the French also treated infectious diseases in separate places and away from the main hospital building (i.e, lazaretto, which was a structure built for contagious diseases, especially leprosy) and outside urban areas. Besides, the hospital gradually became a more hygienic landscape and was located near facilities that provide essential services. These measures were taken to prevent and fight diseases. As a result, Indochina was systematically recognized as "the best sanitary served" among the French colonies (Rousselot 1999, p.102).

The last and most crucial factor in founding social medicine is a vaccination for the indigenous population. This work was closely linked to the success of medical doctors, bacteriologists like Léon Charles Albert Calmette, and Alexandre Yersin. They created a turning point in the study about the origin of diseases and the way to treat them through vaccination. The vaccine has become a tool that not only helped prevent diseases, mainly smallpox, but also represented the birth of public health policy in colonial Indochina.

In Indochina, immunization was a health policy for indigenous people. French doctors conducted it, followed by indigenous doctors and nurses. However, doctors were unable to visit all the villages, so they gathered the children to specific locations on a predetermined date according to an agreement with the local administrators to do vaccination (Rousselot 1999, p.127). Furthermore, they did not depend on the source of the vaccine from the metropole because they could create it at Saigon Institute and Pasteur Institute. In 1880, 50,000 people had been vaccinated in Cochinchina, and then the number of vaccinations increased steadily, reaching over 8 million in 1940 around Indochina despite budgetary constraints and a shortage of staff. In particular, Indochina also provided vaccines

for Madagascar, Reunion, Somalia, New Caledonia, as well as many British colonies in Asia and the Philippines (Rousselot 1999, p.128). Finally, it can be argued that the disease has become less dangerous and that the mortality rate from diseases has fallen faster than the rate of infection as soon as they persisted in Indochina.

Resistance and reception

Although the French tried to apply Western medicine to colonial society, in the beginning, Indochina indigenous peoples did not prefer Western medicine because the cost of hospitals and services was too expensive; or Western treatments and indigenous religions, traditions, and beliefs were different. For example, women were not interested in giving birth in hospitals or under Western midwives' guidance because of differences in the conception of giving birth, taking care of babies, and abstinence thoughts of people. Moreover, indigenous people would refuse any form of surgery because of moral and religious obstacles. Even while the mandated colonial law was to bury the body quickly to preserve public health, Indochinese continued maintaining the long-lasting funeral.

Because of Indigenous' resistances, medical researchers had to find a way to combine Western medicine with traditional Eastern medicine. For instance, in 1925, the government assigned Drs Sallet in Annam, Menaut in Cambodia, and Crevost and Petelot in Tonkin to fully analyze Annam's pharmacopeia. Medical researchers also proposed the establishment of a traditional medical materials laboratory. At the same time, local doctors were encouraged to move to the countryside to propagate the benefits of Western medicine (Rousselot 1999, p.367). Thus the number of indigenous going to hospitals increased and they accepted Western medicine methods in treatments and prevention of diseases. For example, in 1904, the Hospital for Indigenous Protection received only 80 patients until 1906, the number of people examined at the Hospital for Indigenous Protection was 12,998, with nearly 1,000 surgeries (Hà 2019, p.57). However, for people living in the countryside or highlands, it is difficult to access medical services. Therefore, the aim of establishing social medicine has not been fully realized.

Conclusion

Under the guise of a moral mission, the French government used both medicine as a useful tool to control and change indigenous society. In particular, building social medicine was a long step in the history of fighting disease in Indochina. In the beginning, this policy was more beneficial for the military and Europeans than for indigenous people. However, the diffuse influences of medical knowledge and practice have fundamentally changed these indigenous's medical lives. The application of advances in medicine, hygiene, and vaccination has improved the health of Indochinese. The morbidity rate from smallpox declined to the point that the French claimed that they had controlled this epidemic in Indochina. Finally, hospitals and schools' birth had a seminal contribution to the medical development of Vietnam, Cambodia, and Lao. Especially, the vaccination service is still practiced in these countries now. However, establishing a social medicine has not yet been completed in Indochina for several reasons. First, these medical administrative organizations had a small budget. Second, although medical policies would be implemented across the Indochina peninsula, there was a significant disparity between regions. Tonkin and Cochinchina had more big hospitals than Laos and Cambodia. Third, indigenous doctors only became subordinates or French doctors' assistants (Pyenson 1993, p 65). Fourth, the indigenous population did not prefer Western medicine to treat their illnesses because of financial, moral, and religious issues.

References

Arnold, David. 1988. *Imperial Medicine and Indigenous Societies*. Manchester University Press.

Burchell, Graham, Colin Gordon, and Peter Miller. 1991. *The Foucault Effect Studies in Governmentality with Molectures by and Aninterview with Michel Foucault*. The University of Chicago Press.

Cohen, Wilbur J. 1968. “AN INTRODUCTION TO SOCIAL MEDICINE.” *American Journal of Public Health and the Nations Health 58 (5)*: 993–94. https://doi.org/10.2105/AJPH.58.5.993-b.

Dean, Mithcell. 2010. *Governmentality Power and Rule in Modern Society*. London EC1Y 1 SP.

Foucault, Michel. 2001. *Power*. New York: The New Press.

Foucault, Michel. 2007. *Security, Territory, Population LECTURES AT THE COLLÈGE DE FRANCE, 1977-78*. London: Palgrave Macmillan.

Hà, Bùi Thị. 2019. “Y Tế Tây Phương ở Bắc Kì (Western Health Care in Tonkin).” Viện Hàn Lâm - Học viện Khoa học Xã hội.

Headrick, Daniel R. 1981. *The Tools of Empire: Technology and European Imperialism in the Nineteenth Century*. Oxford University Press.

Legg, Stephen. 2005. “Foucault’s Population Geographies: Classifications, Biopolitics and Governmental Spaces.” *Population, Space and Place 11* (May): 137–56. https://doi.org/10.1002/psp.357.

Macleod, Roy, and Milton Lewis. 1988. D*isease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion*. Routledge.

Pyenson, Lewis. 1993. *Civilizing Mission: Exact Sciences and French Overseas Expansion 1830-1940*. The Johns Hopkins University Press.

Rousselot, Laurence Monnais. 1999. *Médecine et Colonisation: L’adventure Indochinoise 1860-1939*. Laurence Monanais-Rousselot.

Trankell, Ing-Britt, and Jan Ovesen. 2004. “French Colonial Medicine in Cambodia: Reflections of Governmentality.” *Anthropology & Medicine 11 (1)*: 91.