

# Making secular ‘French’ medical ethics: transcendent morality and patient subjectivities in southern French hospitals

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Drawing on ethnographic fieldwork with physicians and nurses working in two state-funded southern French hospitals, this article explores why and how medical care providers connected their everyday deliberations about patient care to what they considered to be distinctively *French* forms of medical responsibility. Many healthcare professionals saw French medical morality in opposition to ‘Anglo-Saxon’ discourses of individual autonomy and transactional choice. In contrast to such ‘transactionalism’, they insisted that ‘French’ ethics required limits that transcended particular circumstances. And yet it was difficult for doctors and nurses working in secular and increasingly neoliberal hospitals to argue against individual transactionalism in an overtly moral register, one that might appear religious and paternalist. Through a close look at two different cases – one in assisted reproduction and one in palliative care – I show how the language of folk psychoanalysis provided some health professionals with a way out of this impasse. Care providers used pseudo-psychoanalytic accounts of patient subjectivities to depict individuals as incapable of knowing, let alone ‘owning’ or rationally mastering, themselves. This, in turn, suggests that some aspects of French secularity may be far less Protestant and liberal than contemporary anthropological work tends to assume.

In the spring of 2017, a southern French hospital’s public-facing bioethics institution, its *espace éthique*, brought in a national superstar – Jean-François Mattei – to give a talk on comparative bioethics. Mattei, a former legislator, practising doctor, and founding member of a prestigious regional bioethics institution, drew a crowd of doctors, nurses, and midwives to the old medical school amphitheatre. All were keen to hear a talk on what Mattei called ‘various approaches to questions with no good answers’.

But rather than talk about questions with no good answers, Mattei delivered an encomium to ‘French’ bioethics. Focusing on issues often covered in the French press, notably embryonic stem cell research and surrogacy, he told the audience that other countries had bad political or philosophical reasons for their approaches. According to Mattei, British doctors were too ‘pragmatic’, engineering the category ‘pre-embryo’ as a ‘convenience’ that allowed scientists to experiment on embryos during the first weeks of existence, when they can still divide. This exceptional pre-person form of life, he noted, was a cynical ploy that allowed the British to claim that they were respecting human dignity from the moment the embryo became an indivisible entity, or a person.

Rolling his eyes, Mattei added: 'France could *never* do that'. The United Kingdom was particularly singled out for ridicule, but Mattei found other countries' practices equally problematic. Spain was too close to its authoritarian past not to embrace 'liberty at any cost', placing few limits on contractual negotiations and allowing a private market for eggs and sperm. Germany, on the contrary, refused to permit any experimentation for fear that the newspapers would say 'they have started again!' And Italy, as everyone knew, was still under the thumb of the Vatican. The audience laughed at each jibe.

France's relatively restrictive approach to the development and use of biotechnology – particularly in the domain of assisted reproduction<sup>1</sup> – is often viewed as a scientific liability (Druiez 2017; Frydman 2017). Through Mattei's performance, evocation of these particular restrictions instead became a form of 'cultural intimacy' (Herzfeld 2004) solidifying belonging to a stigmatized but nonetheless moral French medical community. For Mattei, France alone had chosen the perfect balance between what he called 'liberty and dignity', ensuring that 'dignity always trumped liberty'. But why was Mattei using bioethics in the service of creating a seemingly united and distinctively *French* medical public? What does the discursive construction of bioethics in France have to do with imaginaries of national difference? Furthermore, what might it mean, outside of Mattei's highly generalized moral discourse, to link French national distinction to a preference for human 'dignity' over human 'liberty'? Mattei mocked Italy for its deference to Catholicism, and yet the fight for a transcendent, obligation-based understanding of 'human dignity' is at the root of contemporary social Catholicism (Hollenbach 2014: 252). So what were the secular norms that allowed care providers to limit liberty and rights in the name of dignity? And finally, what might the answers to these questions tell us about French secularity?

I listened to Mattei's speech while sitting with a few of the palliative care doctors I had come to know over the previous few months. My companions were surprised when it turned out that I knew quite a few of the doctors and nurses sitting in the amphitheatre. But there was nothing surprising about my growing familiarity with care providers who were interested, and imagined themselves as actively participating, in serious ethical deliberations. Hospital-based medicine is a small world in the medium-sized Mediterranean university town Mattei had come to visit. By the time he spoke at the town's medical school, I had spent six months – and would ultimately spend eight – doing ethnographic fieldwork in two of the town's closely connected hospitals. In these hospitals, one public and the other semi-public, I had done participant observation and interviewing with care providers involved in ethically sensitive medical domains, including ethics committees, assisted reproductive services, and palliative care. Not surprisingly, many of the doctors, nurses, therapists, and psychologists I met through this work were interested in Mattei's take on what they were, or perhaps should be, doing.

This article connects Mattei's concerns about the production of a distinctively 'French' and fully secular bioethics with the everyday conversations I watched in committee discussions and staff meetings (Ticktin 2011). Many French care providers, like some anthropologists (Das 1999; Lambek 2010; Zigon 2007), are invested in distinctions of scale, epistemology, and/or practice behind 'moral' versus 'ethical' discourses (Vilanova 2013). For many of my interlocutors, if 'morality' was about abstract, absolute values that reeked of religious imperatives,<sup>2</sup> 'ethics' was – as Mattei tried to suggest – about the dialogical and intersubjective work of seeing a particular problem from all angles. But, just as Mattei's speech blurred the boundaries between

abstract, absolute morality, on the one hand, and the ‘no good answers’ of ethical deliberation, on the other, so, too, did everyday attempts to provide appropriately ‘ethical’ care for individual patients. Like Mattei, medical professionals connected their everyday deliberations about patient care to what they considered to be distinctively *French* forms of medical responsibility. Whether positively or negatively valued, they saw these French forms of medical responsibility in opposition to a caricature of ‘Anglo-Saxon’ individualism and ‘transactionalism’, meaning the reduction of morality to any outcome successfully negotiated between two individualized, contracting parties. Many care providers thus suggested that an appropriately ‘French’ ethics could not be done without limits that transcended particular circumstances. But at the same time, the hospital as a secular, institutional space created certain ‘ethical affordances’ while foreclosing others (Keane 2014). In this space, and at a moment in French medicine when liberal, rights-based discourses about patient choice and ‘autonomy’ were becoming legal leitmotifs,<sup>3</sup> doctors and nurses had great difficulty arguing against individual transactionalism in an overtly moral register, one that might appear to be simultaneously ‘religious’ and paternalist.

In this article, I argue that some care providers – particularly those who thought of themselves as doing ‘ethics’ – responded to these affordances through the language of folk psychoanalysis. Following Camille Robcis’s (2013; 2015) insightful work on contemporary French family politics, I take up the idea that, over the course of the second half of the twentieth century, some Freudian and Lacanian psychoanalytic tropes became part of a cultural language used in the service of conservative, moralizing projects.<sup>4</sup> These projects have included opposition to gay marriage, resistance to giving homosexual couples and single women access to reproductive technologies, and restricting adoption to families that expose children to ‘gender complementarity’ (Perreau 2014; Robcis 2013). As I will show, this secular language allowed care providers to simultaneously scale up towards the moral and down towards the ethical, while also representing patients as incapable of knowing, let alone ‘owning’ or fully mastering, themselves. These representations of patient personhood implied the existence of transcendent, corporatist morals that served as necessary counterweights to individual ‘choice’. Neither every clinician nor every debate drew on these tropes. But such arguments cropped up in different contexts, among different kinds of practitioners, for a similar purpose: to allow doctors to do moral work in the name of ethics.

In arguing that southern medical practitioners viewed everyday bioethics debates as important sites for preserving and constructing a secular, national moral order, I may seem to be ignoring the growing literature on the ‘anthropology of morality’ (Laidlaw 2013; Lambek 2010; Mattingly and Throop 2018; Zigon 2007). As mentioned above, some of this literature pushes back against the collapse of ethics into morality by positing them as analytically (and socially) distinctive processes (Zigon 2007). In addition, much of this literature has an anti-Durkheimian bent, refusing the idea that either ethics or morality can be equated with falsely homogenized abstractions like social cohesion or social order (Lambek 2010). I am, however, arguing that in the context of the French public health system, a Durkheimian fantasy of shared morality as social glue provides a good ‘model of’ and ‘model for’ (Geertz 1973: 93) thinking about how bioethics sometimes works. Furthermore, I suggest that this Durkheimian streak – with its transcendent, authoritative, corporatist character (Durkheim 1984 [1893]; 1995 [1912]) – has implications for thinking about French secularity. Over the last decade or so, Talal Asad’s (2003; 2018) provocative work on secularity and the

secular has considerably influenced anthropological thinking on the subject (Agrama 2012; Fernando 2010; 2014; Hirschkind 2011; Mahmood 2011; 2015). With that influence has come a tendency to conflate 'secular' affects and practices with both philosophical liberalism (Fernando 2014) and neoliberal state projects (Asad 2018). As I will illustrate more clearly below, I am pushing back against such a conflation, and the noticeably 'Protestant' appearance of secularity in this literature. I do this by highlighting the ways that southern French doctors' secular defence of 'dignity' mobilizes anti-liberal, corporatist affects and assumptions that have considerable elective affinities with social Catholicism.<sup>5</sup>

I present my argument into two parts. First, I illustrate the everyday ways that care providers discursively constructed what they thought of as a distinctively 'French' bioethics. I then turn to two ethnographic examples, one focused on reproduction and the other on terminal sedation, to show how pseudo-psychoanalytic analysis allowed doctors to evoke transcendent corporatist moral values while escaping the charge of being either religious or paternalist.

### **Secularity, secularisms, and France**

But first, back to my claim that medical debates in southern France may offer new perspectives on French secularity. There is no shortage of work on secularism in France (Asad 2006; Baubérot 2004; 2008; 2009; Bowen 2007; 2009; 2010; Fernando 2014; Oliphant 2015; Willaime 1985; 1990) or on secularism more generally (Agrama 2012; Asad 2003; Casanova 2006; Mahmood 2015; Taylor 2007). However, with some notable exceptions, most of this literature neither predicts nor illuminates the forms of personhood and authority evoked by care providers in moments of ethical debate.

In the approach to secularity inspired by Talal Asad, 'the secular' works as a universalizing category that both produces and manages its putative opposite: 'the religious'. Across this structural opposition, affects, modes of reasoning, and dispositions are constantly being disciplined and classified into those that are 'secular', and therefore unmarked and universalizing, on the one hand, and those that are 'religious', and therefore particular and private, on the other (Asad 2003). Asad acknowledges that all secular contexts can be somewhat different; but the fundamental structural *similarities* across secular contexts best illustrate his argument about secularity's disciplinary effects and universalizing ambitions. As a result, for writers in an Asadian tradition, it is less the specificity of a particular context than the putatively universal features of the 'secular' that are interesting (Fernando 2014; Mahmood 2015). And following Foucault (1990; 1995), these features are simultaneously large scale and intimate, making demands on the everyday ways that people perceive and act in the world. These demands include the elevation of internal conscience over external authority (autonomy), the denigration of ritual action as a mask for interiorized belief (internal individual sincerity), and the imperative of individual self-making (choice) (Fernando 2014; Mahmood 2011; 2015). In many ways, then, secularity can sound like it is a fundamentally liberal and/or Protestant affair.

Asad's approach does not help us understand the arguments made by doctors and nurses in southern French hospitals, arguments that were used to *deny* the possibility of individual self-making, responsibility, and autonomy. There is, however, an alternative literature on secularity, one that focuses on 'secularisms' rather than 'the secular'. This literature operates at a different scale than Asadian approaches to 'the secular'. If Asad focuses on both the intimate and the epistemic, studies of secularism(s) focus on

the *national* organization of church/state/citizen relations (Calhoun, Juergensmeyer & VanAntwerpen 2011; Casanova 1994; 2006; Kuru 2008; Pellegrini & Jakobsen 2008; Warner, VanAntwerpen & Calhoun 2013). In this vein, both John Bowen (2007; 2010) and Jean-Paul Willaime (1985; 1990) have argued for the continued relevance of the historical relationship between French Catholicism and the secular Republic for understanding everything from state attempts to control public space to the masses said before the annual opening of parliament. For Bowen (2007), the threat Catholicism posed to the Republic required that citizens be protected *from* religion, thus justifying attempts to limit religious liberties in the name of public order. For Willaime (1985), the Republic established a 'civil religion' that has always – if inconsistently – drawn on Catholic practice. This literature sheds considerably more light on how and why French secularity looks and feels different from Protestant counterparts in Europe and North America. But it, too, may have a problem of scale. By remaining at the level of historical relations and national institutions, this literature does not seek to explain the deeply held assumptions that come to circulate as 'secular' in any particular context. The literature that usefully pluralizes forms of secularity also abandons attention to how particular ethical motivations and dispositions come to register as 'universal' and therefore 'secular'.

I seek to bridge this gap by attending both to Asad's interest in what counts subjectively as 'universal' *and* to the possibility that deeply local contexts shift the grounds of that universality. I do this through close ethnographic attention to the ethical affordances at work in the context of southern public hospitals. I suggest that these affordances allowed concerns with elective affinities to social Catholicism – the condemnation of excessive individualism, liberalism, denaturalizing technologies, and consumerism (Robcis 2016: 323) – to be aired in the form of the seemingly universal discourse of psychoanalysis. This recourse to psychoanalysis allowed care providers to foreground the impossibility of individual autonomy, mastery, and choice, at least in a medical setting. Illustrating this requires close attention to the particular goals and dilemmas of a French public medicine stuck between paternalism and global biomedical norms, *and* to the ways hospitals disciplined what care providers could say and how they could say it.

### **An ethical nation?**

'Bioethics' is a new term, field, and practice in France (Memmi 1989). It is split between two competing imperatives that some doctors feel keenly. On the one hand, global bioethical norms around patient consent and autonomy increasingly shape French medicine. The early institutionalization of bioethics in France in the 1980s and 1990s focused on informed consent in order to align French practices with clinical trial best practices (Memmi 1996; Mino, Copel & Zucker 2008). By the early 2000s, this logic of consent was extended to everyday features of patient care. In 2002, a national law, the *Code de la santé publique*, required medical professionals to allow patients access to their medical files and to participate in treatment choices. Since then, a number of incremental changes have increased the scope of patients' rights, among them making advance directives legally binding and allowing patients to request terminal sedations under certain conditions (Claeys & Leonetti 2016; Leonetti 2005). These global bioethics norms are built on a particular model of personhood, described by some doctors as transparent and transactional. In this model, a rational, self-knowing subject can negotiate and agree to a conditional use of his or her body. This is a familiar

notion from the literature about Protestantism and secularity (Asad 2003; Fernando 2014; Keane 2007; Taylor 2007), as well as neoliberalism (Brown 2003; Harvey 1989).

But it is only one of the models at play in French medicine. At the same time, much of French medicine is tied to a paternalist and authoritarian tradition that specifically denies patients these characteristics and rights. Physician autonomy and responsibility is still prioritized in French law, meaning doctors remain the ultimate arbiters of their own conduct while patients have little legal recourse (Mino *et al.* 2008). More fundamentally, much of France's national bioethics legislation rests on the idea that individuals do not own and cannot dispose of their own bodies. Instead of protecting individual rights, this kind of approach attempts to ensure that people will *not* treat their bodies in ways seen as antithetical to morality. The principle of the *indisponibilité du corps humain*, or inviolability of the human body, often invoked in (bio)ethics discussions exemplifies the corporatist aspect of French law (Robcis 2016: 316). This principle is used in French legislation and jurisprudence to *deny* the possibility that people can individually consent to certain uses of their bodies – for example, refusals of medical treatment, sex changes, gestational surrogacy, commodification of human tissue or organs – and implies that individuals must be protected from themselves (Commission nationale consultative des droits de l'homme 2007; Hennette-Vauchez 2014). Mattei's invocation of 'dignity' works very similarly. His distinction between 'dignity' and 'liberty' fits into a wider discursive (and legal) pattern of using 'human dignity' as what French legal scholar Stéphanie Hennette-Vauchez calls an 'antonym of rights'. For Hennette-Vauchez, this kind of 'dignity' is focused on 'constraint' and 'obligations' and resonates deeply with premodern hierarchical and corporatist traditions in French and European law (2011: 35). But if both *indisponibilité* and dignity suggest that transcendent forces own and/or should constrain certain uses of human bodies, this opens up the question of how, in purely secular terms, to ground such claims (Chiland 2011: 216).

At the seam between these paradigms of personhood – one associated with individual rights, global capitalism, and neoliberalism and the other with corporatism, Catholicism, and the traditional practice of French medicine – French doctors and nurses developed what they saw as a distinctively French paradigm of secular medical responsibility. Even discussions that had nothing to do with national distinctions sometimes began with a reminder of how different 'Anglo-Saxon' bioethics was. Indeed, Mattei's talk shows how even a conference about comparative bioethics could function as a ritual performance of national distinction and belonging.

Some caregivers had an ambivalent relationship with the legal and ethical constraints of this 'French' bioethics. Hasan,<sup>6</sup> the head of reproductive biology at a public hospital, had been slighted by the hospital administration when it first created an ethics committee in the early 2000s. For years he had organized and financed an annual *journée bioéthique* with an all-star line-up of scientists and humanists. And yet the hospital administration had not turned to him because of his 'transactional' ethics. Hasan complained that while 'France had been ahead of the United States' in legalizing abortion, it was now 'behind' in its clinical approach to infertility. Evoking both corporatism and the tight regulation of assisted reproduction, he elaborated: 'In France, society decides in your place because society pays [through socialized medicine]. So you do not get to say anything.' Hasan was also furious about opposition to what he called genetic 'screening', a procedure that maps out major chromosomal anomalies in embryos produced outside the womb. He attributed his laboratory's high failure rates,

as well as the unnecessary discarding of thousands of embryos, to France's refusal to allow 'screening'. He ranted:

The idiots say that [screening] does nothing, that it's just a cash cow like in the United States. It's all ideological positions. They want to give a moral lesson to everybody. In the United States, there's common sense. You let people decide for themselves ... It shocks me that I have to make people go to Spain or Switzerland [for treatments]. It shouldn't be the state that decides. That's interfering in private lives.

For many of Hasan's hospital colleagues, his 'transactionalism' was 'unethical'. Hasan returned the compliment by describing the members of the hospital ethics committee as moralizing authoritarians.

Hasan had a skewed vision of how patient autonomy and choice work in a North American context (Aronowitz 2007; Christakis 1999; Del Vecchio Good, Good, Schaffer & Lind 1990; Kaufman 2005; 2015). However, even doctors who were interested in *protecting* putatively French differences in care talked in similarly dichotomous terms. Claire, a geneticist involved in reproductive medicine, was appalled when I asked whether France should make 'screening' legal in the interest of 'saving' embryos that might be viable. 'Screening?' she spluttered. 'That's America. That would be an opening to anything goes. It would be sex selection ... It would no longer be medicine. It would be a social choice, one that other countries have allowed but France has not.'

This dichotomy between 'French' and 'Anglo' approaches manifested itself even in discussions of everyday patient care. Sam, a young intern in palliative care at a semi-public hospital, asked Françoise, his mentor and attending physician, why the doctors on the service did not adopt an 'Anglo-Saxon model' of diagnosis and prognosis and 'tell it like it is'. Françoise responded by condemning the French system while also praising its psychological attention to patient needs. She explained:

I have high hopes for your generation in terms of the way you will approach these questions [about patient information and autonomy]. But you ... won't be supported by any of your colleagues. And you are not going to be thanked by the patient or the patient's family. We see patients who refuse to see a doctor again if he or she tells them something they don't want to hear ... I have a philosophy – it's to not lie, ever. I'm Kantian about it ... But I don't necessarily tell the whole truth either ... I think this *arrangement* [tacit agreement] in France is not just because of doctors. It's about patients and doctors together because it suits everyone. In order to tell someone what is really going on with them, you need both sadism and masochism. You have to say something you don't want to say to someone who often doesn't want to hear what you have to say... And if patients were not in on this – or at least their families – the whole system would have fallen apart because we are legally obligated to do full disclosure and yet we have tons of files full of false information. And few patients ever end up suing their doctors for this.

In this pedagogical moment, Françoise suggested that there were perverse 'cultural' reasons for skirting the truth in doctor-patient interactions; but she also suggested that the 'Anglo-Saxon' approach was too brutal to be ethical.

It matters little whether French medicine is either nationally coherent and/or different from its North Atlantic counterparts. The point is simply that doctors insisted that it was 'French' to denounce a naïve embrace of consent-based models of personhood.

But this does not explain how care providers offered a secular defence of commitments to *indisponibilité* or dignity. To answer this question, I turn to two ethics debates taken from two very different medical and institutional contexts. The first discussion, about whether or not a young man should be allowed to have a vasectomy,

took place in the hospital's *comité local d'éthique*, a legally mandated body with a rotating membership drawn from participants in all aspects of hospital life: patient advocates, nurses, doctors, psychologists, administrators, chaplains, and lawyers. The second discussion, about whether to allow a palliative care patient access to terminal sedation, took place in the staff meetings and informal hallway conversations involving an interdisciplinary group of care providers working in one of the city's major palliative care units.

### Vasectomy and the dignity of the male body

In January 2017, a staff urologist asked the committee to discuss a vasectomy request that made him uncomfortable. The committee president, a neo-natalist named Mathilde, the committee jurist, Robert, and the hospital's deputy administrator, Paul, presented the case to the assembled group in the doctor's absence. The man requesting the vasectomy was in his late twenties, ostensibly healthy, and not in a relationship. He had told the urologist repeatedly that he did not want to have children. As Robert explained, the man had a right to request and then receive a vasectomy at the end of a four-month waiting period. The urologist also had a right to conscientious objection *if* he had stated his objection during the first consultation. The doctor had not done so. Since no legal issue was involved, Robert directed the committee to limit their discussion to ethical questions.

Like the urologist, the committee seemed stunned by the man's request and his refusal to justify it.

*Psychiatrist:* Is the patient a carrier for a genetic disease that is potentially very serious?

*Mathilde:* We don't know. All we know is that he doesn't want to have kids.

*Neurologist:* Don't we need to know more about why he doesn't want to have kids? For obesity surgery, patients are required to see a psychiatrist who evaluates their case. Why not for this kind of surgical procedure [*geste*] that has heavy consequences? Don't we need to know?

*Robert:* The why is that he doesn't want to have kids. You want the why of the why.

*Neurologist:* Not good enough to stop at the first answer.

*Paul:* The urologist doesn't want to know why because he is afraid of what he will learn. He's worried about the possibility of sexual abuse. And if the patient starts talking, what will he do with that information?

After the Muslim chaplain asked whether a psychiatric evaluation was built into the four-month waiting period (it is not), Robert raised a legal concern: 'This patient has a recognized right to a vasectomy. If there is no doctor willing to do it, it is an illegal denial of healthcare.' Robert was reminding the committee of their power. Only state-run hospitals can perform vasectomies, meaning a committee refusal might reduce the man's chances of finding a doctor willing and able to do the procedure. At the very least, he might have to travel to another major city for treatment.

*Psychiatrist:* But we have a right to object.

*Neurologist:* We are not saying that people cannot have vasectomies. It's just about this particular case; and maybe he won't find anyone to do it.

...

*Protestant chaplain:* [The patient] is panicked about being a father. Maybe his father was horrible. So our obligation is to send him to someone who is going to help him. If our hypothesis is correct, this kid is not going to be helped by a surgical act.

...

*Catholic chaplain:* The stakes here are fatherhood. Yes or no ...

*Nurse:* He's refusing to be a father. He can decide not to be a father in lots of ways ...

*Catholic chaplain:* Right. Instead here he's saying, 'I'm going to break my toy' [*je casse mon jouet, quoi!*]



[Generalized laughter at the crudeness of the joke.]

Apprentice lawyer doing an internship at the hospital: I'm a little confused by this conversation. [If he has a vasectomy,] he won't be able to father a child. But he can always be a father. This doesn't stop him from being a father, just from procreating. I think the urologist needs a little bit of distance from this question. We are only talking about biological, not about legal or emotional, paternity.

This comment was followed by silence finally broken by the psychiatrist: 'We're talking about helping the patient, not the doctor. Making the patient see someone is for the patient, not the doctor.' The neurologist summed up the deliberation using the formal language of bioethics:

[This] case is malfeasance. We all know and have seen that people can change their minds. [Denying access to a vasectomy in this case] is not paternalism; it's realism. What if we do this and we deny him the ability [to have children], through a surgical case that is against all medical values? ... Here is a case of we just want things – we want a car, a television, a vasectomy.

This is a fascinating conversation, not least because a vasectomy is a minimally invasive and generally reversible procedure. What therefore comes across is a consensual investment in a particular vision of the male body and destiny rooted in biological reproduction. This is precisely what the young apprentice jurist – the only person in the room with no ties to medicine, the committee, or the hospital – said confused him. Why did committee members find it impossible to imagine that a man without any known genetic or physical defects would refuse to pass on his genes? Why not distinguish between being a 'genitor' and a 'father'? But the committee's conflation of naturalized reproduction with full human dignity was perhaps impossible to articulate as a grounding moral claim. As the neurologist noted, the committee were *not* forbidding vasectomies or even discouraging requests for vasectomies. And indeed, just after objecting to the young man's case, the committee went on to approve a vasectomy for a man with Down's syndrome who was most likely infertile. They could therefore plausibly insist that they were not interested in categorically limiting the kinds of choices people could make; they were simply focused on the ethical issues raised by this particular case.

But ultimately, the referring urologist and the committee members saw vasectomy as an affront to the integrity of the patient's body and destiny. And they felt obligated to protect that integrity. In the words of the psychologist: '[W]e have a right to object'. These moral concerns about preserving the patient's dignity rather than rights may have led to the invention of circumstances that justified the committee's *ethical* refusal: the collective construction of a traumatic past. This construction was ostensibly rooted in the urologist's seemingly ungrounded concern that asking the patient about his personal history might uncover sexual abuse.

This invented past completely transformed the ontological status of the patient's request. In Freudian terms, it changed what might have been seen as an individual choice into a symptom, meaning a sign that revealed an underlying psychological problem. For the committee members, it did not matter that the patient had never talked about abuse or given the doctor any concrete reason to think he had been abused. In fact, this silence may have been part of the pseudo-psychoanalytic play present in the discussion. In a lay Freudian frame, the patient might have repressed this past, leaving it inaccessible to either consciousness or reason. As a result, this hidden past – precisely *because* it was hidden – could become the irrational motivating source of the man's request. As a result, the doctors could reason that the patient did not 'really' want to

renounce children, but his unconscious was getting in the way of both appropriate action and self-recognition. He therefore had not met the minimum requirement for free rational choice: either what philosophers call positive (true to self) or negative (free from external constraints) freedom (Laidlaw 2013: 143-5). This psychic lack is perhaps best captured by the chaplains' comments. The Catholic chaplain's joke about the patient wanting to 'break his toy' likened him to an unreasonable child having a temper tantrum. The Protestant chaplain similarly urged the committee members to help 'the kid' rather than harm him with a surgical operation. And the Muslim chaplain hoped they might *compel* the patient to see a therapist. These comments emphasized both the patient's internal psychic turmoil and his inability to recognize it.

Many of these concerns *might* have been mitigated if the patient had crafted his own narrative of past experience and deliberation. This does seem to be one of the imperatives of contemporary medicine (Gandsman & Burnier 2014; Mattingly & Garro 2000; Memmi 2000). But this nonetheless assumes that doctors would agree that a young healthy man could 'freely' imagine a life for himself that did not involve biological children. This seems unclear. Focusing on the patient's invented history and psychological state allowed doctors to insist that they were making ethical arguments about an irreducibly particular case. But contrary to actual psychoanalysis, the content of their discussion was purely symbolic in the sense that it depended heavily on psychoanalytic theory and only vaguely on the specificities of the case. The committee knew almost nothing about the patient and seemed to be uninterested in eliciting his story *before* evaluating his request. For the medical professionals on the committee, the problem seemed more general, tied to continental interpretations of Freud that focus on the uncontrolled and largely uncontrollable unconscious (Kirschner 1996; Murray 2016; Turkle 1978). In this framework, the human psyche fundamentally escapes individual attempts at self-mastery and control. Not only might *any* patient 'change his or her mind' without realizing how or why he or she was doing so, but also complex psychological dynamics might prevent anyone from being able to know or articulate authentic desires. Given these assumptions about human subjectivity, no healthy young male without children could meaningfully 'choose' to dispose of his reproductive capacity.

This raises a final point. For the committee, this unmasterable self was handicapped in its capacity for discernment. As a result, despite the committee's lack of expertise in reproductive biology, its members easily imagined themselves collectively as the kind of authority required to provide this discernment. This authority was partially built into the institution itself: the *comité local d'éthique* is charged with providing guidance to doctors. But it is also part of how medical professionals, particularly doctors, thought about medicine. Medical authority was not just about expertise in a particular, clearly delineated scientific field (Memmi 1989; 1996; 2000). Instead, in the context of socialized medicine, doctors in a number of domains – particularly those associated with reproduction – styled themselves as guardians of the social order. In their own staff meetings, assisted reproduction doctors worried about the kinds of families that deserved the financial and medical investment that might lead to children. And some told me that if they did not ask such questions, no one else would. This conflation of medical and national pastoral care helps explain why and how medical professionals with so little knowledge of a case, or even of each other, transformed a particular doctor's ethical dilemma into a moral account of transcendent human dignity and medical responsibility.

### Terminal sedation and the psychosis of self-mastery

My second ethnographic event comes from a crisis among palliative care providers in a semi-public hospital focused on cancer care (hereafter ‘the Center’). In 2016, legislation governing end-of-life care in France changed: for the first time, it became possible for patients with poor short-term prognoses and refractory symptoms to request and receive ‘continuous and terminal sedation’ (Claeys & Leonetti 2016). Although physicians inside and outside palliative care had long been sedating terminally ill patients – many of whom never woke up – those sedations were never intended to be fatal. Such sedations were also not typically *requested* by patients, but counselled by doctors trying to temporarily ease pain and anxiety. These physician-driven, ‘temporary’ sedations have long been justified by even the most conservative Catholic doctors through the concept of the *double effet* (two consequences): although doctors intentionally use drugs like morphine to attenuate pain and anxiety, such drugs also might, secondarily, shorten life. In Catholic and medical justifications of the *double effet*, what matters is the doctor’s intent, not the ultimate outcome (Pope Pius XII 1957). This fine line of intention created the gulf many palliative care doctors saw between pre-2016 sedations and terminal sedations, which many Center doctors felt were morally abhorrent and equivalent to euthanasia. As one such nurse explained: in France, you do not get to decide when you die because you do not really own your body.

By the summer of 2018, Center care providers were feeling besieged by terminal sedation requests. Among the besiegers was Mrs Ferrault, a middle-aged woman with colon cancer who had been seen by a palliative care team at the Center for over a year. Upon initial diagnosis, she had refused treatment. An avid tennis player and sports fanatic, Mrs Ferrault told her care team that she preferred to maximize her quality rather than quantity of life, a project the team fully supported. At the time, she also had put the team on notice that when no longer able to do the physical activities she loved, she would ask to be terminally sedated. The team were proud that they had helped her ‘get over the hump’ of various physical losses – tennis, jogging, biking – during the months that followed her diagnosis. But they no longer seemed able to do so. Mrs Ferrault was now, in the words of the team psychologist, ‘activating’ her terminal sedation request.

As with the vasectomy discussion, legal requirements and moral commitments diverged in this case. Many on the palliative care team thought Mrs Ferrault had a *legal* right to terminal sedation. She had a terrible short-term prognosis and symptoms, notably incontinence, that the medical team could not treat. She seemed to meet the requirement for autonomous and informed consent, having thought about – and deferred – terminal sedation for well over a year. And she was not being pressured by family members to ‘end it’: she had no children and her husband opposed her desire to die. But even conceding this, there was palpable discomfort with Mrs Ferrault’s demand. This was particularly true because Françoise, the head of the team, was what the psychologist called a *militant*, someone morally opposed to anything that looked like an intentional attempt to shorten life. Françoise openly expressed her moral reservations and indignation. But the rest of her team were uncomfortable with such flagrant opposition. It foregrounded moral convictions in a way that some felt ‘mixed’ spheres: the political and the medical, the moral and the ethical. So care providers were confronted with two problems: avoiding Françoise’s anger over ‘intellectual and moral laxity’ and registering discomfort with Mrs Ferrault’s request in terms that respected a secular division of spheres.

I happened to be sitting in the nurses' office when Colette, Mrs Ferrault's principal doctor, walked in, slumped into a chair, and – shaking her head in disbelief – began talking to Eva, a relatively junior nurse. Colette had just hung up the phone with Mrs Ferrault, who wanted to discuss the details of how terminal sedation worked. For Colette, Mrs Ferrault was far too preoccupied with bodily aesthetics. This worry about Mrs Ferrault's narcissism was a leitmotif in discussions about her care. In this particular conversation, Mrs Ferrault had a specific set of concerns.

*Colette:* She wanted to know if we could leave her false teeth. Her husband has never seen her without false teeth.

*Eva, incensed and disgusted:* It's worse than trying to control her death. She wants to control everything after her death. Doesn't she understand that when you are dead you are ugly? You are dead! She's psychotic ... She doesn't really want to be hospitalized [to be sedated].

*Colette:* No, she really just wants a pill [meaning euthanasia, to be killed instantly]. What are we going to do?

Here I want to flag Eva's characterization of Mrs Ferrault as 'psychotic'. In this context, the term 'psychotic' had clear Freudian resonances, referring to someone who sought to replace reality with a fantasy world (Freud 1961 [1924]). For Eva, this referred to Mrs Ferrault's 'fantasy' of being able to control not only the moment and means of death, but also what happens to the body after death. For Colette, it also meant that what Mrs Ferrault 'really' wanted was neither legally available nor possible. Instead of wanting a terminal sedation, she really wanted to take a pill and die instantly, like sleeping beauty.

Eva's description of Mrs Ferrault as 'psychotic' was not idiosyncratic. A senior palliative care nurse, Héloïse, also characterized her as 'psychotic' during a staff meeting several days later. At that meeting, Colette suggested that Mrs Ferrault was showing only slight signs of clinical decline, but was exhibiting more and more *grande souffrance morale* (serious emotional distress). *Souffrance morale* is one of the legal criteria for being granted a terminal sedation. But Colette also noted that Mrs Ferrault had started consulting with the ADMD, the *Association pour le droit de mourir dans la dignité* (Association for the Right to Die in Dignity), France's most visible and vocal right-to-die organization. Palliative care providers are almost universally hostile to the ADMD's moral and political demands because they are premised on a transactional relationship between doctors and patients, as well as a project of full individual self-mastery (Castra 2003). And in this case, the mere mention of the organization set off Héloïse. She snapped: 'She [Mrs Ferrault] is almost psychotic in the way she talks about her body. I think we should treat her as psychotic.' The psychoanalytically trained psychologist, Simon, carefully intervened: 'And yet she is not ... I'm not sure that she isn't right in what she is asking for. She has been looking for other solutions, and hasn't found any.' Françoise, agitated and angry, shot back:

I am not comfortable with what I hear here. Her asking [for sedation], working on this for a long time, having her husband write a letter [to the palliative care team pleading for them to take her request seriously], getting the ADMD involved in the affair is not going to make us agree to a sedation!

Colette then noted: 'The arguments in the letter do not make this any easier. They sound like the ADMD'. Eva echoed Colette: 'She is using the same arguments that people use for euthanasia. This is a request for euthanasia!'

Once again, the team took the request for sedation into the realm of the psychoanalytic. Héloïse tied Mrs Ferrault's 'psychosis' to her obsession with two interwoven forms of mastery: avoiding living with a body that was falling prey to disease

and seeking recourse with the ADMD, an organization dedicated to the individual orchestration of death. Colette and Eva indirectly echoed this assessment by expressing deep discomfort with the involvement of the ADMD. For Colette, 'sound[ing]' like the ADMD disqualified the arguments in the letters. For Eva, once again, it transformed the request into a symptomatic demand for something neither legal nor morally thinkable: euthanasia.

This psychoanalytic register allowed the conversation to scale back and forth between deliberation about a particular case and patient, on the one hand, and moral arguments about the 'right' way to live and die, on the other. Concerns about Mrs Ferrault's obsession with her body and her refusal to accept the physical reality of its decline tied the conversation to a specific, sports-obsessed patient whose narcissism was wrapped up in her body image. Because care providers thought Mrs Ferrault misunderstood the nature of human dignity, reducing it to a beautiful, well-regulated body, *she* needed to be protected from herself. But at the same time, any appeal or reference to the ADMD also seems to have worked as a general proof of psychosis. At the very least, it could be used to raise serious questions about the validity of a 'request' for terminal sedation. Given the ADMD's focus on what palliative care providers thought of as an impossible fantasy of rational self-mastery, requesting terminal sedation using the organization's rights-based language suggested psychological disorder rather than an autonomously reasoned demand. At its most extreme, simply trying to exercise the legal right to terminal sedation might be enough to raise questions about the mental state of the requestor, since all attempts to control death *could* be read as fantastical understandings of reality. And indeed, it was not until after the staff meeting – when Françoise read Mr Ferrault's letter – that she began to shift her position. Mr Ferrault did *not* use the language of rights or mastery; he simply talked about his wife's experiences with refractory symptoms that undermined her sense of meaningful selfhood. The letter, as Françoise tearfully explained to me a few days after the staff meeting, did not *ask* for anything. It was not a demand for mastery, but a plea for acknowledgement of the suffering that medicine was powerless to palliate. At least for Françoise, when Mrs Ferrault stopped *asking* for terminal sedation, terminal sedation became a reasonable path forward.

As in the vasectomy debate, Mrs Ferrault's care providers assumed a fundamentally irrational patient who was incapable of even recognizing, let alone addressing, her own irrationality. Under these circumstances, moral questions about the proximity between terminal sedation and euthanasia were transformed into ethical concerns about allowing terminal sedation in one particular context and for one particular patient. But at the same time, framing Mrs Ferrault as 'psychotic', at least in part because of her request, undermined the idea that autonomy, rationality, and choice could *ever* be the framework within which patient demands were evaluated. Instead, care providers set themselves up as indispensable moral guardians of Mrs Ferrault's body and dignity.

Ironically, it was Simon, the psychoanalytically trained psychologist, who was most uncomfortable with this turn of events. In response to Héloïse's insistence that the team treat Mrs Ferrault as psychotic, he insisted that she was in fact being quite reasoned and reasonable in her request. She had not rushed into a decision; she had tried many other options; she simply was running out of ways of making sense of her life. And yet also note how difficult it was for him to make these objections. He pushed back with a hesitant double negative – 'I'm not sure that she isn't right' – that spoke to his own marginality. Simon certainly did not recognize this scaled-up psychoanalytical language

as faithful to person-centred psychoanalytic technique, nor did he think training as a psychoanalyst gave him the authority to push back against the nurses' and doctors' psychologizing language. In fact, while I was marvelling over how well versed everyday clinicians were in psychoanalytic language, he – and his fellow psychologists – were lamenting the loss of space in French medicine for language-based approaches to care.

### Conclusion

French doctors practise medicine at the seams between two paradigms: one that figures patients as autonomous, rational, transactional subjects and another that requires doctors to protect patients and their bodies from themselves in the name of *indisponibilité* and dignity. Doctors were left to negotiate these contradictions under considerable constraints. Although they were dedicated to a 'French' medicine that was more 'moral' than its transactional Anglo-Saxon counterparts, they had to construct arguments that 'circulated' as secular while avoiding charges of moralism by embedding their deliberations in the particularities of individual cases. I have suggested that care providers sometimes used a kind of folk psychoanalysis to negotiate this impasse. The symbolic language of psychoanalysis allowed care providers to highlight the individual aspects of particular cases while simultaneously making wider moral claims about the ultimate impossibility of individual mastery and self-fashioning.

To illustrate these points, I used two cases, both of which posed major challenges to tenets of social Catholicism. In the first case, a healthy young man was denied access to a vasectomy because care providers assumed that renouncing biological paternity required him to be a victim of (perhaps) unrecognized paternal abuse. In the second case, a dying woman was temporarily refused access to terminal sedation because care providers assumed that she was 'psychotically' attempting to 'master' both her life and her death in ways that defied nature and reality. In both of these instances, psychoanalytic language allowed care providers to insist that they were doing 'ethics' not 'morality', advancing universal arguments around particular cases not particularistic appeals to divine or natural law for universal moral purposes. In addition, although Mattei's language of 'liberty' and 'dignity' did not appear in either of these cases, both nonetheless showed how medical professionals filled these categories and walked the tightrope between the two. In both, doctors and nurses acknowledged patient rights, 'demands', or 'choices' – what Mattei referred to as 'liberty' – and yet styled themselves guardians of forms of human dignity rooted in corporatist social norms misrecognized by patients. In the first case, care providers saved what was perceived as human dignity by preventing a young man from denaturing his body and male reproductive destiny. In the second, care providers rescued human dignity from what they saw as a superficial woman's attempt to reduce it to an aesthetically pleasing, functionally intact body. In the process, care providers raised serious and global concerns about whether *any* patient could balance liberty and dignity without the guidance of appropriate moral experts.

I now want to return to what this means for understanding French secularity. Following Asad's (2003: 16) injunction to explore 'the secular' 'through its shadows', much of the contemporary anthropological work on French secularity focuses on the legal as well as discursive treatment of Islam and Muslims (Asad 2006; Bowen 2007; 2009; Fernando 2014). These laws and public discourses condemn Islam for failing to prioritize belief over practice, for undermining autonomous and rational individual choice in the religious domain, and for insisting on the hierarchical and corporate character of the social world. From this perspective, 'French secularity' does

indeed come to look very Protestant, thus confirming Asad's universalist account of both the emergence and manifestations of 'the secular'. But my account of southern French medical ethics suggests that such 'Protestant' assumptions hardly characterize French secularity writ large. Instead, in the secular domain of southern public hospitals, medical care providers made deeply corporatist, hierarchical assumptions about personhood, society, and morality. These assumptions certainly coexisted with much more liberal approaches to individual rights, but they nonetheless made it almost impossible to imagine how and when a patient might successfully assert such rights in the face of the medical establishment's commitment to 'dignity'. And yet these assumptions were fully 'secular' in an Asadian sense. None of the care providers I got to know either acknowledged or recognized Catholic or Christian resonance with their concerns and practices. In fact, in one of our early interviews, Françoise vehemently and loudly denied that her ethical positions on care and euthanasia were Christian. This is one of my major points. In the context of southern French hospitals, commitments to the hard moral limits implied by 'dignity' counted simply as 'French', rendering the 'Catholic' dimensions of this particular form of French secularity both ubiquitous and invisible. These invisible elective affinities between social Catholicism and care providers' secular ethics hold yet another lesson, suggesting that the qualities of secularity may vary not only by nation-state, but also by social domain. If this is the case, attempting to understand French 'secularity' through an exploration of one particular social domain may provide only a very partial understanding of the kinds of assumptions and dispositions that can and do circulate as 'universal'. This, in turn, may imply that anthropologists of Europe have mistaken the legal and political management of Muslims for secularity itself.

#### NOTES

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<sup>1</sup> French bioethics legislation is changing as I write (Cordier & Carriat 2019). But since the French legislature passed its first bioethics legislation in 1994, medically assisted reproduction in both private and public clinics has been restricted to heterosexual couples of reproductive age with documented medical conditions. Third-party gametes are available only through state-run egg and sperm banks (Fortier 2011; Mathieu 2013; Mehl 2011; 2013). Surrogacy is banned and not even on the table for real legislative discussion.

<sup>2</sup> In one of our first conversations, I asked a psychologist working in assisted reproduction about the 'moral' concerns that preoccupied the clinicians on her service. She snapped: 'We have no moral concerns because morality is religious'. She then explained that France was secular, and that meant they did 'ethics', not morality.

<sup>3</sup> French hospitals work much like schools in debates about French secularity (Stasi 2003). Medical caregivers are expected to present themselves as religiously 'neutral', offering no indications of what, if any, religious convictions they might hold.

<sup>4</sup> On the cultural reception of psychoanalysis in France, see, further, Roudinesco (1990) and Turkle (1978).

<sup>5</sup> There is a growing literature that sees anti-liberal political theologies as complicit with neoliberal state projects (Muehlebach 2012; Rudnycky 2009; Zigon 2011). I am, however, trying to show the ways in which southern French medical providers were working against the neoliberalization of national medicine.

<sup>6</sup> All names, excepting those of public intellectuals like Mattei, have been changed to protect the anonymity of my interlocutors.

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## **Éthique médicale laïque « à la française » : moralité transcendante et subjectivité des patients dans les hôpitaux du sud de la France**

### *Résumé*

En s'appuyant sur un travail ethnographique de terrain réalisé auprès de médecins et d'infirmières dans deux hôpitaux publics du sud de la France, cet article explore pourquoi et comment le personnel médical associe ses délibérations quotidiennes concernant les soins aux patients à ce qu'il considère comme une approche typiquement française de la responsabilité médicale. De nombreux soignants perçoivent la moralité médicale française comme contraire aux discours « anglosaxons » d'autonomie individuelle et de choix transactionnel. Contrairement à ce « transactionnalisme », ils insistent sur le fait que l'éthique « française » exige des limites qui transcendent les circonstances particulières. Il est pourtant difficile pour les médecins et les infirmières qui travaillent dans des hôpitaux laïques et de plus en plus néolibéraux de s'opposer au transactionnalisme individuel sur un plan ouvertement moral, au risque de paraître religieux et paternaliste. L'attention plus particulière portée à un cas d'insémination artificielle ainsi qu'un cas de soins palliatifs permet de montrer comment le langage de la psychanalyse populaire apporte à certains professionnels de la santé une solution à cette impasse. Les soignants s'appuient sur des témoignages pseudo-psychanalytiques de la subjectivité des patients pour décrire l'individu comme incapable de se connaître lui-même, encore moins de se « posséder » lui-même ou de se maîtriser rationnellement. Cela suggère que certains aspects de la laïcité à la française relèvent peut-être beaucoup moins du protestantisme et du libéralisme que les travaux anthropologiques contemporains ne tendent à le présupposer.

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