

Which medications did they trust ?
The Role of French Colonialism in Vietnamese Attitudes towards
pharmaceuticals, 1858-1939

Dr. Laurence MONNAIS

Assistant Professor

Department of History – Centre for East Asian Studies (CETASE)

University of Montreal (Canada)

Through an historical analysis of the attitudes towards medication and especially towards pharmaceuticals¹ in French colonial Vietnam, this paper examines the complex terms of the intersection of two distinct systems of health care, an intersection oscillating between confrontation and conciliation.

Some research has been done on the Vietnamese consumption of pharmaceuticals in the context of the privatization of the Vietnamese health system since 1989, and more particularly on therapeutic pluralism (in this instance, a combination of traditional and Western medicines), self-medication and on the overconsumption of certain products such as antibiotics. However, such changes in the political line only begin to suggest the complexity of Vietnamese behavior in this regard, this set of behavior being the product of the introduction of Western medicine and Western medication and the imposition of a “civilizing” health policy, constructed on the French model in the region from the beginning of the twentieth century and aiming to *medicalize* the region.

This analysis draws on three main sources of information: legislation (medical, commercial, industrial, tariff) dealing with medications; the medical -colonial and “Indochinese”- and popular

¹ What we are studying are medications best described by the term *pharmaceuticals*, chemical medications produced by the pharmaceutical industry, as opposed to natural medications (herbal medicines) or any form what might be called traditional medicines. We do not, however, include vaccinations in our definition. Indeed, the history of vaccinations in Indochina illustrates certain Indochinese particularities having to do with their vision of prevention or of the role and meaning of preventive obligations, such as the sometimes violent obligation of inoculation, which can be particularly meaningful in the context of the domination of one society by another.

press; and finally the monthly and annual medical reports—obligatory from 1907 on—providing a variety of data, most often on the availability of medications, their distribution, and, on occasion, their consumption. These sources allow a tentative first reflection² on a series of questions, including: the role of medications in the context of the health care policy instituted by France in Indochina; the place of the various actors intervening directly or indirectly in health care matters in Indochina, and in the production and distribution of medications. By helping to better understand the place of medication in Vietnamese society, and the manner in which medication was viewed by the Vietnamese people at the time, these data also reveal the ambiguities of colonialism and its influence on the process of health-seeking in the country.

1. A Promising Simultaneity

Vietnamese colonization began in the 1860s, as part of the colonization of Indochina (one colony, Cochinchina, and four protectorates: Tonkin, Annam, Cambodia, and Laos³). Among the weapons of exploitation and “civilization”—the two justifications for the colonial enterprise—was Western medicine, crowned with the glory of its recent scientific achievements symbolized by the Pastorian revolution and the invention of the practice of vaccination. Indeed the French victory over the Saigon area (Cochinchina) in 1861 led to the first anti-smallpox vaccinations of the indigenous population and the creation of the first civilian hospitals. Further progress, such as that of determining a large-scale health care policy would have to await the advent of the Third Republic in France and the creation of the *Union indochinoise* in 1887.

The French health care mission was justified by political as well as economic and “humanitarian” reasons; “Vaccinate, Register, and Disinfect” became its motto⁴. On 7 January 1890, a decree issued by the office of the State Secretary of the Colonies established a Colonial Health Advisory Council, a Colonial Health Corps (*Corps de santé colonial*, a company of French colonial doctors) and provided for hospital services in every French colony and protectorate. A specific health care plan for Indochina was drawn up between 1897 and 1902

² This paper is part of an ongoing project on the history of pharmaceuticals in Vietnam. A research trip is planned for the summer of 2004 to consult the national archives in Hanoi and Ho Chi Minh city on this topic.

³ Tonkin, Annam and Cochinchina make up today’s Vietnam.

⁴ Monnais-Rousselot, L. (1999), *Médecine et colonisation : l’aventure indochinoise*, Paris : CNRS Editions, p. 59-63.

under the orders of *Gouverneur-général* --Governor-general, the highest colonial authority in the region-- Paul Doumer. In 1897, the first “medical assistance” program was created. It included the creation of a health care director for each of the five territories. In 1902, the French *Loi de santé publique* (Public Health Law) was directly put into practice throughout Indochina and the Hanoi School of Medicine was opened to train local “auxiliary doctors”. Finally in 1905, the Governor-general Paul Beau announced an ambitious health care plan specifically designed for Indochina but still modeled on the French metropolitan system. This plan, known as the *Assistance Médicale Indigène* (Indigenous Medical Assistance, AMI), favoured collective prevention, focusing on the fight against the principle endemic and epidemic diseases (smallpox, cholera, plague, malaria), and on hygiene education. The primary goal, no doubt, was to reduce mortality and morbidity rates in order to multiply and strengthen a labor force from which much was expected. One might add that this program was a prototype, the first of its kind in a French territory. A number of different medical facilities existed alongside stores of medicines. The program rested on the dual principles of free treatment in hospitals and free medical consultations, and also stressed the importance of vaccination campaigns against smallpox, plague or cholera.

The appointment of governors-general Antony Klobukowski (1908) and Albert Sarraut (1911) coincided with the severing of the umbilical cord between France and its Far Eastern territory: all health care decisions thereafter were made in and for Indochina. Although Klobukowski did not advocate the expansion of the AMI, which in his opinion would have been too costly, he supported a secular medical assistance program “for the benefit of individuals suffering from acute or chronic diseases”⁵. Sarraut was more generous than his predecessor: he considered AMI to be an indispensable part of colonial development. As the AMI was placed under the direction of an *Inspection générale de l'hygiène et de la santé publique* (Inspectorate of hygiene and public health, 1909) the medicalization of Indochina was placed under the framework of a five-year plan (1911-15). Specialized facilities were on the rise, and the health care system found itself charged with new functions: providing care for mental and venereal diseases; developing care for women (especially for pregnant women); increasing the number of small rural facilities. By the 1920s, official efforts turned toward the mobility of the medical

⁵ Speech given by Klobukowski at the Consul Supérieur des Colonies, October 29, 1910 (reprinted in *Gouvernement général de l'Indochine* (1913), *Rapport au Conseil du Gouvernement*, Hanoi: Imprimerie Nationale).

personnel –World War I had brought its share of problems such as budget and staff cutbacks- and the expansion of assistance to rural areas. Much had been learned during the past four decades about the Indochinese milieu, about its diseases and about local reactions to the French health care initiatives. In 1924, the third five-year plan was inaugurated and called for the organization of a specific rural assistance plan (finally enacted into law in 1927). Its guiding principle would become: “the doctor should go to the patient and not the patient to the doctor”. The second innovation called for more protection against “social diseases” and social problems such as tuberculosis, venereal and ocular diseases, cancer, malnutrition and, more importantly, child welfare. Finally, the new plan insisted on the role that the local Westernized medical personnel (auxiliary doctors, midwives in particular) should play. The 1930s strengthened these new directions given the more delicate Indochinese political context (increasing nationalist actions and urban uprisings against the French administration)⁶. Basic Western medicines became more readily available as a result of these undertakings.

Yet another aspect of the simultaneity between domination of Indochina and the emergence of “modern” medicine is often forgotten : the colonization of the region also occurred in the context of the rapid growth of the Western pharmaceutical industry. Indeed, biomedicine soon came to demand a monopoly (a monopoly which we will want to discuss below) in this tropical environment which required a structured and well-managed health care system, and Indochina became an important field for the drug industry, both in terms of experimentation and distribution. Given the imposition of scientific medicine and the rise of a Western pharmaceutical industry, what place could be preserved for local medical practices, which were essentially drug-based?

Without going into detail on the specific nature of these practices, it is important to know that traditional Vietnamese medicine was –and still is- generally separated into two branches: *Thuộc bắc* (northern medicine, a descendant of the Chinese medical tradition) and *Thuộc nam*, southern medicine, more purely Vietnamese, more “popular” in the sense that it is based less on a uniform theory taught in manuals than on the oral transmission of familial practices. Nonetheless, these two bodies of medicine followed more or less the same rules and therapeutic

⁶ Monnais-Rousselot, L. (2002), « In the shadow of the colonial hospital : Developing Health Care in Indochina, 1860-1939” in G. Bousquet & P. Brocheux (Eds) *Việt-Nam Exposé. French Scholarship on Twentieth-Century Vietnamese Society*, Madison: Michigan University Press, 161-63.

formulae, and make use of many similar ingredients⁷. We should also note that, traditionally, the Vietnamese considered their medical speciality to be therapeutics --*Thuộc* can be translated as “medicine”, “medication”, or “tobacco”. The extreme richness of local biodiversity, especially in terms of vegetation, accounts for this emphasis. In a similar vein, we might add that until recently, to be a doctor in Vietnam meant also to be a pharmacist as well as a botanist⁸. Still, although traditional medicine was an important part of Vietnamese social practice, it had never been institutionalized as a formal system of training or of the transmission of knowledge, except fitfully under the emperor Gia Long (who began the organization of a state-supported medical corps in 1802) and under the emperor Tu Duc, who gave official status to the teaching of Chinese medicine in 1850. It is entirely likely in any case that until the first half of the nineteenth century, knowledge of medicine and pharmacopoeia did not go beyond the limited circle of the literati elite. At the same time, most villages would have had an experienced practitioner who treated cases that went beyond everyday first aid and other such basic cures. This « master »-- *thầy thuốc* ou *thầy lang*, master of the pharmacopoeia—possessed a social status which we have difficulty evaluating⁹. In any event, imperial authority did not touch such healers except in the event that an error in the prescription of the medications resulted in a death (see the Gia Long Code).

In fact, in the pre-colonial period, no legislation or educational structure determined the prerogatives of the doctor versus the pharmacist, a notable difference with the French situation where these professions had been strictly codified and their fields of practice clearly defined throughout the 19th century. For instance, a French law established in 1803 regulations on pharmaceutical training and practice, and in particular on those aspects having to do with the rules of the preparation and sale of medications (regulations on the preparation of medicines in pharmacies and by the manufacturer according to the French Codex). Several texts try to control

⁷ In the present context, the differences between these two bodies of medicine are relatively insignificant, and we prefer to discuss a « Sino-Vietnamese medical tradition » which includes all traditional practices without distinction with regard to region, origin or particular contents. This is consistent with the manner in which the colonial administration and colonial doctors characterized Vietnamese medicine.

⁸ Le Quang Trinh (1911), *Croyances et pratiques médicales sino-annamites*, medical dissertation, Faculté de médecine de Montpellier; Thompson, C-M. (1998), *Transfer and Transmission : Materia Medica and the Development of Vernacular Scripts in Vietnam*, Ph. D. thesis, University of Washington.

⁹ Nguyễn Văn Kỳ (1995), *La société vietnamienne face à la modernité*, Paris : L'Harmattan, p. 89-92; Marr, D. (1987) “Vietnamese Attitudes Regarding Illness and Healing” in N.G. Owen (Ed.) *Death and Disease in Southeast Asia. Explorations in Social, Medical and Demographic History*, Singapore: Oxford University Press, p. 162-86.

the sale of secret remedies¹⁰ : every new panacea have to receive an authorization from the Academy of Medicine in order to be sold by its inventor¹¹. Following the logic of several laws which had sought to eliminate the variety of medical practitioners working in France since the French revolution, a 1892 law made it mandatory to have a medical degree from a French university in order to practice medicine.

It seems in any case clear that the clash of these two medical systems would have complex consequences, given that one, the system of the foreign and coercive dominator, sought to impose itself by any means possible, and the other, strongly anchored in the dominated society, was already well adapted to its needs. The application of the French law of 1892 in Cochinchina only five years later, in 1897, is revealing of a readiness to impose a similar process of professionalization on Vietnam. And we must surely not forget the place and the meanings of medication in this confrontation as the European pharmaceutical industry sought to spread its production by relying on the colonial authorities and their health policy¹². The fact that colonial authorities produced a profusion of legislation on medication and pharmaceutical practice in Indochina constitutes one of the most –if not the most- revealing proofs of the difficulties associated with the confrontation of French and native medicine and the French willingness to impose a brand-new way of thinking about diseases, their prevention and their cure.

2. The Misadventures of Colonial Legislation on medication

The attempt to poison the French garrison in Hanoi with the lethal hallucinogen *datura stramonium* on June 27, 1908, is considered the starting point of a proactive Vietnamese nationalism, as well as the beginning of the persistent repression of this nationalism by the

¹⁰ In 1837, in an addendum to the law of 1803, we find the following definition of a secret remedy : « by ‘secret remedy’ we mean any substances which are not in conformity with the legally published codex, which are not bought or distributed publicly by the government, and which are not prepared for each particular patient following the prescription of the doctor or the health officer. ».

¹¹ French medical authorities of the time saw secret remedies as being a major threat to public health. Nonetheless the popularity of these remedies made it very difficult to impose this legislation (Faure, O. (1993), « Le succès du médicament en France au XIXe siècle et ses significations », in J-C. Beaune (Ed.), *La philosophie du remède*, Paris : Champ-Vallon, p. 216-25).

¹² Nguyễn Van Ky (1995), *op. cit.* ; Monnais-Rousselot, L. (1999), *Médecine et colonisation, op. cit.*

*Gouvernement général*¹³. This attempted poisoning can be read any number of ways, but in the present context we wish to emphasize the link between this daring attempt and the intervention of the colonial administration in a field which was the official responsibility of the Vietnamese Imperial Court (the Court of Annam in Hué) at the time: the field of regulation of Sino-Vietnamese pharmaceutical practice¹⁴. To French authorities, the abortive poisoning of 1908 made native therapeutics into a weapon which could be employed against the regime and its representatives, a weapon, moreover, which was all too readily available. While the authorities had early on begun to keep watch over the European networks of importation and distribution of certain medications in the colony—especially secret remedies—¹⁵ there had to this point been no legislation on native medication and pharmaceutical practice, nor on the particular question of the distribution of toxic substances. Only one restriction had been regularly insisted upon, even if such insistence did not necessarily produce the expected results: Asian pharmacists had no right to sell European products, a monopoly conceived to allow French colonial pharmacists to avoid the damage of native competition.

It is thus hardly coincidental that the colonial administration established agencies to inspect both Western *and* Sino-Vietnamese pharmacies in 1908 : the attempted poisoning had occurred only a few months earlier...The same initiative allowed colonial authorities to make progress in their efforts to control certain cases of medical fraud as well—the sale of miracle cures and illicit substances, and the counterfeiting of Western products. The 1908 law was restrictive, and imposed a uniform system of annual inspections of all colonial and native sites of manufacture and sale of medications, allowing for « quality control of products...[the seizure of] counterfeit drugs, suspect and non-authorized medications, [the collection of] samples for later analysis, »

¹³ The colonial order was genuinely destabilized in 1907, and for the first time, by a series of violent anti-French actions under the leadership of the nationalist Phan Boi Chau: these actions began in Annam, on March 11, 1908, with popular demonstrations demanding tax reductions; in Tonkin, over the summer, such activities went even further with the attempted poisoning, using *datura stramonium*, of 200 soldiers in the capital by underlings of the Native Guard. The poisoning came to naught—it seems that one of the poisoners confessed and the priest betrayed his trust, thus allowing the affected soldiers to receive prompt treatment—but the incident led nonetheless to the first great waves of arrests of Vietnamese nationalists demanding independence, who were sent by the hundreds to the infamous prison Poulo Condore—when they were not executed.

¹⁴ The field of regulation of Sino-Vietnamese medical practice was the responsibility of the Imperial Court at the time as well.

¹⁵ Colonial authorities sought to control the distribution/ consumption of secret remedies which, in addition to the health dangers posed by their use, also sabotaged the effort to build an exclusive link between the French pharmaceutical industry and its potential European clients in the Far East. Normally it fell to the Customs service to enforce a variety of controls on imports (a heavy tax on non-French products, prohibition of the importation of any therapeutic product not included in a Western pharmacopoeia) and to watch for counterfeit products crossing the frontiers.

and, if necessary, imprisonment for those offenders found guilty¹⁶. It seems clear that while this law was the result of a flagrant case of abuse—the attempted poisoning—its primary goal was to control the sale of toxic substances.

This ambition proved difficult to realize as the laws were ill-adapted to local circumstances and were thus never truly enforced. A document of July 1908 had already established a list of dangerous substances, not to be bought or sold by local pharmacists and therapists, but these substances were given French names which Vietnamese were unlikely to understand given that they were either not used in local medications at all or were used in a large number of them. On the eve of World War I, in a moment of genuine reflection on how best to realize the goals of the initial health care policy, certain new propositions took on concrete form. However the “*Réglementation du commerce des officines et des médicaments sino-vietnamiens en Indochine*” (« Regulation of the commerce of Sino-Vietnamese pharmacies and medications in Indochina »), introduced in 1914, signaled a draconian reduction of the native pharmaceutical field, despite the fact that the Commission of Pharmaceutical Inspection had indeed gained knowledge about local pharmaceutical practice¹⁷, and despite the fact that the general Inspector of health services in Indochina had not hesitated to seek out the opinion of administrators and doctors working in the field¹⁸. Once again based on French metropolitan restrictions, the law focused on what the French considered to be the minimum requirements for the operation of a pharmaceutical business—the necessity to be licensed and to own the pharmacy—and on toxic substances. These substances were to be listed in an *ad hoc* register, and were to be sold exclusively when accompanied by the prescription of a doctor, the dosage was to be respected, and the list of such products was short.

This 1914 law was apparently rejected because of the objections of the general Inspector of Health Services, Dr. Paul-Louis Simond. Simond knew Indochina well, and objected to the idea

¹⁶ Centre des Archives d’Outre-Mer, Aix-en-Provence (CAOM), Fonds du Gouvernement général (Gougal), dossier 17165.

¹⁷ CAOM, Résidence Supérieure du Tonkin Nouveau Fonds (RST NF) dossier 3683. This dossier, which contains the annual report on social services in Tokin in 1930, submitted to the local health director of the Protectorate, underscores the importance of the duties and the results obtained the Service of pharmaceutical inspection which had inspected some 164 native pharmacies over the course of the previous 12 months (roughly 10% of the Sino-Vietnamese pharmacies of the region), and had examined as well several rural stocks of medications. At the same time, the inspections inspired detailed reports on the products most in use, the most widespread counterfeit products and the “vietnamization” of French drugs by local pharmacists.

¹⁸ CAOM, Gougal, dossier 17172.

of placing severe restrictions on local medical practices, arguing that “many medications which we find [in European pharmacopoeia are also found in native pharmacopoeia,” and that local Sino-Vietnamese pharmacies could be of service in diffusing the benefits of certain European medications in current use. He further explained:

“That it would be unjust and illogical to restrict the commerce of native pharmacies to the few drugs (most of which have no positive effect) listed in Article 7...and to deprive a population of some 18 million inhabitants, in a country where there exist [no more than] a dozen European pharmacies, of common medications and drugs, which pose no danger, and which are found in European, American, and Japanese pharmacopoeia.”¹⁹

Even if Simond’s attitude suggests a more open attitude towards Vietnamese therapeutic practices, official recognition was not yet in the offing. We find a series of rulings on the trade in Sino-Vietnamese medications between 1916 and 1938, the enforcement of which was delayed or suspended as well. In each instance, the popular and “professional” reactions of the native population, seem to have prompted the French administration to back down in their efforts to control indigenous pharmacies. One might add that the inadequacy of the laws remained an obstacle in itself. And indeed, it was not until 1933 that the *Inspection générale de l’Hygiène et de la Santé publique* set up a commission to study the Sino-Vietnamese pharmacopoeia, a study judged to be indispensable to the drafting of appropriate legislation, and above all a realistic initiative in an attempt to control a parallel industry which had taken on important dimensions:

“Many drug merchants possess and sell, either in their own stores, or in other locations which are quite readily found, a variety of products in the form of medications or remedies which have nothing to do with the traditional pharmacopoeia...Free of any legal constraint, these merchants, most of whom are Chinese...have begun to manufacture in Vietnam, and on an industrial scale, secret remedies which in the past they received from abroad...These secret remedies –in which analysis most often reveals the presence of substances from the French pharmacopoeia or the existence of inert powders of no therapeutic value, when these powders are not replaced by drugs which are dangerously active—these drugs are found throughout the provinces.”²⁰

¹⁹ CAOM, Gougal, dossier 17172.

²⁰ CAOM, Gougal, dossier 44461.

In 1938, a second investigative commission handed over to a sub-committee the mandate to study yet again the regulation of toxic substances²¹. The sub-committee deplored the non-application of the laws already on the books, as well as the legislative vacuum which continued to characterise state regulation of indigenous medico-pharmaceutical practices. As a result, two rulings in 1939 and 1943 sought to define the contours of native medicine and medical practice. The list of substances which were no longer to figure in native medical commerce is in and of itself quite informative: alongside arsenic, sulphur, aconite, belladonna, cannabis, and datura, we also find sodium carbonate and lead oxide—substances used in a great many traditional remedies. Most importantly, Sino-Vietnamese medicine was defined as exclusively “natural,” not to enter into “conflict” with Western practices.

“Article 2. We take the traditional Sino-Indochinese or Sino-Vietnamese pharmacopoeia to be the corpus of mineral, vegetable, or animal products, used either in their natural form or prepared or otherwise transformed according to traditional practices, to be used in therapy on human beings in conformity with Sino-Vietnamese traditions. Excluded from the Sino-Vietnamese pharmacopoeia are: medications, or chemical or synthetic products, or products whose preparation requires industrial techniques; mineral waters; vaccinations and serums against toxins or viruses; medicines which take the following forms: tablets, pills, capsules [and the like]... liquid solutions in ampoules for usage with hypodermic needles, medicated pencils, granules, glycerated pills, suppositories, grape wines, or any pills, drops...prepared industrially.

Article 3. We take Sino-Indochinese or Sino-Vietnamese therapeutics to mean traditional therapeutic practices based on the pharmacopoeia defined above. Sino-Vietnamese medicine employs special traditional methods, such as moxibustion, acupuncture, suction therapy, and scarifications, but does not employ any surgical act...or any obstetrical intervention, any medical procedure using the methods or instruments of Western diagnosis or therapy.”²²

This was a big step, but a step which nonetheless defined Sino-Vietnamese medicine as a second class medicine, to be used only in mild cases and common symptoms (indigestion, burns, minor pains, for instance). This vision does not seem to accord with the original intentions of French authorities to offer an optimal health care policy to the colonized populations, a policy which did not paper over the inappropriateness of certain Western medical practices and which, as we see it, was more indicative of the ambiguity which characterized the colonial (i.e., administrative and medical) understanding of the “value” of traditional Sino-Vietnamese

²¹ CAOM, Gougal Service économique (SE), C49 c 2 (2).

²² CAOM, Gougal SE, dossier 213.

medicine, its therapists and its therapeutic methods. Indeed, what we are examining in this essay is a paradox which became more important over the course of the decade of the 1920s: at the same time that colonial authorities placed increasingly draconian restrictions on traditional medications and traditional medicine, they also “rediscovered” the potential value of local pharmacology.

3. Draconian restrictions on Sino-Vietnamese medications : A sign of disdain

Given the risk that traditional medications represented in the view of the public health administration, official respect for native practices and beliefs could not be sustained...This respect had been superficial in any event, and a close look at the legal documents in our possession reveals a long-standing intention to control Sino-Vietnamese medical practices. This control took as its earliest and most limited form the desire—visible from the 1870s—to strictly separate the fields of Western and native medical practice, a separation which clearly reveals the segregation and denigration of the latter. Articles denouncing cases of poisoning as a result of ingestion of traditional remedies, found in the colonial medical press (*Annales d'Hygiène et de médecine coloniale*, *Archives de médecine et de pharmacie coloniale*, *Bulletin de la Société de Pathologie exotique*) and the Indochinese medical press (*Bulletin de la Société médicochirurgicale de l'Indochine*, *Archives des Instituts Pasteur d'Indochine*), as well as in legal proceedings as a result of criminal intoxication (admitted or supposed) are revealing of the disdainful attitude toward native practices, less by the number of such cases than by their sensationalism. Authors of articles and of legal briefs emphasize the death of the person who ingested, intentionally or not, the toxic substance; they warn against the dangers of what they describe as a stupefying admixture of medications, often the result of the practice of auto-medication, a practice which absolutely had to come to an end; they speak of both toxic and harmless drugs—their arguments are frequently contradictory—which have in common their origins in backward medical traditions, in “grossly empirical” (and thus not deductive, scientific)

practices²³. Native pharmacists themselves are also accused of a frightening incompetence.

The negative view of the pharmacist was to remain fairly consistent as well : by definition, he is the origin of the abuses, he is a fraud, a copier. Thus he is accused frequently, particularly in the 1930s, not only of the illicit sale of Western products, but also of reproducing them or of procuring them from other neighboring countries, such as China or Japan, which produced counterfeit versions, or through such hot spots of international trade as Singapore or Hong Kong. His negligence was on a level with their shameful monetary ambitions. To demonstrate the size of the problem, the colonial administration regularly denounced the implication of certain Vietnamese druggists in the narcotics traffic, both local and international.

At the core of these colonial attitudes lay the conviction of superiority of Western medicine and, by extension, of the wisdom of the health care policy imposed on Indochina. The documents surrounding the cases of poisoning, the medical reports, and the medical press all note repeatedly the same deadly combination of ignorance and danger: Sino-Vietnamese medicine is an empirical, ignorant medicine, practiced by ignorant charlatans and consumed by ignorant patients. Putting toxic substances in all these ignorant hands is tantamount to a death sentence. We should note as well that if native habits of medicinal use were a favorite object of the larger colonial condemnation of indigenous “lack of civilization”, other health practices were also roundly denounced; hygienic practices, eating habits, bodily hygiene, and sexual practices constituted other battlegrounds contributing to the condemnation of popular medical practices²⁴. In a report noting the very high level of mortality due to typhoid at the hospital of Soc trang (in Cochinchina) in 1933, Dr. Ch. Massias blames:

“The family’s delay in bringing the typhoid-stricken patient to the hospital. According to Vietnamese prejudice, typhoid is a local sickness, unknown to Western doctors. Most of the typhoid-stricken arrive at the hospital in the most alarming state, completely dehydrated...Their families do not give them liquid, and instead ply them with all sorts of remedies coming from the Chinese quackery; no attention is paid to the cleanliness of the patient. It is only after the failure of Chinese sorcery and witch doctoring that the family

²³ Beaujean, Dr. (1914). « Un cas d’intoxication par absorption de drogues indigène à base de mercure », *Bulletin de la Société Médicochirurgicale de l’Indochine*, 5 : 129-31; Pouge, de la, Dr. (1921). « Observations concernant les cas de fièvre bilieuse hémoglobinurique », *Revue de médecine et d’hygiène tropicales*, vol. 13, pp. 82-89.

²⁴ The collective work edited by D. Arnold illustrates this colonial posture in several contexts of domination (Arnold, D. (1988), *Imperial Medicine and Indigenous Societies*, Manchester/ New York: Manchester University Press).

brings the patient to the hospital, in some cases after the onset of the illness...The average stay of those who died in hospital has been only nine days, which means that they were already in extreme condition when they arrived.”²⁵

Another manifestation of this rather arbitrary caricature was the frequent insistence on the “cultural tendency” of the Indochinese to make use of certain well-known psychotropic drugs, such as opium²⁶. While efforts had been made in the early decades of the twentieth century to regulate the consumption of this drug at the international level²⁷, it seems clear that, in the case of Vietnam, stigmatizing a socially accepted opium “addiction” added fuel to the fire of the French contempt for this degenerate people, who valued excess and depravation even to the point of death²⁸. In this manner, yet another stereotyped and pejorative vision of Vietnamese sociocultural reality took form, which was to have important consequences. One notes even a reject of everything which is not Western medicine or Western medication: for example, although Japan had already built a modern chemical pharmaceutical industry, the products of this industry were forbidden for import into Indochina. This was first and foremost because any Asian product was the object of suspicion, considered because of its very origin to be potentially dangerous and/or ineffective²⁹.

These attitudes also bear the stamp of a variety of French metropolitan interests which feared competition—even if we lack documentary evidence to analyse this factor in depth. Among these interests are those of colonial pharmacists who benefited from a monopoly in France and served a very limited Indochinese market—that of the Europeans in Indochina and of the Indochinese who had the means to afford their products. The recurring conflicts over adjudications*—, as well as the denunciations of the sale of “forbidden” products by this or that

²⁵ Massias, Ch. (1934), « La fièvre typhoïde en Cochinchine. Etude de 89 cas à l’hôpital de Soc trang », *Bulletin de la Société de Pathologie exotique*, 27 : 406-13.

²⁶ Opium was the object of ambiguous regulatory efforts even those opium production was the monopoly of the colonial state and hence very lucrative (Le Failler, P. (2001), *Monopole et prohibition de l’opium en Indochine: le pilori des chimères*, Paris: L’Harmattan). The purchase, sale, and use of Indian hemp, cocaine, morphine as well as codeine were also regulated throughout this period without marked success.

²⁷ Musto, D. (1998), « International traffic in coca through the early 20th century », *Drug & Alcohol Dependence*, 49: 145-56.

²⁸ Levet, J., Nghiêu Xuan Tho (1939), « A propos d’un cas d’empoisonnement par l’opium », *Revue médicale française d’Extrême-Orient*, 17 (1) : 71-72.

²⁹ CAOM, Gougal, dossier 17162.

* Legal decisions on the allocation of contracts providing colonial pharmacies with pharmaceutical and useful chemical substances.

European pharmacy constitute striking proofs of their objectives³⁰. We might point out that, in 1940, of the 84 French pharmacists who were members of the Professional Association of Pharmacists of Indochina, 16 were in Saigon-Cholon and 16 in Hanoi. In Hanoi, there were in 1939 no more than 6,000 French residents.

Nor were the interests of the French pharmaceutical industry in the colony to be ignored. Indochina early on became an important field of experimentation and distribution. The links between the firm Spécia –Rhône Poulenc (founded in 1895) and colonial health authorities—to cite only this one example—were forged in the 1910s with the introduction of the anti-syphilis drug Salvarsan 606, and remained solid thereafter. These ties are abundantly illustrated by the correspondance between the Governor-General, the General Inspection of Health Services and the company headquarters in Paris, concerning particularly the experimental use of new products in Indochinese hospitals. We might add that, for the pharmaceutical industry, Indochina was also an extraordinary field for the cultivation and exploitation of promising, rare, or expensive substances used in drugs and also cosmetics (quinine, camphor, badian anis, etc.³¹).

These commercial interests in fact reflected a variety of more general colonial interests based on the fact that Indochina, as a colony of exploitation, should make money and lots of it. These interests also illustrate the depth of the ambiguity of colonial attitudes with regard to Sino-Vietnamese medicine and its products.

4. The ambiguity of colonialism: the rediscovery of native medical traditions

We begin our analysis of this ambiguity and its interpretation in the order already employed above, meaning with the exploration of the flaws and paradoxes of health care policy in Indochina. If the « copying » of French health care measures has already been discussed, we should nonetheless recall here that several aspects of this unnuanced reproduction related to the subject of medications: the strict control over the work performed in the pharmacies, in

³⁰ CAOM RST NF dossier 3710; Gougal dossiers 17156/ 17166/ 17178.

³¹ CAOM Gougal, dossier 9648.

particular the uses and distribution of products considered toxic; the fixing of mixing formulae and dosage levels for medications; sale *by prescription only* for a variety of substances, etc. In fact, there were so many regulations that it was unrealistic to imagine that they could be enforced. At the same time, it is important to note the priority which had long been accorded to preventive measures over curative measures in the context of the AMI. Whether this choice arose out of local pathological conditions, out of the need to “attend to the most urgent matters first,” or out of the successes of the bacteriological approach, this preventive priority was the product of French and Western mistrust of therapeutics³², a stance which relegated the use of medications to a secondary position and thus by the same token put off until later on a genuine reflection on local practices of drug use and how best to oversee and reorient such practices³³.

It is nonetheless indispensable to repeat as well that World War I constituted in both these respects a turning point as the decade of the 1920s illustrates the degree to which the health care system was capable of correcting and adapting itself. Indeed, beginning in the 1920s, Western medications came to be perceived by colonial administrators as « products of choice » and « basic methods of treatment » as such, a change revealed among other things by the development of pharmaceutical outlets in rural areas and the advertisements for basic medicines appearing in medical journals and journals written in *quoc ngu* *. As for the simultaneous growth of the French pharmaceutical industry³⁴ and the arrival in Vietnam of pharmaceutical products which proved immediately effective in the prevention and treatment of certain widespread diseases—synthetic quinine against malaria, principally in the form of the drug Prémaline, sulfamides against a variety of venereal diseases—these were to finally allow the colonial administration to consider the “good native consumer” (of Western medications, of course) as being on the road to civilization.

³² Collin, J., Faure, O., Monnais-Rousselot, L. (2002). « Therapeutic pluralism and the nature of drug use in three Francophone societies around the beginning of the Twentieth Century », 38^e Colloque de la Société internationale d'histoire de la médecine, Istanbul (Turquie); Weisz, G. (1996), “Academic Debate and Therapeutic Reasoning in Mid 19th Century France” in I. Löwy (Ed.) *Medicine and Change: Historical and Sociological Studies of Medical Innovation*, Paris: INSERM; Warner, J.H. (1986), *The Therapeutic Perspective: Medical Practice, Knowledge and Identity in America, 1820-85*, Cambridge: Cambridge University Press.

³³ The example of quinine should be seen here as a separate case, even when, in a variety of pharmaceutical forms, it became the very symbol of the effectiveness of Western preventive medicine. The distribution of quinine was organized fairly early in Indochina (State quinine service, 1909), a free distribution of daily doses in the regions most infested by the mosquito responsible for the disease.

* The romanized form of Vietnamese.

³⁴ Chauveau, S. (1999), *L'invention pharmaceutique: la pharmacie française entre l'Etat et la société au XXe siècle*, Paris : Sanofi - Synthélabo.

The degree of popular respect enjoyed by Sino-Vietnamese medicine also explains the failure of colonial legislation on medications, all the more because this respect clashed with the Western disdain which was to endure, at least through the 1920s, as we have already noted. It is equally indispensable to bear in mind the weight and influence of the native pharmaceutical and commercial environments. The intervention of several groups of native businessmen and druggists, arguing for the rejection of colonial legislation touching their field of practice, constitutes an irrefutable proof of their place in society. We should recall that production and trade of Asian medicines were already very well established at the time that France chose to invest in the exploitation of the region. We should recall as well that this production and trade were very lucrative, particularly for the Chinese community who headed up the principle precolonial networks, largely in Cochinchina (Saigon-Cholon) and Tonkin (Hanoi, the port of Haiphong). True, we do not have yet all the information we would wish on this milieu and its role in the medical history of Indochina. But what we do know, thanks to the popular press in *quoc ngu* emerging in the 1920s (for instance *Phu Nu Tân Van*, *Women's News*, *Nam Phong*, *Southern Wind*³⁵) and especially to the advertisements dealing with medications and health issues, leads us to believe that these merchants benefited particularly from a variety of local “miracle cures” --of which several anti-venereal cures were apparently the most widely sold³⁶-- as well as others from neighboring countries such as China and Japan³⁷.

And beyond the economic activities of this community, the political weight of the Chinese and Vietnamese pharmacists of Indochina, most of whom were grouped together in associations which defended the “professional” rights of their members illustrates the great difficulty, inherent in the exercise of colonisation, of imposing one’s will without risking an uprising.

³⁵ *Nam Phong* (1917-31) was one of the most read monthly magazines of the 1920s, published in *quoc ngu*, French and Chinese, and edited by Pham Quynh, an intellectual, close to the French government, who advocated Franco-Vietnamese collaboration. Although one must of course read with care, this journal remains nonetheless an indispensable source of information on health and pharmaceutical issues.

³⁶ CAOM, RST NF, dossier 3856.

³⁷ ‘It is...more than ever [necessary]...to bring to term a law which will put an end to abuses associated with the sale of Sino-Vietnamese medicines and secret remedies in the various parts of the Union. In the absence of such legislation, many drug merchants procure and sell, either in their own stores or in their numerous outlets...a wide variety of products having nothing to do with traditional pharmacies...Free of any legal restraint, these merchants, for the most part Chinese from Cholon, Haiphong, Hanoi and other places, have begun to produce on an industrial scale remedies which they once received from abroad, and with which they now literally flood the colony. These remedies which, according to analysis, show traces of French materials or the existence of inert powders...when these are not replaced by drugs which are dangerously active—are found in every province, down to the smallest village’ (CAOM, Gougal, dossier 44461).

Nonetheless, reading the administrative exchanges between French and Indochinese health care authorities, it is hard to overlook a certain French interest in Sino-Vietnamese pharmacopoeia. In the second half of the nineteenth century, this interest, which was of a scientific nature, was part of the vast movement to explore conquered territories and to classify their resources. Thus French writers note the potential of certain local plants and discover the astonishing biodiversity of Vietnam³⁸. This was not, at this point, a genuine medical investigation into the therapeutic potential of the local remedies made possible by this flora, or into the larger structure of local medicine in which such remedies inhered even if a handful of practitioners already pronounced themselves in favor of the eventual use of Vietnamese empirical medicine³⁹. In any case, this “practical” interest³⁹ was the base of another movement which was to take form during the interwar period, a movement toward a more open exploration of local medicine and its therapeutic potential.

Indeed we find increasingly fine distinctions in the discourse of the *Inspection générale des services de santé* in the 1930s: not *all* Sino-Vietnamese pharmacists, after all, were counterfeiters or poisoners; some even had useful knowledge. A number of French doctors even came close to admitting an interest in local medicine, which they turned to when their arsenal of Western treatments seemed incapable of curing a particular patient: in the context of the “humanization” of health care policy in the 1920s and 1930s, patients with leprosy were among those who prompted some colonial practitioners to ask for traditional therapists’ help⁴⁰. It is of course likely that such occasional forays into Sino-Vietnamese practices had occurred before the 1930s; but it was not until the 1930s that a French practitioner would have admitted as much in the medical press, for he would have surely been severely criticized before. At a certain point, extended exposure to the tropical Vietnamese milieu had taught some doctors a certain humility, and they acknowledged that Western medicines were not necessarily effective on local patients,

³⁸ CAOM, Gougal dossier 9831, « Echantillon d’un produit extrait du latex d’une liane croissant en abondance en Cochinchine de M. Mengin, pharmacien, 1895 »; dossier 9848, « Mission sur l’étude de l’exploitation industrielle de la Gutta des forêts du Cambodge par M. Langlebert, pharmacien de 1^{ère} classe, 1894-95 ».

³⁹ The example of Dr. Jules Regnault’s research illustrates the extent of this early—if marginal—interest (Regnault, J. (1902), *Médecine et pharmacie chez les Chinois et les Vietnamiens*, Paris : Challamel; (1902) « Médecine européenne et médecine indigène en Extrême-Orient », *Archives de Médecine Navale*, 77 : 270-73).

⁴⁰ CAOM, RST NF dossier 3823; Guillerm, J., Banos, M., Nguyen Van Lien (1933), « L’utilisation du krabao indochinois pour le traitement de la lèpre », *Archives des Instituts Pasteur d’Indochine*, 18 : 171-86; Sallet, A. (1931), *L’officine sino-annamite. La médecine annamite et la préparation des remèdes*, Paris : Imprimerie nationale.

that certain products of *their* therapeutic arsenal could even be dangerous⁴¹. And this type of awakening, in particular in the face of the invasion of little known pharmaceutical products—for example, several anti-syphilis medications used in dangerous experiments in Indochinese hospitals⁴²-- surely served to increase the French tolerance of, even interest in, local therapeutics.

Let us recall that beginning in 1933, the Governor-General set up several commissions charged to study the traditional pharmacopoeia. One of the reports presented to the sub-committee studying the question of regulation of Sino-Vietnamese pharmacy in 1938 advises, by way of conclusion:

- “The incorporation of certain products and certain native plants into the Western pharmacopoeia;
- the cultivation and harvesting of medicinal plants in industrial quantities, in order to build up a new resource for Indochina, which currently imported 80% of its needs from China
- The systematic study of the Sino-Vietnamese pharmacopoeia with the necessary attitude of scientific objectivity, so that students in medicine or pharmacy could take advantage—but also avoid the dangers—of this pharmacopoeia.
- The translation of books of Chinese medicine, the amassing of work already done on this subject in a central library accessible to scholars”.⁴³

We do not know what response such propositions evoked as World War II came onto the horizon...It remains nonetheless clear that the “movement” in question was at best ambivalent: certain doctors and administrators admitted resignedly that a better understanding of local medical practices should help to better fight local charlatans as well as to better educate and to *Westernise* native patients⁴⁴. The introduction of a course on Sino-Vietnamese medicine in the Hanoi School of Medicine in 1938, which was to educate native Westernized doctors speaks to this same ambition⁴⁵. At the same time, this movement occurred in a political context which was itself ambiguous: the discourse and the gestures which sought to find value once again in

⁴¹ Farinaud, E., Baccialone, E., Lataste, C., Nguyễn Van Lien (1937), « Recherches préliminaires sur l'élimination de la quinacrine chez le malade paludéen », *Bulletin de la Société de Pathologie exotique*, 30: 791-99.

⁴² CAOM Gougal SE, dossiers 2919/ 2921. The documents found in these two dossiers attest to the experiments carried out with medicines against syphilis sent by the Theraplix labs to the *Inspection générale de l'Hygiène et de la Santé publique*, to be tested for the first time on humans in Hanoi hospitals in 1936.

⁴³ CAOM, Gougal SE, C49 c2 (2).

⁴⁴ Gaide, L., Inspecteur général des services d'hygiène et de santé publique, « Préface » (1931), in A. Sallet, *op.cit.*

⁴⁵ CAOM, Gougal, dossier 17172.

traditional Vietnamese culture were a reaction to indigenous critical voices which were motivated by an increasingly virulent nationalism.

5. Medicalization and medical pluralism

In fact, it is crucial to understand that this rediscovery movement was driven by a number of scientific, political but also economic and practical needs. And if the movement can be understood in a variety of ways, we think it important to link it to certain factors which are too often ignored.

Several “practical” realities in particular stand out as going beyond the difficulty of enforcing one’s will in a context of colonial domination or the political pressures brought by certain interest groups interested in seeing that Sino-Vietnamese pharmacopoeia continue to survive. Of course, the needs of a French pharmaceutical industry, in competition with others, constantly looking for substances which could be produced, or extracted, or transformed or distributed in an economical way—the memory of the rarefaction of cinchona, a Dutch monopoly until World War I, was still fresh in their minds⁴⁶—is not to be dismissed. But here we would like to focus on certain sociocultural realities and obstacles more difficult to discern.

In 1895, the reasons enumerated by Dr. Péralle to explain the Vietnamese mistrust of Western medicine were: Vietnamese fear of innovation, the high cost of consultation and prescription of pharmaceuticals, the native lack of understanding of the “ritual of absorption” of the medicine (how long to take the medicine, in what dosage), the Indochinese notion that Western medicines were not made for the bodies of sick Asians, their refusal of preventive measures and of surgery, and of course “superstitious behavior” linked to a fear that those who took Western medicines might be badly judged by their ancestors for having foresaken Vietnamese traditions⁴⁷. Twentieth century doctors evoked more or less the same reasons to explain indigenous disdain for Western medications. Our work in the colonial archives, leads us to posit an explanation which for the moment relieves the indigenous patient of his “responsibility”: the question of the *accessibility* of medicines in Indochina.

⁴⁶ Archives de l’Institut Pasteur de Paris, Instituts Pasteurs d’Indochine, cartons « Plantations ».

⁴⁷ Péralle, Dr. (1895), « De la diffusion de la médecine européenne en Cochinchine », *Bulletin de la Société des Etudes indochinoises* : 17-27.

The pharmaceuticals and substances used by colonial doctors and pharmacists came most often directly from France. Consequently, they were expensive and frequently unavailable, even the products most sorely needed: several provincial medical reports suggest that this supply problem was the number one enemy of the doctors employed there; several of them insisted that the native patients would have liked to have been treated in a Western manner, but for want of supplies were unable to do so, which left the field open to local charlatans. The supply of medications remained problematic throughout the period, dependant on the hasards of transport but also on problems associated with counterfeit substances, on the diligence of Customs Services, or even on the colonial climate—the difficulties of preserving medications are often mentioned. And this omits yet another important problem: the Vietnamese patient had ready access to his local druggist and could ask him for what he wanted (he would have known several products and remedies, and would not necessarily have needed to consult a doctor), but it was more difficult for him to seek out a French pharmacist who would recommend products rarely known by him, products which were more expensive and for which the pharmacist would require a prescription issued by a doctor⁴⁸.

Such problems of availability prompted a handful of French doctors to demand the establishment of the rudiments of a local pharmaceutical industry and to make discrete use of local remedies trusted by the natives for their effectiveness⁴⁹. Some even went so far as to defend a therapeutic pluralism through the establishment of “mixed” stocks of the most crucial medicines in a great number of Vietnamese villages, a practice which achieved genuine results⁵⁰.

In a context of increasingly strident demands on the part of associations of Sino-Vietnamese doctors—doctors whose practice had also been the object of a failed attempt at regulation in the interwar period—and pharmacists against the overly strict regulation of their activities in the late 1930s, several articles appearing in the Indochinese press illustrated in unison how these factors came together:

⁴⁸ CAOM, Gougal, dossier 17171.

⁴⁹ Seyberlich, Dr., Le Thi Van (1939), « Action véritablement merveilleuse d’un pansement annamite à base de plantes », *Revue médicale française d’Extrême-Orient*, 17 : 1129-30.

⁵⁰ Of course, this was never formally carried out throughout the colony. Indeed, certain local and exceptional initiatives suggest a different reality which would be confirmed under the Democratic Republic of Vietnam: the construction of a “two-tiered” health system, Western medicine for the cities and for the rich, traditional, popular medicine for the countryside and for those without the means to afford anything else.

« The disappearance of the healers commonly called charlatans would not necessarily lead to an increase in the numbers of partisans of the Pastorian method... Many obstacles currently stand in the way—and will continue to do so—of the widespread acceptance of European therapeutics among the masses of our compatriots, especially those who live in the countryside and those of modest social standing. Even if they had complete faith in the disciples of Claude Bernard and Marcelin Berthelot, our humble secretaries who earn 40-60 *piastres* per month would refuse to pay three to five *piastres* for a single office visit. By the same token, the rural dwellers are not going to take it on themselves to make a round trip of 100 kilometers to be treated by the kinds of professional which are found only in provincial capitals, if not in the capitals of Saigon or Hanoi.”⁵¹

Much depended as well on the medicine in question: popular enthusiasm for an « effective » medication, even if Western and « powerful » was genuine, as is illustrated by the example of quinine. According to certain doctors of the AMI, the Vietnamese refused categorically to take quinine just as they refused everything else that the “well-meaning civilizer” proposed. According to others, however, the stocks of the drug made available through the free distribution outlets created after the establishment of a State Quinine Service in 1909 disappeared very quickly... In fact, it seems that in this instance, the product, to be taken daily for preventive reasons, was judged to be useless and toxic; by contrast, quinine taken during an epidemic or other “crisis” was viewed as a miracle product by those who were already sick. Other documents speak of the popular enthusiasm for certain products which, in spite of their potential toxicity, had also proven their effectiveness in hospitals through free consultations or the rural medications counters. Examples of these include analgesics and antipyretics (aspirin, antipyrin), vermifuges and sulfamides such as Dagénan (Rhône-Poulenc) and Septoplix (Laboratoires Theraplix). The popularity of these products was illustrated by their frequent theft and the black market trade in them, as well as by advertisements in the popular press –found next to the advertisements for local panaceas, as we already noted. The same evidence underscores an administrative blindness who saw in native auto-medication and therapeutic pluralism only through the lens of deviance and danger⁵².

We arrive at the conclusion that the refusal to make use of Western medicine was less a refusal based on *conviction* than one based on *necessity*, that what many doctors denounced as a

⁵¹ « Plaidoirie en faveur de la médecine sino-annamite », *La Tribune indochinoise*, 27.07.1938.

⁵² CAOM, RST NF, dossier 3710.

tendency to seek out colonial medicine, colonial doctors and colonial hospitals as a “last resort” was often the result of problems of accessibility to the services offered. With the exception of hospitals where the patients were cared for free of charge and thus had free access to the medicines prescribed for them, the Vietnamese had little access to the products that he might have desired to use. Having little access meant that he would have known them poorly, and thus would rarely have had the opportunity to integrate them into his medical worldview. During the French colonisation of Indochina, the endurance of traditional Sino-Vietnamese medicine was not only a reality, but also a necessity.

The post-war experience, the increasing shortages in times of prolonged war, but also the effort to rediscover and to institutionalise a “national” traditional medicine by the Republic of Vietnam from 1945 onward, lend credence to this conclusion. Moreover, the marked interest in Western medicines, and the construction of a local pharmaceutical industry which reproduced what was done in the West to compensate for local shortfalls, are clear facts which once again illustrate the genuine and historically proven enthusiasm for chemical medications among a not insignificant part of the population⁵³.

As this paper has illustrated, historical contingencies, combined with local needs, local realities, and frequent errors of judgement by colonial health authorities concerning Vietnamese attitudes toward health and medications, came together to render the process of colonial medicalization extremely complex (the same could of course be said of the larger process of colonialism itself). Part of this complexity stems from Indochinese environmental, pathological and sociocultural particularities, which differed greatly from those with which Western administrators and practitioners were familiar; these differences clearly had—and still have—a major impact on local health practices. Our analysis, however, has focused on the role played by colonialism in shaping a Vietnamese medical pluralism, in which, moreover, the two therapeutic systems forming the basis of this pluralism were of unequal status. Such a perspective may be

⁵³ Bigot, A., Auriol, R. (1947), «Le problème des médicaments en Indochine de 1940 à 1945,» *Produits Pharmaceutiques*, 2 (3) : 109-19; Craig, D. (2002), *Familiar Medicine. Everyday Health Knowledge and Practice in Today's Vietnam*, Honolulu: University of Hawaii Press.

helpful in attempting to understand certain aspects of health policy in contemporary Vietnam, as well as in other countries where traditional medical practices are deeply imbedded in local cultures. If we take Western medicine as the ideology of the (former) colonizer, and medication as a vehicle for the implantation of this ideology, how did (or do) native consumers of such medications understand their actions? Does the emergence of a “two-tiered” health care system reproduce the division between Western and traditional medical practices and facilities observed during the colonial period? Has traditional Sino-Vietnamese therapeutics been transformed by the colonial experience in such a way as to be devalued? There are some of the questions that lead us back yet again to a reflection on the complex difference between use *by conviction* and use *by necessity*.