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# Une analyse anthropologique de la relation entre médecine conventionnelle et médecine complémentaire dans la France contemporaine

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# Une analyse anthropologique de la relation entre médecine conventionnelle et médecine complémentaire dans la France contemporaine

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*« Il faut tout un village pour élever un enfant »*

*Vous êtes mon village chers amis et je suis reconnaissante*

## Résumé

Cette thèse porte sur l'étude de la relation paradoxale entre la médecine conventionnelle et les médecines complémentaires dans la France contemporaine, pays dans lequel une multitude de pratiques complémentaires s'épanouissent malgré la présence d'une hostilité institutionnalisée contre ces formes de pratique médicale non autorisées et l'absence générale de législation nationale réglementant leur exercice et statut. Pour ce faire, j'utilise une approche ethnographique reposant sur trois ans et demi d'observation participante et d'entretiens ouverts, semi-dirigés avec des praticiens, des utilisateurs, des administrateurs, des organisations, des syndicats et des éducateurs des deux côtés de la relation conventionnelle-complémentaire. L'analyse est encadrée par une approche des « systèmes complexes adaptatifs » et la théorie de la mondialisation. Elle met l'accent sur l'interrelation et la coévolution de la science, de la médecine et de la société. Les représentations de la santé, de la maladie, du bien-être et de l'art de guérir sont examinées à travers une analyse rhétorique des données recueillies auprès des participants pendant mon travail de terrain, ainsi que les stigmates, les stéréotypes et les peurs qui caractérisent leur perception des deux côtés. De nombreuses études de cas sont présentées, mettant en évidence l'intégration de pratiques complémentaires dans les hôpitaux privés et les hôpitaux universitaires en France. Ensemble, ces cas fournissent une notion nuancée de « l'acceptation » de pratiques complémentaires et de dynamiques émergentes qui témoignent des efforts individuels pour intégrer la médecine complémentaire dans la société française. Ces dynamiques sont à situer dans le contexte de la mondialisation et des tendances en matière de santé publique, « lieu » dans lequel les médecines complémentaires s'étendent. Les résistances comme par exemple la polémique actuelle autour du déremboursement de l'homéopathie peut être considérée, dans la société française, comme une réaction à l'empiétement des médecines complémentaires sur la médecine conventionnelle. Pour conclure, cette thèse se termine par quelques réflexions sur le potentiel de croissance continu de la médecine complémentaire dans la France contemporaine, malgré les représentations négatives qui y sont associées et leur manque de régulation.



**Mots clés** : la médecine conventionnelle, les médecines complémentaires, la mondialisation, les systèmes complexes adaptatifs, France

## Abstract

This thesis explores the paradoxical relationship between conventional and complementary medicine in contemporary France; a country in which a multitude of complementary practices are flourishing despite the presence of an institutionalized hostility against these unsanctioned forms of medical practice and the overall lack of national legislation for their regulation. To do so, it uses an ethnographic approach that is based on three and a half years of participant observation and semi-directed, open-ended interviews conducted with practitioners, users, administrators, lobbies, organizations, and educators on both sides of the conventional-complementary relationship. The analysis is framed using a complex adaptive systems approach and globalization theory, with an emphasis on the interrelationship between and co-evolution of science, medicine, and society. Representations of health, illness, well-being, and the art of healing are considered through the analysis of rhetoric collected from both sides of the conventional-complementary relationship; as are the stigmas, stereotypes, and fears that characterize the perceptions of both sides. Multiple case studies are presented evidencing the integration of complementary practices in both private hospitals and public university-hospitals in contemporary France, as are case studies drawn from participant observation. Together these cases provide a nuanced notion of the "acceptance" of a complementary practice in French society and the patterns emerging from individual efforts to integrate complementary medicine in mainstream French society. These dynamics are considered within the context of globalized public health trends that are creating a "place" for complementary medicine and in terms of the current backlash against complementary medicine in French society. This thesis concludes with some reflections on the potential for the continuing growth and integration of complementary medicine in contemporary France, despite the negative representations associated with it and the enduring political unwillingness to create legislation regulating it.

**Keywords:** Conventional medicine, Complementary medicine, Globalization, Complex adaptive systems, France

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## Acronymes

| | |
|---|---|
| **ANAP** | **L'Agence Nationale d'Appui à la Performance** |
| **ANSEM** | **Agence Nationale de l'Evaluation et de la Qualité des Etablissements et Services Sociaux et Médico-sociaux** |
| **AP-HP** | **Assistance Publique Hôpitaux de Paris** |
| **ARS** | **L'Autorité Régional de Sante** |
| **CAM** | **Complementary and Alternative Medicine** |
| **CAS** | **Complex Adaptive Systems** |
| **CHU** | **Centre Hospitalier Universitaire** |
| **DIU** | **Diplôme Inter-universitaire** |
| **DREES** | **La Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques** |
| **DU** | **Diplôme Universitaire** |
| **EBM** | **Evidence Based Medicine** |
| **EU-OSHA** | **European Agency for Safety and Health at Work** |
| **FAEMC** | **Fédération des Arts Energétiques et Martiaux Chinois** |
| **FFK** | **Fédération Française de Kinésiologie** |
| **FFST** | **Fédération Française de Shiatsu Traditionnel** |
| **GHT** | **Les Groupes Hospitaliers de Territoire** |
| **HAS** | **Haute Autorité de Santé** |
| **HPST** | **Loi Hôpital, Patients, Santé, Territoires** |
| **INM** | **Interventions Non Médicamenteuses** |
| **INSERM** | **Institut National de la Santé et de la Recherche Médicale** |
| **MAC** | **Médecines Complémentaires et Alternatives** |
| **MIVILUDES** | **Mission Interministérielle de Vigilance et de Lutte Contre les Dérives Sectaires** |
| **MRI** | **Magnetic Resonance Imaging** |
| **MTC** | **Médicine Traditionnelle Chinoise** |
| **NCCIH** | **U.S. National Center for Complementary and Integrative Health** |

| | |
|---|---|
| **OMNC** | **Observatoire des Médecines Non Conventionnelles** |
| **OMS** | **Organisation Mondiale de la Santé** |
| **RCT** | **Randomized Controlled Trials** |
| **RNCP** | **Répertoire National des Certifications Professionnelles** |
| **SMR** | **La Service Médicale Rendu** |
| **SNK** | **Syndicat National des Kinésiologues** |
| **SNMHF** | **Syndicat National des Médecins Homéopathes Français** |
| **SROS** | **Schéma Régional d'Organisation des Soins** |
| **TCM** | **Traditional Chinese Medicine** |
| **UNESCO** | **L'Organisation des Nations Unies pour l'Education, la Science et la Culture** |
| **UE** | **Union Européenne** |
| **USPE** | **Un Sourire pour l'Espoir** |
| **WHO** | **World Health Organization** |

## Première Partie : Résumé Détaillé

## Une analyse anthropologique de la relation entre médecine conventionnelle et médecine complémentaire dans la France contemporaine

# Introduction

Cette thèse, écrite en anglais est le fruit d'un travail ethnographique de trois ans et demie dans la France contemporaine, faisant suite au diplôme de Master « Relations Internationales, la Résolution de Conflit et le Développement de la Société Civile » à l'université américaine de Paris où j'ai fait l'analyse de politiques publiques au niveau européen et mondial. J'ai fait connaissance avec le milieu hospitalier français pour un problème de santé personnel. J'ai refusé de suivre la prescription du médecin qui me paraissait trop invasive et je me suis tournée vers les médecines complémentaires. Ce thème m'a paru intéressant à explorer pour une thèse, d'autant plus que mon père a été chirurgien avant d'opter pour la psychiatrie aux États Unis et que ma mère était psychologue. J'ai découvert un monde de praticiens que je ne soupçonnais pas et qui m'a paru riche à investir et à comparer avec le milieu de la médecine officielle. D'un point de vue éthique et méthodologique j'ai démarré le travail d'enquête en prenant soin de ne rien vouloir démontrer, d'être sans a priori ou sans préjugé, bref, avec l'ambition d'être la plus objective possible.

**Synthèse de la méthodologie détaillée dans la thèse en anglais.**

***Population enquêtée*** : elle comprend trois groupes, l'un relatif aux médecines conventionnelles, l'autre aux médecines complémentaires et le troisième aux personnes appartenant aux deux précédents.

*Dans le groupe des médecines conventionnelles j'ai interviewé 38 personnes :*

- 2 infirmiers, 3 élèves infirmiers, 6 administratrices d'une école de formation d'infirmiers et d'aides soignantes, 3 médecins, 2 administrateurs des hôpitaux, 2 chefs des services hospitaliers, 1 chercheur clinicien, 1 membre du Conseil National de l'Ordre des Médecins et 1 membre de l'Ordre National des Pharmaciens, 3 membres d'institutions publiques médicales, (Ministère de Santé, ARS, ANAP), 1 représentant de la Miviludes, 1 ancien ministre de la santé, 3 représentants des syndicats (médecins généralistes, médecins urgentistes, la Conférence Régionale de la Santé et de l'Autonomie- Bourgogne), 1 président d'une association antisecte, 1 directeur du bureau français d'une alliance non gouvernementale d'associations de malades, 3 professeurs enseignants dans des facultés de médecine (Paris, Nice, Amiens), le fondateur et directeur d'une plateforme universitaire de recherche en interventions non médicamenteuses, le fondateur d'une association promouvant l'évaluation des thérapies complémentaires, 2 créateurs des applications de « e-santé »

*Dans le groupe des médecines complémentaires j'ai interviewé environ 50 personnes :*

- Des clients et des praticiens de ces médecines : chamanique ; Médecine Traditionnelle Chinoise- acupuncture, qi gong, tai chi, etc. ; Médecine Ayurvédique ; Médecine Tibétaine ; Médecine Prophétique ; yoga ; exorcisme ; homéopathie ; les fleurs de Bach ; aromathérapie ; naturopathie ; phytothérapie ; énergétiques-magnétisme, reiki, barreurs de feu etc. ; réflexologie ; shiatsu ; ostéopathie ; kinésiologie ; biofeedback ; myotenofasciotomie ; hypnose ; programmation neurolinguistique ; méditation ; sophrologie ; relaxation ; les pratiques psychocorporelles- danse sacrée, danse initiatique, danse d'ancrage etc. ; art thérapie ; les soins avec des sons- tambour, bol tibétain, chants etc. ; les rituels des groupes spirituels variés- Daimoku, féminin sacrée etc.

- Des membres d'associations « Un Sourire pour l'Espoir » et « Le Souffle Libre »

- Des représentants des syndicats et fédérations : ostéopathie ; médecine anthroposophique ; homéopathie ; kinésiologie ; shiatsu ; réflexologie

- Des étudiants, professeurs et administrateurs des écoles de formations privées : naturopathie ; homéopathie ; ethnomédecine ; hypnose ; shiatsu ; kinésiologie

*Dans le groupe mixte des personnes appartenant aux deux groupes précédents, conventionnels et complémentaires (ayant la double valence), j'ai interviewé environ 20 personnes :*

- Homéopathie, Médecine Traditionnelle Chinoise, aromathérapie, naturopathie, médecine anthroposophique, hypnose, yoga, qi gong, tai chi, acupuncture, méditation, ostéopathie

**Les méthodes d'investigations**

***Observation participante* :**

- En qualité de : Secrétaire d'un chaman péruvien durant 3 ans en France et en Europe, j'ai exercé comme traductrice des paroles du chaman auprès de ses clients, chargée de faire en amont les anamnèses des clients (récit de leurs antécédents, débriefing après leur séance)

- Membre de l'association « Un Sourire pour l'Espoir », rencontre des handicapés moteurs, j'ai intégré l'association en qualité d'interprète pour les consultations en biofeedback et j'ai observé plusieurs consultations et une réunion du comité scientifique de l'association

- Membre de l'association de Yoga « Le Souffle Libre » en pratiquant les cours, les ateliers et en faisant des entretiens avec le fondateur et les autres membres, animation de stand dans un salon de yoga pour cette association

- Participations à des colloques et des congrès conventionnels et complémentaires, et à des salons de bien-être etc.

- Participations aux cours dans des écoles privées pour l'homéopathie, la naturopathie et l'ethnomédecine en faisant des entretiens avec les professeurs, les administrateurs, et les étudiants

- Participation à des séances, des ateliers, des stages et des consultations de médecines complémentaires

J'ai systématiquement fait la description de ce dont j'ai été témoin dans ces participations actives et impliquées.

***Les entretiens :***

J'ai fait une centaine d'entretiens durant mes observations participantes et j'en ai traduit une quarantaine. Puis j'ai gardé une trentaine de contacts pour revenir et approfondir les premiers entretiens. Les entretiens étaient semi-directifs, avec des questions semblables et systématiques pour chaque interviewé (cf. thèse en anglais, p.47) et non directifs pour les relances ouvertes.

J'ai fait une analyse de contenu des entretiens et j'ai regroupé des thèmes récurrents, des logiques d'acteurs, des conceptualisations de mots clés comme « santé », « maladie », « bien-être », « rôle du médecin et du patient », « acceptation et efficience », « globalisation », « diagnostic », « diabolisation de l'autre », « médecine préventive », « les évolutions dans ces deux médecines ».

Du fait de mon origine américaine, les entretiens ont pris souvent une tournure particulière, dans la mesure où beaucoup ont cherché de façon didactique à me faire comprendre comment s'élabore et se déploie la pensée française. L'insistance sur le cartésianisme par exemple entre dans cette stratégie pédagogique. De fait, je ne peux échapper à mon « background américain », qui donne à cette thèse une approche singulière de l'autre, le français!

Pour l'analyse, j'ai examiné les groupes de données qui se sont formées autour des mots clés. J'ai ensuite considéré les points communs entre ces groupements et leurs implications par rapport à la relation entre la médecine conventionnelle et les médecines complémentaires. Cela a fait émerger des traits saillants que j'ai interprétés à partir des discours et expériences récoltés lors de mon travail de terrain et que j'ai mis en relation avec des approches scientifiques et surtout anthropologiques issues de ma revue de littérature sur le sujet.

***La revue de littérature :***

Pour mon cadre de référence théorique, la thèse s'appuie principalement sur des auteurs anglais, ainsi que les publications de l'OMS et de l'Union Européenne

Les recherches documentées des deux médecines trouvent leurs sources dans des ouvrages et articles français consultés à la bibliothèque universitaire de Paris Descartes, la bibliothèque nationale de France, la bibliothèque de l'Université de Caroline du Nord à Chapel Hill, et la bibliothèque de la Fondation Maison des Sciences de l'Homme ; ainsi que les rapports du gouvernement français et des agences nationales (le Ministre de la Santé, Miviludes, le Sénat, l'Assemblée Nationale, l'Assurance Maladie, l'Inserm, la Haute Autorité de Santé, la Drees etc.). Il faut y ajouter des rapports de l'Ordre des médecins et de l'Académie de Médecine ainsi que des articles disponibles enligne sur PubMed, des thèses doctorales françaises concernant des pratiques complémentaires, les rapports des syndicats, et des articles destinés au grand public (Le Figaro, Le Point, La Libération, Le Télégramme etc.).

# Chapitre 1: Définitions des termes, des cadres théoriques et revue de littérature

Le chapitre 1 fait un état des lieux des nombreuses appellations relatives à la médecine conventionnelle et aux médecines complémentaires, ainsi que leurs contextes d'émergence, leur implantation en France et leurs implications sémantiques. Il explore la logique des rapports entre médecine conventionnelle et médecines complémentaires et fonde la terminologie employée tout au long de cette thèse. La théorie des « systèmes adaptatifs complexes » est présentée comme l'approche théorique qui fond l'analyse des chapitres suivants. Quelques mécanismes de la mondialisation sont mis en avant comme caractéristiques d'un environnement plus étendu dans lequel « se niche » le système sanitaire Français contemporain. Les données quantitatives viennent de l'OMS et autres organisations nationales et internationales (cf. thèse en anglais).

## *1,1: Définition de la médecine conventionnelle*

Pour délimiter les termes de médecine conventionnelle nous partons d'un moment clé, témoin d'une crise identitaire dans la constitution de la profession médicale en France, au XIXe siècle, signifiée notamment au congrès médical de 1845. Celui-ci organise l'identité de cette profession avec ses droits et ses devoirs donnant naissance à l'Ordre des médecins. Nous situons cela dans le contexte de « l'explosion des connaissances » au XIXe siècle, l'avènement du « scientisme » et l'émergence du capitalisme et des nouvelles formes de communications qui bouleversent la société de cette époque (Rhodes, 1985). L'Ordre des médecins exerce alors le contrôle de ce qu'il reconnaît comme « pratiques légitimes médicales ». Cette médecine acquiert le label de médecine occidentale et s'impose dans ses normes et ses visions dans l'expansion coloniale, reposant sur les découvertes scientifiques européennes comme la théorie atomique de Dalton en Angleterre, la théorie moléculaire d'Avogadro en Italie, la théorie de l'évolution de Darwin en Angleterre, l'introduction de l'électromagnétisme de Maxwell en Écosse, et les travaux de Pasteur en France.

Cette médecine est devenue la biomédecine notamment grâce aux découvertes dans l'étiologie, la bactériologie... Elle revendique aussi sa scientificité en tirant sa légitimité des méthodes d'investigations scientifiques : introduction des méthodes quantitatives et expérimentales, importance d'une nouvelle rationalité. Au cours du XXe siècle, la biomédecine a refaçonné les relations entre les sciences : physiologie - biochimie - génétique (ADN), faisant émerger une médecine moléculaire. La biomédecine a gagné du terrain dans de nouveaux réseaux des laboratoires pharmaceutiques, cliniques, systèmes sanitaires qui ont pris plus d'importance économique au cours du XXe siècle. C'est dans ce contexte que Guyatt a introduit « evidence based medicine » en l'appelant « un nouveau paradigme pour la pratique médicale » (Guyatt & al, 1992) qui permet de prendre des décisions cliniques à partir des évaluations critiques des recherches cliniques. Les méthodes statistiques de randomisations sont devenues la méthode officialisée, le standard d'or de la meilleure évidence dans ce paradigme « evidence based medicine ». Le développement de cette standardisation a conduit à en faire la méthode quasi exclusive pour valider les traitements médicaux, conduisant au cours du temps à exclure toute autre approche raisonnable basée sur d'autres méthodes. Cette conception correspond à ce qu'on désigne en France comme « la biomédecine », « la médecine allopathique », « la médecine occidentale », « la médicine

universitaire », « la médecine orthodoxe », « la médecine officielle », et « la médecine conventionnelle ».

Jusqu'à la fin du XXe siècle, d'après Wiseman (2004), cette médecine était tellement dominante qu'elle était désignée au singulier comme La Médecine, « l'Unique », pour parler de l'art de guérir. Le passage obligé par les sciences et le régime de la preuve scientifique deviennent hégémoniques et fondent à eux seuls la légitimité de la médecine.

C'est ce cheminement qui a conduit à la définition de la médecine conventionnelle. Mais au cours du XXIe siècle, la représentation des spécialités médicales a amené à une multiplicité des façons de la désigner. Dans mes recherches j'ai dénombré quatre critères qui définissent la médecine conventionnelle en France :

1- ce qui est remboursé par l'assurance maladie

2- ce qui s'enseigne dans le cursus standard des facultés de médecine

3 - ce qui est pratiqué dans les lieux médicaux officialisés comme des hôpitaux et des pharmacies

4- ce qui est prouvé scientifiquement et accepté par « evidence based medicine »

### *1,2 : Définition de la catégorie des « médecines complémentaires »*

Elle relève d'une représentation négative dont la définition signifie ce qui n'est pas la médecine conventionnelle. En France, elle est connue sous les appellations suivantes : « médecines complémentaires et alternatives (MAC) », « les médecines traditionnelles », « les interventions non médicamenteuses (INM) », « les médecines non conventionnelles », « les médecines intégratives », « les médecines holistiques », « les médecines douces », « les médecines parallèles », et dans certains cas comme les « pseudo médecines », « les sectes », « les pratiques ésotériques », « les dangers » et « le charlatanisme ».

L'OMS parle de médecines traditionnelles et complémentaires, catégorie incluant plus de 400 pratiques différentes. Selon l'OMS (2013), la médecine traditionnelle est la somme des connaissances, compétences et pratiques qui reposent sur les théories, croyances et expériences propres à une culture, et qui sont utilisées pour maintenir les êtres humains en bonne santé ainsi que pour prévenir, diagnostiquer, traiter et guérir des maladies physiques et mentales. Les médecines complémentaires sont définies par ailleurs comme un ensemble large de pratiques sanitaires qui ne font partie, ni de la tradition, ni de la médecine conventionnelle d'un pays et qui ne sont pas complètement intégrées dans le système sanitaire dominant. Deux points importants relativement aux travaux et publications de l'OMS, qui regroupent les médecines traditionnelles et complémentaires dans une seule catégorie et utilisent indifféremment alternatif et complémentaire sans aucune distinction (OMS, 2013, p15).

Les concepts de médecine alternative et médecine complémentaire sont synonymes pour l'OMS alors que le parlement européen les distingue en ce que complémentaire est toujours associée avec la médecine conventionnelle et non à la place de cette médecine. En France, on rejette généralement l'association de médecine complémentaire et alternative, alors que dans

la littérature anglophone MAC - médecine complémentaire ET alternative- sont utilisées dans une même catégorie. Ces imprécisions font émerger la question de qui parle ou selon quel point de vue. Considérer les médecines traditionnelles comme des médecines complémentaires met en évidence une représentation ethnocentrique de l'occident. Les médecines ayurvédiques de l'Inde et traditionnelles chinoises de Chine n'ont rien de complémentaires et forment un système complet de soins. Il y a des processus étonnants où des parties traditionnelles s'intègrent à la médecine occidentale conventionnelle comme par exemple l'acupuncture, pratiquée par un médecin et qui est aujourd'hui remboursée par la sécurité sociale, critère de validation par l'Ordre des médecins d'une pratique scientifique officielle.

Quant aux définitions d'autres termes utilisés, la plupart ne sont pas appropriées : *médecine parallèle* est impropre à l'usage car elle sous-entend que les pratiques ne se rencontrent pas et donc ne peuvent être complémentaires; *intervention non médicamenteuse* ne relève pas d'une spécificité des médecines complémentaires, un grand nombre de pratiques médicales conventionnelles ne sont pas médicamenteuses- kinésithérapie, thérapies cognitives et comportementales, et autres techniques paramédicales. De plus, cette terminologie dévalorise totalement les pharmacopées traditionnelles comme la pharmacopée chinoise. Un autre terme équivoque et non approprié est celui de *médecine douce*, qui donne l'impression qu'elle n'utilise pas des poisons comme des métaux, des venins, des plantes toxiques alors qu'elle peut engendrer des réactions synergiques parfois nocives.

Au niveau méthodologique, la diversité des moyens utilisés dans les médecines complémentaires empêche des classifications efficientes. Au niveau des enquêtes, y compris des enquêtes statistiques, on constate des résultats totalement dissonants et la raison en est que les définitions des termes employés ne sont pas stabilisées. Il n'y a pas d'agrément sur les définitions à propos de la dénomination des praticiens, des méthodes, des résultats. Par exemple plusieurs études quantifient l'audience de l'ostéopathie, mais elles ne donnent pas la même définition de qui sont les praticiens et cela diffère d'une enquête à l'autre. Par ailleurs certaines médecines complémentaires font régulièrement l'objet d'études (ostéopathie, acupuncture, hypnose, mésothérapie, homéopathie, chiropractie....) pendant que d'autres sont totalement exclues du champ des recherches (reiki, magnétisme, barreurs de feu...) et cette éviction est d'autant plus importante que ces thérapies introduisent une dimension spirituelle dans leur fondement.

### *1,3 : Comprendre le système de soins français comme un « système adaptatif complexe »*

Les tentatives d'objectiver des pratiques, des méthodes et des acteurs dans un complexe mouvant d'inter influences permanentes qui modifient des parties et des ensembles nous conduisent à choisir le paradigme du « système adaptatif complexe » pour mieux éclairer ce qui transforme le système médical français. Il s'agit d'un système qui n'est pas gouverné par une simple règle ou directive mais qui constitue plutôt un réseau dynamique d'agents agissant chacun selon ses propres inclinations. Cette dynamique est engagée par les actions et réactions des uns par rapport aux autres et en relation avec leurs environnements proches et plus larges. Donc dans ces systèmes, les agents s'adaptent et anticipent les changements dans les contextes environnementaux qui à leur tour ont des effets sur les comportements

individuels et sur le réseau plus important (Holland, 1992). Ces systèmes complexes ont en commun plusieurs caractéristiques identifiables :

- un grand nombre d'agents qui interagissent d'une façon dynamique et non linéaire

- des motifs émergeant qui découlent des interactions des agents et leur rétro-alimentation dans le système qui ont des effets sur le comportement des agents et sur le système dans son ensemble

- une coévolution liée aux adaptations entre système, environnement, agents, et cela en boucles rétroactives

- une inter-connectivité entre les agents dans le système qui fait qu'il est plus important d'éclairer et de comprendre les relations, que les personnes objectivées. Il s'agit d'imbrications dans des séries de systèmes nichés. Par exemple comment un hôpital est niché dans un groupement hospitalier territorial qui fait partie lui-même du système sanitaire national.... européen.... mondial comme en témoigne l'incursion de holdings financiers étrangers dans des hôpitaux privés français

- comme pour le vivant sur la planète, il faut suffisamment de variables et de diversités pour que le système adaptatif reste créatif, connecté et dans le flux .... ou dans le flow !

- des normes assez simples

- l'émergence d'auto-organisations

- des changements itératifs qui prennent une ampleur conséquente au fur et à mesure du développement des parties et de l'ensemble

- un point d'équilibre qui est toujours au bord du chaos

Cette approche holistique est particulièrement pertinente pour analyser un système de soins, qui est un macro-système comprenant de nombreux microsystèmes constitués de nombreux agents (patients, famille et entourage, praticiens de santé et soin, administrateurs des structures différentes, des politiques publiques et privés, acteurs économiques et scientifiques etc.) et de nombreuses offres thérapeutiques ou voisinent médecine conventionnelle et complémentaire. Dans mes entretiens, la complexité a été souvent évoquée pour expliquer combien les ressorts du système médical restaient difficiles à saisir dans leur totalité. Jusqu'aux témoignages d'agents du ministère de la santé, qui ont fait état d'une véritable perplexité devant l'imprévisibilité des dynamismes modifiant le terrain sur lequel ils devaient établir des politiques à plus ou moins long terme et devant le cloisonnement des missions institutionnelles, pour lesquelles ces agents devaient en même temps tenir compte des exigences du terrain et des lignes de fonctionnements des politiques aux niveaux nationaux, internationaux etc.

Ramsey (1999) évoque le « paradoxe français » qui fait de la France, un des plus grands producteurs et consommateurs de remèdes et de médecines non conventionnelles en Europe alors que ce pays est l'un des plus hostiles sur le plan institutionnel à propos des formes médicales qui ne sont pas autorisées par les instances gouvernementales. La France a institué la Mission Interministérielle des Vigilances et des Luttes Contre les Dérives Sectaires (Miviludes), avec une section spéciale dédiée aux médecines complémentaires, relayée en cela par un certain nombre d'articles dans les médias qui dénoncent le danger des sectes

médicales. Cette thèse examine ce paradoxe français à travers l'investigation des différents terrains qui alimentent ce chaos.

### *1,4 : La globalisation et le système sanitaire français*

Le système sanitaire français évolue sous l'effet de la globalisation car de nouveaux agents de médecines autres comme la médecine traditionnelle chinoise, ou ayurvédique ou les soins chamaniques... proposent leur service de soins à travers des paradigmes totalement étrangers à la médecine moléculaire, faisant émerger des conceptions hybrides des soins et de la santé. L'aspect préventif devenant un véritable bien de consommation y compris auprès des gens encore en bonne santé et soucieux de vivre le « bien-être » comme prophylaxie aux maladies de civilisation qui deviennent un risque pour tout un chacun. Le système adaptatif complexe a ainsi créé dans l'objectif médical des soignants conventionnels et de la recherche médicale, une nouvelle prise en compte des « facteurs de risque dans les comportements et les façons de vivre », ainsi que dans l'environnement vis à vis des polluants et autres facteurs nocifs. On se soucie de détection précoce qui repositionne la maladie dans l'avenir. La médecine préventive se spécialisant dans le contrôle et l'élimination des pathologies et la quête pour gérer, façonner et créer les capacités vitales des humains (Rose, 2007). Des normes internationales entrent dans le système sanitaire français à travers « la médecine 4P » : *préventive, prédictive, personnalisée, participative*.

Ce concept, a été inventé en 2006 par Leroy Hood en s'appuyant sur ses travaux en biologie et en technologie. Le but de « la médecine 4P » est de réorienter la médecine vers la santé au lieu de la maladie en utilisant les technologies de pointe (tests génétiques, technologie moléculaire, recherches biologiques en laboratoire etc.) pour traiter la santé en pronostiquant et en prévenant les maladies avant même leur apparition. Au cours de la dernière décennie, cette notion réductrice et technologisée de l'individu en tant qu'un système d'informations biologiques a circulé dans les publications internationales de santé, devenant une norme internationale façonnant la médecine conventionnelle « occidentale » (Vogt, Hofmann, Getz, 2016). Par exemple, dans leur plan stratégique 2015-2019, l'Assistance Publique-Hôpitaux de Paris (l'AP-HP) cite « la médecine 4P » spécifiquement comme « la médecine de demain » et fournit des recommandations pour développer chacun des quatre « P » dans leur système hospitalier universitaire de 39 établissements (AP-HP, 2014).

Ainsi, on constate que le système de santé français évolue en conjonction avec son environnement international et les tendances sanitaires, les normes médicales et les avancées technologiques mondialisées. Cela indique que ce système national est directement touché par ce que Boris Petric (2013) appelle une « transnationalisation du pouvoir, c'est-à-dire la multiplication des liens tissés à l'échelle mondiale dans tous les domaines de la vie sociale » (p. 190). Cela comprend, bien évidemment, la conceptualisation et la pratique de la médecine. A ce titre, plusieurs mécanismes de globalisation qui propagent ces liens (la compression temps-espace, la formation des réseaux, la notion d'une « société des risques »…) sont présentés en relation avec la santé et le système sanitaire français.

## Chapitre 2: Les représentations réciproques des catégories des médecines conventionnelles et complémentaires

Le chapitre 2 explore la perception des stigmates, des stéréotypes et des peurs qui étaient fréquemment cités pendant mon travail de terrain pour caractériser la relation actuelle entre la médecine conventionnelle et la médecine complémentaire en France. Spécifiquement, cette relation est présentée en termes de perception d'une séparation entre les deux médecines et de l'antagonisme que cette séparation engendre. La peur et la méfiance réciproques qui séparent ces deux médecines conventionnelle-complémentaire; les stigmates et stéréotypes que cela engendre.

### *2,1: La stratégie de distinction : Une façon de s'identifier en s'opposant*

Dans la visibilité commerciale : les médecines complémentaires se présentent dans les salons, les publicités, les stratégies marketing comme distinctes de la médecine conventionnelle.

Elles se présentent comme nouvelles, innovantes, révolutionnaires alors qu'elles se réfèrent à un marché du capitalisme mondial. Mes observations montrent qu'elles sont dans la logique du capitalisme dominant comme n'importe quel autre produit sur le marché : par exemple des chamanes principalement français, vendent leurs ateliers de tambours, leurs soins, les voyages initiatiques...., comme le font aussi les maîtres de yoga, de reiki, de sophrologie, jouxtant la vente d'objets rituels spirituels, (bols tibétains, bougies, encens, etc.), de géomancie... Ces salons ont une structure et une logique d'organisation (stand, conférence, produit, brochure...) totalement identique aux salons des médecines conventionnelles. Finalement sur le plan commercial, les deux médecines utilisent les mêmes plans marketing.

Dans les stratégies de reconnaissance : s'intégrer ou bien s'imposer comme égales sur le plan du statut professionnel (selon une logique de « *separate but equal* »)

Parmi les nombreux exemples que je présente dans la thèse, je retiens ici le cas de l'ostéopathie qui développe un double discours paradoxal : médecine non conventionnelle jusqu'à ce qu'elle soit reconnue et qu'elle intègre la filière institutionnelle et économique de la médecine conventionnelle, afin que les ostéopathes acquièrent un statut professionnel équivalent à ceux des médecins et soient reconnus par la sécurité sociale (cf. thèse en anglais, pp. 102-3).

Dans les stratégies d'identité et de légitimation

Les praticiens des médecines complémentaires se présentent comme critiques des bases ontologiques des médecines conventionnelles (corps machine, mécaniste, symptomatique, trop médicamenteuse...) et valorisent l'approche holistique connue dans les médecines traditionnelles cosmologiques notamment, et d'autres comme l'homéopathie ou l'hypnose... Elles revendiquent de prendre en compte pour le diagnostic, la vie de la personne, son contexte, son histoire, la façon de se nourrir et d'autres comportements, et travaillent selon les théories qui permettent de rééquilibrer un déséquilibre qui est apparu dans le parcours de leur patient. On relève un discours assez semblable au travers de toutes ces médecines complémentaires et systèmes de soins. Pour exemple, quand j'ai demandé à l'Hypnothérapeute M- un médecin généraliste qui a publié plusieurs livres sur l'hypnose et

qui est souvent cité dans les médias français à titre d'expert- si l'hypnose peut être considérée comme la médecine conventionnelle il a répondu :

> "C'est sûrement pas ça […] Le patient fait, par exemple, venir un souvenir triste, mais c'est dans son corps- il n'est pas bien, il fait de l'adrénaline et son sommeil s'en va- c'est ça peut être que l'hypnose rappelle. C'est que le corps et l'esprit ne sont pas séparés ; on dit qu'on va soigner une pensée triste, donc c'est de la psy, non ! La pensée est dans le corps, c'est pour ça que le gars a mal au ventre et il ne dort pas, parce qu'il est triste ; c'est dans son corps. C'est la médecine moderne qui les a séparés, elle a tellement séparé […] qu'elle a fait des facultés de médecine et des facultés de psychologie ce qui est complètement idiot » (2017).

Selon les orientations ontologiques du praticien, ces conceptions holistiques peuvent aller bien au-delà de l'unité esprit-corps qui a été abordée par l'Hypnothérapeute M. Par exemple, le Docteur J - un médecin généraliste nous dit que :

> « Ces médecines globales intègrent la matière avec d'autres dimensions de l'être et du vivant […] Ca veut dire que la tradition chinoise comme la tradition indienne comme les autres traditions proposent une lecture du vivant qui est beaucoup plus universelle. La médecine [conventionnelle] a juste la version pour l'humain ; mais on parle du vivant, on parle de la vie, on parle de l'âme, c'est-à-dire ce qui anime notre vie et non pas simplement la mécanique ce que fait la société occidentale qui est mécaniste » (2014).

Du coté des médecines conventionnelles on critique cette ontologie holistique en reléguant ces pratiques sur le versant des croyances qu'elles opposent à leur scientificité.

### *2,2 : Une perception antagoniste et agonistique : la critique de la médecine conventionnelle à l'égard des médecines complémentaires et la défense des médecines complémentaires*

L'analyse des données montre une continuité dans les types de critiques qui sont faites aux médecines complémentaires:

- Elles ne peuvent pas se soumettre à la preuve scientifique et ne sont donc pas cartésiennes

- Elles se mettent en compétition avec la médecine conventionnelle alors qu'elles sont dangereuses et largement non réglementées;

- Elles ouvrent des portes aux dérives sectaires en provoquant des dépendances, des destructions qui parfois ont une issue fatale.

Étonnamment, ce sont les thèmes qui ont déjà servi à la critique du magnétisme d'Anton Mesmer au XIX e siècle et que nous retrouvons aujourd'hui concernant l'homéopathie entre autres.

La défense des accusés apparaît à travers les entretiens et autres recherches avec les arguments suivants :

- La méthode de la preuve expérimentale n'est pas ajustée aux raisonnements de certaines théories qui irriguent les médecines complémentaires. Les éléments actifs de guérisons sont autres qui échappent à la vision moléculaire, parce qu'elles sont « vibratoires », « énergétiques », « quantiques ». Certains théoriciens des médecines complémentaires proposent d'autres paradigmes et d'autres échelles pour administrer des preuves scientifiques.

Tel ce médecin qui conjugue à la fois médecine conventionnelle et complémentaire à travers l'homéopathie et qui nous a fait part de ses recherches:

> « Je vous exprime une petite expérimentation que j'ai faite- et d'ailleurs pour l'institut national de recherche médicale et scientifique hospitalier. J'avais travaillé sur des récepteurs du cerveau et travaillais sur les récepteurs […] dopaminergique et j'avais bloqué ces récepteurs avec des marqueurs radioactifs et j'ai réussi à les déplacer en effectuant des dilutions comme pour les médicaments homéopathiques, concrètement je les fais déplacer […] puis j'ai vu le travail du docteur Benveniste […] actuellement je travaille en collaboration avec une association dirigée par le professeur Luc Montagnier qui est prix Nobel de médecine […] dans ses recherches il a trouvé également de son côté que les dilutions homéopathiques laissaient leur empreinte dans le cerveau- il y avait l'empreinte de la dilution, il y avait la longueur d'onde de la dilution du produit […] alors qu'au début on pensait que c'était chimique et alors évidemment si on ne pense qu'à la chimie […] au-delà d'une certaine dilution il n'y a plus de molécule donc ce n'est pas chimique. Mais avec la physique quantique etc., là où on est actuellement, on se rend compte que ça peut contenir une information… comme par exemple avant vous avez eu besoin d'une clé pour ouvrir votre voiture n'est ce pas ? Et maintenant comment vous ouvrez votre voiture ? Avec un bip […] vous avez un émetteur et un récepteur donc il s'agit d'une longueur d'onde il ne s'agit pas du tout d'une question de molécule chimique » (Docteur Q, 2015).

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- Les polémiques autour de l'usage du terme de « médecin », du droit de faire un « diagnostic », autour du droit de nommer ses clients des « patients » alimentent l'antagonisme des deux médecines. Bien que « complémentaire » soit qualifiée comme une médecine - médecine complémentaire- il est strictement interdit à cette dernière d'employer des terminologies médicales.

Le droit de faire un diagnostic est un passage obligé de la consultation médicale, une méthodologie revendiquée et légalement codifiée par la médecine conventionnelle. Le diagnostic apparaît comme une prérogative exclusive de la médecine conventionnelle, réservée aux médecins qui ne sauraient s'y soustraire.

Le Docteur T nous explique en parfaite clarté ce que nous entendons par le diagnostic et le parcours du malade dans la médecine conventionnelle :

> « En définissant bien les différentes étapes que doit franchir un malade, quelqu'un qui a une souffrance […] il faut bien distinguer trois étapes distinctes. La première étape c'est l'étape de la sémiologie- je m'appelle un sémiologiste- alors il y a la scène clinique […] un patient arrive en disant 'moi j'ai mal à la tête, j'ai mal au ventre, je suis angoissé,' ça ce sont des symptômes. Il faut savoir les identifier et puis ensuite il faut les regrouper en ce qu'on appelle des syndromes, les syndromes sont les associations des symptômes […] ça c'est la première phase

> […] cela ne peut pas être non conventionnel, elle est conventionnelle, c'est-à-dire qu'il faut qu'on connaisse tous les symptômes qu'on observe en clinique […] tout des types de douleur […] Ensuite la deuxième partie c'est le diagnostic […] Dans le diagnostic il faut classer ces symptômes […] et ensuite il faut évoquer des hypothèses diagnostiques, ces hypothèses diagnostiques rentrent dans le cadre de ce qu'on appelle la nosologie, - la nosologie c'est la classification des maladies-, ça ce ne peut pas être non conventionnel, c'est obligatoire que des maladies soient reconnues comme telles […] Il n'y a pas de place une seconde à une réflexion non conventionnelle dans ce genre de description, c'est déjà pour savoir à quoi on a affaire, c'est-à-dire catégoriser le malade dans un diagnostic […] c'est très difficile […] c'est pour ça que les études médicales sont longues […] et on ne peut pas penser à quoi que ce soit tant qu'on n'a pas étudier tout ça […] La troisième et dernière partie c'est l'aspect du traitement et il faut distinguer des traitements qui ont fait leurs preuves et qui sont reconnus par les sociétés savantes » (2017)

Du côté des médecines complémentaires, les praticiens savent qu'ils ne peuvent, sous peine d'être poursuivis pour « exercice illégal de la médecine », ni se nommer « médecins », ni procéder au « diagnostic ». Pour rester politiquement prudent, ils choisissent de procéder à des lectures de l'état de leur client (et non du « patient », terme réservé au vocabulaire des médecines conventionnelles). Ils parlent de faire un « bilan énergétique » lorsque les pratiques sont issues des médecines chinoises et ayurvédiques ou bien comme « un examen ou une interrogation du corps » dans des pratiques, comme la kinésiologie, qui s'appuient sur le biofeedback.

Pour illustrer, voici le discours du Praticien de Shiatsu C, maître de shiatsu et président d'une fédération des praticiens de shiatsu :

> «  Déjà en France on ne va pas parler du diagnostic, parce que ça les médecins disent que 'le diagnostic c'est moi, *bah* vous, vous n'êtes pas médecin donc vous ne faites pas du diagnostique'. On parle de bilan énergétique, bon je dirais que c'est hypocrite mais enfin c'est comme ça. Alors le bilan énergétique […] il repose sur un examen qui est la prise du pouls qui vient à l'origine de la médecine chinoise- vous savez que vous avez 12 pouls comme les 12 méridiens et le médecin chinois va prendre le pouls aux 12 endroits différents sur le poignet. Donc […] il faut faire un bilan de la personne avant de commencer un shiatsu en principe on essaye de savoir à qui on a affaire. Il y a des fois ou il ne faut pas faire le shiatsu ou il y a des contres indications » (2015)

D'autres revendiquent de ne pas faire un diagnostic comme le Docteur J qui, bien que médecin diplômé de la faculté de médecine, tient ce discours critique sur la faiblesse de ne s'en tenir qu'à la classification des symptômes alors que l'investigation peut être plus exigeante :

> « Je fonctionne plutôt par symptôme, dans l'interrogatoire je ne parle pas du diagnostic […] Quand la personne vient j'écoute, '*bah* voila j'ai un nez qui coule clair' je ne marquerai pas un diagnostic, je marquerai un écoulement clair, éternuement picotant […] je ne marquerai pas rhume de ça je m'en fout […] En homéopathie comme en acupuncture un rhume ça veut rien dire parce que il y a dix mille manières d'envisager un rhume- comme le rhume qui coule clair ou jaune très liquide […] Donc le diagnostic n'a pas d'intérêt pour le traitement parce que pour nous ce qu'il nous faut c'est des symptômes avec leurs caractéristiques et c'est comme ça qu'on choisit le remède. Quand quelqu'un vient

> en disant ‘j’ai mal à l’estomac’ que ce soit un ulcère d’estomac ou de duodénal de ça les gens s’en foutent. Ou ils viennent avec leur diagnostic, *bah*, je ne sais pas ‘j’ai des hémorroïdes’. C’est un diagnostic, mais c’est certainement ni le but ni le début du traitement […] en homéopathie c’est la manière de comment ça se passe pour telle personne, c’est pour ça que j’ai dit c’est une médicine individualisée […] donc on considère comment la personne et sa vitalité agissent dans le monde et on va essayer de l’accompagner sur un mode privilégié » (2015).

### *2,3 : Les arguments idéologiques autour de la rationalité : cartésianisme contre dérives sectaires*

J'ai découvert, à travers mon « background américain », l'importance fondamentale de la culture cartésienne dans la société française. En effet les critiques systématiques des médecins conventionnels sur les médecines complémentaires ont porté principalement sur l'irrationalité- et par conséquent le danger- de ces dernières. Descartes reste la référence incontournable pour représenter la pensée rationnelle sur laquelle se fonde la médecine conventionnelle, défendue par l'évidence de la supériorité du rationalisme cartésien. Par exemple, le Docteur M admet :

> « Je vais vous donnez une opinion mais ça ce n’est pas du tout une réponse scientifique, mon sentiment est que la médecine conventionnelle française est profondément Cartésienne, et que lorsque que Sackett aux Etats Unis a créé son concept de ‘evidence based medicine’ […] il a complètement adhéré au concept français Cartésien- le discours de la méthode. Le concept de ‘evidence based medicine’ c’est remettre du discours de Descartes sur le plan scientifique, c’est complètement la même chose et nous avons adhéré complètement à ça. Et si vous voulez le médecin français dans son parcours universitaire il ne connait qu’un type de discours, il ne connait que les techniques statistiques, que les essais prospectifs contrôlés etc. On est très très très profondément Cartésien » (2015).

Les praticiens complémentaires quant à eux, revendiquent d'échapper à la standardisation de la médecine conventionnelle du fait de la diversité de leurs approches et de leur objectif principal qui est de modifier le terrain et la personne dont les comportements l'ont engagée dans une impasse de santé. Au lieu de traiter la maladie, ils traitent plutôt la personne. A leur tour, ils attaquent la médecine conventionnelle en lui faisant le procès d'être trop technique, trop basée sur la technologie, trop loin du patient comme personne humaine, traitant le corps comme un objet ou un ensemble d'organes, jusqu'à parler de « médecine déshumanisée ».

La critique de l'irrationalité des médecines complémentaires ouvre la voie vers des accusations de dérives sectaires, pour lesquelles le gouvernement français en 1996 a créé « l'Observatoire interministériel des dérives sectaires » (gouvernement Juppé); consolidé en 2002 sous l'appellation Miviludes. Cette mission interministérielle est particulièrement vigilante pour le contrôle des médecines complémentaires afin d'assurer la sauvegarde des personnes malades qui pourraient être abusées et non soignées.

Sur ce sujet, Madame T, la présidente d’une association travaillant directement avec Miviludes sur la vigilance des dérives sectaires dans le domaine de la santé était très claire sur les dangers associés :

> « Alors dans le domaine de la santé les dérives sont très importantes. Par exemple dans le cadre des maladies très graves comme le cancer on pense que des médicaments ont un côté qu'on appelle la poudre de *perlimpinpin* qui sert à rien. Ce n'est pas très grave si le patient continue son traitement, mais très souvent le gourou lui fait arrêter son traitement, enfin le premier traitement, pour avoir plus d'emprise sur le malade- alors des cas, on a beaucoup […] Un monsieur avait un cancer et était suivi par un kiné qui lui a dit 'voilà je connais quelqu'un qui organise un voyage aux Philippines pour les gens qui sont malades comme vous'. Donc ça coûtait beaucoup d'argent bien sûr et il a été opéré aux 'mains nues'. Ce qui est un mensonge parce que 'aux mains nues' ça veut dire qu'on ne touche pas le malade. Et bien entendu il est mort […] il faisait des chants de son gourou et bien sûr il est mort » (2015).

En s'appuyant sur ces exemples effroyables, Mme T. condamne sans appel toutes les pratiques, parlant de « viol du cerveau », et assimilant la psychiatrie conventionnelle à une dérive de ce type ! Cette posture extrême reste néanmoins très minoritaire dans les entretiens que j'ai menés, y compris au sein des membres de la Miviludes.

Hors de ses types d'histoires « extrêmes » au cours de mes enquêtes dans les observations participantes et dans certains salons commerciaux, j'ai rencontré plusieurs praticiens de médecines complémentaires avec des egos démesurés se vantant au nom de leurs « dons spéciaux », leurs « talents d'un autre monde », « leurs capacités spirituelles », et leurs « connaissances illuminées ». Certains organisent des voyages initiatiques, des soins, et/ou des activités en groupe pendant lesquels ils mélangent des références entre la Terre-Mère et des bricolages mythologiques en employant une palette d'outils variés comme des plumes, des cristaux, des antennes, et des instruments- le tout payant, bien évidemment. J'ai même été témoin d'un praticien volant de l'argent dans les sacs des participants dans des cercles de tambours, et d'autres praticiens qui établissaient des relations douteuses avec des personnes faibles et vulnérables, y compris avec des personnes ayant des maladies mentales. Généralement leur objectif était de créer une dépendance qu'ils pourraient exploiter financièrement et/ ou sexuellement et encore jouir d'une posture de toute puissance.

Par contre, concernant les praticiens complémentaires avec lesquels j'ai fait mes entretiens (32 au total), ils ont tous été humbles, compétents soucieux d'envoyer d'abord leur client chez des médecins lorsqu'ils n'étaient pas eux-mêmes médecins. D'autres travaillaient en association avec des médecins. Ainsi les représentations sociales sont très dépendantes des opinions qui, le plus souvent comportent des fantasmes, d'autant plus radicaux que les personnes qui s'expriment ne connaissent pas leurs adversaires.

A travers les entretiens, nous constatons que l'antagonisme des deux types de représentations sociales se traduit en peur. Les pratiquants complémentaires ont peur que la police puisse se présenter à leur porte à tout moment (ce qui est arrivé à deux des pratiquants qui j'ai interviewés); et les médecins conventionnels craignent l'arrivée de patients présentant des maladies à un stade avancé ou même terminal, suite à leurs recours inconséquents aux médecines complémentaires, sans même avoir consultés un médecin conventionnel au préalable. Mon travail de terrain a montré que ces deux craintes sont, dans une certaine mesure, fondées.

### *2,4 : Discussion sur les représentations des stéréotypes stigmatisant et leur symétrie*

L'enquête relativise la rationalité indiscutable de la médecine conventionnelle autant que le procès d'inhumanité qui lui est fait par ses concurrents. En réalité, on ne peut occulter le fait que dans le soin, il s'agit d'une rencontre humaine et qu'elle est toujours singulière. Il s'agit des deux côtés d'un art du soin et cette dimension artistique comprend un aspect de magie. Cette dépendance de confiance réciproque, de la force des croyances, des qualités empathiques ou compassionnelles éclaire en partie le mystère des effets placebo, de mieux en mieux connus et enfin étudiés !

Les médecines complémentaires ne sont pas non plus l'apanage de l'irrationalité, elles ne sont pas ignorées des recherches scientifiques (cf. thèse anglaise, pp.147-8), mais hélas il n'y a pas ou si peu de subventions pour des recherches sur les médecines complémentaires. Par ailleurs, certaines recherches qui aboutissent néanmoins ne peuvent trouver des revues ou des médias pour les rendre publiques. Elles restent dispersées et fragmentées, et dans les marges politiques.

Le biofeedback est donné à titre d'exemple d'une pratique complémentaire qui est présente mais marginalisée en France malgré la littérature scientifique sur son efficacité (e.g. Yucha & Montgomery, 2008 ; Sender, 2013). Le neurofeedback, une branche du biofeedback, est l'objet d'études à l'hôpital de la Pitié-Salpêtrière à Paris pour l'autisme et les troubles du sommeil et à l'hôpital Sainte-Marguerite à Marseille pour le TDAH et l'épilepsie (Docteur D, 2015). Aux États-Unis, le biofeedback est considéré comme une pratique conventionnelle utilisée dans de nombreux grands centres médicaux, tels que le *Mayo Clinic*, pour traiter une grande variété de problèmes de santé (douleur, troubles gastro-intestinaux, cancer, maladies chroniques, etc.). Néanmoins, selon la Praticienne D de biofeedback, médecin américain qui consulte deux fois par an en France, et avec qui j'ai fait de l'observation participante lors de ses consultations avec ses patients en France, constate ceci :

> « La peur est un grand problème en France ; puisque le biofeedback n'est pas bien compris ici, les médecins et les patients ont peur. Un médecin s'est tellement 'énervé' à cause de l'amélioration particulièrement sensible d'un de ses patients avec le biofeedback qu'il a écrit un article le critiquant et qualifiant mon centre de biofeedback à Miami comme 'horrible'. J'ai beaucoup de patients dont les médecins n'ont jamais entendu parler du biofeedback […] Certains de mes patients ont été virés par leurs médecins et leurs centres de rééducation parce qu'ils l'avaient essayé et qu'ils avaient obtenu de bons résultats. La communauté scientifique ici s'oppose car elle n'en comprend pas le fonctionnement. La critique est que ce n'est pas scientifique et donc que ça doit être mauvais. Ces médecins sont prompts à 'condamner' » (2015)

Mon travail de terrain indique que des discours comme ceux-ci sont liés à la définition négative des médecines complémentaires qui sont regroupées dans une seule catégorie stéréotypée comme « non scientifique » par nature et donc stigmatisées comme incluant des pratiques « mauvaises ». Selon la discussion entre différents professionnels de santé qui se penchent sur le développement des recherches scientifiques des médecines complémentaires, j'ai pu constater lors de mon observation participante à une réunion de l'Observation des Médecines Complémentaires Non Conventionnelles (OMCNC) à Nice en 2017, que ces stigmates et stéréotypes sont généralisés dans la catégorie en entier comme un « sujet délicat et électrique » (Docteur V, 2017 ; cf. thèse en anglais, p.151) et peuvent entraver la collecte de fonds nécessaires pour mener des recherches scientifiques.

# Chapitre 3 : Les tendances actuelles des médecines complémentaires en France

Ces tendances tendent à montrer que, malgré la séparation et les représentations sociales présentées dans le chapitre précédent, les médecines complémentaires sont de plus en plus intégrées dans les milieux de la médecine conventionnelle et sont parfois réglementées (par exemple, l'acupuncture, l'ostéopathie, l'hypnose…).

## *3,1 : L'introduction de la médecine complémentaire dans des hôpitaux privés*

Certaines spécialités médicales s'ouvrent aux médecines complémentaires dans des domaines spécifiques comme les domaines concernant la maternité, la pédiatrie, les soins palliatifs, la réanimation, le traitement des douleurs et des cancers.

Considérant que ce sont des domaines dans lesquels de nombreux traitements médicaux ne peuvent pas être utilisés (maternité, pédiatrie), ne peuvent pas guérir ou empêcher l'inévitable (soins palliatifs), sont à la marge de l'action médicale de guérir, demandent une autre approche du corps (réanimation, douleurs), ou sont si lourds que les patients nécessitent un soutien supplémentaire (cancer) ; on peut voir l'intérêt d'ajouter des pratiques complémentaires dans les soins thérapeutiques de ces services. Dans ce sous-chapitre, j'examine les cas de deux professionnels de santé travaillant dans un service de soins palliatifs et un professionnel de santé travaillant dans un service d'oncologie dans des hôpitaux privés à Paris pour illustrer ce processus paradoxal de rejet et adhésion simultanés :

- Le Docteur O- un médecin qui a intégré l'hypnose dans son service des soins palliatifs

-L'infirmière V- une infirmière dans le même service des soins palliatifs que Docteur O et qui promeut l'utilisation d'aromathérapie par tous les soignants dans son service et plus largement en organisant des formations ouvertes à tout le personnel de son hôpital

-Chercheur Clinique R- qui travaille dans un service d'oncologie et vise à introduire sa pratique de naturopathie en synergie avec les deux sophrologues qui travaillent déjà dans son service

Leurs discours démontrent leur intérêt commun pour utiliser les médecines complémentaires comme un moyen de prise en charge des aspects « humains » de leurs patients. Ceci est identifié en termes de la détresse et les souffrances que les patients peuvent expérimenter au-delà de leurs symptômes. Par exemple, le Docteur O explique que:

> « Les soins palliatifs sont des soins qui sont destinés à apporter le meilleur confort possible à une personne dans toutes ses dimensions en sachant que derrière il y a une maladie qui ne peut pas être guérie. Donc le plus de confort possible, c'est-à-dire bien sûr le confort physique avec des traitements des symptômes difficiles avec la prise en soin de la douleur- des douleurs plutôt- mais aussi de toutes les souffrances de tout ce qui est la fin de vie annoncée et les dimensions psychiques, psychologiques bien sûr ; et aussi la dimension sociale, la notion d'avoir régler ses affaires et d'être en sécurité dans ce domaine. La dimension spirituelle aussi, ce qu'on prend peut-être moins en compte à d'autres moments de la vie » (2015).

L'infirmière V et le Chercheur clinique R indiquent tous deux que les médecins n'ont ni le temps ni, dans certains cas, l'intérêt pour traiter « tout ce qui se passe autour du patient pendant la chimiothérapie ou quand il y a des symptômes particulièrement difficiles » (2015). Par exemple, le chercheur clinique R explique que dans son service d'oncologie les médecins passent « entre 10 et 15 minutes avec le patient quand il vient pour une chimiothérapie, c'est le temps consacré à sa visite » (2015). Il a ensuite évoqué la « logique de rentabilité » qui prédomine dans son hôpital et la pression sur les médecins pour qu'ils consultent le plus grand nombre de patients possible afin de « faire du chiffres » (2015). Selon ces deux praticiens, leurs pratiques complémentaires peuvent soigner les aspects de ce que Susan Sontag (1978) décrit comme « l'expérience de la maladie ».

Dans les trois cas, les initiatives de ces praticiens ont eu lieu avec le soutien financier de leurs hôpitaux. Par contre selon certains de mes interlocuteurs ce n'est pas toujours le cas. L'utilisation individuelle de pratiques complémentaires dans des services hospitaliers se produit souvent « dans l'ombre » ; c'est-à-dire hors du consentement des chefs de services et de l'administration hospitalière (cf. thèse en anglais, p.169). Les discours présentés dans ce sous-chapitre indiquent que les professionnels hospitaliers ont la possibilité d'intégrer leurs pratiques complémentaires préférées dans leurs soins sans l'autorisation, mais les autorités hospitalières doivent être informées si le praticien tente d'incorporer plus largement leur pratique dans leurs hôpitaux. En outre, s'il y a suffisamment d'intérêt, les praticiens peuvent obtenir des fonds hospitaliers pour financer des manifestations et des formations.

### *3,2 : L'introduction de la médecine complémentaire dans des hôpitaux publics et des centres hospitaliers universitaires en France et leur connexion avec des formations publiques et privées*

Ce sous-chapitre présente l'introduction de médecines complémentaires dans ces institutions qui est assortie de formations dans les facultés associées ou dans l'établissement à travers l'initiative des professionnels de santé concernés. Trois cas constituent la base de cette discussion :

- Le Docteur M- Coordinateur du Centre Intégré de Médecine Traditionnelle Chinoise (MTC) dans un CHU parisien qui développe la recherche clinique sur la médecine traditionnelle chinoise, de l'enseignement sur les médecines non conventionnelles et du soin par la MTC avec l'objectif d'une médecine intégrative. Il est également responsable d'un DU des pratiques corps-esprit en MTC.

- Le Docteur R- Chef de service d'un centre d'études et de traitement de la douleur dans un CHU à Amiens qui est responsable d'une structure des traitements non médicamenteux dans son hôpital et le fondateur d'un DU général des thérapies non médicamenteuses incluant des enseignements sur des pratiques complémentaires variées qui sont corporelles, psychocorporelles, psychologiques et socio-éducatives. Cela comprend la relaxation, l'acupuncture, le qi gong, le tai chi et la musicothérapie.

- L'administratrice B- qui travaille dans un CHU et est missionnée sur les thématiques transversales sur la douleur et les soins palliatifs. Elle travaille aussi avec un centre fédératif des soins de support et thérapies complémentaires.

On examine des points de similitude entre ces cas comme leurs concentrations sur une approche éducative aux pratiques complémentaires. Il est à noter que dans les cas des docteurs M et R, la formation proposée est sous la forme institutionnelle d'un DU dans leurs facultés de médecine respectives. Leurs formations, ce qu'ils décrivent comme des « études généralistes » fournissent un aperçu des diverses pratiques complémentaires, mais n'habilitent pas leurs étudiants à pouvoir s'installer en tant que pratiquants. Selon le Docteur R, cette décision reposait sur la logique suivante:

> « Quoi que vous en pensiez individuellement, ces techniques [complémentaires] sont et seront de plus en plus utilisées- soit on les abandonne en disant qu'elles ne sont pas scientifiquement validées […] et donc, finalement on abandonne une mission qui est la nôtre de valider ou d'accompagner scientifiquement en termes de formation ; soit on se penche sur le problème avec prudence en essayant de montrer aux étudiants […] ce que sont ces techniques, quelles sont leurs forces et leurs faiblesses, quelles sont leurs références, quel est leur niveau de preuve, quelles sont leurs indications » (2017).

Dans les deux cas, les motivations de ces médecins à créer leurs formations viennent directement de leurs expériences personnelles en tant que praticiens conventionnels. Ils ont tous deux vu que la spécialisation et la technicité de la médecine conventionnelle contemporaine ne leur permettaient pas de traiter des patients avec une prise en charge globale. Le Docteur R a constaté que l'introduction de pratiques telles que la relaxation et des activités physiques adaptées entraînait « une amélioration globale. Il y a un impact sur la qualité de vie du patient quelle que soit la maladie y compris le cancer ». Cela l'incitait à ajouter des thérapies complémentaires telles que « des groupes de qi gong » au service d'oncologie de son hôpital (2017).

Pour le Docteur M, ses expériences dans le domaine de la santé publique ont ouvert ses yeux à :

> « L'incomplétude de notre prise en charge médicale […] Je travaillais beaucoup dans le cadre de la santé publique avec des instituts de soins infirmiers et je me suis rendu compte qu'il y avait une différence dans la prise en charge entre un médecin et un paramédical- qui travaillait beaucoup sur l'empathie et sur la prise en charge globale. La prise en charge médicale était très éclatée, très spécialisée, très scientifique. Donc cette inquiétude et cette espèce d'ouverture d'esprit étaient nouvelles [pour moi] » (2015).

Par conséquent, le Docteur M a développé une formation qu'il considère comme « un enseignement d'ouverture d'esprit » qui aide les étudiants en médecine à voir qu'il y a « d'autres médecines qui servent à soigner des gens » (2015). Selon le Docteur M, ceci est important pour 3 raisons:

- Pour surmonter « une espèce d'ignorance qui est une espèce d'une barrière intellectuelle entre la population et les médecins » qui résulte de la réticence des médecins à se rendre compte des pratiques complémentaires utilisées par leurs patients. Il cite la cancérologie comme exemple et des statistiques indiquant que la moitié des patients atteints du cancer en France s'intéresse aux médecines complémentaires.

- Pour contribuer à la réflexion parmi des professionnels de santé et fournir une prise en charge globale en vue d'améliorer le parcours des patients.

- Pour réduire l'utilisation des produits pharmaceutiques, qu'il considère comme une approche primordiale dans la médecine conventionnelle. Il cite l'affaire du Vioxx aux États-Unis et le scandale du Mediator en France comme exemples qui soulignent l'importance des interventions non pharmaceutiques dans certains soins conventionnels.

Au travers de ces exemples, on voit que l'introduction de médecines complémentaires dans ces institutions est assortie de créations de réseaux pour des formations continues, et d'autres formes qui structurent l'implantation de médecines complémentaires, à l'initiative de différents personnels.

Dans les trois cas, leur mission est de mettre en lumière les pratiques complémentaires déjà présentes dans leurs hôpitaux grâce à la création de formations sérieuses et rationnelles. De plus, ils avouent qu'ils ne sont pas seuls dans leurs initiatives. Par exemple, la Faculté de médecine de Nice offre un DU en méditation et relations de soins, d'autres facultés de médecine fournissent des DU dans des pratiques complémentaires telles que l'ostéopathie, le shiatsu, etc.

En outre, dans ces trois cas, les effets de leurs initiatives vont bien au-delà de leurs hôpitaux et leurs universités. L'administratrice B envisage de partager ses activités avec d'autres administrateurs d'hôpital dans son groupement hospitalier de territoire ; le Docteur R se coordonne avec des facultés de médecine en Côte d'Ivoire et à Madagascar pour que leurs étudiants puissent participer à ses formations ; et le Docteur M travaille de différentes manières avec le gouvernement chinois. On peut constater qu'ils s'organisent en réseau pour couvrir plus de territoires spatiaux et sociaux.

### *3,3 : L'accueil des médecines complémentaires : une démarche paradoxale*

Mes résultats montrent deux critères pour que les pratiques complémentaires soient acceptées en tant que légitime pour entrer dans les cadres de la médecine conventionnelle :

- atteindre une « masse critique » de visibilité dans la société,

- entrer dans des circuits financiers qui les promeuvent (formations, remboursements, subventions de gouvernements étrangers comme pour la médecine traditionnelle chinoise, paiements des clients pour les traitements et surtout pour des formations...)

L'ostéopathie est donnée à titre d'exemple d'une pratique complémentaire qui a atteint une masse critique de visibilité et un nombre suffisant de personnes prêtes à payer pour des formations privées que le gouvernement a été contraint de réglementer (cf. thèse en anglais, pp.200-1) ; même si elle n'est pas toujours remboursée, l'ostéopathie est considérée comme faisant partie du « domaine de la santé ». Elle est pratiquée dans des hôpitaux, par des médecins, et il existe des DU et des DIU en ostéopathie dans certaines facultés de médecine. En outre, les syndicats ostéopathiques « travaillent à structurer l'ostéopathie dans des hôpitaux en créant un statut pour les employés qui permettrait de placer plus de professionnels ostéopathes non médecins » (Président D, interview 2017).

Le Docteur R, administrateur d'un DU en médecines complémentaires dans une faculté de médecine, explique comment ce processus s'est déroulé :

> « Des écoles se montaient […] et le Ministère est devant le dilemme suivant : 'soit on crée un diplôme- mais ça va coûter une fortune à l'État- soit on laisse des écoles privées et les gens vont payer pour s'inscrire dans ces nouvelles formations'. Voilà. Et l'attitude des français, qui est de ne pas payer ou seulement très peu pour suivre des études universitaires- parce que […] ça coûte à peu près rien les premières années d'université en France- cette attitude n'existe pas pour l'ostéopathie, les gens sont prêts à payer 1000 euros 2000 euros 3000 euros par an s'il le faut. Donc […] le Ministère de Santé et je pense aussi le Ministère en charge de l'enseignement […] ont à superviser la formation ou à donner un cahier des charges et voilà » (2017).

Pour acquérir une certaine légitimité, des collectifs se regroupent, comme des fédérations, des syndicats, et d'autres réseaux qui développent leur visibilité dans des colloques, des congrès, des salons où des ateliers de démonstrations pour conquérir un public toujours intéressé aux frontières du soin et du bien-être. Ils travaillent à rentrer dans le Répertoire National des certifications Professionnelles pour accéder à une structure reconnue légale, leur apportant des financements pour des formations par lesquelles ils promeuvent leur pratique. S'ils rencontrent trop de résistance au niveau français, alors ils peuvent sauter un étage et participer aux manifestations de niveau international. Une structure européenne étant toujours plus importante qu'une structure plus locale.

Certaines pratiques qui partagent des conceptions compatibles se regroupent pour tenter d'atteindre une masse critique comme le regroupement de kinésiologie et naturopathie, fleurs de Bach etc. Un membre d'un syndicat pour la kinésiologie, interviewé en 2015 explique leur esprit commun et leurs démarches collectives sur le plan européen :

> « Nous avons fait une démarche […] sur le rôle et la reconnaissance de la naturopathie en Europe. Et donc nous avons fait un gros travail […] pour monter un cursus européen […] où il pourrait y avoir des passerelles entre la naturopathie et la kinésiologie. En fait, aujourd'hui il y a de plus en plus des naturopathes qui choisissent la kinésiologie comme technique complémentaire dans leurs pratiques […] il y a d'autres techniques aussi, par exemple la réflexologie, l'iridologie etc. Donc la kinésiologie entre dans une certaine manière dans ce cadre de leurs pratiques opérationnelles et donc ça veut dire que dans ce genre de cursus une personne pourrait commencer ses études de naturopathie dans une école, venir faire un cursus de kinésiologie et revenir ensuite et continuer à pratiquer, voilà. Ce sont des passerelles on va dire, avec des niveaux d'équivalences des diplômes obtenus » (Kinésiologue R, 2015).

### *3,4 : L'émergence d'auto-organisation par les clients et patients*

De leur côté, les clients et les patients s'organisent aussi en réseaux d'influence et créent des événements et des structures dans ce sens. Je présente des cas provenant de mes observation-participantes faites auprès de l'Association « Un Sourire pour l'Espoir » et auprès des personnes handicapées moteurs et leurs aidants (cf. thèse en anglais, pp.208-10).

Selon la présidente de cette association, leur objectif est de sortir les patients et leur entourage « de l'isolement qui résulte de leur exclusion sociale » (2015). Pour ce faire, l'association

rassemble des informations sur des pratiques complémentaires avec des bonnes réputations et puis elle facilite leur accès aux patients atteints d'un handicap moteur. En expliquant la raison de la création de l'association « Un Sourire pour l'Espoir », la présidente m'a donné l'exemple suivant:

> « Par exemple, j'ai entendu de bonnes choses sur un thérapeute brésilien qui vient occasionnellement en France, mais c'est 70 euros par session et ça c'est trop cher. Donc, je veux mettre diverses techniques ensemble pour un très bon prix. Comme ça, même les familles qui n'ont pas de grands moyens peuvent avoir accès à différentes pratiques. Une fois que nous avons commencé à pratiquer, nous pouvons faire des recherches et ensuite nous pouvons essayer de faire reconnaître ces pratiques en France » (2014).

Pour ce faire, « Un Sourire pour l'Espoir » rassemble des praticiens complémentaires, souvent originaires de différents pays, dans des lieux de l'association qui leur permet de faire des consultations avec les membres de l'association. Ce type de stratégie d'auto-organisation est d'autant plus active auprès des personnes dont la situation de vie touche une frontière institutionnelle, comme c'est le cas pour les personnes en fin de vie, ou pour les malades chroniques ou pour les personnes atteintes de maladies orphelines et on voit apparaître des groupements de « patients experts » qui entrent en communication avec les médecins et autres représentants du milieu médical conventionnel pour participer aux soins et faire connaître leurs connaissances particulières du vécu de leur maladie ou de leur situation; leur intention est de collaborer avec la médecine et de participer à son évolution.

Lorsque des relations participatives entre patient et médecin sont perçues comme difficiles par l'un des deux, mon travail de terrain indique que les patients sont disposés à essayer des soins complémentaires. Par exemple, un représentant d'Eurordis, un réseau européen de défense des droits des patients atteints de maladies rares, m'a dit que face à l'échec thérapeutique les patients se servent des pratiques complémentaires :

> «Il existe d'autres situations dans lesquelles la maladie est si grave et le pronostic si sombre que même si l'efficacité du soin complémentaire n'est pas évaluée, ou qu'il peut même s'avérer dangereux ou pas efficace, les gens essaieront quand même, même si cela a un coût énorme […] Nous ne savons pas exactement dans quelle mesure les gens sont disposés à faire tout ce qu'ils peuvent […] et [les patients atteints de maladies rares] ont répertorié une quinzaine de types de soins différents qui ne sont pas du tout évalués par les médecins eux-mêmes […] ou qu'ils ne veulent pas prescrire mais les patients y ont toujours accès et on se rend compte que c'est le cas dans beaucoup, beaucoup de maladies rares » (2014).

La présidente d' « Un Sourire pour l'Espoir » m'a dit la même chose ; les patients avec des maladies difficiles sont prêts à essayer des pratiques complémentaires quand ils atteignent les limites de la médecine conventionnelle. C'est pourquoi ces deux organisations travaillent activement à la création d'un réseau pour leurs patients afin de faciliter leur accès à des informations fiables par rapport aux différentes options thérapeutiques. Selon les deux interlocuteurs, il s'agit d'une étape importante à franchir pour que les patients puissent identifier et accéder aux pratiques complémentaires en toute sécurité.

Le chapitre s'achève avec l'identification des modèles émergents que j'ai trouvés dans les dynamiques autour de l'intégration de la médecine complémentaire en France. Ces pratiques complémentaires se font reconnaître spécifiquement par : l'auto-organisation ; la structuration de sa visibilité par ses formations ; et l'utilisation du niveau international. Toutes ces

dynamiques, qui caractérisent ce « complex adaptive system » imbriquent les actions des personnes ou acteurs sociaux, fédérations, associations, et lobbies.

# Chapitre 4 : Les tendances dans le système sanitaire français et les dynamiques de l'intégration des médecines complémentaires

Le chapitre 4 souligne quelques tendances actuelles en matière de santé publique en France ; notamment la présence accrue de maladies chroniques et de ce qui peut être identifié comme un malaise croissant dans la société. Selon mes interlocuteurs, ces tendances nourrissent une réorientation sociétale vers la notion de « bien-être » et, par conséquent, un intérêt grandissant dans les médecines complémentaires. Afin de mieux comprendre la résistance à l'intégration des médecines complémentaires dans un tel contexte social, ce chapitre met en lumière ce que les interviews ont identifiées comme des spécificités de l'idéologie française façonnant les contours de la relation conventionnelle-complémentaire. L'homéopathie est présentée comme un exemple de l'interaction de ces tendances.

## *4,1 : Les impasses du système sanitaire français*

Il s'occupe de la santé de la population qui vieillit en contractant de plus en plus de maladies chroniques, (diabète, maladies cardiovasculaires, neuro-dégénératives...) dans un environnement alimentaire et physique de plus en plus pollué générant d'autres maladies (obésité, asthme, cancers...). Cette évolution nécessite des prises en charge globales incluant des parcours de soins pluridisciplinaires et à long terme.

Une littérature abondante dénonce de nombreux problèmes dans le système sanitaire français, venant de différentes institutions (revues académiques, administrateurs des hôpitaux, médias professionnels et grand public...) Les problèmes financiers, les déserts médicaux, l'inégalité d'accès aux soins, l'insuffisance de personnels, le manque de coordination entre les différents intervenants... figurent parmi les principaux problèmes. L'organisation française qui sépare le médical du médico-social constitue une faille majeure dans la capacité à prendre en charge la personne dans sa globalité et dans son parcours de vie. L'hôpital par exemple prend en charge un problème organique puis renvoie la personne sans connaître sa situation sociale, sans se soucier de savoir si elle est SDF, en difficulté etc. (cf. thèse en anglais, p. 185) L'ancien ministre de la santé que j'ai interrogé, souligne qu'il faut prendre en compte l'état de fragilité des personnes qui ont alors besoin d'un **accompagnement social** et parfois à long terme. Cela signe une défaillance actuelle des missions hospitalières qui ne peuvent répondre à ces soins.

Cet accompagnement social se trouve plus facilement dans les démarches des médecines complémentaires qui à travers un suivi de la personne peuvent maintenir une vigilance et un dispositif de prévention. D'autant plus qu'elles peuvent réorienter les motivations de ces malades vers des objectifs de bien-être, en leur laissant espérer un avenir positif et de nouvelles attentes de la vie future. (cf. thèse en anglais, p.229)

Les réformes structurelles du système sanitaire français sont analysées dans ce chapitre et interprétées comme une réponse locale, française aux tendances mondiales de diversification des soins dans la santé publique. Cette analyse éclaire les difficultés qui sont créées par la séparation française entre le « médical » et le « médico-social ». Cette dichotomie est identifiée comme obstacle empêchant l'élargissement du regard médical au-delà de la maladie vers une inclusion de la santé et du bien-être particulièrement en termes de la prise en charge compréhensive à long terme que les maladies chroniques nécessitent.

La notion de la prévention est sondée ainsi que le concept de personne dans sa globalité à travers des citations de praticiens complémentaires concernant leurs définitions de la santé- comprise comme un état d'équilibre entre le corps, l'esprit, et les énergies naturelles. Par exemple, le Docteur Q- un médecin conventionnel avec une spécialité en homéopathie explique :

> « Le bien-être est un équilibre et pour moi il faut mieux stimuler la personne et ses défenses plutôt que de virer ses défenses, ce qui peut provoquer des inconvénients. Prendre un anti-inflammatoire et après avoir un ulcère à l'estomac ce n'est pas gentil, ce n'est pas sympa […] donc finalement on va essayer justement de donner des médicaments pour éviter des effets secondaires et donner un équilibre à la personne. Pour moi il vaut mieux faire aussi de la prévention qu'uniquement des soins. Il y a un proverbe qui dit il vaut mieux prévenir que guérir. Donc pour moi l'équilibre c'est la santé et la force et l'énergie vitale. C'est de stimuler l'énergie de l'organisme de l'individu […] l'énergie est le potentiel d'un individu à réagir devant toutes les situations » (2015).

Ce discours et le recueil d'autres données des praticiens complémentaires dans ce sous-chapitre mettent l'accent sur ce qui peut être compris comme une conception partagée de *l'écologisation du corps*. Dans leurs représentations de la santé, nous voyons une vision du corps avec une intelligence naturelle que différentes pratiques complémentaires cherchent à développer et à harmoniser avec la personne accueillie dans sa globalité. En ce sens, les discussions sur le *corps vivant*, telles que celles données par Andrieu et Burel (2014), constituent une passerelle entre la science du corps et la subtilité de l'intelligence du corps – une intelligence qui met le corps en mouvement avant même que nous ne soyons conscients (2014, p 48).

## *4,2 : Le gap entre santé mentale et dispositifs de prise en charge*

Selon les indicateurs et la littérature, les maladies nerveuses comme la dépression, le stress, l'anxiété, les phobies, l'insomnie.... se développent de façon exponentielle montrant un malaise plus large dans la société. Le système structurellement focalisé sur la maladie n'apporte pas des réponses appropriées, d'autant plus que les autorités médicales comme l'Ordre des médecins restent focalisées sur des missions thérapeutiques en étant incapable d'intégrer un diagnostic social et sociétal. Ainsi la catégorie « bien-être » ou encore le sentiment de sécurité etc., n'entrent pas dans les compétences des médecins. Ce manque d'intérêt pour comprendre les liens à faire entre conditions de vie et santé, notamment santé mentale, crée une niche nouvelle pour les médecines complémentaires (yoga, méditation, sophrologie et toutes les autres).

Depuis une dizaine d'années, l'OMS souligne un accroissement des troubles mentaux comme une part importante de la charge de morbidité globale (Whiteford et al., 2013). Il existe également une littérature française en matière de santé publique qui indique que les problèmes liés à la santé mentale représentent un coût important pour le système de sécurité sociale. Par exemple, en 2015 la sécurité sociale a remboursé 19 milliards d'euros pour des médicaments psychotropes, soit 5 milliards d'euros de plus que les remboursements liés au cancer (Assurance Maladie, 2017, p.13). Selon l'OMS et l'UE, les mécanismes de la mondialisation et leur compression espace-temps sont des facteurs importants qui ajoutent du stress à la vie

dans notre monde hyper connecté (EU-OSHA, 2014). Donc on voit une coévolution du système sanitaire français en tant qu'un système adaptatif complexe dans un environnement mondialisé qui met l'accent sur la nécessité d'adapter la prise en charge des préoccupations croissantes de la population en matière de santé mentale.

Alors que dans la section précédente, nous avons vu qu'il y avait une séparation structurelle entre le « médical » et le « médico-social », nous voyons ici qu'il y a aussi une séparation idéologique entre le « bien-être en matière de santé » et le «bien-être en termes de bonheur ». Par exemple, un conseiller du Ministère de la Santé, Femme politique C, a clairement énoncé cette distinction:

> « Le problème est dans la difficulté à définir le « bien-être » parce que c'est variable selon la personne. La maladie, la santé, le bien-être sont subjectifs et nous devrons distinguer entre le bien-être en matière de santé et le bien-être en termes de bonheur » (2015).

Étant donné que ce discours m'a été cité lors d'une discussion sur la manière dont le ministère sélectionne les thèmes prioritaires pour les politiques de santé publique- ce qui signifie qu'il y consacrera son attention et des ressources financières- nous pouvons constater qu'au-delà des limitations structurelles du regard médical français, il y a aussi une considération idéologique. Selon le représentant de l'Ordre des médecins avec qui j'ai parlé, ce regard structuro-idéologique contribue à la création d'une lacune dans la capacité du système de santé à traiter ce que beaucoup des clients dans les médecines complémentaires ont identifié dans les entretiens, comme leur malaise. Cette hypothèse a été décrite par le représentant de l'Ordre des médecins qui m'a expliqué :

> « Maintenant on parle de la prévention et du bien-être. Les gens veulent tout, comme on dit en France 'vouloir le beurre, l'argent du beurre, et le sourire de la crémière'. Donc ils veulent être en bonne santé, ils veulent être en bonne forme, ils veulent être sereins, ils veulent être heureux et tout ça. Ils exigent tout maintenant les gens, donc du coup, *bah* le médecin- d'abord il est débordé maintenant par les soins habituels- et donc tout ce qui est bien-être il n'a pas du temps pour s'en occuper. Et du coup il y en a d'autres qui ont pris le créneau […] alors il y a des médecines alternatives […] les gens qui traitent les bien portants […] comme disait Knock » (2015).

En d'autres termes, on voit que la Femme politique C et le représentant de l'Ordre des médecins- qui est un des chefs de la section de la santé publique- ont admis que le stress et les troubles de santé mentale constituaient une préoccupation parmi la population française. Néanmoins, ils rejettent tous deux une partie de ces problèmes d'un point de vue de la médecine conventionnelle, estimant que ces malaises sont liés au bien-être. Le représentant de l'Ordre nous dit ensuite que les limites structurelles du système sanitaire créent un espace dans lequel les pratiques complémentaires se développent.

La section fournit diverses citations de mon travail de terrain indiquant qu'un nombre important des personnes souffrant de stress, d'anxiété, de dépression et de toxicomanie recherche diverses formes de pratiques complémentaires. Par exemple, le Chaman C confirme que:

> « Oui, c'est vrai, un grand nombre, la majorité, de mes clients sont angoissés ou déprimés. L'anxiété provient des désirs de l'esprit qui provoquent des problèmes, l'angoisse est l'impuissance qui découle quand on ne réalise pas des choses dans nos

> vies, et la dépression est l'illusion résultante du néant. Tous les gens qui viennent me voir ont des problèmes. Les gens qui sont en bonne santé- heureux et en bonne santé- ne viennent généralement pas vers moi, pourquoi le feraient-ils? » (2016).

Sont abordées ensuite les définitions de la santé qui m'ont été données par plusieurs interlocuteurs avec lesquels j'ai parlé en lien avec la notion de Foucault (1973) de l'autorité du regard médical qui définit les objets qui sont considérés comme légitimes pour figurer au sein du paradigme médical conventionnel. Ainsi nous constatons que la médecine conventionnelle contemporaine en France ne « voit » pas facilement des malaises tels que le stress et l'anxiété. Dans une interview accordée à *Libération*, Bruno Falissard met en lumière des nuances importantes sur ce thème :

> « A un moment donné, il faut bien trancher: à partir de quand y a-t-il un trouble, ou n'y en a-t-il pas? C'est compliqué : qu'est ce qui fait qu'il y a un trouble?... Certains disent que toute souffrance ne doit pas être médicalisée : dans la vie il est normal d'être malheureux, voire de souffrir, par exemple après un deuil ou une rupture sentimentale. Ce serait même un élément essentiel de la vie humaine. D'autres font remarquer que certains sujets endeuillés souffrent terriblement et que, s'ils le souhaitent, il n'y a pas de raison de leur refuser un traitement pour les soulager. Difficile de trancher en fait. Mais ce qui est bien, tout le monde en parle, on en débat » (Falissard cité par Favereau, 9 mai 2013).

Donc on voit non seulement la difficulté nuancée à médicaliser la santé mentale, mais aussi une dynamique de pouvoir entre le médecin et le patient. En effet, les patients peuvent consulter un médecin avec une idée de l'état de santé et du bien-être qu'ils souhaitent. À ce titre, cette section aborde également la notion d'autorité médicale et les nouvelles possibilités d'autonomie offertes grâce aux nouvelles technologies de communication. Cela indique qu'une partie de la croissance de la médecine complémentaire est liée au fait que le public s'intéresse au bien-être dans notre monde stressant. Cette tendance prend de l'ampleur grâce à notre pouvoir de nous informer et de créer de nouveaux réseaux sociaux- c'est un fait qui, selon mon travail de terrain, affaiblit l'autorité absolue de la médecine conventionnelle.

### *4,3 : Comprendre la résistance des autorités médicales à accepter les médecines complémentaires*

En tant qu'américaine, c'est en France que j'ai entendu parler de sectes et de charlatanisme à propos des médecines complémentaires. Le conflit semble tellement exacerbé, que de l'autre côté on parle de « chasse aux sorcières » : le PDG du laboratoire Boiron parle d'un Ku Klux Klan à propos de la chasse à l'homéopathie (cf. thèse en anglais, note de bas de page 81, p.265)

Aux États Unis, personne n'oppose une médecine officielle à des médecines non officielles, le terme de conventionnel ne s'oppose pas à celui de complémentaire, et inversement beaucoup de médecines complémentaires en France font partie du système général des soins.

Dans les entretiens, les personnes ont parlé de la France comme d'un pays historique, conservateur, représentant la « vieille Europe » sur le déclin. Le système démocratique que l'on nomme souvent à l'image d'une monarchie perdue souligne la crispation de la classe

dominante pour tout gérer, contrôler et soumettre les administrés sans être capable de susciter leurs avis ni d'entendre leurs voix. Mes interlocuteurs parlaient d'une sclérose collective propre à une régression sur l'image d'une identité triomphante perdue. Selon le Docteur J :

> « Je pense que notre société s'accroche à son passé, donc c'est une société décadente parce qu'elle n'accepte pas de mourir pour se transformer. C'est un ego une société, comme un ego collectif qui ne veut pas lâcher parce qu'il croit qu'il ne peut s'identifier qu'à lui-même, donc il y a plein des nouvelles choses qui émergent, il y a plein des choses nouvelles, mais l'ordre ancien ne veut pas se nourrir de nouveau pour se rajeunir. Les pouvoirs de roi pendant la République ils ont été récupérés, ils ne sont pas aboutis, ils ont donné une autre forme une autre allure, mais les choses essentielles sont toujours là. Il y a ceux qui obéissent et ceux qui dirigent » (2014).

***Élucidations autour de ce blocage :***

Cela implique que la résistance actuelle contre la médicalisation des pratiques complémentaires est liée, en partie, aux vestiges historiques toujours présents dans la mémoire sociale française. La France s'est fait une spécialité, déjà au XIVe siècle, d'opposer la médecine officielle aux charlatans, sorciers, guérisseurs traditionnels en utilisant l'autorité de l'église pour affirmer l'hégémonie de l'autorité médicale. C'est donc sur une dynamique de terreur que la médecine officielle s'est fondée à travers des chasses aux sorcières et les répressions de l'inquisition qui durent jusqu'au XIXe siècle. C'est comme si une mémoire historique continuait de fonctionner dans les formes d'autorités françaises. L'identité française s'étant aussi crispée sur le cartésianisme comme spécifique à une nation rationaliste, positiviste au XIXe siècle, et profondément idéologique par rapport aux USA, n'ayant pas investi l'argent comme une divinité nouvelle.

Mes entretiens sur ce sujet mettaient en évidence la conception de Jonathan Friedman de l'entrelacement de l'histoire avec des positions sociales (cf. thèse en anglais, p. 267). Cela indique que la mémoire historique décrite ici peut être considérée comme étroitement liée à la position sociale des médecines complémentaires dans la France contemporaine. Selon Friedman (1992) cette mémoire historique influence « les conditions d'existence et les formants de l'identité espaces ou habitus » (p. 194).

Un autre aspect apparu au cours de mon travail de terrain montre l'habitus français de toujours justifier leur propos en faisant référence à la nature « scientifique » de la langue française. Cet élément a été souligné par mes interlocuteurs comme une façon de maintenir la distinction entre la médecine conventionnelle et les médecines complémentaires. Nous avons vu au chapitre 2 que cela était utilisé comme une stratégie visant à mettre l'accent sur la séparation des deux médecines. Mais dans ce contexte, nous voyons également que cela peut être interprété en tant que forme d'une résistance à l'empiétement des médecines complémentaires dans les domaines de la médecine conventionnelle.

L'un des meilleurs exemples de cette résistance a été mis en lumière lors de mon observation participante à la réunion de l'OMNC à Nice. Cette réunion d'environ 30 personnes a rassemblé des experts conventionnels et complémentaires. Il s'agissait de discuter la problématique suivante : « Y a t-il de la place pour une médecine complémentaire dans les facultés de médecine françaises ? » Cinq orateurs ont été invités à répondre à cette problématique incluant un doyen d'une faculté de médecine, un médecin qui a créé un groupe de réflexions sur les médecines complémentaires, un professeur qui gère une plateforme de recherches sur les médecines complémentaires, un neuro-radiologue qui fait des recherches sur la relation

neuroscience-hypnose, et un médecin chinois. Pendant leurs discours, tous les cinq ont souligné la difficulté sémantique entourant les médecines complémentaires. Plus précisément, ils ont tous déclaré que les médecines complémentaires ne pourraient pas être facilement intégrées dans les facultés de médecine françaises du fait qu'elles n'avaient pas de définitions suffisamment délimitées.

Par exemple pendant les échanges de la réunion, le Docteur T, un chirurgien et professeur universitaire, a déclaré que « tout commence avec la sémantique […] le problème est que nous avons besoin de créer des terminologies communes ». Le Neuroradiologue R a soutenu cette affirmation en disant qu'il était nécessaire de disposer d'une « précision du langage » pour l'hypnose. Même le Médecin Chinois S a convenu qu'il n'y avait pas de « langage commun » permettant la « communication entre spécialités ».

Selon ces experts, le plus grand blocage empêchant l'intégration des médecines complémentaires dans les facultés de médecine est que cette catégorie englobe un grand nombre de pratiques diverses, la plupart avec des variations internes substantielles, qui les rendent quasiment impossible à définir « scientifiquement ». La méditation est un bon exemple de ce problème - le terme « méditation » comporte de nombreuses versions différentes de pratiques méditatives telles que la méditation zen, la méditation de pleine conscience, la méditation transcendantale, le scan du corps, la relaxation progressive, etc. - Chacune de ces versions implique des protocoles, des champs de focalisation, et des objectifs différents, ce qui entraîne des résultats variés. En ce sens, même si toutes ces pratiques sont regroupées sous le nom de « méditation », elles constituent à bien des égards des pratiques distinctes ayant des racines culturelles différentes. En conséquence, il devient difficile de mener des recherches scientifiques et d'élaborer des cours universitaires rigoureux nécessitant la normalisation d'une telle diversité des pratiques parmi les médecines complémentaires. Les travaux de Jon Kabbat Zin et du psychiatre Christophe André, militant pour « la méditation de pleine conscience » ou de conscience présente, tentent de résoudre ce problème.

Dans cette optique, on approfondit notre réflexion sur la « guerre sémantique » identifiée au chapitre 2, et les divisions entre des termes tels que « le traitement » des « patients » (médecine conventionnelle) et «les thérapies » pour des « clients » (médecines complémentaires). Nous voyons que même si dans mes entretiens ces différences ont été justifiées par des médecins conventionnels en tant qu'approche scientifique permettant de distinguer les médecines complémentaires, il s'agit plutôt d'une classification arbitraire en pratique. Tel est le cas, par exemple, pour des domaines paramédicaux aux bords ambigus comme la psychologie. L'Hypnothérapeute A- un psychologue qui pratique un mélange de psychanalyse, d'hypnose, et de Programmation Neuro Linguistique- constate que parmi les psychologues la différence entre un « patient » et un « client » n'est ni claire ni scientifique:

> « C'est un grand débat, on utilise les deux. Il y a certains de mes collègues qui n'utilisent que le mot patient et d'autres qui disent, '*Ah* quand c'est lié à un acte qui sera suivi avec un médecin là on peut parler d'un patient.' Quelqu'un qui vient […] pour un problème de stress, *bah* c'est un client […] c'est dans le langage. Si on se considère professionnel dans le domaine de la santé on parle de patients, mais quand je fais de l'analyse pure et dure je ne parlerais jamais des patients je parle des clients […] si vous allez sur les forums professionnels vous allez voir que certains parlent des patients, certains parlent des clients, certains utilisent les deux mots en permanence, mais à partir de quel moment est-ce qu'on parle des clients et à quel moment on parle des patients ? *Bah*, je ne sais pas ! » (2015).

Ces conflits illustrent parfaitement la théorie de Pierre Bourdieu (1979), concernant les conflits des acteurs sociaux qui partagent un même champ professionnel ou plus largement culturel et rivalisent pour atteindre seuls les sommets de la dominance. Les différentes stratégies de promotions sociales et économiques concernent également l'investissement dans ce que Pierre Bourdieu appelle 'le capital culturel' et ‘le capital économique'. Mais la nouveauté concerne la dynamique promotionnelle des médecines complémentaires qui progressent dans l'échelle du capital culturel et parfois même du capital économique, ce qui constitue une réelle menace pour la médecine conventionnelle.

Dans ce contexte, nous constatons que l’accent mis sur les distinctions sémantiques fait de la médecine complémentaire un « autre » culturel qui n’est pas accepté comme légitime pour partager le capital culturel qui est incarné dans la langue de la médecine conventionnelle. Selon le Docteur J, un médecin qui pratique également l'acupuncture, l'homéopathie et la médecine anthroposophique:

> « Il faut faire attention, ceux qui ont le pouvoir et qui font des décisions ont une influence qui est énorme, parce que c’est relayé par les médias et des émissions médicales de télévision. C’est dès qu’on sort de la science- du scientisme plutôt- qu’il y a un regard souvent suspicieux et ironique, dédaigneux par rapport à tout qui est ‘autre’ et ça déclenche des offensives beaucoup plus radicales. On met l’accent sur des sectes et là il y a des mesures judiciaires et de l’intimidation, des procédures etc. qui sont assez typiques de la France » (2014).

Nous voyons donc que la relation entre la médecine conventionnelle et les médecines complémentaires en France peut être considérée comme une lutte pour assurer l’hégémonie culturelle que Pierre Bourdieu (1979) décrit en termes de la transformation de petites différences en une hiérarchie de capital culturel et de capital économique. Dans les réunions comme celle de l’OMNC on voit que les praticiens de la médecine conventionnelle utilisent la sémantique pour justifier la séparation des médecines conventionnelles et complémentaires en mettant l'accent sur le caractère « non scientifique » de cette dernière catégorie. Ainsi les pratiques complémentaires sont situées plus bas dans la hiérarchie culturelle avec un accès limité au capital culturel « sérieux » (langue et terminologie) et au capital économique (prix de la pratique que le client paie, remboursements ou pas, accès aux fonds de recherche...).

### *4,4 : L’usage de l'autorité médicale française contre les médecines complémentaires et la résistance de ces dernières*

Cette section examine le cas de l'homéopathie et la polémique actuelle entourant la mise en question de son remboursement par la sécurité sociale. On commence par présenter des preuves démontrant l’assimilation de l’homéopathie dans la société française:

- L’homéopathie est pratiquée en France depuis environ 200 ans
- Depuis 1965, les remèdes homéopathiques sont inscrits dans la pharmacopée française qui implique des instructions détaillées sur leurs préparations et usages

- Selon le représentant de l'Ordre des pharmaciens que j'ai interviewé, l'homéopathie « est un médicament […] il est enregistré comme étant et pouvant modifier ou corriger des maladies » (2015).
- Au moment de la rédaction de cette thèse, une vingtaine de facultés de médecine offrent un DU ou un DIU en homéopathie et il a été enseigné dans les facultés de pharmacie depuis environ trente ans.
- L'homéopathie est acceptée comme une pratique légitime par l'Ordre des médecins. Les médecins sont autorisés à faire état de leur titre d'homéopathe.
- L'homéopathie correspond à ce que cette thèse a identifié comme deux critères clés pour qu'une pratique complémentaire soit envisagée comme légitime. Elle a une masse critique de visibilité et bénéficie du financement (remboursement de la sécurité sociale). La vente de médicaments homéopathiques en France a généré plus de 300 millions d'euros pour les laboratoires Boiron en 2014 et ses produits ont été utilisés par plus de 50% de la population française en 2014 (cf. thèse en anglais, p.275).

Néanmoins, une tribune cinglante signée par 124 médecins condamnant la médecine complémentaire en général et l'homéopathie spécifiquement a été publiée le 18 mars 2018 dans le journal quotidien, *Le Figaro*. En dénonçant l'homéopathie et les médecines complémentaires comme « des pratiques qui ne sont ni scientifiques, ni éthiques, mais bien irrationnelles et dangereuses », ces médecins demandaient l'annulation de tous les points énumérés ci-dessus. Cela a déclenché un affrontement mettant des syndicats homéopathiques sur la défensive qui les a conduits à dénoncer les premiers signataires de la tribune. La polémique a pris une telle ampleur, que la Ministre de la Santé demandait à la Haute Autorité de Santé (HAS) d'étudier scientifiquement l'efficacité de l'homéopathie et de faire une recommandation sur la continuation, ou pas, de son remboursement. En effet, comme me l'a expliqué le représentant de l'Ordre des pharmaciens, « les médicaments homéopathiques sont traités séparément car il n'y a évidemment aucune randomisation qui fonctionne » (2015). Cela signifie que les médicaments homéopathiques n'ont jamais été soumis à la même procédure d'évaluation rigoureuse que celle utilisée pour les produits pharmaceutiques vendus dans les pharmacies françaises.

Alors que la tribune reproche à l'homéopathie d'être « coûteuse pour les finances publiques », la documentation relative à l'utilisation de l'homéopathie et son remboursement indique que selon plusieurs médecins les remboursements représentent moins de 1% des charges totales de la sécurité sociale, et que les clients de l'homéopathie tombent moins malades que le restant de la population. Par exemple, le Docteur R, un psychiatre qui est chef d'un service de douleur dans un hôpital public et qui administre un DU généraliste en médicaments complémentaires nous dit que:

> « Il est hors de question d'adhérer ou de rejeter des procédures thérapeutiques qui sont largement utilisées ou qui produisent des effets. Pourquoi l'assurance maladie a-t-elle remboursé en partie les médicaments homéopathiques ? Parce que l'assurance maladie, la sécurité sociale, disaient 'Si les gens utilisent des traitements homéopathiques qui ne coûtent pas très cher, ils utiliseront peut-être moins des médicaments qui coûtent très chers et que nous devrons rembourser,' donc c'est un intérêt économique » (2017).

On voit également des témoignages tirés de plusieurs de mes entretiens, tels que ceux des représentants de l'Ordre des médecins et de l'Ordre des pharmaciens, incluant des discours qui

soulignent les témoignages de ces praticiens sur les preuves qualitatives positives concernant l'efficacité des médicaments homéopathiques. Par exemple, selon un représentant de l'Ordre des pharmaciens :

> « J'ai des dentistes partout autour de la pharmacie, ils me disent que quand ils prescrivent l'arnica et qu'ils font une extraction à la main des dents de sagesse, ils me disent 'bon, on a moins d'hématomes et ça saigne moins'. Ils sont formels et je les connais, ils sont des praticiens honnêtes, pas convaincus particulièrement par l'homéopathie. Donc on est incapable de dire comment ça marche, mais ils me disent 'on t'assure, on fait prendre la dose la veille et le matin avant qu'on fasse l'anesthésie et puis après l'extraction c'est mieux'. On ne sait pas pourquoi […] mais selon les gens ça fonctionne » (2015).

Malgré les évidences qualitatives sur l'efficacité de l'homéopathie qui m'ont été données par différents professionnels de santé, les discours entourant la polémique actuelle de l'homéopathie dans les médias sont forts, la nommant « dangereuse », « ésotérique », et les « fake médecines » utilisée par « des charlatans en tout genre qui recherchent la caution morale du titre de médecin pour faire la promotion de fausses thérapies à l'efficacité illusoire » (Collectif Fakemed, 2018).

Donc, pour mieux comprendre la puissance de si peu de médecins contre une pratique utilisée par un si grand nombre des français, nous explorons les notions de Foucault (1974) relatives à la réglementation médicale et la médicalisation de la société française. Foucault définit la réglementation médicale comme « un système d'observation de la morbidité… et de l'enregistrement au niveau étatique des différents phénomènes épidémiques et endémiques observés » (p.18). En outre, il souligne l'importance de la normalisation de la pratique et du savoir médical, particulièrement en ce qui concerne la formation médicale et l'attribution des diplômes.

Dans ce contexte on constate que ce monopole du pouvoir médical est toujours en place donnant forme au discours contre les médecines complémentaires. Encore une fois, on voit la relation conventionnelle-complémentaire en termes d'une lutte contre l'hégémonie médicale sur le capital culturel et le capital économique. Cela a été mis en avant par le Praticien de Shiatsu C, président d'une association pour le shiatsu :

> « Les gens maintenant, je suis effrayé, ils ont un véritable garde-manger de médicaments et ils consomment des médicaments […] et le shiatsu combat ça. Donc déjà on fait des concurrences effectivement aux kinésithérapeutes et aux médecins, on fait des concurrences aux pharmaciens et comme toutes les techniques de santé- *bah* on ne joue pas le jeu, on ne joue pas le jeu de la consommation. Bon, ça ce n'est pas bien, on comprend bien qu'il faut consommer. C'est un peu politique ce que je vous dis là mais, ce n'est pas complètement faux » (2015).

Les médecines complémentaires partagent une vision commune globale ou holistique qui est fondée sur la connexion entre le corps, l'esprit et la Nature (selon des sens multiples : terrain, environnement, vibration, énergie cosmique etc.) Ce mode d'appréhension de la « réalité » reste encore un « savoir rejeté », ostracisé comme « autre » sur le plan culturel selon Hanegraaff (2015 cf. Thèse en anglais, p. 267). La polémique autour de l'homéopathie montre la pertinence de l'analyse d'Hanegraaff. On l'a vu dans la discussion du chapitre 1 par rapport à « la définition négative » des médecines complémentaires dans la façon de regrouper dans une seule catégorie « complémentaire » au singulier, une incroyable diversité de pratiques.

Cela crée une image de désordre, toutes ces différences dans une seule ‘boîte’ conceptuelle, ce qui ne permet pas de déterminer les singularités de ces différentes thérapeutiques. De plus, dans la section précédente nous avons aussi vu des discours indiquant que ce regroupement positionne les pratiques complémentaires à l’écart, ce qui ne leur permet pas d'accéder à des recherches scientifiques et à des enseignements universitaires, bien qu'ici ou là, sous des initiatives personnelles, certains enseignements sous forme de DU s'organisent. Ces DU sont-ils des sortes de « cheval de Troie » qui ont pour projet de modifier l'enseignement universitaire de la médecine officielle de l'intérieur ?

Dans cette dernière partie, nous voyons que le discours actuel concernant l'homéopathie démontre que si une pratique n’est pas strictement définie comme un composant de la médecine conventionnelle en France, elle peut être facilement rejetée, comme effet placebo ou tout autre suspicion due à son appartenance identitaire à la catégorie des « médecines complémentaires ». Pour l'homéopathie cela signifie que, même si elle est présente depuis plus d'un siècle en France et utilisée par plus de la moitié de la population ; largement prescrite par un nombre considérable de médecins français croyant à son efficacité ; une centaine de médecins ont la possibilité de la faire marginaliser en alléguant le manque de preuves scientifiques selon la méthodologie classique. Compte tenu de cela, dans le débat sur l'homéopathie nous pouvons voir que la médecine complémentaire en tant que catégorie est perçue en France comme une « deuxième façon de penser », de se comporter et de consommer. Cela positionne les médecines complémentaires comme potentiellement dangereuses, comme menaces à l'ordre social général et au monopole de l'autorité médicale tenue par l'institution de la médecine conventionnelle dans la société française contemporaine.

Cette dynamique conflictuelle, très instable et au « coup par coup » doit être étudiée sur le plan sociologique et du point de vue de l’anthropologie culturelle comme une lutte non seulement idéologique, mais aussi politique pour maintenir la dominance d'une certaine médecine conventionnelle comme monopole exclusif de domination d'un seul système de soin, mais aussi d’une lutte économique qui met la médecine dominante en situation de rivalité avec d'autres prétendants ! La pression des marges exercée par la créativité des nouveaux thérapeutes, alliée à l'engouement des clients pour expérimenter des soins sur d'autres horizons introduit du « bruit » dans le système hégémonique des médecines conventionnelles qui sont devant le dilemme, soit de se faire dépasser et même déprécier sous certains aspects, soit réussir à intégrer les formes complémentaires que les patients réclament, au prix de reconnaître l'intérêt de certaines médecines complémentaires concurrentes. Nous voyons ainsi que la relation paradoxale entre la médecine conventionnelle et les médecines complémentaires dans la France contemporaine est prise dans une lutte des acteurs sociaux, créant des systèmes de défenses et des systèmes d'alliances extrêmement mouvants et instables qui va bien au-delà d'une question de rationalité ou de responsabilité.

# Conclusion

Cette thèse conclut par quelques réflexions sur la présence significative des médecines complémentaires en France et son intégration grandissante dans les milieux médicaux malgré les perceptions négatives qui sont associées à sa pratique et l'absence d'un encadrement législatif.

La conclusion souligne les défis politiques qui bloquent une acceptation officielle des médecines complémentaires, liés aux spécificités idéologiques et structurelles du système sanitaire français. Pourtant, le développement des médecines complémentaires est interprété comme relié aux mécanismes de la globalisation et donc comme une instance de la coévolution. Dans cette optique, cette thèse conclut qu'il semble probable que les médecines complémentaires vont continuer à s'épanouir malgré la résistance politique et médicale des lobbies dominants. Considérant les défis sanitaires et financiers français, les médecines complémentaires sont interprétée par l'auteur comme une opportunité de mieux soigner la population et d'aider au contrôle des dépenses sanitaires. En outre, au regard de l'intérêt international pour les médecines complémentaires, la France aurait la potentialité de devenir leader dans l'organisation et la reconnaissance de ces systèmes de soins qui ont tissé des réseaux dans le monde entier.

## Duxième Partie: Thèse en Anglais

# An anthropological analysis of the relationship between conventional and complementary medicine in contemporary France

## Introduction

The following thesis is the fruit of three and a half years of ethnographic fieldwork conducted in contemporary France; largely in and around the Paris area, but also in various other parts of France. This fieldwork consisted of both qualitative interviews and several different types of participant observation. Following the initial data collection, all of the results were dissected and regrouped according to theme, which allowed for several unexpected patterns to emerge from the chaos of a fairly expansive anthropological fieldwork. While the interviews were open-ended they were also semi-directed, including a set of questions that were asked of all participants. The first question that was routinely asked in every interview was: "Who are you, where do you come from, and how did you end up here?" When I asked Doctor R this question, before responding he laughed and said, "*Ah* yes, so you want to know who you are dealing with!" Indeed, this question was asked precisely as a means of getting into the "deep background" of the participant in order to have a better understanding of the perspective informing their responses. As such, I feel that as the researcher it is only fair that I offer my readers the same courtesy by responding to this initial question.

My name is Laurel McEwen and I am an American who has been living and studying in France for the past ten years. I have a joint academic background in International Relations and Anthropology. I am also the daughter of a PhD psychologist and an ear, nose, throat, head, and neck surgeon who retrained as a forensic psychiatrist during my youth. As a result, I grew up immersed in medicine and mental health. When I was a child not only did my father stitch up kids from our neighborhood at our kitchen table, he also left me waiting in the doctors' lounges, nursing stations, and cafeterias of the various hospitals he worked in. In order to pass the time, I would study and trace the lines of muscle groups, veins, and organs in anatomical diagrams and play with stethoscopes, tongue depressors, teaching skulls and skeletons. My mother would take me along to her lectures on psychology and addictionology and would regularly give me lectures on the genetics and dangers of alcoholism. In my later years, dinner conversation frequently involved my parents' discussion of the various cases they had encountered in their private practice and long car rides often involved my father explaining the intricacies of schizophrenia, personality disorders, anxiety, depression, and how various medications worked on brain chemistry. Any friend that came over to our house for dinner was psychoanalyzed without their awareness, and afterwards to my horror, my parents would always give me the conclusions of their analysis. During my university years, I became a regular stand-in receptionist for my father's private practice, which gave me first-hand experience putting theory into practice with his patients and the pharmaceutical representatives that came to his office. Even now, every time I go home for the holidays, I spend my Saturday mornings accompanying my father to the county jail and listening to his review of cases, drug recommendations, and the occasional session with a prisoner-patient. As a result, I have always been and remain fascinated with medicine, the body, the mind, and medical practice.

Up until I lived in France, I did not have any experience with complementary medicine. My understanding of the body and disease was classically conventional and I simply dismissed complementary medicine as crystal-waving, new age nonsense unworthy of my intellectual attention. Then one day, I developed a benign medical problem. It was nothing new and nothing worrisome; I had already been treated for it once before in the United States with a simple out-patient procedure. So, I made an appointment with a French specialist and went in search of treatment. Rather than opting for a surgical intervention, my doctor prescribed antibiotics. Her treatment worked, and several weeks later I was feeling fine.

Nevertheless, eventually the problem reoccurred, so I went back for another round of antibiotics. And then it happened. My doctor declared that she had reached the limits of her treatment options and referred me to a surgeon with the recommendation for a much more invasive procedure than I had undergone in the United States. I pointed this fact out to her and she reacted defensively, becoming irritated. I refused her referral and asked for more antibiotics to control the situation until I could make other arrangements. She became angry, scolded me as if I were a negligent child, refused to give me a prescription for antibiotics, and sent me out into the street tearful and in pain. I was shocked; in the United States no doctor had ever gotten emotional, patronized me, and left me empty-handed and in pain. As can be expected, I eventually ended up in the emergency room. After hours and hours of tests, I realized that the doctor's thoroughness was taking him down a variety of unnecessary side-paths in his diagnostic procedure. As I did not yet have French health insurance and was paying out-of-pocket for my emergency room experience, I attempted to refuse the tests that I knew were unnecessary precautions. As a foreigner, I did not know that French law gives the patient the legal right to refuse treatment at any time. Instead, I felt trapped as the doctor, nurses, and hospital administrators strongly attempted to convince me to stay for tests that I knew I did not need and would have a difficult time paying for. When they left me alone for a moment, I fled; feeling like a thief in the night.

Thus, yet again, I found myself in pain and bewildered by my experience with what felt like a paternalistic and overwhelmingly dominating form of conventional medical authority that I had never encountered before. After speaking with an acquaintance about the situation, she gave me a card for a homeopathic doctor and acupuncturist. I went and was profoundly moved by his gentleness, kindness, and by the attention he paid to my responses to his questions that went far beyond the standard inquiry into my medical history and allergies. I had never received acupuncture or such compassionate care before and was amazed when I was able to walk out of his office upright and smiling after arriving doubled-over and in pain. I was also skeptical about and had never taken homeopathy before either, which led to a conversation with this doctor about his approach, experiences, and philosophy. I was shocked; not only did I learn that there was a radically different way of understanding health and the body that I had never been exposed to before; I also found out that there is a whole community of practitioners in France who share a similar vision. The idea that there was some semi-underground community with some form of shared and seemingly esoteric knowledge sparked my natural curiosity, so I began researching. Ever since, I have been living in both the conventional and the complementary "worlds" in France, exploring their relationship and they way they are represented; this thesis is the result of that research.

In light of my background, in many ways, this research constitutes a personal attempt to reconcile my own conventional and complementary leanings. As such, I made a conscientious effort to get as balanced a picture as possible of the conventional-complementary relationship. To these ends, I conducted open-ended and semi-directed interviews with approximately 100 different individuals on all sides of the conventional-complementary relationship. This research population can be divided into three groups: individuals associated with conventional medicine; individuals associated with complementary medicine; and individuals pursuing a combination of the two.

In the first group I conducted interviews with approximately 38 individuals. Specifically, I spoke with 2 nurses; 3 nursing students; 6 administrators in a Paris-area hospital training school for nurses and nursing aides; 3 doctors of different specialties (obstetrics and gynecology, gastroenterology, cardiology); 2 hospital administrators; 2 heads of services in Paris-area hospitals (maternity, palliative care); 1 clinical researcher; 1

representative of the *Ordre des médecins* and 1 representative from the *Ordre des pharmaciens*, 3 staff-members from public institutions (the Health Ministry, the *Agence Régional de Santé*, and *Agence National d'Appui à la Performance*); 1 representative of Miviludes, an Interministerial anti-sect organization; 1 former Minister of Health; 3 representatives of medical syndicates (for generalists, urgent care physicians, and the *Conférence Régionale de la Santé et de l'Autonomie de Bourgogne*); 1 president of an anti-sect association; 1 director of the French office of a non-government patient advocacy association; 3 professors from French medical schools (in Paris, Nice, and Amiens); 1 founder and director of a university platform for research in non-pharmaceutical interventions; 1 founder of an association promoting the evaluation of complementary therapies; and 2 creators of e-health applications.

In the complementary medicine group, I interviewed multiple practitioners and clients of the following practices: shamanism; Traditional Chinese Medicine, including acupuncture, qi gong, and tai chi; Ayurvedic Medicine; Tibetan Medicine; Prophetic Medicine; exorcism; yoga; homeopathy; Bach Flowers; aromatherapy; naturopathy; phytotherapy; various energetic practices, including reiki, magnetism, and the laying of hands; reflexology; shiatsu; osteopathy; kinesiology; biofeedback and neurofeedback; myotenofasciotomy; hypnosis; neurolinguistic programming; various forms of meditation; sophrology; relaxation; assorted psychocorporal practices, including sacred dance and new age dance; art therapy; sound-based therapies, including healing with Tibetan bowls, drums, chanting, and song; and the ritual practices of various spiritual groups including Daimoku, the sacred feminine, and a full moon ceremony. I interviewed multiple members of two complementary associations: *Un Sourire pour l'Espoir*, an association for motor-handicapped patients; and *Le Souffle Libre*, a hatha yoga association. I interviewed the representatives of various complementary syndicates and federations for the following practices: osteopathy; anthroposophic medicine; homeopathy; kinesiology; shiatsu; and reflexology. Finally, I also interviewed students, professors, and school administrators for private complementary training in the following practices: naturopathy; homeopathy; ethnomedicine; hypnosis; shiatsu; and kinesiology. In total, this resulted in approximately 50 interviews.

In the third, mixed, group I conducted interviews with approximately 20 conventional practitioners who also pursued: homeopathy; Traditional Chinese Medicine; aromatherapy; naturopathy; anthroposophic medicine; hypnosis; yoga; qi gong; tai chi; acupuncture; meditation; and osteopathy.

All of these interviews involved open-ended questions tailored to the individual participants' responses. Nevertheless, all of the interviews were also semi-directed, following a similar structure beginning with a series of introductory questions about their individual background and motivation for being where they were; and including a standard set of questions on the participant's definition of health, definition of illness, conception of the role of the doctor, and conception of the role of the patient. A variety of different questions were then asked depending on the individual participant and their responses. Most of these interviews lasted anywhere from 30 minutes to 90 minutes. Of the total interviews conducted, 40 were recorded and transcribed. For all interviews and especially when recording was refused or not possible, I took detailed notes before, during, and after the interview. Furthermore, 30 of the 40 participants who allowed me to record their interviews also gave me repeated interviews over a period of one to three years. This allowed me to get to know them, to further explore the topics and themes they raised, and to ask questions on their perception of changes in the conventional-complementary relationship.

In addition to the interviews, I conducted several forms of participant-observation. The most intensive was three years spent with a Peruvian shaman practicing in multiple Western European countries. Two and a half of those years were spent acting as a volunteer secretary for his Paris practice taking appointments, welcoming clients, and acting as a translator between the clients and the shaman. Not only did this give me the opportunity to conduct multiple interviews with the shaman, it also allowed me to observe his actions, speech, and behavior over an extended period of time. Over the course of my fieldwork, he explained the history, theory, and practice of his technique to me as well as his reflections on shamanism in general and his background in particular. He also allowed me to practice his technique on his clients.

In addition, acting as secretary gave me first-hand access to this shaman's considerable client list, numbering above 1,400 individuals in France. This gave me the opportunity to interview, observe, and interact with those clients. As such, not only was I able to monitor the general demographics and trends among his client base over time, I was also able to gather information about his clients' medical histories, their motivations for coming to see a shaman, and their progress; giving me incredible access to a considerable number of individual case-histories. Furthermore, my position as an ad hoc translator also allowed me to observe and take part in much of the shaman's interactions with his clients. Over time, I was able to build up my own relationships with many of his repeat clients, which allowed me to delve deeper into their cases, opinions, and experiences with both conventional and complementary medicine. It is of note that I was also able to have comparative experiences with clients due to my acting as secretary for his Belgian practices and my travels with the shaman and his team to practice his therapies in 6 different French cities as well as in Spain, Belgium, and the Netherlands.

Furthermore, I also conducted participant-observation at an association called *Un Sourire pour l'Espoir* (USPE), which offers support and complementary therapeutic options to families with members suffering from motor handicaps. For this part of my fieldwork, I spent time at the USPE consultation center conducting interviews, attending meetings with the association's president and staff, participating in the association's scientific committee meeting, observing consultations with clients, and acting as a translator for one of the association's biofeedback practitioners. This allowed me to observe and conduct interviews with the clients, their families, and the association's staff and practitioners. Over the course of my participant-observation at USPE, the president of the association was actively working to open a therapy center for the association's clients. As such, I was able to discuss the progress as well as the challenges that she faced in the opening of this center, which is now fully operational. Thus, I was able to follow this significant complementary project from conception to implementation, which provided me with valuable insights on the contours demarcating the terrain of complementary medicine in France.

I also conducted participant-observation over a three-year period with a yoga association, *Le Souffle Libre*, during which I attended classes, workshops, and observed the operations of the association's stand at a Parisian trade event. I conducted interviews with the association's president and participants at the association's events and was able to observe the association's staff interact with potential clients and vendors during and after the trade event. Much as was the case for my observations of USPE, this extended observation allowed me to watch *Le Souffle Libre* grow from a recently formed association conducting yoga classes, to a more developed association with multiple staff members, events, more diverse service offerings, and the successful coordination of trips to an ashram in India.

In addition, over my fieldwork period, I also conducted several incidences of participant-observation in the form of various meetings and conferences. Specifically, I attended a closed meeting of the *Agence Regional de Santé* (ARS) in 2014 in the Essonne area, which explained an ARS policy change to local healthcare professionals. I attended a closed pre-conference meeting of the *Observatoire des Médecines Non Conventionnelles* (OMNC) in 2017 in Nice that brought together healthcare professionals and complementary practitioners in a discussion of potential methodologies for studying, regulating, and integrating complementary medicine in France. I attended the conference organized by the CEPS Platform in 2017 in Montpellier as well as the closed workshops following the public event. This brought me into discussions with Canadian and British healthcare professionals and academics concerned with better integrating various forms of non-pharmaceutical interventions into their healthcare systems and research. I attended a conference organized by the *Fédération des Arts Energétiques et Martiaux Chinois* (FAEMC) in 2017 at a Parisian university hospital focusing on the application of *qi* and energetic therapies in relation to pain management. I attended a conference organized by the *Comité pour le Développement Durable en Santé* in 2017 in Paris that was intended for healthcare professionals and hospital administrators interested in the potential of complementary medicine. I attended the Doctors 2.0 & You conference in 2016 in Paris advocating the medical use of new communications technology, social media, and collaborative tools to globalize interactions with doctors, patients, industry, and government. I attended an international forum organized by the Foundation of the Academy of Medicine at UNESCO headquarters in 2018 in Paris focusing on reverse innovation for health with the potential to address French healthcare concerns such as "medical deserts." Finally, I attended and presented my research at a conference organized by the European Society for Health and Medical Sociology in 2018 in Lisbon focusing on emerging paradoxes in health related to rights, knowledge, and trust. During all of these events, I conducted interviews or exchanged with the event's organizers and multiple presenters. Taken together, these events gave me a better understanding of current French healthcare priorities, overall healthcare trends, the potential role and interest in complementary medicine in French healthcare, and the relationship between globalization and the French healthcare system.

On the complementary side, I attended a wide variety of different events from the period 2015-2017, including multiple trade events dedicated to organic foods, dietary supplements, and products; yoga and meditation; and complementary medicine. These events brought together hundreds of industry representatives; numerous product and service vendors; artisans; representatives of complementary associations, federations, and schools; as well as individual complementary practitioners. I took part in various full-moon ceremonies, drum circles, sacred dance classes, shamanic gatherings, workshops, group meditations, and group prayer rituals from different traditions. I also spent a week at a Tibetan Buddhist temple in central France studying healing rituals and discussing health with different Lamas. While at the temple, I was able to meet, interact with, and interview a variety of different complementary practitioners from various parts of France. Over the course of my fieldwork, I also tried many different forms of complementary therapies including acupuncture, homeopathy, shiatsu, shamanic dance, trances, drum healing, sound therapy, reiki, osteopathy, magnetism, and various energy treatments including a healing with an egg. Additionally, I attended multiple exorcisms conducted by different practitioners, and received energetic treatments from the Peruvian shaman. None of these experiences involved psychoactive substances of any kind.

At the end of my fieldwork, I transcribed all of my recorded interviews and gathered all of my field notebooks together. I went over them one by one and identified the themes that

emerged including, but not limited to: the definition of medicine; the definition of complementary medicine; the definition of illness; the definition of health; the definition of well-being; the role of the doctor; the role of the patient; the role of medicine and healthcare practitioners; the acceptance of a practice; channels towards acceptance; the definition of efficacy; the demonization of both sides; the notion of preventative medicine; changes in medicine; changes in complementary medicine; globalization; and the specificity of France, French language, and/or French culture. I then dissected each interview transcription and the notes taken from every fieldwork experience and reorganized them by theme. Not only did this allow me to identify patterns and clusters in my data, it also allowed me to compare the responses of different participants and my observations about different events on a thematic basis. As a result, I was able to identify some trends among my data that I had not anticipated. These trends are the basis of the chapters that follow. Most strikingly, this approach to data analysis brought to light the interrelationship between beliefs, medicine, illness, and healing. As such, throughout this thesis, I have taken an analytical approach that focuses on the cultural embeddedness of medicine in the French context that delimits this study. With this in mind, I feel as though it would be incredibly interesting to conduct a comparative analysis in order to identify the differences and similarities in the conventional-complementary relationship in other countries and cultures; particularly in light of the influence that globalization mechanisms appear to currently have on the developments on both sides of this relationship. For now, however, it is my hope that this analysis brings to light some interesting considerations in terms of the current conventional-complementary relationship in contemporary France.

It is of significant note that my American background directly impacted the themes that emerged during my interviews. This is because many of my interlocutors in all three participant groups explained the "specificity of France" to me including comments on the particularities of French language, French culture, French history, French ideology, and the French mind-set. For example, there was a repeated emphasis on the "Cartesian" nature of French doctors and French medicine as well as on the "scientific" precision of the French language. As such, the analysis in this thesis clearly reflects my understanding and experience as a "foreigner" studying in France as a "cultural other," despite my ten-year residency and both Master's level and Doctoral level education in this country. This gives this thesis its singular approach to the analysis presented.

For the literature review, the analysis that follows is primarily based on Anglophone theory, English translations of French theorists, publications from the World Health Organization, and European Union reports. Much of the historical documents on conventional medicine were obtained during a two-month research period spent at the University of North Carolina, Chapel Hill library. Francophone documents related to conventional and complementary medicine in France were obtained at the libraries of the *Faculté de Médecine, Paris Descartes*; the National Library of France; and the *Fondation Maison des Sciences de l'Homme* in Paris, France. French government reports were collected from various government agencies including the Ministry of Health, the Senate, the National Assembly, the National Social Security, the High Authority of Health, and various government research agencies for medicine, and demographics. Additionally, I read multiple reports from the National Order of Doctors, and the French Academy of Medicine. Various medical studies on different subjects related to this thesis were obtained online from the PubMed database. I also consulted several French doctoral theses concerning specific complementary practices; the reports generated by lobbies and syndicates of both sides; and in articles published in the popular presses such as *Le Figaro*, *La Libération* and *Le Télégramme* among others.

# Chapter 1: Definition of Terms, Theoretical Frame and Literature Review

## *1.1: Definition of Terms- Conventional Medicine*

On November 1st, 1845, a remarkable event in the history of French medicine occurred in the *Hôtel de Ville* of Paris. It was the Medical Congress of 1845, a meeting that brought together 2,000 doctors from all over France along with a significant number of health officers, pharmacists, and veterinary surgeons. Responding to the, "French medical identity crisis," of the time, this meeting formalized the French medical corpus, reformed teaching, reformed medical practice, and established the general organization of the medical profession (Bourquelot, 1979, p. 302). Among the resolutions adopted during this congress was the creation of local medical colleges that were to annually elect and be guided by a medical council, which would maintain the rights of the medical profession, its members, and its professional dignity (British Medical Journal, 1936). Thus, the idea of an "ordinal medical institution" was born in France, formalizing the relationship between, "the medical corpus and society, between the medical corpus and each of its members" (Sauvy, 2004, p.3). This congress was also significant because of the scope of its participants; it gathered so many urban and rural, novice and veteran, exalted and humble practitioners together that it was considered to be have been representative of, "all medical activities" (British Medical Journal, 1936).

This congress is significant in the context of this thesis because it played a fundamental role in the "birth" of conventional medicine. Due to its inherent dichotomy, we cannot discuss the relationship between "conventional" and "nonconventional" medical[1] practices without first exploring the concept of "conventional medicine" and its definition. Curiously, delimiting and defining conventional medicine as a category is far from evident. For example, the "identity crisis" that led up to the highly representative 1845 Medical Congress indicates that conventional medicine is neither a fixed nor a static entity; if it were, its practitioners would not have felt the need to formalize the identity of the "official" medical corpus. Furthermore, an examination of the history of medicine shows that its constitution is historically, socially, politically, philosophically, and technologically contingent. Nevertheless, in the literature 'medicine' is often taken for granted and presented as a fixed monolith and as a single object with various appellations. As such, in this section we will trace the developments in medicine that led to its appellations in the current literature, focusing on its relationship with complementary medicine. This is important and will show itself to be a useful exercise; especially due to the 'negative' definition of complementary medicine, which defines it as everything that is "not" conventional medicine. Thus, a nuanced understanding of conventional medicine as a category will not only shed light on the definition of complementary medicine, it will also provide important information on the current relationship between the two categories in contemporary France.

The "identity crisis" that led to the 1845 congress occurred within the context of the 19th century and the significant changes that occurred in the philosophy, science, economics, and society of the time. It is no coincidence that the medical council that would become the professional society known as the *Ordre des médecins*[2] in France began merely a decade after

[1] "Medical" is used in its large sense here, meaning practices that are curative, medicinal, or therapeutic
[2] In English, the Order of Doctors

and only two years before the establishment of the British Medical Association (1832) and the American Medical Association (1847). Nor is it coincidental that this "identity crisis" occurred shortly after William Whewell coined the term "scientist" in 1840 within the context of the "knowledge explosion" of the 19th century, the emergence of capitalism, and new socially transformative forms of communication (Rhodes, 1985). The 1845 congress' delineation of an ordinal medical institution was a significant step in the establishment of the "official" French medicine we know today. While it did not delve into the techniques or products that were considered legitimate for practice by the newly organized medical professionals, the medical council was charged with overseeing the practices of French doctors. Should a doctor implement techniques or use products that were not considered as part of "official" medicine, the *Ordre* would intervene. Thus, it was granted considerable de facto decision-making power over what was and was not considered to be a legitimate part of medical practice; a power that it continues to maintain.

Furthermore, not only did the establishment of the British, French, and American professional medical societies work to create an "official" medicine, they also contributed to the development of the contemporary notion of "Occidental or Western medicine." Again, this emergence was largely the result of the significant social, philosophical, economic, and scientific developments over the course of the 19th century. For example, European advancements in 19th century public hygiene and the improvement of disease control resulted in the application of European medicine in 19th century imperial projects (Lock & Nguyen, 2010). Additionally, since the appellation "Occidental or Western medicine" denotes geographical origin, it gained meaning due to the vast numbers of transformative discoveries that were made by 19th century scientists throughout the West. Take for example: Dalton's 1804 atomic theory in Britain; Avogadro's 1811 molecular theory in Italy; Darwin's 1859 theory of evolution in Britain; Maxwell's 1865 electromagnetic theory in Scotland; and Pasteur's 1865 advancement of germ theory in France. Not only did all of these advances in the Western sciences redefine the understanding of nature as something that was, "in dynamic motion," they resulted in the disappearance of, "the idea of the static, unchanging world" (Rhodes, 1985, p.95). They were also influential in redefining the relationships between biology, chemistry, physics, and medicine; a redefinition that gave the notion, "Occidental or Western medicine" its contours within the age of imperialism.

Now that we have examined the evidence of the creation of "official medicine" and the beginnings of the notion of "Occidental or Western medicine," it is time to delve in a little deeper in order to shed light on the origins of the notion of "scientific medicine," which would turn into the 20th century concepts of "biomedicine" and "evidence-based medicine." The theory of evolution lent considerable weight to the Linnean classification system, helping to extend it to natural phenomena such as disease (Dubos, 1965). The principle of causality began replacing that of vitalism, allowing experimenters to flourish in their explorations of the causes, effects, and treatments of diseases. This ultimately developed into the theory of specific etiology, "the most powerful single force in the development of medicine during the past [19th] century" (Dubos, 1965, p. 325). One notable example of this type of thinking was John Snow's study of the 1854 cholera epidemic in London. His dot map helped him to identify a water-pump as the source of the outbreak, which acted as a forerunner to epidemiology and an influential argument against the miasma theory of disease. Furthermore, Koch's work on bacteriology and his 1876 proof of the bacterial cause of anthrax helped to solidify the importance of specific etiology and the origins of infectious diseases. This, when coupled with Pierre Louis' introduction of the numerical method in the 1820s, known today as the clinical trial, effectively transformed medicine into a, "rational discipline;" a prodigious development due to the overwhelming prevalence of acute microbial diseases in Europe in the

19th century (Singh & Erst, 2008, p. 24; Dubos, 1965). As such, over the course of the 19th century, doctors began increasingly evoking the notion of "science" and the discoveries of the laboratory sciences (Löwy, 2011). While there is no single narrative reflecting the development of the prevalence of "scientific medicine," the 19th century explosion of scientific knowledge that was reported on, "without reference to gods and devils," culminated in the triumph of the experimental method over, "assumptions of authority" (Robinson, 1943, p.392; p.441). This coup extended across the disciplines, including medicine, and thus corresponded to the emergence of "scientific medicine."

Despite the growth of bacteriology and laboratory sciences in the 19th century, it was not until the 20th century that the term, "biomedicine," was introduced and ultimately able to significantly change the, "relationship between science, medicine, and public health" (Quirke & Gaudillière, 2008, p.446). Even though the term was coined in a British medical dictionary in 1923 to refer to, "clinical medicine based on the principles of physiology and biochemistry," it was arguably not until the post-war intensification of the alliance between the State and research in the life sciences that "the era of biomedicine" came into full force (Quirke & Gaudillière, 2008, p.445; Clarke et al., 2003; Löwy, 2011). This was largely the result of research that led to the relocation of life and its basic processes to macro-molecular structures such as DNA. As a result, medicine became "molecularized" or "macromolecularized" as new roles for entities such as proteins and amino acids, diagnostic tools, and explanatory models were introduced (Quirke & Gaudillière, 2008; Löwy, 2011). Biomedicalization gained significance through the large-scale testing and production of pharmaceuticals in the post-war period. While biomedicalization flourished in a heterogeneous fashion, the networks linking the laboratory, the clinic, and medical production plants grew denser as healthcare took on economic and political significance in the 20th century (Lock & Nguyen, 2010; Löwy, 2011).

Medical professionalization, regulation, and specialization continued to expand in the 20th century, as did patient activism. It is within this context that Guyatt introduced the term "evidence-based medicine," as a, "new paradigm for medical practice" (Guyatt et al., 1992). Based on the pioneering work of his mentor, David Sackett, Guyatt introduced the concept of evidence-based medicine (EBM) as a new approach to clinical decision-making with a heavy emphasis on drawing from critical evaluations of clinical research. What is extremely interesting about EBM is that it was originally introduced as a new form of bedside practice aimed at replacing the historical "art of medicine" in clinical decision-making with the scientific methodology of biomedical research (Sur & Dahm, 2011). EBM brought to light two significant implications: 1) that bedside decision-making was dramatically affected by exposure to critical appraisal; and 2) that there were important differences in the quality of evidence in medical articles, especially in the application of that evidence to clinical scenarios (Guyatt et al., 1992; Sur & Dahm, 2011). In other words, EBM began as an educational approach intended to assist doctors in their application of the literature to the cases of individual patients.

Meanwhile, the work of Tom Chalmers, Ian Chalmers, and Murray Enkin resulted in the 1993 creation of the Cochrane Collaboration. This collaboration was based on the principle of a hierarchy of evidence going from randomized controlled trials (RCTs) to meta-analysis, or the pooling of data from multiple trials (Daly, 2005). Enkin and Ian Chalmers became conscious of the importance of avoiding medical dogma and worked together to create a massive database of medical research known as the Oxford Database of Perinatal Trials (Sur & Dahm, 2011). This database formed the model framework for the Cochran Collaboration, which went on to support and inform EMB's main argument that doctors

should use the, "best available external clinical evidence from systematic search" (Sackett et al, 1996,p.71). The principles of the Cochrane Collaboration became the basis of the "gold standard" of what constitutes the "best evidence" called for in EBM. As such, RCTs, systematic reviews, and meta-analyses gained significant legitimacy over non-experimental analyses and the "soft," qualitative data that doctors use to make diagnoses and determine treatments (Sur & Dahm, 2011).

Thus we have arrived at the current conception of what is known in France as biomedicine, allopathic medicine, Occidental or Western medicine, university medicine, mainstream medicine, orthodox medicine, and official medicine. Until the late 20th century, this form of medicine was so dominant through the Western world that it was generally simply called 'medicine' in reference to the various forms of healing practiced in the Occident, some of which were present since pre-history (Wiseman, 2004). It was not until the post-war development of the notion of biomedicine and the late 20th century introduction of EBM that medicine stopped referring generally to the age-old "art of healing" and began referring specifically to medical practices and products that are based on the natural sciences, with biology at their core. These medical practices are only considered to be legitimate if they are informed by the "gold standards" of scientific medical experimentation.

It is of note that 'medicine' comes from the Latin derivative of *medico*, which simply means 'to heal' or 'to cure.' Nevertheless, the story of conventional medicine that has been presented here indicates that all of its common appellations are politically, economically, socially, and philosophically loaded. Within the international literature, "modern medicine," "Occidental or Western medicine," and "biomedicine" are the most commonly-used terms (Wiseman, 2004). Another commonly-used name that came up repeatedly in the literature and in my interviews with healthcare professionals is "allopathic medicine." Deriving from the Greek *allos* meaning 'other' and *pathos* meaning 'suffering,' allopathy was a term coined by the founder of homeopathy, Samuel Hahnemann, in reference to conventional medicine's approaches to overcoming disease through, "the use of such medicines as are capable of producing in the healthy body a different…affectation from that exhibited by the disease to be cured" (Whorton, 2004, p.52). It is important to emphasize that Hahnemann explicitly rejected allopathic epistemology, its "misguided" placement of medical faith in "theory over experience," and its treatments that he claimed worked against the curative effects of nature (Whorton, 2004, p.52). Hahnemann's objections to allopathy were so vehement they led the editor of the New York Journal of Medicine to write, in 1847, that to adopt homeopathy was to do, "nothing more nor less than *deny* well-established facts" (New York Journal of Medicine, 1847, p.13). As such, due to the philosophical and biased connotations of the term, "allopathic medicine" will not be used in the context of this thesis. Furthermore, some scholars have indicated that Chinese Medicine also draws from an allopathic approach, which further serves as an argument against the use of the term (Wiseman, 2004).

"Orthodox medicine" will also not be used in the context of this thesis due to the inherent value-judgment stemming from its Greek root, *orthos*, meaning 'straight,' 'upright,' or 'correct'. "Modern medicine," will not be used due to its theoretical loading in relation to the notion of post-modernism and its inherent implication of medicine having a static nature that was defined and fixed in the modern era. Furthermore, since many complementary practices were developed in the modern era, "modern medicine" fails to maintain its specificity to conventional medicine. While "mainstream medicine" is a viable appellation, this thesis will employ the term "conventional medicine" as a means of reflecting the presupposed, oppositional relationship between conventional and nonconventional medicine that is often presented in the literature (e.g. Bausell, 2007; Park, 2000; Singh & Ernst, 2008).

In the latter part of the 20th century, a growing number of articles on various "nonconventional" practices began appearing in major medical journals (Bausell, 2007). This corresponded to a growing interest in and consumption of various complementary practices in the West, such as an increase from 16% of the French population using homeopathy in 1982 to 36% in 1992 (Singh & Ernst, 2008). While many nonconventional practices were known about, popular, and used prior to the second-half of the 20th century in Europe and America, this period is marked by a dramatic upswing in their reputation and use; take for example the publicity following Henry Kissinger's highly-publicized interest in acupuncture as a result of his 1971 trip to China in the company of New York Times journalist James Reston[3].

While there are a myriad of factors that led to the burgeoning interest in complementary medical practices in the latter part of the 20th century, one often-cited reason was the growing dissatisfaction with, "the worsening failures of a model of medical practice driven by merciless financial bottom lines to the brink of disaster" (Campo, 2003, p. 3). The "failures" mentioned by Campo refer to the biomedical assumption that, "all aspects of human health can be understood in physical and chemical terms," which led medicine to become, "increasingly impersonal and technical" (Sobel, 1979, p. 8-9). In their discussion of 20th century biomedicalization, Clark et al. (2010) identify five broader processes that it engendered in medicine, which explain the critiques presented by Campo and Sobel: 1) privatization and commodification; 2) risk and surveillance; 3) expanding technoscientific processes; 4) production and distribution of knowledge; and 5) the transformation of bodies and subjectivities (p. viii). Together these developments gave medicine a new form of control over medical phenomena and our bodies, largely through technoscientific interventions. As David Morris (1998) indicates, this technoscientific reliance also oversimplifies the illness experience, leading to the critiques cited here and the resistance that is implied by the phenomenal growth of complementary medicine beginning in the late 20th century. The World Health Organization also identifies this medical control as a significant factor, citing medical paternalism as a main contributor to the, "widespread and increasing appeal of traditional and complementary/alternative medicine throughout the world, particularly in the past 20 years" (WHO, 2001, p.3). As we shall see throughout this thesis, these critiques of conventional medicine will prove to be extremely important to the growth and interest in nonconventional practices[4].

In France, late 20th century developments in medicine occurred within the context of French efforts to reorganize healthcare delivery, increase control mechanisms on health expenditure, and to reorganize healthcare organization, control, and monitoring (Nay et al., 2016). Whereas the previous paragraph implies a reorganization in the power relations

[3] While in China covering Kissinger's visit, Reston had to undergo an appendectomy and his post-surgical pain was treated with acupuncture and moxibustion. Angry about being unable to report on Kissinger, Reston wrote an article from his hospital bed about his experience entitled, "Now, about my operation in Peking," which appeared on the front page of the New York Times along with an article about the Apollo 15 lift-off on July 26, 1971. Reston's article, "unwittingly sparked widespread 'acupuncture fever' across the United States," furthered by Kissinger's mention of the experience in a press briefing and Nixon's 1972 visit to China, resulting in a variety of articles on acupuncture in popular US magazines and newspapers (Li, 2014, p. 82).

[4] It is of note that the growth of complementary and alternative practices in the Occident has not occurred in a linear fashion. One of the more public examples of this is the growth of the chiropractic profession in the United States. Begun in the 1890s in the US, the practice grew throughout the 20th century leading the American Medical Association (AMA) to actively work against it from the 1960s to the 1980s, spreading information discrediting the practice as quackery. In 1987 the AMA was convicted in a trial for unlawful attempts to constrain or eliminate the chiropractic profession (Wilk v. American Medical Ass'n, 671 F. Supp. 1465, N.D. Ill. 198). Interest, research, and practice of chiropractics continued leading to its medicalization and current place within mainstream US healthcare. (see Cooper & McKee, 2003).

between patients and practitioners with late 20th century medicine, these reforms bring to light a reorganization in the relationship between the French State and medicine. One of the key reforms to these ends was the French State's attempts to increase its power over the governance of the French health insurance funds (Franc & Polton, 2006). The complex relationship between the French State and health insurance administration will prove to be significant in later sections of this thesis.

Furthermore, the 'biomedicalization' of medicine and the tensions resulting from the French State's attempts to reorganize the organization, finance, and delivery of the French healthcare system also occurred within the larger context of late 20th century globalization. Globalization is defined here as, " a process (or a set of processes) that embodies a transformation in the spatial organization of social relations and transactions, generating transcontinental or interregional flows and networks of activity, interaction, and power" (Held, McGrew, Goldblatt, & Perraton, 1999, p.483). While interconnections between the world's regions have be present throughout the entirety of human history, it was the 20th century's new communication technologies, the reordering of social life "across time and space," and subsequent "compression of distances and time-scales" that promoted, "the lateral extension of social connections across time and space," and equated to the most significant aspects of globalization in the late 20th century (Giddens, 1990, p. 64).

This reordering occurred along with a dramatic upsurge in French immigration in the late 20th century; and as Held et al. (1999) point out, "when people move, they take their culture with them." Part of the cultural heritage that moved with the masses was their healing practices. As Arthur Kleinman (1978) indicated in his sub-division of health care systems into the three social arenas in which sickness is experienced and treated, sickness is predominately managed by both Western and non-Western populations in the popular and folk arenas rather than in the professional arena (Kleinman, 1978). Thus, in the context of globalization, these arenas, which, "organize particular subsystems of socially legitimated beliefs," become "disembedded" or lifted out their formerly localized contexts of interaction and restructured across, "indefinite spans of time and space" (Kleinman, 1978, p. 87; Giddens, 1990, p.21). In other words, as people moved, they brought their healthcare beliefs and practices with them. As communication technologies greatly facilitated the spread of information and lateral social connections, information about these beliefs and practices also flourished with important consequences on care practices, such as the substantial growth in nonconventional medical practices.

Pordié and Simon (2010) discussed these consequences in the context of their work on contemporary healers. They noted that globalization deeply touches on the domain of therapies creating an influx of transnational ideas, knowledge, therapies, therapists, and patients. They indicate the fluidity of "traditional" systems of healing and the globalization of healers who move around the world mixing cultural systems and references as they work and publish on the internet, in medical journals, and in various settings. As such, they indicate that healers can no longer be defined according to their "local" and "traditional" systems. This directly corresponds to the disembedding mechanism of globalization emphasized here for its key role in the proliferation of nonconventional medical practices throughout the Occident since the late 20th century.

Thus, throughout the late 20th and early 21st centuries, these developments resulted in the appearance, in the literature, of references to appellations such as "conventional medicine," "mainstream medicine," "university medicine," and "orthodox medicine" as a means of differentiating 'medicine' from the plethora of 'alternative' and 'complementary'

forms of curative practices that were proliferating throughout the Occident. From this point forward, this thesis will employ the term "conventional medicine" to refer to the "system of treatments" used by doctors and healthcare professionals to treat symptoms and diseases that is, "based on medicines, health products, for example dialysis, and surgical acts-when there is a tumor we remove it, that is our conventional medicine" (Doctor M, 2017). As it stands in the literature, complementary medicine is generally defined negatively, encompassing anything that is 'not' conventional; but this begs the question, what constitutes conventional medicine in France and can it be considered as a single object?

While French conventional medicine may seem relatively straightforward as a category, in practice it is both complex and problematic. When asked about the definition of medicine, several French healthcare professionals made sure to specify that conventional medicine could not be considered as a monolith. Doctor M noted that, "we have the impression that it is something that is fixed when we refer to Occidental medicine," but in reality it is, "very societal" (2017). Hospital Administrator A also underscored the sociality of medicine saying, "the treatment system is inscribed in society" (2015). Doctor O illustrated this point by referring to medicine as, "the Spanish hostel, there is everything" (2015). All of these quotes reflect the fluid and socially-inscribed nature of conventional medicine. As we shall see, its complexity only increases with further exploration.

For example, the medical profession has arguably always been and remains fraught with internal disputes over fundamental questions concerning issues such as disease pathologies, recommended practices, and preferred treatment options. As evidence to this point, in a discussion of the definition of conventional medicine Doctor O emphasized that, "we don't take care of everyone in the same way […] we don't necessarily have the all of the same standards as in other services […] some services are transitory places involving technical treatments for a particular problem […]in an internal medicine service with average stays of 3 days they don't have the time […] the standards are focused on performance, the efficiency of investigations and complementary exams, rapid treatments, we take them [the patients] and transfer them elsewhere to another place, such as their homes" (2015).

This implies the presence of fundamental differences in the treatment approaches and priorities of different medical services; differences that were brought into sharper relief when various practitioners were asked to describe the role of a doctor. Responses ranged significantly from: "to heal the physical body," (Kinesiologist R); to "improve [the patient's] state of health," (Pharmacist F); to "find a solution to a patient's distress," (Clinical Researcher R); extending all the way to "taking care of people and not letting the patient die" (Doctor H). Some doctors emphasized more human aspects of their role, characterizing it as: "serving others," (Doctor M); "using their knowledge to restore a person's autonomy," (Doctor J); and "creating a relationship" with the patient (Doctor O). It is of note that all of these responses clearly reflect each practitioner's specialty and the service they work in. Keeping the patient alive clearly corresponds to a doctor working in an acute care service, in this case a maternity service, while creating a relationship corresponds to a doctor working in a palliative care service. As you can imagine, the types of treatments offered and treatment priorities differ dramatically between these practitioners.

Not only are there differences between different medical specialties and branches, there are also country by country variations in standard treatment practices. In a discussion of national rates of caesarian section (c-section) deliveries, Doctor H effectively discredited the term "Western or Occidental medicine," merely by highlighting the considerable differences in standard obstetrical practices. He observed that, "if you are in Latvia or in Cypress, if you

had a first pregnancy with a c-section the secondary c-section rate is more than 90 percent; in our country if you had a previous c-section, just one, the rate of normal delivery is around 50 percent and the rate of c-section is just 50 percent" (Doctor H, 2015). This demonstrates that if we cannot even consider "European medicine" as a single category then there is no possible way to consider the entirety of the Western world as sharing a unified medicine or therapeutic system.

So, what is conventional medicine in France? While this question brings to light the potential interest in a comparative study of national differences in the definition of conventional medicine; in France, there is no legal text that specifically defines what constitutes conventional medicine. It is curious that something as prevalent, important, and regulated as the practice of medicine occurs without any formal or official definition of exactly what that medicine is. Within their dictionary, the French Academy of Medicine does provide a definition of medicine, but it is vague and without any references to specific practices or techniques[5]. Over the course of my fieldwork, I asked every interviewee several of the same questions. One of these questions was, "what is the definition of medicine?" During my data analysis, I noticed the clustering of data around several points that seem to be the de facto demarcations of conventional medicine in France. Conventional medicine was consistently defined as practices, techniques, or products which met several or all of the following criteria: 1) reimbursed by the national health insurance; 2) taught in core curriculum at French medical school; 3) practiced or dispensed in official medical settings, such as hospitals and pharmacies; and/or 4) scientifically proven and accepted as part of evidence-based medicine. Due to their specificity, each of these requirements needs to be unpacked individually.

In France, all persons working or residing in the country in a stable manner have the right to national health insurance. This insurance provides patients total or partial reimbursements for various their medical acts, hospitalizations, treatments, and prescriptions. What is interesting in France is that while the Social Security system was created by the State and is largely dependent on the State, it is managed by "social partners," such as employee unions and companies, in dialogue with the State. Here we see why French health insurance reforms are so important to the, "respective roles of the government and the sickness funds" (Franc & Polton, 2006, p.28). Due to the fact that it is managed by social partners in dialogue with the State rather than directly administered by the State, the health insurance regime maintains a considerable and important amount of decision-making power on determining reimbursements. It is important to underscore that the health insurance regime does not act or decide unilaterally, but works in dialogue with various government entities, namely the *Haute Autorité de Santé* (HAS), which recently merged with the *Agence Nationale de l'Evaluation et de la Qualité des Etablissements et Services Sociaux et Medico-Sociaux* (Anesm)[6]. These entities provide scientific evaluation of and recommendations on medical procedures and medications. While this is a multi-step, multi-partner process, it is the health insurance regime that determines, formulates and provides the recommendations sent directly to the Minister of Health for final approval. Thus, the health insurance regime wields considerable influence

[5] Medicine is defined as a, « *discipline dont l'objet est le secours de la vie, le soulagement et la prévention de toutes les souffrances physiques ou mentales de la personne humaine, depuis sa conception jusqu'à sa mort. L'exercice de la médecine fait appel à de nombreux moyens médicamenteux et chirurgicaux, à de multiples procédés d'investigation, qui doivent être adaptés aux attentes de celui qui souffre, assortis d'explications, pratiqués dans le respect de ses croyances et valeurs. En toutes circonstances, les besoins du patient doivent être pris en compte de façon globale » (*Dictionnaire médical de l'Académie de Médecine version 2018*).*

[6] In English, the High Authority of Health and the National Agency for the Evaluation and Quality of Establishments, Social Services, and Medico-Social Services.

over the decision-making process for medical reimbursements. For example, as Doctor R indicated:

> "I have seen people in the Ministry of Health begin a discussion on new subjects in health, until one of the interlocutors said, 'yes well the directors of the health insurance regime will not give us money for that,' and that had an effect that was completely debilitating. In the end, they quickly agreed, saying that it wasn't worth discussing because whether the ideas were good or bad they would never amount to anything as they would never get money [for reimbursement]" (2017).

This decision-making power was echoed in the language of Hospital Administrator A, "the people who are the guarantors of the system, *the guardians of the health insurance temple* say, for example, 'careful, those techniques have not been evaluated, we will not take them under the [financial] charge of the collectivity' […] and slam! we are blocked" (2014, italics added for emphasis). Further reflections on the implications of the French health insurance regime's role in the determination of the relationship between conventional and complementary medicine will be presented in later sections of this paper. For now let us turn to the second criteria of French conventional medicine: that which is taught in the medical school curriculum.

In order to become a doctor in France, all students must complete three cycles of medical studies. These cycles are uniform throughout all French medical schools and their contents are administered by the Ministry of Higher Education and Research. As Doctor T emphasized:

> "We are subject to legal texts that we are obligated to follow […] each year we are given a legal text by the Ministry of Higher Education with themes and programs […] it [school compliance] is verified every three years […] a committee that comes to the universities to verify that the programs correspond to the national ministerial directives, so there is no room for improvisation" (2017).

Since French medical schools follow Ministry-determined curriculum, their role becomes one of, "validating and scientifically accompanying in terms of formation" (Doctor R, 2017). In order to facilitate this role, the presidents of the 34 medical schools in France are organized into a group known as, the *Conférence des Doyens des facultés de médecine*[7], which meets monthly in order to ensure that the directives are being applied in a homogenous manner. It is this instrumental role of medical schools that leads some to refer to conventional French medicine as, "university medicine;" however, as subsequent chapters in this thesis will show, universities have a considerable leeway in the courses they provide within the context of continuing medical education.

According to Doctor R, "there is concern about introducing teachings that have not been scientifically validated into universities;" a concern that becomes important with respect to University Diplomas (DUs) and Inter-university Diplomas (DIUs) (2017). Once a French medical student has successfully completed their education, they receive a State-recognized, national diploma of medicine. While the national diploma is a prerequisite for legally practicing medicine, it is not the only diploma offered by universities. All medical schools have DUs and DIUs that are offered as part of continuing medical education. These diplomas are not State-recognized, but rather are organized by individual universities as a means of providing intensive instruction in specific domains such as in cardio-vascular imagery,

[7] In English, the conference of medical school presidents

medical toxicology, or in wounds and healing. The content, access, and fees for these diplomas are determined independently by the university, in the case of a DU, or in partnership between several universities in the case of a DIU. In other words, these courses are organized without State oversight, involvement, or recognition. As we shall see in later chapters of this thesis, the DUs and DIUs are proving to play a key role in shaping the relationship between conventional and complementary medicine in France. Furthermore, it is the DUs and the DIUs that bring to light the role of the *Conference des Doyens* and the power of individual *Doyens* in the determination of medical instruction, as was implied by Doctor R.

This leads us to the third criteria of what constitutes conventional French medicine, that which is practiced or dispensed in official medical settings; which results in the appellation of conventional medicine as, "hospital medicine." In France, the relationship between hospitals and the State is a complicated panorama. In order to begin to understand this landscape, it is important to keep in mind that there are three different legal statutes for the 3,089 hospitals in France: 1,389 are public hospitals; 1,009 are private, for profit hospitals; and 691 are private, non-profit hospitals, 21 of which are cancer centers (Drees, 2017). It is of note that public hospitals represent the slight majority of health establishments. No matter their statue, all French hospitals have the same general mission that is legally codified in the Public Health Code[8] (Drees, 2016). Thus, all hospitals share, "the same finance structure […] we are all constrained by the same regulations, the same obligations," even if the mix of activities offered in any establishment varies (Hospital Administrator A, 2014). All hospitals function on the basis of activity-based payments, with prices set each year by the government. The main difference between hospitals of different statutes rests on the amount of public money they receive. According to Hospital Administrator A, the director of a private Paris-area hospital, "90.95% of our finance is assured by activity-based payments, whereas for a public establishment […] a little less than half their budget is assured by activity-based payments and a little more than half is assured by inter-regional finance for teaching and research" (2015).

Aside from the amount of public funding, one of the key differences between the three types of hospitals is the difference in the statutes of the doctors working within them. In public hospitals, "doctors are appointed by the Ministry of Health on the recommendation of the establishment, not by the director of the establishment" (Hospital Administrator A, 2014; Drees, 2016). This fact gives doctors in public hospitals a certain amount of individual power that circumvents the authority of the individual establishment they work for: "it's complicated, they are paid by the establishment, so they are accountable to their establishment, but at the same time it's not the hospital director who appoints them and who has the power to revoke their appointment […] I don't know of one example of a public hospital doctor who was dismissed" (Hospital Administrator A, 2014). Doctors working in private hospitals have even more individual agency, since they practice *à titre libéral*, meaning as independent providers contracted by the hospital. This statue severely limits the hospital administration from imposing decisions on private doctors, "we are partners […] I manage them by influence but I cannot use the lever of authority […] liberal doctors are absolutely independent […] they organize their own consultations and don't even have to ask before going on holiday" (Hospital Administrator A, 2015). Doctors in the private, non-profit sector are recruited and paid by their hospital and are governed by labor codes and the rules of their establishment, thus these hospitals have more authority over their doctors. As will be shown in subsequent chapters of this thesis, the statutes of doctors and their semi-independence from the authority of hospital administrators will prove to be another key that is

[8] Public Health Code L.6141-1

shaping the relationship between conventional and complementary medicine in contemporary France.

For now it is important to understand how the overall hospital system is organized and managed in France. The overall hospital system is organized in a sort of vertical hierarchy with the Ministry of Health at its head. As of 2016, all public hospitals are organized into one of 135 Territorial Hospital Groups (GHTs), which allows them to work together in order to promote patient access and to better coordinate their efforts to respond to the medical needs of the population at the territorial level. The GHTs and the entire hospital system are piloted by the Regional Health Agency (ARS), which acts as the State's intermediary. The ARS is charged with ensuring the implementation of health policies with respect to the medical needs and specificities of the regions. As such, the ARS has a considerable and significant amount of agency in the shaping of the overall healthcare system and powers that go well-beyond simple oversight. In addition to their oversight capacity, the ARS is charged with evaluating the medical needs and the healthcare system's responses to those needs in all of the regions. Thus, the ARS maintains a two-way dialogue ensuring the implementation of national policies and providing the State information that defines the priorities and contours of those policies. The ARS oversees and determines funding allocation for a variety of activities ranging from preventive health measures in a particular region or territory, to the training of nurses in each hospital. Furthermore, it is the ARS that provides authorizations for hospital services, activities, and equipment. For example, if a hospital wanted to create a maternity service, it would need ARS approval to do so. These approvals are given on the basis of the Regional Schema for the Organization of Care (SROS), a cartography of the services offered within the different regions. This acts as, "the strategic plan […] of the characteristics and health indicators of the territories and the services offered" (Hospital Administrator A, 2014). For example, Hospital Administrator A told me that within the Essonne territory of the Ile-de-France region, the ARS has determined a need for between 4 and 6 maternity services. As there are currently 6 services in operation, no new authorizations for creating a maternity service will be given to Essonne-area hospitals that would like to create one (2015).

It is important to underscore that these authorizations are relatively broad and are based on medical activities. For example, Hospital Administrator A explained that should there be a need identified in the SROS, the ARS may authorize a hospital to buy a Magnetic Resonance Imaging (MRI) machine. Once the machine is installed, it is largely up to the physicians in that hospital to determine how and when that machine is used outside of the quantifiable standards required within ARS oversight, such as reporting on how many patients go into the machine per day. What is interesting is that unless they come for an on-site visit, the ARS will only be aware of the declared uses of the machine, i.e. the number of acts submitted for reimbursement. Furthermore, as contested by Hospital Administrator A, in both public and private, for profit hospitals, doctor activity is largely independent of hospital administration. As such, a group of neurologists in one Paris-area hospital has been able to use their MRI machine on weekends in order to conduct their own, unfunded research on the changes in the neural activity of various people in meditative states. They simply use the machine outside of the hospital's working hours with their independent research subjects. This acts as evidence of the fact that despite the ARS' "omnipresent control" and the presence of hospital administrations, there are many activities occurring within the hospital setting that are going on undetected by the State and even by hospital administrators. This is possible, in part, because of the organization of the system and, in part, due to the scale of the system. According to Hospital Administrator A, there were "hundreds of doctors and between 400 and 500 employees," in a medium-sized hospital (2015). In a large, public hospital in Paris, Doctor M cited the presence of, "10,700 practitioners, including both full-time and

temporary" and more employees than he knew about (2015). As such, it is rather impossible to oversee all of the individual activities occurring in all of the hospitals in France; nevertheless, the reality of the power arrangements between the State and hospitals, and between hospital administration and their practitioners, will show itself to be an incredibly important factor shaping the relationship between conventional and complementary medicine in contemporary France.

Before moving on to the final criteria of what constitutes conventional French medicine, it is important to make a few, brief comments on the role of French pharmacies. As was confirmed by one of the council presidents of the *Ordre Nationale des Pharmaciens*[9] in 2015, French pharmacies maintain the monopoly over all medicinal sales in France. Once a medication has been approved for sale in France, it is inscribed in the official French Pharmacopoeia. This is a book describing the chemical composition, principles, uses, and dosages of all official *materia medica* in France: "it's included in the Pharmacopoeia, it's official" (Homeopathic Doctor Q, 2015). All medications requiring prescriptions are available for sale exclusively in pharmacies. It is of note that pharmacies also sell parapharmaceutical products, meaning health and hygiene products that must be sold by a pharmacist, but without the need of a prescription. Pharmacists are considered as health professionals and they are charged with the responsibility, "to help the doctor […] to advise and to orient people so that they don't unintentionally hurt themselves" (Pharmacist M, 2015). As confirmed by a representative of the *Ordre des pharmaciens*, pharmacists have the right to refuse a treatment prescribed by a doctor. In this sense pharmacists can be understood as, "the second part of corrective medicine, meaning that the first part is the doctor and the surgery […] there are two parts, surgery and pharmacy" (Representative F of the *Ordre des pharmaciens*, 2015). While pharmacists have the ability to select from a huge range of parapharmaceutical products for sale in their pharmacies, the oversight of the *Ordre de pharmaciens* ensures that the products selected are of a high-enough quality for sale in a pharmacy, which is considered to be an official part of medicine. This fact will come into play in subsequent chapters of this thesis.

For now, it is time to turn to the final criteria delimiting the contours of conventional French medicine: practices and techniques that are scientifically 'proven' using the principles of EBM. When asked what conventional medicine was, most practitioners were quick to cite EBM and science. For example, Doctor O (2015) stated, "I am very EBM, it's things that are proven, we have studies, we have done clinical trials and after, we have results and these results show what is significant." This statement implies that what has not been proven by clinical trials is not significant and thus, not a part of medical practice. Doctor M echoed this sentiment in his discussion of what conventional medicine is: "Sarkett said that the best is the prospective, controlled trial for showing scientific efficacy, but you have other means […] the guidelines and recommendations of scientific and academic societies […] medicine draws from scientific data and many doctors, in my opinion, consider medicine as nothing other than science" (2017). Again, this relates back to the historical development of contemporary conventional medicine presented at the beginning of this section. If medicine is considered to be nothing other than a science, then what is valid for inclusion in medicine is what is able to be scientifically proven or evidenced. Thus, if something does not fall within the scope of scientific medicine, it is not considered to be a valid part of conventional medicine. Notice that Doctor M references "many doctors," which is significant coming from this experienced practitioner working in a large and well-reputed public hospital at which tens of thousands of doctors are practicing.

[9] In English, the National Order of Pharmacists, the professional society of pharmacists ensuring deontology and representing the pharmacists in negotiations with the State.

In this sense, scientific and academic societies, known in France as *sociétés savantes*, also play a significant role. These societies, such as the French National Academy of Medicine, conduct studies and research with the goal of furthering the development of medicine. As such, their reports and recommendations often prove to be of considerable weight in the consideration of the validity of a technique, treatment, product, or therapy. Professional societies, such as the *Ordre des médecins* also play a role as a *société savante*, providing their official opinion as needed on medical matters. As we shall see in subsequent chapters, this criteria of medicine as being that which is proven and therefore included in the evidence-based literature will be used as one of the most enduring and significant arguments hindering the growth of complementary medical practices.

### *1.2: Definition of Terms- Complementary Medicine*

As stated in the previous section, complementary medicine is 'negatively' defined as that which is "not" included as a part of conventional medicine. It is known in France as complementary and alternative medicine (MAC), traditional medicine, non-pharmaceutical interventions (INM), nonconventional medicine, integrative medicine, holistic medicine, soft medicines, parallel medicine; and in some cases as pseudo-medicines, cults, esoteric practices, dangers, and charlatanism[10]. For reasons that will be explained in this section, this thesis will employ the term complementary medicine to describe the myriad of practices that are "not" considered to be included among the conventional medical practices meeting some or all of the four criteria outlined in the previous section.

At the outset it is important to draw from the World Health Organization's (WHO) definition of what they refer to as, "traditional and complementary medicine;" a category including over 400 different practices (WHO, 2013). This term combines what the WHO defines as two separate categories, but groups together under one umbrella term: traditional medicine, "the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness;" and complementary or alternative medicine, "a broad set of health care practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant health-care system"(WHO,2013, p.15). It is of note that the WHO presents complementary and alternative as interchangeable terms, while the ENVI Committee of the European Parliament made a clear distinction between these two terms in their 2017 Report. According to the ENVI report, complementary and alternative medicines are described using the prevalent term "CAM" defined as, "a variety of medical systems, products and practices that are usually not part of conventional health care" (EP, 2017, p.7). Unlike the WHO report, the European Parliament report makes a clear distinction between what is complementary, "all treatments used alongside conventional medical treatments," and alternative, "treatments that are used instead of standard medical treatments" (EP, 2017, p.7).

[10] For example, in 2018 a group of 124 French doctors jointly signed an opinion piece, which was published in *Le Figaro* 18 March 2018, denouncing complementary medicine for being ineffective, costly, and dangerous. This piece referred to homeopathy as an esoteric practice and used some of the language cited here for several other complementary practices, including acupuncture. This piece was commented on in various media sources and is available online at: http://www.lefigaro.fr/vox/societe/2018/03/18/31003-20180318ARTFIG00183-l-appel-de-124-professionnels-de-la-sante-contre-les-medecines-alternatives.php

Within my fieldwork in France, I found that despite the overwhelming prevalence of the term CAM in the Anglophone literature and its use (MAC in French) by the *Ordre des médecins* in their landmark 2015 webzine on the subject, most of the French practitioners and users I spoke with, both conventional and otherwise, were strongly opposed to this appellation. The most common reason for this was the inherent opposition that is implied by the word "alternative," as is clearly stated in the European Parliament report. In my interviews with various users of nonconventional practices, I found no significantly clear distinction between using nonconventional treatments in compliment to or as an alternative of conventional treatments. In general, there was a great deal of intermixing between these two categories such as a nurse using peppermint oil as a first recourse for a headache in some cases and Doliprane in others. While in some cases I did run across users who were strongly opposed to, say the use of all pharmaceutical products, those same opponents still occasionally had recourse to conventional medicine in certain instances, such as getting an x-ray after a fall (Madame M, 2016) or taking antibiotics for an infection (Madame C, 2015). Consider, for example, the discourse of Shiatsu Practitioner C, who openly declared, "I don't take medicines and I don't want to take them and up until now, I haven't died yet," exactly 55 minutes into our interview (2015). 30 seconds before this statement, this same practitioner admitted, "I take aspirin from time to time when I have a headache," and 45 seconds after stated, "for me, medicine is a last resort"(2015). This inconsistent rhetoric indicating the mixed usage of practices and products both in complement to and as an alternative of conventional medicine depending on the circumstance is reflective of the overall trend that came to light in the analysis of my fieldwork. While I can imagine that in France there are people who completely abstain from the use or consumption of any and all conventional medical products and practices, I strongly suspect that they are the exception rather than the rule and I did not run across any such persons throughout the three and a half years of my fieldwork, participant observation in the context of an energy-healer with an extremely high volume of clients, or in the context of my interviews.

The U.S. National Center for Complementary and Integrative Health (NCCIH) confirmed the validity of this same trend in the United States in 2015. Formerly the National Center for Complementary and Alternative Medicine (NCCAM), the United States Congress renamed the center NCCIH in 2015. According to the NCCIH Director, Josephine Briggs, this change better reflected the center's research focus, which was shaped by the results of population studies and surveys indicting that the use of alternative medicine instead of conventional care is, "quite rare." Instead, Dr. Briggs confirmed that "most Americans" use complementary practices as an "adjunct to" conventional care (NCCIH, 16 January 2015)[11]. My fieldwork experiences clearly confirmed this same trend in contemporary France. As such, in light of this finding and due to the strong opposition I consistently met when I used the term CAM in my interviews, I will employ the term "complementary medicine" throughout the rest of this thesis.

Furthermore, it must be noted that following the lead of the WHO, I will also be regrouping traditional and complementary medicine into the category encompassed by the term complimentary medicine. While I did meet some resistance to this on the part of several practitioners of Traditional Chinese Medicine and among some complementary practitioners who did not appreciate the regrouping of their "modern" technique with entire, and often historical, systems of traditional medicines; due to the general acceptance in the literature of this regrouping, and its repeated appearance throughout my fieldwork and data analysis, I will be maintaining this combination. Again, I evoke the negative definition of complementary

[11] Available online at: https://nccih.nih.gov/about/offices/od/nccam-new-name

medicine as justification for this choice as practices, techniques, and products from traditional medicinal systems are considered as "not" conventional in France. Perhaps the strongest example of this is acupuncture, a core component of Traditional Chinese Medicine that has been partially medicalized (i.e. mainstreamed into conventional medical practice and limited to doctors) and is widely practiced in France, and yet, is still considered to be a complementary practice (e.g. Bontoux, Couturier, & Menkès, 2013; l'Ordre des médecins, 2015; Barry et al., 2014). The case of acupuncture will be discussed throughout this thesis.

Likewise, much like the case of conventional medicine, complementary medicine is a complex and problematic category, due to the variety of the practices it encompasses. While conventional medicine is far from a monolith and fraught with differences, regrouping the differences between the innumerable practices that are "not" conventional, but present in the Occident is far more problematic due to their increased variety. As Doctor M (2015) observed, "I think reflecting on complementary and alternative medicine is somewhat false in the sense that these medicines are profoundly different, there is no relation between Ayurvedic medicine and homeopathy, even less if we look at them with a medical and scientific eye." This is an extremely astute observation, especially considering the incomparability of the origins, ontological, epistemological, and material bases of these two systems. While in the previous section we highlighted important differences in the approach and techniques of specific domains of conventional medical practice using the example of birthing techniques, many complementary domains are marked by even more diversity. Hypnosis is one such example. As Doctor O indicated, hypnosis is practiced in a multitude of contexts ranging from shamanism to Zen meditation to hospital surgical blocs and is, "something that is so very vast that to make a philosophy about it would be to reduce it" (2015).

In addition, complementary medicine is a problematic category because it regroups medical systems, such as Ayurvedic medicine and Traditional Chinese medicine; with individual techniques and practices, such as shiatsu and osteopathy; with methods, such as naturopathy and reiki; and belief systems, such as shamanism. Some practitioners are opposed to their regrouping under the umbrella term 'medicine,' either because they do not consider it to be an appropriate appellation for their technique or because they were reluctant to be associated with the domain of medical professionals. As an example of the former case, Shiatsu Practitioner C was opposed to considering shiatsu as a form of medicine, saying: "we avoid the word 'medicine,' rather we say it is a therapy […] shiatsu is, we can say a discipline, we can say a technique, which is a little pejorative […] the Japanese would say that it is a 'way', *do*, like judo like aikido" (2015). As an example of the latter case, Kinesiologist R (2015) objected to using the word medicine to refer to kinesiology, saying that: "it is not a medicine and has a different approach that is based on the globality of the person." Over the course of thesis, we shall see that while Shiatsu Practitioner C objected to the 'medicine' appellation on a semantic basis, Kinesiologist R is opposed on what will be identified as the more political basis of an opposition to the medicalization of kinesiology. This is an incredibly important aspect of the relationship between conventional and complementary medicine that will be explored in subsequent chapters of this thesis, in particular in relation to the practice of osteopathy.

For now, we will remain focused on the semantics of the various appellations informing this paper's selection of complementary medicine as a preferred term. In this sense, it is useful to recall the Latin root of medicine, meaning 'to heal' or 'to cure,' as this is an important consideration informing this paper's selection of the appellation complementary 'medicine.' Along the same lines, 'complementary' was selected over 'parallel' as a result of

the Greek root *para* meaning 'alongside,' but never meeting. Semantic reasons also informed this thesis' avoidance of the term "non-pharmaceutical interventions" (INMs) on the basis of two considerations. The first is that INMs also include a variety of behavioral therapies, cognitive therapies, and paramedical techniques, such as kinesiotherapy[12]; all of which are full-fledged components of conventional medicine that are not based on pharmaceutical product use (HAS, 2011). As such, the appellation INM does not retain its specificity to nonconventional practices. The second reason is that when used in reference to complementary medicine, which includes traditional medicinal systems, such as Traditional Chinese Medicine, the term 'INM' carries with it an inherent cultural bias that dismisses the pharmacopeias, patented medicines, and compound prescriptions of entire countries, such as China (Hao & Jiang, 2015).

Along similar lines, this thesis also does not use the appellation, "soft medicine," since many of the medicinal products in various traditional and nonconventional systems include toxic, dangerous, and poisonous substances ranging from animal venoms, to poisonous plants, to heavy metals. Some of the herbs used in various complementary medicines and herbal supplements can interact with pharmaceuticals, have serious and dangerous side-effects, or can be unsafe for people with certain medical conditions. While there are many reasons for the adverse reactions associated with various traditional medicinal herbs and products, one of the reasons is the inherent toxicity of some of the herbs used (Ko, 2004). As such, semantically speaking, 'soft' does not take into account the full panorama of the contents included under the umbrella term complementary medicine and will not be used in this thesis.

Another appellation that will come into play in later in this thesis, and thus requires an initial analysis and definition is "integrative medicine." Integrative medicine can be defined as, "a comprehensive primary care system that emphasizes wellness and healing of the whole person (bio-psycho-socio-spiritual dimensions) as major goals, above and beyond suppression of a specific somatic disease" (Bell et al., 2002, p. 134). The two most fundamental aspects of integrative medicine are its focus on the patient as a "whole person" and its emphasis on the importance of a positive, therapeutic patient-physician relationship. As such, occasionally holistic medicine is used within the literature as a synonym for integrative medicine; however integrative medicine is clearly the standard term for this particular approach. What is particularly important about the notion of integrative medicine within the context of this thesis is that it draws upon both conventional and complementary approaches for application in a patient-centered approach within a conventional clinical care setting (Rakel, 2012; Bell et al., 2002). One of the key tenets of integrative medicine is that both conventional and complementary medicinal practices can be sources of good medical practice, especially due to its consideration of illness as a multifactoral manifestation affecting a person in their totality. As such, it is a category in and of itself that cannot be reduced to being merely a component of complementary medicine.

Defining, understanding, and categorizing the complex and dynamic body of health care systems, practices, products, and techniques that are grouped together under the umbrella of complementary medicine is proving to be of great difficulty in the medical, academic, scientific, and political domains. This difficulty is magnified as various complementary systems, products, therapies, and practices are removed from their original contexts, broken into smaller pieces which are researched, analyzed, and in some cases proven to be safe

[12] It is important to highlight the difference, in France, between kinesiotherapy- a paramedical practice that is part of conventional medicine and known as physiotherapy in English- and kinesiology- a complementary practice involving a direct communication with the body's memory via muscular tests that identify physical and emotional blockages and determine the nature of the necessary corrections for these blockages.

and/or effective and incorporated into conventional care and medical research (Bell et al., 2002; Pelletier, 1997). In fact, subsequent chapters of this thesis will show that it is precisely this mechanism- which we call the disembedding mechanism- that is playing the most significant role in the configuration of care practices that is currently emerging in France. Furthermore, due to globalization forces, this thesis will argue that this disembedding mechanism and the subsequent integration of various complementary practices into national systems are occurring exponentially. One obvious example of this phenomenon that will be further explored in this thesis is acupuncture. As it stands, there is not an agreed-upon operational definition of complementary medicine in the literature. While there is general agreement that there is a group of therapies that fall outside of conventional medicine and that can be grouped together as complementary medicine, there remains considerable debate over exactly which therapies should or should not be included in this category, such as in the case of vitamin and other dietary supplements. As a result, there are significant variations in the therapies that are commonly considered to be complementary practices and a general lack of a standard list of complementary therapies (Wieland, Manheimer, & Berman, 2011).

In the absence of accepted descriptive, normative, theoretical, or operational definitions that are able to answer the question of what complementary medicine is; there have been efforts to create taxonomic systems to classify the multitude of complementary practices into an organized field (Institute of Medicine, 2005). One of the more widely-used classification structures groups complementary therapies into the five categories developed by the U.S. National Center for Complementary and Alternative Medicine, specifically: 1) alternative medical systems; 2) mind-body interventions; 3) biologically-based treatments; 4) manipulative and body-based methods; and 5) energy therapies (NCCAM, 2000). It is of note that this structure has since been abandoned by what is now called the NCCIH, in lieu of a simpler three-category classification that appeared as part of the center's 2016 strategy. This is divided into: natural products; mind and body practices; and other complementary health approaches.

The *Ordre des médecins* draws from the WHO to classify complementary medicines into four categories: 1) biological therapies that use plant, mineral, animal, or other natural products, such as in phytotherapy and aromatherapy; 2) manual therapies that use physical manipulations of the body, such as osteopathy and chiropractic; 3) body-mind approaches, such as hypnosis and meditation; 4) complete systems with their own theoretical and practical bases, such as homeopathy and acupuncture[13] (Ordre des médecins, 2015). In France, there is also a well-funded university collaborative, known as the CEPS platform, which is working on facilitating and fostering evaluative research on complementary medicines. This research consortium is working to create a digital ontology of complementary practices as a means of facilitating research and database organization of findings. According to their publicity materials, the CEPS platform is a response to calls from researchers and public health authorities to better describe and evaluate complementary medicines. As justification of this mission, the CEPS platform cites the publication of approximately 70,000 studies appearing annually on complementary practices since the year 2000 and the current existence of more than 2 million publications of complementary medical studies (plateformeCEPS, accessed 2 January 2018).

[13] It is of note that the Ordre considers acupuncture as a "complete system," when it is merely a component of the complete system that is Traditional Chinese Medicine. This is indicative of what this thesis will identify as the "disembedding mechanism" that is facilitated by globalization and that we will argue is the key driver of the growth and relationship between complementary and conventional medicine in contemporary France.

The CEPS platform is cited here due to its mission and scope, which brings together academic, scientific, and governmental involvement and support extending across France. As such, it acts as evidence of the importance of complementary medicine's presence, usage, and popular interest in contemporary France. It is important to state here that throughout my fieldwork on this subject, one of the most consistent difficulties I experienced was finding reliable statistical data on the presence, scope, and use of complementary practices in France. While there are a variety of statistics on individual practices that have been generated by various parties, these often come from lobby groups and associations representing various complementary practices; which raises obvious questions about the validity of the numbers in light of research bias. Furthermore, even in official government publications, such as those produced by the *Institut national de la santé et de la recherche médicale* (Inserm)[14], reflect the methodological complexities of generating numbers for complementary medicine.

For example, in their 2014 report on acupuncture, Inserm indicated that there were 1,739 doctors with "orientations in acupuncture," registered with the *Ordre des médecins*; 3,442 doctors/acupuncturists registered in the national Adeli registry[15]; 700 doctors/acupuncturists listed in an online directory for such practitioners; and between 1,300 and 4,000 adherents of the French doctors/acupuncturists syndicate (Barry et al., 2014, p.12). All of these numbers were cited on the same page. Taken together, we get a glimpse of the methodological complexity for developing statistics on the number of doctors who are currently practicing acupuncture in France. Furthermore, in light of the methodological difficulty, many reports are left with no other recourse than using out-dated numbers. This becomes significant considering the exponential growth of acupuncture in France evidenced by: the presence of growing numbers of DUs and DIUs available for acupuncture in French universities; and the fact that the French Social Security noted that acupuncture was among the 35 most reported medical techniques in 2006 (with 714,939 instances reported out of 105 million acts performed by liberal doctors that year) (Barry et al., 2014, p.13). In addition, this same report cites a figure from the daily newspaper, *Le Parisien*, indicating the existence of between 3,000 to 4,000 people illegally practicing acupuncture in France without a recognized medical diploma (Barry et al., 2014, p.13)[16]. Here, it must be reemphasized that acupuncture is one of the most medicalized and mainstreamed complementary practices in France[17]; meeting all four of the criteria for inclusion listed in the previous section. As such, the fact that even a highly mainstreamed complementary practice remains so difficult to quantify implies that there is clearly an un-told story of complementary medical practice that is currently occurring in France.

Another highly mainstreamed complementary practice in France that will come into play repeatedly in this thesis is osteopathy. The most commonly-cited statistic is that there are currently roughly 26,000 health professionals with a diploma in osteopathy in France or one osteopath for every 2,500 inhabitants. This statistic was published in 2017 by the *Registre des Ostéopaths de France* (ROF), a non-profit association that aims to promote ethics, deontology, and expertise in French osteopathy[18]. According to the Adeli register in 2017, there were 29,612 health professionals with diplomas in osteopathy, or one for every 2,269 inhabitants (Villemain, 2018). Both of these figures position France as having the highest density of osteopaths per inhabitant worldwide; higher than the United States, where

[14] The National Institute of Health and Medical Research in English
[15] Adeli is the national repertoire of licensed health professionals listing their place of practice, their diplomas and their statue (liberal or salaried). Adeli registration is obligatory and managed by the ARS.
[16] http://www.leparisien.fr/espace-premium/air-du-temps/en-bref-11-02-2012-1855887.php 11 February, 2012.
[17] Also in this "most mainstreamed" group is hypnosis, osteopathy, mesotherapy, and homeopathy
[18] https://www.osteopathie.org/demographie.html ; https://www.osteopathie.org/55-qui-sommes-nous-.html

osteopathy originated and is fully medicalized. The 26,000 osteopath figure has re-appeared in the popular presses, such as in *Le Figaro* (Cost, 2017) and was even alluded to me by a Representative of the *Ordre des médecins* in our 2015 interview: "we created, I think 25,000 in a span of 4 or 5 years; 25,000 can you imagine the number ? […] so, on every street-corner now there are osteopaths."

The "creation" that the Representative of the *Ordre* is referring to corresponds to the creation of the 2014 regulatory framework for osteopathy instruction which partially, but not fully, mainstreamed osteopathy. By 2013 there were so many private osteopathy schools and professionals in France that a commission was created by the Health Ministry to develop and implement an accreditation system for qualifying private schools[19]. There are currently approximately 30 accredited private schools and three statues for osteopaths in France: "doctors, physical therapists, and what we call '*nie-nies*,' those who are neither doctors nor physical therapists and who have done their studies in an accredited school" (Representative of the *Ordre des médecins*, 2015). As such, it is of note that the "25,000 osteopaths," cited by the Representative of the *Ordre* in the previous paragraph erroneously equates this number of osteopaths with those who have received their diploma from the newly accredited schools without reference to the multitude of DUs and DIUs available in osteopathy in various French medical schools. Furthermore, none of the statistics concerning the number of osteopaths cited here take into account the number of "*nie-nies*," or osteopathy diploma-holders who are not health professionals, but who are able to legally practice osteopathy in France. It also does not take into account the scores of non-accredited osteopathy schools that are still operating and providing non-accredited diplomas to unknown numbers of students each year.

While 30 schools are accredited, as of September 2014, the Ministry of Health listed a total of 62 osteopathic training establishments in France (ROF, 2017). I was unable to find demographics on the total number of osteopathy schools currently in operation in France, but I can safely say that it is significantly more than the 30 that are accredited. This assuredness stems from my fieldwork, which confirmed evidence drawn from the current debate about osteopathic mainstreaming that was alluded to in this quote by Philippe Sterlingot, the president of a French osteopathy union: "schools lacking professionalism and rigor are still too numerous. Some are nothing but small offices playing at formations" (Cost, 2017). In the context of my fieldwork I had the pleasure of visiting one such Paris-area school, which actually was nothing more than a cramped office containing 3 staff-members and a school president. Classes were held in rooms rented at a nearby church and teachers were hired as independent consultants.

This theme concerning the marked differences in the quality of training in various complementary practices will be developed in later chapters of this thesis. For now, taken together, all of this indicates that there are considerably more people practicing osteopathy in France than the roughly 26,000 or 29,000 health professionals cited in official sources; especially considering that the official number has multiplied by 2.5 since 2010, which indicates a notable interest among the French population (Villemain, 2017). Unfortunately, due to the lack of data on non-health professional training and practice, it is impossible to have even a basic idea of the actual scope of osteopathic practice in France beyond stating that it is highly significant. Hence, there is a bit of truth underlying the representative of the *Ordre*'s pleasantry that there is now an osteopath "on every street corner" in France.

This difficulty with quantification is not unique to France; the academic literature on complementary medicine also suggests great variability at the European Union level as well.

[19] Décret n° 2014-1043 du 12 septembre 2014 relatif à l'agrément des établissements de formation en ostéopathie

For example, the European Parliament ENVI Committee's 2017 report cited the presence of 145,000 to 180,000 non-doctors practicing complementary medicine throughout the European Union. Just as was the case in the French numbers, a 35,000 practitioner difference is statistically significant. The problem of quantifying and evaluating the scope of complementary medicine stems from the methodological difficulties resulting from the unclear definition of what complementary medicine is, which practices it includes, and how to identify its practitioners. In France, complementary medical demographics generally include a mix of national self-reporting data (in both obligatory and voluntary professional registers), the number of acts declared to Social Security (which is only valid for the small minority of practices that have been medicalized enough to qualify for reimbursement), numbers generated by syndicates and organizations representing individual complementary practices, online practitioner directories, and numbers cited in the popular presses. This mix generates a high amount of variability in the resulting statistics for several reasons.

First, self-reporting data is unreliable in voluntary registers as some health professionals may not declare their complementary certificates or orientations for fear of stigma. For example, Hospital Administrator A admitted to hiding books with "metaphysical" complementary medicine themes in jacket pockets due to the "strange looks" they elicited in public places as if they were "pornographic" (2015). Other doctors also shared different stories involving the dissimulation of their complementary orientations from colleagues and family. Obligatory self-reporting data, such as the Adeli register, is reliable, but limited in terms of its definition of the complementary practitioners that are counted. We saw this in the case of osteopathy, in which only two-thirds of the osteopathy diploma-holders are accounted for in the Adeli register, because it is exclusively for nationally-certified health professionals. Thus, this limited definition of 'countable' complementary practitioners substantially reduces their numbers.

Numbers generated by organizations representing different complementary practices and practitioners are also of mixed reliability for several reasons. First, these organizations are usually inherently biased as they are often involved in lobbying activities in the political arena. For example, this is the case in osteopathy, "it's difficult, but you see for osteopaths, for example, I believe that recently osteopaths were recognized by Social Security and things like that, they fought;" and it is the case for kinesiology, "kinesiologists are actively working towards professionalization, so a dossier was created for the recognition of kinesiology" (Clinical Researcher R, 2015; Kinesiologist R, 2015). The "they" that Clinical Researcher R is referring to are the osteopathy syndicates and associations; likewise the "kinesiologists" who "are actively working towards professionalization" are led by kinesiology syndicates and associations. Furthermore, since these organizations are politically-oriented, rather than scientific or academic, the rigor of their data-collection methods remains questionable. Second, the numbers represented in the membership lists of many of the complementary medicine syndicates that are cited in demographics are also limited by the syndicates' membership criteria. For example, in order to become a member of the National Syndicate of Kinesiologists (SNK), practitioners must show proof of training that satisfies the SNK requirements and must sign the SNK deontology code. While the 2014 accreditation system for osteopathy schools is working to harmonize the standards and quality of osteopathic formations, kinesiology schools do not yet benefit from this level of professionalization. As such, there remains substantial variety in the quality of the myriad of kinesiological trainings available in France. As a result, an unknown quantity of kinesiologists is ineligible for membership in some of the 'big' syndicates, such as the SNK, and is thus excluded from the demographics.

Online practitioner directories can be a useful source of demographical information, but they are reliant on self-reporting data and some practitioners are cross-listed in several different directories. This would affect the numbers if anyone attempted to rigorously use them for a demographic study of complementary medicine; although no one has yet done so. Also, the use of practitioner directories for statistical purposes raises the issue of how to qualify practitioners; on many websites, no credentials whatsoever are required for registration. This means that on some websites, anyone with any or no experience can advertise themselves as a practitioner of some complementary practice. This speaks directly to the definitional difficulty of complementary medicine: How can practitioners be identified? Who should count as a practitioner? And what complementary practices are 'legitimate'? In relation to these questions, what came to light over the course of my fieldwork is rather interesting.

In France, the complementary practices that are repeatedly included in the demographics are: practices that fall into what the *Ordre des médecins* defined as "manual therapies, based on manipulations," such as osteopathy and chiropractic; practices that have been partially medicalized, such as acupuncture and mesotherapy; practices that have been partially mainstreamed and regulated, such as osteopathy; and several of the 'big' practices that have made significant progress in their self-organized professionalization, such as kinesiology. The rationale for this is in part, practical, and in part, normative. Practically speaking, it is easier to quantify and evaluate that which has been medicalized, mainstreamed, or professionalized; as these characteristics lend both a degree of legitimacy and available numbers. However, it is telling that several practices that have made efforts to self-organize and professionalize, such as reiki and magnetism, are habitually excluded from demographical evaluations. This stems from a more normative bias. Manual therapies that involve physical techniques have a material base that lends itself more easily to inclusion in a society dominated by the scientific, evidence-based, biomedical ontology of conventional medicine. Even if a manual practice does involve metaphysical notions, such as kinesiology, its physical, material practice can outweigh consideration of its underlying metaphysical orientations. This is exactly what Kinesiologist R was reacting to in his opposition to regrouping kinesiology under a category containing the word 'medicine.' Practices such as reiki, whose metaphysical orientations greatly outweigh the physical aspects of their practice, do not lend themselves well to the 'medicine' aspect of complementary medicine and are thus, excluded from the demographics. It is also of note that while certain techniques of traditional medicinal systems are taken into considerations, such as acupuncture, the traditional practitioners themselves are excluded from the demographics. For example, there are no statistics on the number of Tibetan doctors in France; even the ones who have become nationally certified for practice in France. This stems in part from the fact that these practitioners do not fall within what is implied by the "Occidental or Western medicine," appellation.

For example, in 2014, Inserm put out a magazine devoted to alternative medicine that covered 9 different practices[20] (Science et Santé, 2014). Of these 9 practices, statistics were provided on the number of practitioners for 4 practices: acupuncture, which is partially medicalized; mesotherapy, which is partially medicalized; osteopathy, which is partially mainstreamed; and chiropractic, which is a manual therapy. Summing up the numbers given by Inserm for these 4 practices results in an estimated total of anywhere from 22,700 to 38,750 total practitioners (Science & Santé, 2014). Not only are we left with a statistically

[20] acupuncture, mesotherapy, osteopathy, chiropractics, hypnosis, psychiatric thermalism, meditation, auriculotherapy, and homeopathy

significant range in the number of potential practitioners, it appears as problematic upon closer examination. Taking into consideration the growth rate associated with Adeli information on osteopathy diploma-holders in 2017, we can estimate that there were approximately 10,000 osteopaths with diplomas in 2010 (Villemain, 2017). This would mean that osteopathy alone would account for roughly one-third to one-half of the numbers for the four types of practitioners cited in the 2014 Inserm report; but this seems doubtful considering the nearly 715,000 instances of acupuncture reported to the French Social Security in 2006, which suggests a large number of practitioners that has only continued to grow exponentially. Considering that the Inserm report reflects what my research indicates are the most reliable and methodologically rigorous statistics in France, the problem of quantifying complementary practices becomes clear. For example, in the case of mesotherapy[21], the 2014 Inserm report confirms the presence of 2,000 practitioners possessing a DIU validated by the *Conseil de l'Ordre*, but goes on to say that there could be as many as 15,000 practitioners in France (Science & Sante, 2014, p. 27). It is of note that a 2010 Inserm report on mesotherapy also emphasizes the "difficulty to estimate the number of doctors practicing mesotherapy" (Barry & Falissard, 2010, p.14).

One of the reasons for this difficulty is in identifying legitimate sources listing practitioners. This is because there are multitudes of associations, syndicates, and online directories for complementary practices and it would be a methodological nightmare to attempt to develop a standard for their quality and harmonize their contents. For example, the 2010 Inserm report on mesotherapy cites the membership data from one association representing mesotherapists; whereas there are no less than four major associations representing French mesotherapists,[22] many of which have overlapping listings. The same is true for French demographics that include reference to the numbers of practitioners listed in online practitioner directories. For example, in the demographics section of the Inserm report on kinesiology (Gueguen et al., 2017), the number of practitioners featured in two online practitioner directories are cited. A Google search for kinesiology results in 8 different online directories on the first results page alone, and a Google search for complementary therapy directories featuring kinesiology results in infinitely more. The Inserm report states that the reason for only including the results from the two online directories they cited is that the practitioners featured in these directories satisfied the SNK adhesion criteria (Gueguen et al., 2017, p. 37). In other words, much like the case with osteopathy, the Inserm report on Kinesiology only takes into account the complementary practitioners who have a certain amount of 'legitimacy;' even if this legitimacy is entirely self-organized. While this is methodologically sound and understandable, it raises the same underrepresentation issue as the demographics for osteopaths. Should 'unofficial' practitioners of complementary therapies who are operating outside of mainstreaming efforts be recognized and counted in demographic statistics? Do these practitioners 'count' as such? How can we identify which of these practitioners are 'legitimate'?

For the moment, these practitioners are not counted in France; which, the case of osteopathy indicates, results in statistics that are not fully reflective of the actual scope and presence of these practices. In cases involving practices, such as kinesiology and shiatsu, that

[21] Mesotherapy involves the multiple subcutaneous injection of small doses of various substances (pharmaceutical and otherwise), has been almost fully medicalized in France. While it can only be practiced by a doctor, it is not reimbursed by the French Health Insurance and is officially considered as a complementary therapy.

[22] The associations referred to here are: *La Société Française de Mésothérapie; l'Association Médecine Morphologique et Esthétique ; Le Syndicat des Médecins Esthétiques* ; and the International Society of Mesotherapy, of which France is an active member country.

do not benefit from national mainstreaming and governmental regulations of some form, but that do benefit from the self-organization efforts of their representative associations, federations, syndicates, and schools; it is more difficult, but still possible, to attempt to put together demographic data. Unfortunately, no one has yet seriously attempted to do so. The self-organization and mainstreaming efforts of various complementary practices that is introduced here will be further explored in later chapters of this thesis; as it is a key mechanism in the configuration of the complementary-conventional relationship that is currently emerging in France. For now, suffice it to say that the vast majority of the 'big' complementary practices are attempting to self-organize and to become 'mainstreamed.' This is occurring even among some of the energy-based therapies, such as reiki and magnetism, and among some of the natural product-based therapies, such as phytotherapy and aromatherapy. In terms of demographics, this trend opens new possibilities for estimating the scope and presence of complementary medicine in France; but due to the definitional difficulty surrounding it as a category, including a bias against counting practitioners that fall outside of the changing boundaries of 'medicalized,' 'mainstreamed,' or 'legitimate' complementary medicines, much demographic data remains unexploited. As a result, this thesis argues that the scope of complementary medicine in France remains vastly underestimated.

This underestimation is only exacerbated by the difficulties associated with yet another methodological approach that is used to ascertain the size of the presence of complementary medicine in a given country: patient or consumer-based research. For example, in their recent study on complimentary medicine use in different European countries, Kemppainen et al. (2018) compared the percentages of the general populations who claimed to have used at least one complimentary therapy in a 12-month period. In France, they found that 31.2% of the French population claims to have done so; a considerably more conservative estimate than the often-cited statistic indicating that 40% of the French population has had recourse to complementary medicine. The 40% figure is commonly-used in official, academic, and popular publications (Ordre des médecins, 2015; Lazarus & Delahaye, 2007; Franceinfo, 2018). Surprisingly, this figure actually dates from 2012 when it was first published by Miviludes in their *Guide Santé et dérives sectaires*[23]. It is significant that Inserm, the *Ordre des médecins*, and the popular press are all content to use a statistic concerning the use of complementary medicine that was generated by the very government entity that is dedicated to fighting against it. Not only is this statistic now outdated, its accuracy in 2012 is questionable due to the bias of its publisher.

One of the reasons for variations in patient or user-based research results from the definitional difficulties associated with many complimentary techniques. This generates confusion among patients/users who may not report their complimentary medicinal uses, because they are unaware that something they used is considered as a complimentary practice. In our interview, Doctor R (2017) shed light on this difficulty in relation to using a patient-based methodology in order to estimate complimentary medicine use:

> "It's difficult because there are hundreds of non-pharmaceutical techniques that people don't understand […] if you ask someone, 'Have you used relaxation?' they will probably say, 'No.' So you write down that they have never used relaxation [...] The majority of women in France, and it seems probably also in a good number of countries, prepare for birth within the context of prenatal consultations [...] these involve both information on birthing and also mental and

[23] In English, the Guide of Health and Sectarian Aberrations

> muscular relaxation exercises. This resembles relaxation and in some places this is called a sophrology session, so we see that actually all of the women who have had babies in France know what relaxation or sophrology is. Nevertheless, if you ask them, 'Have you ever used relaxation?' the majority will reply, 'No, never;' but if you ask about it as part of prenatal preparation they will say, 'Oh yes, now that you mention it, yes there were breathing exercises for relaxation and all that, *ah* yes.' 'Ok, so you have learned relaxation?' 'Oh yes.' Of course a relaxation specialist or a sophrologist will tell you, 'Oh no, my technique is much more elaborate than that!' Granted, but the principle itself is the same" (2017).

This quote reflects a significant source of inaccuracy in statistics that rely on patient or user self-reporting research techniques, that of patient misunderstanding or lack of information. In addition, this quote reflects an important mechanism shaping the current relationship of complementary and conventional medicines in France that comes from debates among the practitioners of various techniques who are trying to professionalize, legitimize, and mainstream an identity for their practice. As an example of this, we can return to Kinesiologist R's argument that kinesiology, "is not an alternative medicine […] indeed we do not consider that it is included" (2015). Nevertheless, Kinesiologist R confirms that, "in general we are classified in the soft medicines, but we do not consider ourselves as medicine […] a priori this does not bother me, personally, but I know that many of my colleagues are very, very opposed" (2015).

As was alluded to earlier in this section, Kinesiologst R makes this statement from a position of opposition to the medicalization of kinesiology, specifically its restriction to exclusive practice by doctors and healthcare professionals. The rationale for this opposition is stated to be because,

> "For us the approach is completely different from the medical approach. The medical approach is symptomatic, it is linked to illness and seeks to heal the illness; this is not at all the approach of kinesiology, which is rather a global approach […] and the way in which we act is to balance" (2015).

In other words, Kinesiologist R is saying that to medicalize kinesiology would be to debase it, because it is ontologically incompatible with conventional medicine; a statement that subsequent chapters of this thesis will suggest may be false. Furthermore, even though this statement represents an inherent opposition to medicalization, it is also reflective of the attempted 'mainstreaming' trend that came to light repeatedly throughout my fieldwork and that was discussed in this section in the context of demographics: various complementary medicines are attempting to create and solidify their identities as independent and 'legitimate' practices. This creates various tensions that both contribute to the definitional difficulties of complementary medicine and shape the conventional-complementary medicine relationship. Additionally, these quotes also imply a resistance among complementary practitioners against being included in the complementary medicine category. In light of the endurance of the negative stigma of complementary medicine, such as the 2018 *Le Figaro* opinion piece condemning complementary practices as a category, this resistance is understandable. All of these aspects will be explored throughout this thesis as they prove themselves to be key elements shaping the contours of complementary medicine in contemporary France.

In its entirety, this discussion sheds light on why it remains difficult to develop demographics on the number of practices, the number of practitioners, the number of users, and the overall market size of complementary medicine in France. When all of the factors that are presented here are taken into account, it becomes clear that doing such a study would

require a massive effort, especially considering that the vast majority of instances of complementary practices remain 'invisible.' My fieldwork experiences and data indicate that the vast majority of complementary practitioners do not have nationally recognized certifications, have mixed levels of membership in complementary medicine associations or syndicates, are not registered in online directories, and do not declare themselves to the government. Many practices occur in the informal sector in spare rooms rented by associations or individuals, and on a cash or check basis. Many users may not be aware that what they are using or practicing is considered a part of the complementary medicine category, and thus, may not report their usage if asked generally; and may lie about their usage if asked specifically for fear of the negative stigma that still surrounds complementary medicine and many of its practices. Furthermore, my fieldwork indicates that many conventional practitioners use complementary techniques within their conventional practice without discussing it openly with their colleagues or declaring it on Social security reimbursement forms. These themes will all be returned to later in this thesis.

Throughout my fieldwork, I did make various attempts to collect some numbers; however the methods necessary to conduct such research far outreached the scope and timeframe of this thesis. Nevertheless, based on the crude and elementary calculations I was able to make, it is safe to say that complementary medicine represents a multi-billion euro industry in France. For example, a simple Google search and a variety of phone calls results in a list of approximately 10 hypnotherapy schools in Paris with classes ranging from 20 to 80 students per level occurring anywhere from 2 to 5 times a year. Google searches and phone calls indicate that approximately 5 to 10 hypnotherapy schools exist in each major French city[24]. In the Paris region alone, a search of six online databases dedicated exclusively to hypnotherapists listed approximately 250 hypnotherapists in or near Paris not including the medical doctors practicing hypnosis in their cabinets and in hospitals, and not including hypnotherapists listed in wider databases for complementary medicine[25]. When I asked a Parisian hypnotherapist how many people he saw per week he answered, "I don't know because I only work one or two days per week […] tomorrow I will see 6 and yesterday I must have seen 10, so you see it depends [I have a] normal practice" (Hypnotherapist M, 2017). My fieldwork indicated that there is consistency in an average of 5 clients per day seen by hypnotherapists working an average of 2 days per week in the Paris area. The database *Annuaire Hypnotherapie.com* indicates that the average price of a hypnotherapy session ranges from 50 euro to 120 euro depending on location, which was confirmed in my fieldwork. When you start doing rudimentary calculations of the potential market value of hypnosis in France, the math is astounding.

For example, imagine that each of the 250 hypnotherapists in Paris saw one person per week for 50 euro a session (an overly conservative estimate). That would equate to 650,000 euro per year in Paris alone. Now consider that hypnotherapy is far from limited to big cities. For example, in Nevers, a commune in department 58 with a population of 38,000, Google searches indicate the presence of 11 hypnotherapists; there are more than 36,000 communes in France! So now, for example, imagine that only one hypnotherapist was present in only 18,000, or half, of the communes in France and that each one saw one person a week for 50 euro. That would equate to a 46,800,000 euro per year for hypnotherapy in France. When the numbers of schools nation-wide are taken into account with what is cited here, we can deduce

[24] Paris, Marseille, Lyon, Toulouse, Nice, Nantes, Strasbourg, Montpellier, Lille, Dijon, Avignon

[25] The databases searched include: hypnose-ericksonienne.com; hypnose.fr; snhypnose.org; hypnoses.com; therapeutes.eu; hypnotherapeute.net. Wider databases all containing hypnotherapists in addition to other types of practitioners include but are not limited to : medecines-douces.eu; annuaire-therapeutes.com; annuaire-de-therapeutes.com; naturosante.com; lesannuaires.com; guide-medecines-douces.com

that hypnotherapy in France easily represents a multi-billion euro industry that is growing; and it is just one of the more than 50 complementary practices I directly encountered over the course of my fieldwork.

This example is intended to give an initial, very basic idea of the potential scope of complementary medicine in France. This puts into starker contrast the complete and total absence of reliable statistics from the government, its research entities, or the media. How is it possible that something so large can exist in France and yet there are no official statistics showing how many complementary practitioners are practicing, how many practices are being used, and how many French people are using them at what estimated price per session? This lack of data extends to the public sector as well. There are also no official statistics documenting the number of complementary practices occurring in French hospitals. As evidence to this point, in the 2014 Inserm publication on complementary medicines, the number of American hospitals including meditation in their services (200) is cited; presumably this is due to the lack of data for French hospitals (Science & santé, 2014, p.32). Furthermore, the invisibility of the presence of complementary practices that are occurring in all of the six Paris and surrounding-area hospitals (which were both public and private), and the three hospitals in other areas of France that I had direct contact with indicates that complementary medicine has a growing presence in French hospital practice.

### *1.3: French Healthcare as a Complex Adaptive System*

Throughout section 1.1 on the construction and definition of conventional medicine and its various appellations, there was an underlying argument that was implied, but not explicitly stated. It is now time to put that argument into words and to develop it in its own right. Tracing the historical development of medicine brings to light an evolution that led to our contemporary understanding of what conventional medicine is: scientific and based on the principles of physiology, biochemistry, and the empirical evidence produced using the principles of the scientific method. In order to arrive at this conception, conventional medicine passed through: its officialization and professionalization (exemplified by the creation of its professional and academic societies); its Westernization[26] (exemplified by its association with the Western imperial mindset); its scientification (exemplified by the growing importance of laboratory sciences and their application to medical knowledge); its biomedicalization (exemplified by the technoscientific view of the body and illness and the 5

[26] I define "Westernization" here as the identification of 19th century scientific medicine as something that was exclusively Western or Occidental. As indicated in section 1.1 of this thesis, this change resulted from the plethora of transformative scientific discoveries made throughout the Occident, especially those made in the fields of immunology, specific etiology, and bacteriology. It is of significant note that while Edward Jenner is generally credited as the founder of immunology and the discoverer of the smallpox vaccine, he was far from the first person to inoculate against smallpox and from first realizing that inoculations created immunity. Evidence suggests that the practice of inoculations actually began either in India (where it was supposedly described in ancient Sanskrit texts) or in China (where it was supposedly practiced as early as 1000AD) (Boylston, 2012). The earliest written records about inoculation use in China date to the 16th century. In India, inoculation use spread to the Ottoman Empire and reached England in the 18th century (Boylston, 2012). Jenner merely improved the method and coined the term "vaccine." He was the first to confer, "scientific status on the procedure and was chiefly responsible for popularizing it" in the West following his presentation to the Royal Society of London in 1796 (Wolfe & Sharp, 2002, p.430). This resulted in the identification of vaccines as part of "Occidental or Western medicine" and exemplifies the Westernization process that occurred in conjunction with the scientification of medicine and the Western imperial mindset.

associated processes described in section 1.1); and its recent transformation as something based on evidence and randomized controlled trials.

The reason for presenting a brief overview of the development of conventional medicine's appellations is two-fold. First, it shows the underlying philosophical and scientific principles that are carried in the various terms mentioned here. Second, it brings to light the interrelation of scientific and philosophical thought, a relationship that Koyré (1957) found to be so intertwined that, "separated, they become unintelligible" (p. vii). In his study of the science and the philosophy of 16th and 17th century Europe, Koyré came to the conclusion that, "the 17th century underwent and accomplished a very radical spiritual revolution of which modern science is at the same time the root and the fruit" (Koyré, 1957, p.1). In other words Koyré found that our understanding of the world, understood here as, "the total of observable phenomena," shapes our analysis of everything that it contains (von Bertalanffy, 1950, p.164). This, in turn, shapes our understanding of the world. Scientific development is thus related to our analytical methods and it both is shaped by and in turn shapes our analysis. Thomas Kuhn (1970) discusses this cycle using the term, "paradigms," which he defines as, "universally recognized scientific achievements that for a time provide model problems and solutions to a community of practitioners" (p.viii).

It is interesting that Kuhn defined a paradigm in a rather restricted sense, limiting it to, "a community of practitioners," rather than to a given society as a whole. While this limitation certainly corresponds to his rigorous analysis, it does not fully take into account the overarching social implications that resulted from the great philosophical and cosmological shifts that occurred throughout the history of scientific revolutions, such as those that were analyzed by Koyré. For example, Koyré indicates that the, "substitution for the conception of the world as a finite and well-ordered whole in which the spatial structure embodied a hierarchy of perfection," led to the mechanistic worldview that was prominent in the 18th and into the 19th century (Koyré, 1957, p. xiii). Newton's laws of motion are an obvious example of this shift. As Kuhn (1970) reminds us, "normal science…is predicated on the assumption that the community knows what the world is like" and shifts in the worldview cause a, "change in the perception and evaluation of familiar data" (p5, p.viv). Newton's mathematical tools were based on the assumption that motion was continuous and could be separated into parts, which could be examined individually and as a means of uncovering the laws that governed them. Thus, for every cause, there would be an effect and for every effect there had to be a known cause. Furthermore, wholeness became nothing more than a sum of its parts, so understanding the part was thought to inevitably lead to an understanding of the whole.

This view became the foundation of determinism, "because physics was able to explain a remarkably large number of physical phenomena, from the movements of planets to the kinetic motions of the tiny particles within an enclosed volume of gas, with only a few principles, it became the model of human knowledge" (March, 1970, p. 95). This had far-reaching consequences, influencing great thinkers from Laplace, who thought everything was predictable since the world followed well-defined laws; to Marx, whose dialectical materialism, "expressed the laws of motion in contemporary scientific thought"; to Freud, whose topographical map of the mind transformed it into a logical, complex mechanical device that was a direct outcome of its material base (Trotsky, 1939; Osborne, 1937; March, 1970). Thus, by the end of the 19th century classical physics and its mechanical materialism acted as the model of both the physical universe and for human behavior. This was alluded to in section 1.1 of this thesis and it is no coincidence that official, scientific medicine was born out of this era; because as indicated in Kuhn's (1970) theory, this mechanistic paradigm shaped the worldview at the time, which in turn shaped scientific investigation. The crux of

Kuhn's theory was that there is a circular interchange between the development of science and the development of the general ontological view that shapes society at different times; they are intrinsically interrelated and should be considered as such. Therefore, it is logical for philosophical debates over our fundamental questions of existence and being to be considered as interwoven with the history of the development of science. By extension, the history and development of science and technology forms an organic whole with the history and development of medicine, "speaking of the origins of modern scientific thinking implies, therefore, also discussing the origins of scientific medicine" (Altschuller, 1976, p. 1). Thus, just as Koyré reminds us, it is nonsensical to separate the exploration of medicine from that of science, philosophy, and by extension, society. Kuhn (1970) echoes this assertion while urging us to change our perspective on science and rather than considering it as a unified and linear whole, we should consider the, "historical integrity of that science in its own time" (p.3). What is interesting is that based on the logic of Koyré, we can extend the contextual integration of science and its paradigms to other aspects of society.

For example, not only did the mechanization of 19th century science influence the psychoanalytical theory of Freud and the social theory of Marx, it also led to the development of ideas such as the division of labor, the interchangeability of parts, and the principles of scientific management (Dooley, 1997). In other words, this scientific paradigm shaped the social understanding of organizations, their structure, and their functioning. As such, it is no coincidence that the development of scientific medicine corresponded to the transformative changes in hospital administration and the emergence of hospitals' curative functions throughout the 19th century (Chauveau, 2011). Not only did these changes organize hospitals and their management along bureaucratic principles of scientific management, it also corresponded to the, "birth of the clinic," in which clinical science appeared resulting in a redistribution, "between the symptoms that signify and the disease that is signified, between the description and what is described, between the event and what it prognosticates, between the lesion and the pain that it indicates etc." (Foucault, 1973, p. xix).

Kuhn (1970) observes that in the late 19th century a scientific crisis began to emerge in the field of physics as it became increasingly difficult to accurately apply Newtonian theory of absolute space and position in the face of the acceptance of the wave theory of light (p. 72-73). When Maxwell was unable to fit his findings in with Newtonian theory, the failure of the paradigm became evident, paving the way for Einstein's theory of relativity. As a result of the strange behavior that was brought to light by quantum physics, the scientific endeavor to attempt to explain phenomena by reducing them to their parts for independent investigation became replaced with a conception, "of what is rather vaguely termed 'wholeness'" (von Bertalanffy, 1950, p.134).

This is cited here because, as was indicated in the development of the notion of conventional medicine, both its definition and its contents are contextually dependent on the scientific and philosophical worldviews of society in any given moment. By extension and due to its negative definition, this logic applies equally both to what is included in the complementary medicine category and to the thinking surrounding complementary medicine's relationship with conventional medicine. In subsequent chapters of this thesis, we will come to see exactly how this shapes the conventional-complementary medicine relationship. For now, what is extremely interesting about this discussion is that it brings to light the, "remarkable phenomenon that similar general conceptions and viewpoints have evolved independently in the various branches of science" (von Bertalanffy, 1950, p. 134).

While the new findings of quantum mechanics emerged in the early 20th century, it remained highly theoretical and relatively restricted in its areas of application until the 21st century. Nevertheless it had a dramatic effect on the ontological shift that began in the 20th century and continues in the current medical paradigm. The effects of the quantum revolution and its redefinition of nature permanently removed the notion of the immutability of matter and interlinked space and time, which is manifesting in the 21st century as a result of globalization processes. Developments in chemistry and physics concerning the nature of the atom and molecular structure allowed for the development of molecular biology, a term coined in 1938. This constituted a shift in the focus of the life sciences to the submicroscopic scale and attempts to discover the, "general physicochemical laws governing vital phenomena" (Kay, 1993, p. 5). As a result of the focus, life processes became separated from their host organisms and a common materiality of all life, that of proteins, was established. Thomas Hunt Morgan noted that this "new biology" was focused on the unity of life phenomena and that which was common to all organisms. Furthermore, molecular biology led to a deeper knowledge of cellular physiology and pathology which ultimately led to the development of biomedicine or the application of biology and physiology to clinical practice. Clinical practice flourished in the 20th century, largely due to rapid technological advances in the area of diagnostic imagery and the application of the experimental method to the clinical setting. Specialization allowed for the sophistication of the scientific method which was understood at the time as, "the method of considering, whenever possible, one thing at a time" (Richards, 1924, p.66). What is interesting is that as more scientific and medical specialties developed with technological advancement, they were able to be better combined in the area of medicine creating a partial indivisibility of the sciences.

Concurrently, the endocrine system of the body was able to be elaborated resulting in a new conception of the nervous system, the brain, and the role of hormones. Once Crick and Watson were able to uncover the double-helix structure, a new vision of the body emerged. The body became understood as more than the sum of its cells, it became a system involving simple components being arranged into amazing complexity. This understanding of the complexity of the body led to the development of the multifactorial conception of illness. Thus, we see that the paradigm shift that was brought about by quantum physics; namely as researchers explored the complex behavior of sub-atomic particles, which did not follow simple cause and effect patterns, a new sense of the 'wholeness' of things emerged shaping our understanding of the world and all its contents, including our understanding of the body. Investigators in various fields began studying phenomena in terms of systems that are based on relationships, emergent patterns, and the interplay between a system and its environment. This way of thinking began shaping investigations ranging from the immune system, to the neural system, to economic systems as researchers began to find a "common kernel," pertaining to all of these different systems (Holland, 1992, p.17). To explain how this is possible, von Bertalanffy developed the notion of general systems theory as a means of accounting for the presence of isomorphic laws in completely different fields such as in the biology, physiology, and endocrinology mentioned in this paragraph. He emphasized that, "this is a well-known fact in physics where the same differential equations apply, for example, to the flow of liquids, of heat, and of electric currents in a wire. But it appears that the significance of this fact, and the possibilities it opens in fields outside physics, have hardly been considered" (von Bertalanffy, 1950, p.136). To demonstrate this point, von Bertalanffy effectively applied the exponential law to simultaneously explain changes in atoms,

molecules, bacteria, animals, and human beings[27]. Despite there being significant differences in both the entities and the causal mechanisms involved in the changes, the exponential law does, in effect, apply equally to them all. As such, von Bertalanffy (1950) concludes that there exists, "general systems laws which apply to any system of a certain type, irrespective of the particular properties of the system or the elements involved" (p. 138)

The purpose of general systems theory was to allow for the formulation and deduction of principles that applied to certain 'systems' in general, regardless of their type. The brilliance of this theory is that it reflected the interconnectedness of science and philosophy, while allowing for an analysis of complexity through its application to different strata of reality; from the sub-atomic scale to the complexity of higher-order strata such as that of human or social behavior. Von Bertalanffy (1950) called it a, "doctrine of 'wholeness,'" which he suggests is a generally-accepted idea across the disciplines (p. 142). In this sense, general systems theory brings the Kuhnian notion of a paradigm shift to a new level of applicability and provides additional insight to Koyré's conclusions on the intertwining of the science and the worldview in a society at a given moment in time. Furthermore, it opens up a variety of concepts not normally accessible to scientific investigation to the possibility of their formulation as parts or consequences of systems. As we shall see in later chapters, this will have interesting ramifications in light of the argument that many systems in complementary medicine are not able to be investigated 'scientifically'.

General systems theory grew out of a concern with the complexity of the world. The quantum revolution overtook the linear, cause and effect logic that had long shaped science. This was because the sub-atomic particles that make up the world were found to behave according to a different set of rules. Furthermore, with the advancement of computer technology, researchers began attempting to simulate systems using computers, but many systems from economies to ecosystems to the brain exhibited complexities that defied equation-based simulations. As such, complexity emerged as a fundamental aspect of the 21st century scientific paradigm. In fact, Heinz Pagels called complexity, "the great unexplored frontier," resulting from science's explorations of everything from the macrocosmos to the microcosmos (Pagels cited in Gare, 2000, p. 327). As scientists began to work with complex systems, a commonality emerged: that these systems, "change and reorganize their component parts to adapt themselves to the problems posed by their surroundings," and that, "the mechanisms that mediate these systems are much more alike that surface observations would suggest" (Holland, 1992, p. 18). Holland (1992) realized that these mechanisms and deep similarities in the "evolving structures" of these complex systems were so significant that he developed the theory of "complex adaptive systems" as a means of grouping systems displaying these characteristics under a common name.

There is no commonly-accepted definition of a complex adaptive system (CAS), but it is generally understood to be a system that is not governed by a single equation or rule; rather it has a dynamic network of parts or agents that each act according to their own rules and that are constantly reacting both to what other agents are doing and to the environment. In other words, these systems display an aggregate behavior that is not derived from the simple action of the system's individual parts or agents. The agents in the system both adapt to and anticipate changes in their environmental conditions, which in turn influences their behavior and the network as a whole (Holland, 1992). In order to better explain his concept of a complex adaptive system, Holland (1992) uses the example of the body's immune system.

[27] Specifically, von Bertalanffy applies the exponential law with a negative exponent to describe the decay of radium; the mono-molecular reaction; killing bacteria with disinfectants; the loss of body substance in a starving animal; and the rate of population decrease when the death rate is higher than the birth rate.

Our immune system is comprised of large numbers of antibodies that continually repel or destroy an ever-changing and infinite array of antigens. Thus, the immune system constantly adapts its antibodies in response to new antigens as they appear. Furthermore, the immune system must distinguish the legitimate parts of itself from the microbial invaders; a difficult task considering the biochemical complexity of the immune system's total component parts numbering in the tens of thousands. The immune system and its phenomenal identification capacities demonstrate the characteristics of complex adaptive systems: they involve huge numbers of parts that are constantly performing a complex interplay of simultaneous interactions both with themselves and with the larger environment. In a CAS, control tends to be decentralized or dispersed and the many decisions and actions of individual agents in a system influence its overall behavior. Order is thus, an emergent property that arises as the components in a system connect and interact with one another in unpredictable and unplanned ways. For example, think of the interaction between the air molecules and the water molecules in a weather system, or the interactions of the plants and the animals in an ecosystem. As patterns naturally emerge in a CAS, they feed back into the overall system and influence the behaviors of the individual agents.

Complex adaptive systems is a model that acts as a framework for thinking about certain complex systems, which are generally considered as having the following properties: a large number of agents that dynamically interact in non-linear ways; emergent patterns that result from the interaction of agents and feed back into the system to inform and affect the behavior of the agents and the system as a whole; co-evolution as the system adapts to fit the changes in the wider environment and the environment changes as a result of the system's adaptations in a constant cycle of interactive feedback; interconnectivity between the system's agents that makes understanding the relationships between agents more important than understanding the agents themselves; embeddedness in a series of nested systems, for example the human brain is its own system that is embedded within the body's overall system, which is nested in the system that is the body's wider environment; considerable variety that is essential to the strength of the system and its ability to co-evolve, for example an ecosystem gains strength from its biodiversity; simple rules that maintain the system, such as the heart rate's guiding of the body; self-organization as the system constantly adapts to its environment and vice versa; iterative change that emerges as small changes within a system grow into larger change; and a constant shift from equilibrium to near-chaos as a result of the mechanisms involved in the system's two-way interaction with its environment. The principles of emergent patterns and self-organization are the essential properties of a CAS that distinguish it from a simple multi-agent system (The Health Foundation, 2010).

It is of note that based on these properties it is possible to argue that complex adaptive systems are all around us and that we are all a part of multiple complex adaptive systems; an argument that this thesis explicitly supports. According to the founders of both general systems theory and the special case of complex adaptive systems, which the logic of both Kuhn and Koyré supports, CAS thinking is an approach that allows us to understand the world and its systems in terms of wholeness and complexity. As such, it reflects the paradigm that is resulting from the new worldview that is being opened by the application of findings in quantum physics to other disciplines. Analyzing using a CAS approach can enable new understandings and the formulation of solutions for complex problems ranging from healthcare expenditure to public health crises, such as AIDS (Holland, 1992). The literature on CAS extends across diverse disciplines including engineering, education, management, urban planning, environmental studies, economics, neuroscience, and as will be taken up in this thesis, healthcare.

A nation's healthcare system is an excellent example of a complex adaptive system as it is a macrosystem that is comprised of a large variety of microsystems; healthcare systems involve an immense number of agents, levels, and complexity. Consider, for example, an individual French hospital, which is its own microsystem of agents. There are patients, and the patients' families, nursing aides, nurses, interns, doctors, and other staff that are organized into different units, each with its own function and rules. It has a decentralized structure of unit heads and hospital administrators and is nested within a larger territorial hospital grouping. It interacts with and responds to the directives of the ARS and other hospital oversight agencies and is nested in the larger national hospital system, which is embedded as a fundamental part of the national healthcare system, which is embedded in the national Social Security system, which is embedded in the national French governmental system which is nested in the European Union, which is nested in a global healthcare system (a point which will be returned to in subsequent sections). This complexity was summarized nicely by a national representative of the *Ordre des médecins* who confessed, "I don't understand it either, I've been here for two years and there are things that I still don't understand, the French system is a system in which there is often too much […] the number of agencies that deal with health is incredible, there are too many" (2015). Hospital Administrator A echoed this sentiment and the presence of, "an administration of collaborators on the level of territorial delegations and the Regional Health Agency […] there is even a misalignment between the head of the Regional Health Agency and the collection of people that are on the ground and who are our interlocutors" (2016). Both of these quotes clearly reflect several of the properties of a CAS, namely that the healthcare system as a whole is not governed by a single rule and that it is directed by a decentralized structure of diverse agents, all of whom are operating according to their own rules and functions.

The French national healthcare system is clearly very complex and it involves the continual interplay of a huge number of agents that are constantly interacting in unpredictable ways. It also adapts to and is affected by the changes occurring in the environment it operates in on the local, regional, territorial, national, and global scale as new local and regional needs are identified or met; new national policies are created, implemented, and reformed; and as new global public health norms, trends and epidemics emerge. Adding to the complexity, the French national healthcare system is not limited to hospitals; it also includes private and military doctors, paramedical staff and establishments, those working in the numerous agencies that "deal with health," scores of health-related associations and syndicates, various specialized public and private clinics, medical researchers and facilities, universities, etc. Despite the high variability of the agents involved and the near chaotic characteristics of a national healthcare system in its totality, patterns and self-organization do emerge, the system does manage to function, and the overall system does co-evolve with the wider, globalized environment. In fact, it is precisely these characteristics that will prove to be of central focus to this thesis.

For now, it is important to emphasize that there exists a considerable amount of Anglophone literature on applying CAS analysis to various aspects of healthcare management, service delivery, organizational development, workforce development, and even clinical analysis (The Health Foundation, 2010). Throughout this literature, there is a common theme: that healthcare systems need to continue, "to depart from a mechanical regulatory approach…and move towards a complex adaptive systems approach that permits creative self-organization" (Lipsitz, 2012, p. 244). As such, this thesis will analyze the relationship between complementary and conventional medicine within the French healthcare system using a CAS approach. Considerable emphasis will be placed on the self-organization and emergent patterns that are allowing for the mainstreaming, medicalization, and the overall de

facto integration of a variety of complementary practices within various strata of the French conventional healthcare system.

This will go beyond the reductionist argument that complementary practices are developing simply in response to the "trendiness" of complementary medicine and the corresponding rise in patient demand. Instead, it will bring to light the importance of the integrationist mechanisms that are occurring both as complementary practitioners self-organize and as conventional practitioners on all levels of the healthcare system's strata interact with complementary practitioners and practices in creative, unexpected, and innovative ways. Furthermore, as will be outlined in the next section, this thesis will take into consideration the wider environment of the French healthcare system in terms of globalization and the generalized trends that are currently occurring within "Western" conventional medicine. Doing so will help to explain the apparent paradox in France, which, "is a major producer and consumer of nonconventional remedies, and by certain measures its use of alternative medicine ranks among the highest of Europe," and yet stands out, "for its institutionalized hostility to unsanctioned forms of medical practice" (Ramsey, 1999, p. 286).

In other words, this thesis will explore how it is possible for French doctors to admit that, "there is a very big consumption of nonconventional therapies outside of classic practices, that patients are highly defensive of these therapies, that these therapies generate a very important economy, and that among these nonconventional therapies there are doctors and non-doctors and dangerous and non-dangerous practitioners" (Doctor T, 2017); despite the fact that the overwhelmingly vast majority of these "therapies" are not legally sanctioned, regulated, or even acknowledged. Going further, this thesis will analyze how this situation is possible in light of the various official and institutionalized structures with missions that specifically include vigilance against complementary medicine. In spite of these structures, realizations about the magnitude of complementary medicine in France are widespread, extending to administrative strata. Hospital Administrator A (2015) noted that, "there are many people like me who are also struck by all of the alternative movements that are occurring." Even at the national level, there was evidence of the general acknowledgement of the significant presence of complementary medicine in France:

> "*Oh la la*! If you only knew! There is […] a market, a space. Now in health we talk about prevention and well-being, people want everything, as we say in France they want to have the butter, the money from the butter, and the mouse from the creamery […] so medicine is overwhelmed with normal care and now with well-being, there's no more time […] and thus, *bah* there are others who have taken the niche […] alternative medicines, alternative treatments, the people who treat the healthy" (Representative of the *Ordre des médecins*, 2015).

While this political doctor clearly has a distinct and normative vision of the reason for the growth in complementary medical use in France, this quote is reflective of the interest in considering the complementary-conventional medicine relationship within the French healthcare system from a CAS perspective. In this case, this quote reflects the healthcare system's nesting within French society and the dynamic interplay in how the agents of the healthcare system and the healthcare system as a whole adapt to social changes; here an emerging interest in well-being. This interest in well-being helps fuel the "market" in complementary medicine. As evidence of this market, consider these recommendations from one of the founders of a French association promoting the scientific evaluation of complementary medicine:

> "I suggest you buy a *Paris Match* special edition […] entitled natural medicines […] the problematic of complementary therapies is very well presented […] on *Arté* there was a very interesting show on […] one of the major [French] specialists in chemotherapy […] one of his patients had breast cancer and he was able to take this patient to India for one month to discover Ayurvedic medicine" (Doctor V, 2017).

Furthermore, the quote from the Representative of the *Ordre* demonstrates the feedback mechanisms, adaptation, and self-organization that are brought to light when French healthcare is analyzed as a CAS: a social shift towards an interest in well-being affects the conditions of medical practice, which modifies the actions of doctors and creates new limits in their time. As a result, this modifies the actions of the members of society, who go looking for alternative treatments. This affects the healthcare system by opening up a new "space" for complementary medicine and its practitioners. Complementary practitioners self-organize into schools and associations as a means of better integrating into this space. While this interactive interference pattern continues and can be analyzed ad infinitum, for now it is demonstrative of the kind of analysis that will be undertaken throughout this thesis with fascinating results. Furthermore, as we shall see in the next section, this quote also reflects the importance of taking the wider environment into account. This is because the current interest in "prevention" is not at all unique to French healthcare, but rather is one of the trends that are occurring in the wider, globalized environment that the French healthcare system is nested in.

For now, there is another argument for the interest in using a CAS approach to analyze the relationship between complementary and conventional medicine in France that must be elucidated. Throughout my fieldwork, I was repeatedly struck by the paradoxical nature of the relationship between these two categories that was so clearly stated above by Ramsey (1999). Throughout my fieldwork, every practitioner that pointed out the growing importance of complementary medicine in France also gave at least one reason for its demonization. For example, Doctor T said that complementary medicine becomes "scary" when a complementary practitioner such as, "a sophrologist is talking about a stomachache […] they don't know what they are talking about. I mean they don't know the range of organic diseases that cause stomachaches" (2017). This quote is far from an isolated incident. Complementary medicine in France was regularly dismissed throughout my fieldwork for being unscientific, "we haven't done the studies" (Doctor R, 2017); for being overly vague and inclusive, "we put everything into it" (Doctor O, 2016); for being a direct pathway to sectarian aberrations, "the main risk […] is in the health domain [...] gurus who propose miracle treatments that are not real" (Representative of an anti-sect association T, 2015); for steering people away from conventional treatments, "people will use it wrongly for things where conventional medicine is much more effective" (Representative of the *Ordre des médecins*, 2015); for acting as direct competitors of conventional medicine, "we are competitors of physiotherapists and doctors, also of pharmacists and all healthcare practices, because we don't play the consumption game" (Shiatsu Practitioner C, 2015) ; and for having practitioners who have not completed "serious studies," and thus, "obviously we are charlatans" (Kinesiologist R, 2015).

Approaching this paradoxical and constantly-changing relationship using a method that is based on a reductionist, mechanical, or linear cause and effect perspective results in a conception of the conventional-complementary relationship that resembles a Venn Diagram. It creates a simplistic picture of two, largely opposed categories that exist in a vacuum, with a small bit of overlap between them. While this picture is clean and clear, it fails to take into account the unexpected relationships that are forming and the innovations that are occurring on various strata, from the micro to the macro levels, as patterns emerge and the healthcare

system adapts in dynamic interactions. Additionally, as indicated in the Representative of the *Ordre*'s comments on the current focus on "prevention" and preventive medicine, developments in the French healthcare system are occurring within a larger environmental context that is shaped by globalization, global public health trends, and international healthcare norms.

Again, this supports a CAS approach since French healthcare is both affecting and being affected by the wider global health strata. Section 1.4 will explain how the "prevention" that the Representative of the *Ordre* alludes to is evidence of a global public health norm that is shaping the French healthcare system. For now, let us consider some of the evidence of how the French healthcare system is shaping global public health. One example of French involvement in the global healthcare arena can be found in the partnership between the French National Academy of Medicine and UNESCO, which is a means of, "promoting prevention, evolution, education, e-health, and the free exchange of best practices" (Albert-Claude Benhamou, a representative of the French National Commission to UNESCO, at *FAMx*, 31 May 2018). It is also evidenced by France's placement among the top 20 contributors to the World Health Organization Programme Budget in 2016 -2017 and France's noteworthy financial contributions to global public health initiatives (WHO, 2017). According to Stephanie Seydoux, the French Ambassador for Global Public Health, France has a, "significant and historical engagement in global health" (Seydoux, at *FAMx*, 31 May 2018). This is attested to by French efforts in the development of international public health policy; French engagement in the global fight against HIV and AIDS; France's international responsive health efforts; multiple French commitments to bi-lateral and multi-lateral health-based engagements worldwide; and active French involvement in various health topics alongside the European Commission, the World Health Organization, and the World Bank (Seydoux, at *FAMx*, 31 May 2018).

As such, summing up we can see that a CAS approach can account for the adaptation, self-organization, iteration and emergent patterns that are occurring within the current conventional-complementary medicine relationship in France and that were alluded to in section 1.2. It takes into account conventional medicine and the healthcare system's identifications of self and of complementary medicine; as well as the healthcare system's adaptations to and changes resulting from societal trends, ranging from the micro to the macro levels. Some of these trends were introduced in section 1.1 and they will be further explored in subsequent chapters. Additionally, a CAS approach is able to take into account the importance of and shifts in the underlying philosophical and scientific ontological paradigms that conventional medicine is inherently based on and responsive to; as was introduced in section 1.1 and theorized by Kuhn, Koyré, and von Bertalanffy, among others. To these ends, a CAS approach is able to take into account the French healthcare system's co-evolution within the wider environment characterized by globalization and the dynamic mechanisms that are shaping the conventional-complementary relationship as a result. The CAS approach will prove invaluable in this regard as it allows us to show the interactions between macro-level trends and the actions of micro-level actors; the emergent response to this interaction throughout various strata of the French healthcare system; and the implications this response has on the macro-level. In order to do so, it is now time to turn to an analysis of the movements that are occurring in the wider international, globalized environment that the French healthcare system is nested in.

## *1.4: French Healthcare and Globalization*

In the previous section, we looked at the intertwining of science, philosophy, and medicine as a means of bringing to light their circular relationship and connection to our conception and analysis of the body, disease, and the world in which the body lives. This is important, because the literature on the history of medicine typically portrays conventional medicine as the apogee of a linear trajectory of cumulative technological and scientific development. Rather than exploring the cyclical interplay of broader philosophical reorientations that can act as both the catalyst for and the result of new epistemological methods and technology, conventional medicine is generally inextricably associated with the notion of disease and with the new diagnostic and therapeutic technologies, leading some to argue that it is actually technology that defines disease (Boenink, 2010). The rapid technological growth of the 21st century caused a reversal in the relationship between science and technology. Paul Forman (2007) equates this to the rise of "technoscience," which involved giving, "primacy of technology over science with a loss of confidence in the trustworthiness of scientists." One of the reasons for this shift was the emergence of logical positivism, which gave the empiricism of science a new level of importance. This is of note in the context of the previous section, as the development of many of the thoughts that informed logical positivism occurred through engagement with the paradigm-shifting findings of scientists such as Einstein and Niels Bohr. For example, Bohr's reflections on the fact that quantum states were formulated using imaginary numbers had significant implications on the nature of reality and scientific epistemology. Bohr was aware of what this meant for reality, as evidenced by what Neurath wrote to Carnap about Bohr:

> "Bohr. Idiosyncratic. An intense man. Came to two lectures and joined the discussion enthusiastically ... Basic line: he does not want to be considered a metaphysician. And he is able to express himself relatively non-metaphysically, when he is careful. Yet obviously there lies a certain tendency in the selection of problems, insofar as the question of life, etc. is discussed, as well as in the stress on uncertainty" (Letter to R. Carnap, 14 November 1934, cited in Faye, 2010, p.34)

Not only does this quote bring the intimate intertwining of science and philosophy to the foreground, the uncertainty about the nature of Nature itself that it attests to had profound consequences that rippled across the disciplines throughout the 20th and continuing in the 21st century. In light of the implications of this ontological shift, the logical positivism that developed within this context gains more sense. This coupled with the growth of technology and the concurrent development of molecular medicine contributed to a change in the epistemology of medicine. Rose (2007) refers to this as the "molecularization" movement in which medicine shifted its focus from the surveillance of pathological bodies to the application of molecules in the transformation of the body. Imaging technology and our understanding of the fundamental units of the body shifted the medical gaze to the level of the body's vital mechanics. Together, this contributed to the birth of a "technological conception of life" based on the technoscientification of medical knowledge[28]. All of this constituted an

[28] For a clear example of this, consider the current debates and national variations in the medical definition of death worldwide. Traditionally, death was associated with the stopping of the heart, but due to advances in medical technology, the body can be kept "alive" artificially. As such, death became associated with the brain and the absence of brain activity. Various cultural traditions are opposed to the association of death with the brain and the artificial prolongation of life using technology. By extension, the debate on the definition of death is interrelated with polemics surrounding organ donation practices and policies. Thus, this illustrates some of the very real and practical concerns about the technological conception of life. (For further discussion of this debate

ontological shift in the definition of illness from the classical anatomo-physiological vision to one of "illness as a dynamic process" that is related to transformations in intercellular components (Boenink, 2010).

Meanwhile, the rapid development of technology also sparked the emergence of what Manuel Castells called the, "network society," a concept that refers to, "the social structure that results from the interaction between social organization, social change, and a technological paradigm constituted around digital information and communication technologies" (Castells, 2004, p.xvii). What is interesting about Castells' concept is that it emphasizes the interrelationship between technology and its social context, with a specific focus on the social processes that are related to, "the emergence of this new technological paradigm" (Castells, 2004, p.xvii). While Castells does point out that networks are not new to the 21st century, but are rather patterns that are fundamental to all forms of life, including social life; he indicates that evolutions in technology, in general, and communications technology, specifically, have accelerated the introduction of new actors and contents in processes of social change. As we shall see, the acceleration of innovation in social processes has direct consequences in the healthcare sector that go beyond the introduction of new imaging technologies. For example, take into consideration Hospital Administrator A's reflections on the reality of the network society:

> "We should be able to adapt these [healthcare] institutions, which in my opinion were once very innovative. How can we adapt them to the challenges of contemporary society? Society has really changed a lot and we have to recognize that we now have relationships that are much more horizontal and that resemble a network model; the vertical organization of society no longer corresponds to the way in which we build relationships today" (2015).

Indeed, facilitating the construction of new horizontal forms of relationships, affiliations, organizations, and structurations is one of the key features of our networked societies. The explosion of portable computing devices and wireless communications technologies has given us the ability to form various kinds of relationships with almost anyone, anywhere, anytime we like. In fact, this quote is a prime example of this phenomenon, as it was uttered in the context of a discussion about the recent sale of Hospital Administrator A's Paris-area hospital to an Australian private healthcare provider. This company, Ramsay Health Care has become the market leader of France's largest private hospital group, *Ramsay Générale de Santé*, acquiring more than 100 French facilities since the company's entry into the French healthcare market in 2010. Not only is Ramsay a leader of private healthcare provision in France, it also operates in 5 other countries around the world and recently partnered with an American company in order to optimize their, "reach internationally," by enhancing, "supply chain operations" globally (Sturman, 2018).

This example serves two purposes in the context of this thesis. First, it further justifies the use of a CAS approach as a means of analyzing the current developments in complementary medicine that are occurring within this globalized environment. Within Hospital Administrator A's newly globalized hospital, various forms of complementary therapies are being actively practiced. According to Hospital Administrator A, while the administration is aware that different complementary therapies are practiced on-sight, two are practiced with the administration's official awareness and acceptance, "for example we decided to propose osteopathy […] a mother who gives birth in our maternity can have a

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see e.g. The Economist, 26 April 2018, "When death is not the end" https://www.economist.com/international/2018/04/26/when-death-is-not-the-end)

consultation with an osteopath […] we have two osteopaths […] and as I've told you our anesthesiologists offer hypnosis to patients- well, to a certain number of patients" (2015).

Going further, this example also testifies to the impact that globalization is having on healthcare practices. In this case, it clearly attests to the "emptying of time" which contributes to the "emptying of space" theorized by Anthony Giddens (1990). For the largest, private health system in the United States to go through with a joint venture in order to, "improve the quality and reduce the costs of the millions of items our caregivers use to provide compassionate, personalized care," worldwide through partnership with an Australian hospital operator running hundreds of healthcare facilities spanning four continents, there must be a separation between the notions of "time," "space," and "place"; otherwise this kind of partnership could not exist (Sturman, 2018). In fact, this kind of partnership is a perfect example of what Giddens (1990) calls, "disembedded institutions," that "extend the scope of time-space distanciation and can coordinate across time and space," which free them from, "the restraints of local habits and practices," and allow them to promote new connections nationally and internationally (p. 20).

According to David Harvey (1989) these particular, flexible modes of globalized capitalist accumulation create new cultural forms and experiences of space and time. Harvey identified these kinds of processes as accelerators of, "time-space compression," which alters the way in which we represent the world to ourselves as the pace of life speeds up and overcomes spatial barriers[29]. Since, as Foucault (1984) reminds us, space is fundamental both to communal life and to the exercise of power, the process of time-space compression dramatically alters our experiences of the world and all its contents. This, in turn, has profound impacts on our notions of identity, which Castells (2010) tells us acts as a, "source of meaning and experience" (p.6). Since globalization has dramatically disrupted our notions that come from stable localities through its facilitation of the displacement of people and its, "market-driven 'branded' homogenization of cultural experience, obliterating differences between locally-defined cultures which had constituted our identities," globalization processes can be understood as containing a disembedding mechanism that lifts-out formerly locality-based understandings, concepts, and practices for worldwide circulation (Tomlinson, 2003, p.269). As a result, this has profound impacts on our experiences and understandings of self, our bodies, disease, and healthcare practices, among other things.

Curiously, this has paradoxical effects on what this thesis considers as conventional medicine. Following the logic of Foucault's discursive power, the conventional medical discourse becomes just one discourse among the many that are freely circulating through the globalized networks of communication. This creates new opportunities for healers from around the world to move and practice using mixes from different cultural systems and references. For example, over the course of my fieldwork I conducted participant-observation with an extremely globalized Peruvian shaman in Paris. This shaman, Shaman C, constantly moved throughout Europe practicing therapies and maintaining a client-list numbering in the thousands and representing every continent. Shaman C regularly published articles, poems, photos, and videos on Facebook and Youtube in three languages; drew from books ranging from neuroscience to esoteric hermeneutics; regularly quoted from the Bhagavad Gita; frequently employed the Koan-practice of Zen Buddhism to test for spiritual progress; and

[29] As a side note: while Harvey ties this notion in with that of post-modernism, which is not used within this thesis, it is of note that he conceptualized this as creating a particular way of experiencing 'being' in the world and as a break from the Enlightenment ontology that brought space and time together. This is significant, as it is an echo of the isomorphism that von Bertalanffy noticed. Thus, perhaps we can think about adding the concept of an ontological archetype to the Jungian notion of the collective unconscious…

had a penchant for Chinese food for lunch and pizza for breakfast. Furthermore, Shaman C displayed evidence of globalized, medical pluralism in his use of an epistemologically mixed construction of healing knowledge that drew from Andean Shamanism, Buddhism, Judeo-Christianity, Hinduism, Jainism, Taoism, and neuroscience, among others. For example, in one discourse Shaman C affirmed that:

> "We live in suffering because the material minds of our bodies do not believe in our spirit. The soul is the sun, fire, life, heat, and joy. This is why the sun exists; the sun gives us life, which is why for Indians it is *El Inti*, what Europeans call God. The sun is inside, it is love and its fire is the spirit of life. When you are with Spirit the cold, winter, and moon are of no importance. Nature and the cosmos teach us that life is fire and in all of the philosophies and doctrines we speak of the same thing" (2017).

This discourse simultaneously and explicitly draws on themes from the neuroscientific conception of the material basis of the mind, the Incan mythological Sun God, the Judeo-Christian notion of God, the shamanistic conception of the Spirit, and the *yin* and *yang* symbolism that is present in various Chinese belief systems. This is evidence of one way in which globalization touches healing practices; it allows healers like Shaman C to move around the world, to consume globalized products, and to use communication technologies to maintain diverse and far-reaching webs of social relations. Doing so facilitates the movement of, "transnational ideas, knowledge, therapeutic practices, therapists, and patients;" all of which were evident in the constitution of Shaman C's clients, some of whom would travel from other countries specifically to receive his therapies, attend his conferences, exchange ideas, and seek counsel (Pordié & Simon, 2013). It is of significant note that Shaman C was one of at least six shamans from various backgrounds and traditions that I met during my fieldwork experience; another one of which, Shaman J, was also Peruvian and also practicing healing touch energy activation therapies with a similar, mixed discourse.

These practitioners are able to draw liberally from what have become globally mobile concepts and practices in order to construct the "meaning" that they need in order to make sense of their experiences. Castells calls this, "the symbolic identification by a social actor of the purpose of her/his action" (Castells, 2010, p.7). To these ends, Fassin (1994) indicates that contemporary healers draw on science, religion, and anything that is seen as legitimate as a means of positioning themselves due to the lack of traditional points of reference (p.351). According to this logic and the globalization discourse presented here, this kind of medical pluralism[30] should also apply to conventional medicine and its practitioners. One example of this application can be found in the changes that have occurred in the positioning of the thresholds that define what constitutes an "at risk" population for things like hypertensive heart disease (Bourrier & Burton-Jeangros, 2014). The lowering of these thresholds and subsequent increase in the size of the "at risk" population occurred in tandem with the growth of both noncommunicable and chronic diseases, such as cancer, diabetes, sexually transmitted diseases, and heart disease. As the medical and scientific worlds struggled to define, explain, and develop treatments for these diseases from the mid to late 20th century, the limits of conventional medicine began to show as the communicable disease reference point shifted.

[30] Here it must be stated that "medical pluralism" is a term of great debate within the medical anthropology literature. In this literature, medical pluralism has generally been used to refer to three concepts: a scientific endeavor to describe the diversity and variability in treatment realities, logics, and practitioners worldwide; a means of emphasizing the political rights and existence of complementary medical practices; and an analytic concept that allows for the understanding of the variability and context-specificity of any and all forms of healing (Hörbst, Gerrets, & Schirripa, 2017). Here, the third conception of medical pluralism is used.

For example, Doctor T explained: "when AIDS appeared in the 80s we had new symptoms and associations of symptoms that we had difficulty identifying. So these symptoms got grouped together and we created the Acquired Immune Deficiency Syndrome, AIDS, which means that we succeeded in creating a definition […] we didn't yet have the aetiology, *aitia* is the cause" (2017)[31].

These developments in conventional medicine fall within what Skolbekken (1995) calls the "risk epidemic" marked by the exponential growth of the word "risk" within the medical literature from 1967 to 1991. While part of this growth resulted from the development of epidemiology and the increasing importance that was being placed on statistical data, Armstrong (1995) argued that it corresponded to what he called the development of "surveillance medicine" or the systematic study of healthy populations, the subsequent problematization of normality, and the blurring of the boundaries between health and illness, the normal and the pathological. What is fascinating about Armstrong's analysis is that it is framed with a reflection on the lateral extension of medical surveillance and a, "concomitant shift in the primary spatialisation of illness as the relationship between symptom, sign, and illness are reconfigured" (Armstrong, 1995, p. 400). This means that instead of something like a lesion acting as a sign or a symptom of an illness, all three of these elements became repositioned under the general category of "factors" and are "conflated in an infinite chain of risks" (p. 400). This caused a shift in the medical gaze as it began considering the illness risk-factors that exist in the space outside of the body in such areas as lifestyle choices and behavioral factors. It also repositioned all of us along an interlinked chain of the semi-pathological.

It seems as though it is not coincidental that this shift occurred within the context of the rise of what Ulrich Beck (1992) defines as the "risk society". Globalization processes including rapid change, techno-economic progress, disembedding, time-space compression, and the explosion in the production and availability of data has dramatically increased the general perception of risk in both medicine and society (Beck, 1992; Giddens, 1996; Harvey, 1990). This is because the "progress" in diverse fields throughout the 21st century has produced numerous risks, which society has become more concerned with regulating. One key component of the risk society is its reorientation of our conception of time: "…risks essentially express a future component. This is based in part on the prolonging of currently calculable damages into the future…by nature, then, risks have something to do with anticipation with destruction that has not yet happened but is threatening…in that sense risks are already real today…"(Beck, 1992, p. 33). This serves as a sort of extension of the time-space compression discussed by Harvey (1990). While Harvey (1990) was referring to the notion of time-space compression in terms of a change in the objective qualities and meanings of space and time (p. 204) as a result of advanced capitalist processes, he also notes that repetitive experiences of time (such as seasons) provide an important sense of security and is essential in the process of the reproduction and transformation of social relations. Thus, the compression of space and time is leading to new subjective experiences of a sort of hyperspace and hypertime as a result of globalization and capitalist processes that are exacerbating the perception of risk and society's future-oriented attitude of risk prevention

As such, it is neither surprising nor coincidental that within conventional medicine we are seeing a marked shift towards preventive medicine, or the mediation of future health risks.

[31] In June 1989, Samuel Broder, then head of the National Cancer Institute, declared in a speech at the international AIDS meeting in Montreal that AIDS was a chronic illness and that treatment should follow the model of cancer. Thus, AIDS was changed from an acute to a chronic illness, with important repercussions (Scandyln, 2000).

Considered in the context of this section, preventive medicine appears as the combined result of technological development and time-space compression. Molecular medicine is a good example of this interrelated development. Nanotechnology allowed for the development of advanced diagnostic technologies that can use biomarkers to detect illness at its earliest possible stage. These biomarkers are molecular characteristics that can be measured as indicators of normal or pathological functioning in biological processes at the DNA level (Lock, 2007). This can be viewed as part of the respatialisation of medicine that Armstrong refers to. While surveillance medicine repositioned many of the risk-factors for illness in the space outside of the body, molecular medicine compressed the time of illness pathologies. Up until this point, illness was positioned in the realms of the past, such as in the hereditary traits displayed in patients' family histories; and the present, such as in the experience of signs and symptoms of disease. Now illness became repositioned to include the domain of the future. This is because biomarkers do not actually signal the presence of an illness; rather, they predict the likelihood of an illness' future development. Nevertheless, this information is considered as an integral part of an illness and statistically, biomarkers embody the "presence" of illness. In other words, preventive medicine and molecular analysis have created a paradox in which the "proof" of a potential future illness is found in the present despite the absence of that illness and its traditional signs, which are directly accessible to our sensory capacities. This predictive logic is incredibly powerful, so much so that finding evidence of the molecular markers for breast cancer has prompted some women to get preventive mastectomies[32]. Thus, we can see that preventive medicine can be associated with the increasing scope, prevalence, and technoscience of the medical gaze. It expands medicine's gaze beyond protecting society through the control and elimination of pathologies; to a vision seeking to control, shape, engineer, and manage the vital capacities of human beings (Rose, 2007, p.5-6).

We can see more evidence of the effects of risk and time-space compression in the development of P4 medicine, which is a perfect case study of the result of the combination of these processes. The term "P4 medicine" was coined in 2006 by Leroy Hood as a result of his work in biology and technology; referring to medicine that is predictive, preventive, personalized, and participatory. According to Hood, the goal of P4 medicine is to address health instead of illness, and to reorient medicine's purpose to maintaining health using the technology of the future. As was indicated in the previous paragraph, this considerably widens the scope of medical intervention. As technology became increasingly used to decipher biological information related to DNA, proteins, and the "four-dimensional (time variant) information of biological systems operating across developmental and/or physiological time spans," our views of biology fundamentally changed (Hood, 2002, p.339, p.345). Systems biology developed, combining biology, medicine, information technology and systems thinking. This reorientation of biology occurred in the wake of the Human Genome Project, an international scientific effort to map human DNA. The genome became the "core of biology…and ultimately knowable," which turned biology into an *information science* (Hood, 2002, p. 345). Whereas up until the results of the Human Genome Project biologists tended to study the human body in terms of one gene or one protein at a time; it became reoriented towards a search to understand the behavior of all of the elements in any given biological system together in terms of their behaviors and their emergent properties. Biology became a

[32] One particularly public example of this that had noticeable and quantifiable repercussions was actress Angelina Jolie's preventative double mastectomy in 2013. Her decision influenced women worldwide; causing a near doubling of the risk-reducing mastectomy rate in both New York and Sydney hospitals. This case influenced so many women that it has been called the "Angelina Jolie effect" in the literature (e.g. Troiano et al., 2017).

cross-disciplinary project bringing together chemists, physicists, computer scientists, engineers, mathematicians, and physicians. This reorientation is clearly the result of the epistemological change in science as a result of technoscience and the new complexity of the globalized world reflected in the biomedicalization processes. Furthermore, it is the 21st century expression of the ontological redefinition of illness along the lines of submicroscopic processes and the common materiality of life processes that followed in the wake of the quantum revolution. According to some, this paradigm is bringing about the "medicalization of health and life itself" (Vogt, Hofmann, Getz, 2016, p. 307).

According to my fieldwork, the term "P4 medicine," is rarely used in France among practitioners or in the Francophone literature. Nevertheless, the concept seems to have permeated the current French conventional medical paradigm deep enough to where it is increasingly considered in French healthcare. There is evidence of the use of language and concepts that are clearly directly inspired by P4 medicine's underlying logic in both the medical literature and in the healthcare system's policy panning. For example, the *Assistance publique-Hôpitaux de Paris* (AP-HP)[33] strategic plan for 2015-2019 explicitly cites "P4 medicine," characterizing it as the "medicine of the future" and calling for:

> "An institutional approach centered on individualized, personalized medicine, according to which the AP-HP will equip itself with tools that allow it to maintain its position (the development of new biomarkers and the introduction of more systematic evaluative methods before their general use; platforms for innovative therapeutic medicines (MTI); the organization of metadata)" (AP-HP, 2014, p.33; p.13)

French interlocutors on various strata of the healthcare system also show evidence of their adoption of the principles of P4 medicine; however they generally only refer to its "preventive" and "personalized" components specifically. For example, in 2011 the French Academy of Medicine held a thematic session on the "Digital modeling of organs: towards personalized medicine and surgery," which featured a discussion on, "Biomechanical modeling of pelvic organ mobility: towards a personalized medicine" (Ardaillou & Couturier, 2011). All four of the discussions within this thematic session focused on the role of technology and its ability to develop digital models that would allow for: improved studies of pathophysiology as a means of allowing surgeries to more accurately address patients' individual physiologies; better predictions of the outcome of surgical interventions; improvement in the planning of future surgeries; and more effective prevention of the occurrence of future medical complications as a result of a patient-specific pathophysiology. As you can see 4P medicine clearly serves as the conceptual undercurrent that shaped these discussions. Evidence of this conception can also be found in the reflections of individual practitioners. For example, when asked about the term 4P medicine Doctor R replied:

> "Developing a personalized medicine seems to me- *voilà*- it's medicine [laughs] It's interesting because we can consider that medicine has always been personalized, but it is a means of underlining or of returning to the foundations of medicine, which is first and foremost a one-on-one relationship […] At its origins the symbol of medicine was the doctor and the patient, so that's a personalized medicine, we adapt the scientifically acquired data that is the most rigorous possible to the patient, as soon as the doctor or healthcare professional knows

[33] The AP-HP is a university hospital collective that includes 39 Paris-area hospitals and treats approximately 10 million people per year thanks to the efforts of over 100,000 staff members, including 12,500 doctors (https://aphp.fr/lap-hp-en-bref)

> their patient. The other Ps, prevention, yes the development of preventive medicine, yes that's 4P medicine, it's a concept that I've heard of (2017).

Again, even if all four of the Ps are not specifically mentioned by Doctor R, we still see evidence of the conceptual basis of 4P medicine within his rhetoric. Thus, this provides insight on the importance the wider environment has on shaping French healthcare. Specifically, it corresponds to what Petric (2013) terms a, "transnationalization of power, meaning the multiplication of ties on the global level [extending] into all domains of social life" (p. 190). In other words, we see that global norms are directly shaping national healthcare system goals and priorities as a result of the complex interconnection of a nation and all its components with the global level. This dynamic is most clear in the case of preventive medicine.

Preventive medicine is not at all unique to the current era. This history of medicine indicates that from the beginnings of man, we have been attempting to understand, cure, and avoid illness (Robinson, 1943). While prevention has been a continual component of medicine throughout its history, it was the 20th century change in the disease-burden that brought preventive medicine to the forefront of global public health. This was because improvements in public health, hygiene, and vaccinations reduced the global morbidity rate of infectious diseases and medical progress improved the general medical response to these diseases. Specifically, 20th century global health efforts dramatically controlled infectious disease rates, reduced child mortality, and facilitated improvements in life expectancy worldwide (Szlezak et al., 2010). Concurrently, noncommunicable diseases flourished, increasing healthcare costs and, "threatening the solvency of even the wealthiest healthcare systems" (WHO, 2011).

What is incredibly interesting about the development of the literature on global public health is that it displays evidence of a shift in the most important causes of both chronic and noncommunicable diseases and in the orientation of the preventive efforts to address these causes. For decades, preventive public health focused on issues related to infectious disease such as sanitation, clean water, secure food supplies, and education. In the last decade there has been a shift in focus onto factors such as tobacco and alcohol consumption; the unequal availability of fresh, non-processed foods, especially in slums and impoverished areas; the general lack of physical exercise and safe spaces for children to play in; the increase in stress and work-related injuries; in short, factors that are directly related to globalized corporations, products, and lifestyle patterns. In her opening remarks at the WHO Global Forum on noncommunicable diseases in 2011, Margaret Chan, the then Director-General of the WHO stated, "today, many of the threats to health that contribute to noncommunicable diseases come from corporations that are big, rich and powerful, driven by commercial interests and far less friendly to health;" prompting her to rhetorically ask these corporations, "Does it really serve your interests to produce, market, globally distribute, and aggressively advertise, especially to children, products that damage the health of your customers?" (WHO, 2011).

These shifts and the growth of the prevalence of chronic and noncommunicable diseases including heart disease, cancer, obesity, diabetes, and sexually transmitted diseases is increasing the burden on healthcare systems worldwide. As such, it is understandable that preventive health services have become increasingly important priorities in many healthcare systems, including in France (Chaulk, 1994). The primary importance that is placed on prevention in French healthcare is attested to in the 2013 National Health Strategy, which gave primary priority to prevention (Ministère des Affaires Sociales et de la Santé, 2013). This built on the 2004 French healthcare reform which also focused on improving public

health through preventive efforts and giving an increasingly important place for preventive measures in French public health expenditures[34]. This shift towards preventive medicine occurred within the larger context of the "global public health system," defined as, "the constellation of actors (individuals and/or organizations), whose primary purpose is to promote, restore or maintain health," using, "persistent and connected sets of rules (formal or informal), that prescribe behavioral roles, constrain activity, and shape expectations among them" (Szlezak et al., 2010, p.2). This "constellation of actors" ranges from private individuals to international organizations, spanning from the local to the international levels. This fact is attested to in the discourse of Xavier Bertrand, the former French Minister of Health. In a 2006 interview, Bertrand stated:

> "Another challenge, in my opinion, is more strategic: the prevention of ill health. In terms of curative care, the World Health Organization considers the French health system to be one of the best in the world. In terms of prevention however, I believe that we can, and we must, make real progress. We can meet this goal not only by providing increased coverage of preventive activities within our health insurance, but also by promoting health education and better awareness on health issues, as well as taking more responsibility for those risk factors that can affect health such as excess drinking and smoking. In my opinion, prevention is the key challenge, and the key driver, improvements in quality, led by the training of health care professionals and accreditation of health care facilities" (Bertrand, 2006).

This comment clearly situates the French emphasis on prevention, which has been developing throughout the 21st century, within the realm of international public health considerations and norms. While it is arguable that this emphasis on prevention occurred organically in a bottom-up fashion within the French system; the reflections that various practitioners shared with me indicate that the focus on prevention in the French health care system is something that comes from the wider international community.

Multiple practitioners commented on the 'foreignness' of prevention and preventive medicine. For example, Shiatsu Practitioner C noted, "it's not in the Occidental state of mind, prevention. Of course, it is beginning to become so, but what I mean to say is that medicine has been essentially oriented around disease" (2015). Hospital Administrator A echoed this sentiment by saying, "you work on an opening to alternative medicine, but we can also talk about the development of prevention. When we look [we see that] we are in a system, a medicine that is very curative" (2015).

These statements become even more interesting when we consider that they were given approximately an entire decade after one French Health Minister officially placed prevention as a French health care priority through reforms in 2004, and a second French Health Minister further underscored the priority placement of prevention in the health care reforms of 2013. Nevertheless, the following comments from Hospital Administrator B indicate that the concept still has not been fully integrated into the system; and thus, continues to actively shape French healthcare:

Q: "In your hospital has there been a movement towards preventive medicine?"

[34]The 2004 reform was legally encoded as the « loi n°2004-806 du 9 août 2004 relative à la politique de santé publique » (Available online at : https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000787078&dateTexte=&categorieLien=id)

> A: "Preventive, no- well yes[…] Yes, there are many services that work […] in nutrition for example […] the hospital of tomorrow will work on prevention, that's sure, prevention against AIDS- we can see that all of this is current news" (2017).

Representative F of the *Ordre des pharmaciens* echoed this reflection and, just like Hospital Administrator A, also associated the implementation of prevention in French medicine with the creation of an opening for complementary medicine:

> "Since prevention has not really been organized effectively by the State, there are other people that are doing it and that is the coaches and gurus and all of those who are doing primary prevention in any way imaginable. That is why I think that healthcare professionals and the national authorities seriously need to appropriate everything about primary prevention" (2015).

Thus, we can see that the French health care system is embedded within the wider international environment and that that wider international environment is being shaped, in a multitude of ways, by developments associated with globalization. Then we see how that international environment, in turn, shapes the priorities of the French health care system. We also see evidence of some ways in which the international, globalized environment interacts with and shapes various forms of complementary medicine in France. Additionally, we see that an internationally-influenced national priority directly acts across strata, touching as far down as the local, individual hospital level and to the individual practitioner level. In so doing, this in turn influences the conceptions and interactions in the conventional-complementary medicine relationship with the French health care system. Taken together, this further underscores the importance of using a complex adaptive systems approach in order to bring to light the co-evolutive dynamics of what appear to be inextricably interlinked micro-systems within the larger French health care system that is embedded in the even larger international system; all of which are directly influenced by and interacting with the dynamics of globalization. In subsequent chapters, we will see more individual instances of these interactions, which take the form of circular interchanges among and across these strata. For example, in Chapter 3, we will see how conferences and the exchanges of best practices provide an opening for French practitioners to shape the international level; as well as, how globalization trends are influencing the preferences of individual French doctors, and how by extension, that influences the dynamics of the conventional-complementary medicine relationship.

Furthermore, throughout this section we have seen how macro-level ontological, epistemological, technological, and economic shifts have directly impacted conceptions of health, disease, and both conventional and complementary medicines. We have seen how these trends change approaches and priorities in health care from the local to the international levels and how these trends have directly impacted the French healthcare system. In so doing, this section has further underscored the importance of taking the wider international environment into account when considering conventional medicine, complementary medicine, and the dynamics between them. As such, the stage has been set and we can see the context in which conventional and complementary practices and their practitioners are interacting; with each other, with the national health care system, and with the international, globalized environment. In section 1.3, we explored the nature of the dynamics of these interactions through a discussion of complex adaptive systems. In sections 1.2 and 1.1, we discussed what complimentary and conventional medicine are and how they are defined. Thus, now that we know exactly what we are talking about, the dynamics that shape their interactions, and the

wider environmental context that we find them in; it is now time to turn to an analysis of the nature of their relationship as evidenced by their specific interactions.

# Chapter 2: The Perceptions of Both Sides of the Conventional-Complementary Relationship

## *2.1: Perceived Separation in the Conventional-Complementary Relationship*

Despite the current popularity of complementary medicine, which is attested to by consumer demand and interest, my fieldwork and literature review indicated that complementary medicine continues to be presented as something that is in a separate domain from that of conventional medicine. While subsequent chapters of this thesis will show that this perception is changing, for now there remains ample evidence of a perceived separation between the two sides of the conventional-complementary relationship. One of the clearest examples of both the popularity of complementary medicine and its separateness from conventional medicine can be found in the press materials for trade events such as the *Salon bien-être, medecine douce, & thalasso*, 2018[35]. A 2018 press release for this event attests to the popularity of complementary medicine: "soft medicines and therapies that reconcile the mind and body have never been so thriving. Linked to the notion of well-being, they have become essential to maintain health capital. It is estimated that today one in four French people use soft medicines" (GBCOM, 2018). In addition to its use of the outdated, Miviludes statistic on complementary medicine in France discussed in Chapter 1, this document indicates that this particular trade event drew over 38,000 visitors in 2018, representing an annual increase of 15%.

This trade event, and its growth rate, is far from an isolated incident. In Paris alone, there are approximately 9 major trade events per year that explicitly feature complementary practices including: corporal practices, such as yoga, tai chi, and qi gong; dietary supplements such as spirulina and various natural substances; elements from traditional Chinese and Indian medicine such as reflexology, acupuncture, and Ayurveda; oil-based practices such as aromatherapy, Bach flowers, and essential oil supplements; meditative practices such as sophrology and various forms of meditation; coaching and personal self-growth practices; sound, color, and art-based therapies; spirituality and health tourism such as initiative voyages, detox workshops, and retreats; and a variety of products related to complementary medicine ranging from meditation cushions and yoga mats to thousands of different books, creams, candles, drums, crystals, lanterns, clothes, cards, artwork etc. These trade events each draw between 10,000 to 40,000 people and feature hundreds of exhibitors covering all the economic sectors from raw goods and manufacturing to product sales and publishing all the way to schools, associations, and individual practitioners. Over the course of my fieldwork I went to 5 of the Paris trade events featuring complementary medicine and was surprised to find that representatives of complementary practices from all of these economic sectors were routinely present at all of them; even at the 4 trade events that advertise themselves as dedicated exclusively to organic products[36]. Furthermore, all of the press kits for these trade

[35] In English, the trade event for well-being, soft medicines, and sea-water therapy. This event occurs annually in Paris and lasts for 5 days featuring approximately 350 exhibitors from 6 sectors: soft medicines, dietary supplements, natural cosmetics, health foods, health tourism, and the art of living.

[36] For example, *Salon Marjolaine* bills itself as "the biggest organic market in France," yet its program includes corporal practice workshops, acupuncture, and aromatherapy among other complementary medicine offerings. Information available at: https://www.salon-marjolaine.com/ . The following list shows the 9 Parisian trade events. Those followed by (bio) are those that are dedicated to organics : *Naturally* (bio); *Salon Zen*; Vivez

events feature double-digit growth in their attendance rates and vaunt the growing interest in "practices of well-being."

One good example that sheds light on this trend can be found in the publicity materials for the *Salon Natexpo*, which advertises itself as an "international trade event for organic professionals." Their website features a detailed visitors profile from 2017 indicating that 4% of the salon's total sales in 2017 were made by a category labeled in the pie chart as, "naturopaths, nutritionists, and doctors"[37]. Not only does this attest to the considerable presence and purchasing power of naturopaths in France, it also provides insight into the consideration of the complementary medical market. For example, the same pie chart also indicates that another 4% of the 2017 *Natexpo* sales were made by hospitals, pharmacies, and parapharmacies. It is worth underscoring that not only were naturopaths placed on a pie chart featuring major buyers; they were grouped among, and placed adjacent to, categories of health professionals. This means that economically speaking, naturopaths are on par with health professionals in terms of their presence and purchasing power at this particular event. Thus, we can see why even organic product trade events are increasingly catering to complementary medicine and its practitioners. In addition, we can see that this connotes a certain 'separate but equal' logic that will be returned to for analysis later in this section.

For now, it is important to underscore that all of these trade events clearly position complementary products, practices, services and therapists as being 'separate' from conventional medicine through their use of rhetoric emphasizing the growing consumer interest in "health and well-being." Specifically, these trade events present themselves as being countercultural opportunities providing people, "an open space to think about the big questions of our society, all while incarnating the values that have found an echo in today's world: a search for sense, personal development, sustainable development, organics, spirituality etc."(AB3C, 2017). These salons are represented as innovative places of exchange and the discovery of "new" health and well-being products and techniques. In their press kit, the *Salon bien-être* noted that 38,500 people visited the event in 2018, of which 73% were between 36 and 56 years old. 88% of the attendees bought an average of 138 euro worth of products, 88% reported that they had plans to visit the event in 2019, and the principal motivation for attendance was, "the search for natural innovations in the domain of health and well-being" (*Salon bien-être*, 2018[38]). These salons are situating themselves in the world of ethics, sustainability, the green movement, and as innovative and revolutionary approaches to health, well-being, lifestyle, self-care, and personal development; yet, it appears that they are merely catering to the "values" of a relatively narrow demographic of society with disposable income.

In their press and sales information, all of these salons promote the economic growth potential that these events offer their exhibitors. Not only do their websites provide overviews of the kinds of exhibitors that are featured, they also provide a window onto the kinds of people that are attending, namely: middle-class professionals; young professionals; and natural health and well-being professionals. Again, we see this same grouping of complementary practitioners with health professionals, in which they are represented using a sort of 'separate but equal' logic. This information, coupled with the sales and number of visitors, expressly promotes the economic incentives and growth potentials that these events broadly offer throughout the production and consumption chains. In other words, these events

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*Nature*; *Festival de Yoga*; *Salon Marjolaine* (bio); *Salon-Behappy*; *Salon Bien-être, Médecin Douce, & Thalasso*; *Vivre Autrement* (bio); and *Natexpo* (bio).

[37] Available online at: https://natexpo.com/le-salon/salon-natexpo-2018/

[38] Available at : https://www.salon-medecinedouce.com/exposants/pourquoi-exposer/

are clearly not alternatives to consumerism and global capitalist processes; in fact, they are proudly presenting themselves as events with the potential for growing businesses internationally. For example, *Salon Naturally* promotes itself as, "a unique occasion to discover and adopt a new mode of life that is healthier for the planet and consumers" (SPAS Organization, 2018[39]). *Salon bien-être* promotes the opportunity to, "appreciate new product lines[40];" even the *Yoga Festival* positions itself using language of international commercialism: "Following in-line with what is happening in London, Berlin, Milan, Barcelona, Toronto, and New York…with great success and in order to respond to the growing interest in the practice and philosophy of yoga, the Yoga Journal team is organizing an annual yogic gathering over 4 days in October: a professional event for the international general public, taking place in over 3,500 m² in a new Parisian space" (Journal du Yoga, 2018[41]). Indeed, when I visited the Yoga Festival in 2016 I very much felt the need to actively develop my yogic practice of breathing as I attempted to navigate through a huge space full of hundreds of stands and thousands of people jostling to get at the best organic purple yoga pants, most-authentic Indian finger cymbals, best-sounding Tibetan bowl, most interesting DVD, or prettiest mandala coloring-book.

Thus, we can see that even if these events promote themselves as a countercultural alternative, it is unclear exactly which cultural aspects they are an alternative to; as it is certainly not that of globalized production and consumerism. Furthermore, upon closer examination, the rhetoric of these conferences appears mixed. So while they are promoting their opening to healthier, more ethical, natural, and sustainable products, life-style practices, and therapies; they are also promoting the further integration of these products and practices within "mainstream" culture. For example, the *Yoga Festival* endorses itself for those, "who would also like to show the social dimension of yoga, its links with health, ageing, education, its relation to science, and feminism" (Journal du Yoga, 2018, see footnote 41). As you can see, none of the "social dimensions of yoga" cited here are particularly counter-cultural. In fact, all of these topics are regularly found within the policy literature pertaining to conventional medicine, as they are all current conventional medical and public health priorities[42]. As such, this constitutes yet another example of a 'separate but equal' presentation of complementary practices at these events.

In this context, it is important to underscore that 7 out of the 9 annual salons featuring complementary medicine or its products in Paris are organized by the same company, Spas Organisation. This company is, "the largest organizer in France for professional and general public events dedicated to organic products, well-being, the art of living, and sustainable development," in the form of 24 events that occur annually throughout France (Spas Organisation, 2018[43]). Due to their breadth and expertise, Spas Organisation began publishing trends reports in 2018, which provide statistical information, analysis, and information on "key transversal trends." According to the president of Spas Organisation, Patricia Berthomier-Massip, this is because:

> "…for more than 30 years, Spas Organisation has held onto a resolutely constructive view of the world. This is why we would like to share the trends that revolutionize the daily lives of your consumers….our objective: to accompany you to be even more inspiring, innovative, and to motivate your future

[39] Available at: https://www.salon-naturally.fr/wp-content/uploads/2018/05/DP-Naturally-.pdf
[40] Available at: https://www.salon-medecinedouce.com/exposants/pourquoi-exposer/
[41] Available at : https://www.yogafestival.fr/view/content/page/623?session=iovceij9obdljim37vk1ku8ln6
[42] For example the AP-HP 2014 strategy document cited in section 1.4 explicitly used all of these terms.
[43] Available at: https://www.spas-expo.com/notre-histoire/

> developments! This publication marks a new step in our ambition to create even more links between you, the major actors in the sector, and your buyers…Spas Organisation wants to generate positive impulses for and with you!" (Spas Organisation, 2018)[44]

Clearly, this rhetoric denotes a clever, commercial use of the identification of complementary products and practices as innovative and revolutionary health alternatives as a means of increasing and capitalizing on their market potential. This implies that consumers like to think of complementary medicine and products as "alternatives," even if they are not presented as clear alternatives to anything specific and even if they are then marketed according to the same capitalist logic and strategies as any other product in the international marketplace. This can be seen in even greater detail when we consider some of the practices that I repeatedly found at the Spas Organisation event, *Salon Bien-être, Médecine Douce, & Thalasso* during three years of my fieldwork: French shamans and magnetizers selling drumming, dancing, cocoa-based workshops, energy therapies, and/or initiative voyages to "sacred" places so you can meet your personal nature spirits, and in some cases, dragons; people with divining rods and/or crystals offering to re-harmonize the energy in your house and combat the dangerous waves from things like electrical outlets for 50-100 euro per session; free, short introductions to meditation and mind-reading techniques ended with a special discount for a series of classes; people offering to read your aura, iris, feet, hands, or muscles and then to sell you a variety of products, therapies and/or classes to heal the energetic and/or physical body; people offering you a variety of different massages so that they can sell you classes and additional sessions at various prices; and of course a stand of women appealing to feminist ecological concern in order to sell you wildly overpriced, organic feminine hygiene products. Also, nothing says revolutionary sustainability better than leaving a trade event with a bag stuffed full of paper pamphlets, brochures, leaflets, business cards and any other number of promotional materials that are offered at each and every show and stand.

The implications of this consumer preference for "alternatives" will be returned to and explored throughout this thesis; but for now, we can say that this discussion of trade events acts as evidence of complementary medicine being popularly presented as a health alternative that is separate from conventional medicine; even if it is being marketed using the same buzzwords and approach as is used for conventional medicine. One such example of this similarity was the *FAMx* Paris conference mentioned in Chapter 1 that was organized by the Foundation of the French Academy of Medicine at UNESCO in 2018. The *FAMx* conference was organized in partnership with a medical conference consulting company called "Doctors 2.0 & You" as an innovative "conference within a conference."[45] What this seemed to mean in practice was that during the coffee breaks at the *FAMx* event, attendees could circulate among stands promoting various e-health start-up companies selling products such as video games for the management and rehabilitation of chronic eye diseases and hospital-grade medical devices for use in mobile environments.[46] I also attended a "Doctors 2.0 & You" event at the *Cité Universitaire* of Paris in 2017, which featured a much larger room full of stands selling various e-health products, apps, and services that were visited between conference speaking events. Other than the differences in size, location, and attendance, the stands at these conventional medical conferences were of the same shape and form; used the

[44] Available online at : https://www.spas-expo.com/tendances-2018/
[45] See the conference website at : http://www.doctors20.com/
[46] The video game is sold by Tilak (www.tilakhealthcare.com ) and the mobile monitoring products by Bioserenity (www.bioserenity.com )

same paper brochures, leaflets, and business cards; and were based on the same logic and organization as the stands at the complementary medicine trade events, albeit with very different products, speakers, and company names. Even some of the same buzzwords pertaining to "innovation," "international," and "inclusiveness" were used by Denise Silber, the Founder of "Doctors 2.0 & You" and its parent company, Basil Strategies: "At a time when patients were rarely invited anywhere, digital health trends were little known, and social media was an exception, we organized an international, patient-included, live-tweeted event that presented real-world digital health results (Silber, 2018)"[47]

As you can see, when viewed within the context and the rhetoric of the event organizers, the collection of products and practices that are included in these complementary and conventional trade events acts as clear evidence of globalization's disembedding mechanism and time-space compression and its effects on both conventional and complementary medicine. These complementary medicine salons and their growing attendance and interest rates provide insight into the effects of these globalization mechanisms on the scope of several complementary practices, such as yoga and naturopathy. The *Journal du Yoga* stated that during its 2017 *Yoga Festival* in Paris, 8,000 people actively participated in yoga workshops during the festival's four days and that the Paris event was a follow-up to yoga festivals in 6 major cities worldwide. Thus, while yoga may have been an ancient Indian spiritual practice, it is now an international commodity that is practiced for everything ranging from personal stress to professional sports. In addition, the collections of products and practices that were included in the conventional medicine events organized by "Doctors 2.0 & You" also provide insight on the similar effects these globalization mechanisms have on conventional medicine and its products. The *FAMx* Paris conference was organized in partnership with the American founder of a consulting company and both the *FAMx* and the "Doctors 2.0 & You" conferences featured speakers and stands representing people and technoscientific products from around the world; such as a South African discussing the application of 3D printing for facial surgery and a Brazilian presenting the applications and benefits of a telehealth technology used in rural Brazil. Furthermore, these events actively promote the association of different disembedded products and practices, such as the use of Tibetan bowls in French yoga classes, the sale of products made from multiple international organic suppliers, and the international sale of an American teleradiology software program that allows radiologists anywhere in the world to read and diagnose medical imaging scans from the rural zones of multiple countries[48].

So, if complementary medicine is not really an alternative to anything in particular, then why are complementary medicine practitioners actively participating in the positioning of their practices as alternatives? Logically, it seems as though this is due to the negative definition of complementary practices as all that is "not" conventional medicine. In the absence of a clear definition of what constitutes complementary medicine, it appears as though market-principles are a key driver both to determining what is included under the banner of complementary medicine, such as which practices are represented in trade shows; and to marketing them as innovative, sustainable, and ethical alternatives. As we will demonstrate throughout the rest of this section, while the significant market potential of complementary medicine also fuels practitioners' rhetoric underscoring the separateness of their practices, marketing concerns are not the only reason for doing so.

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[47] Silber quoted from the Doctors 2.0 & You website online at: http://www.doctors20.com/

[48] The company that develops and sells this software is Lifetrack Medical Systems, accessible online at: http://lifetrackmed.com/. It is of note that Lifetrack founder Dr. Eric Schulze stated that the technology for his system is so simple even his young daughter can use it; in part because the system includes training software to promote the harmonization of radiological readings.

Osteopathy in France is a particularly interesting example of this. For example, President D of an association for osteopaths repeatedly emphasized the specificity of osteopathy throughout our interview. Characterizing osteopathy as, "a young profession in France," President D's association works to "defend, promote, and work on a restructuration to get recognition and to attempt to get the osteopathic profession integrated into patient care pathways" (2017). Nevertheless, President D was careful to underscore that while the legal code and their advocacy efforts for osteopathy positions it within the "health field," osteopathy is not and should not be considered as a "health profession". Thus, while this large and politically active association is working with ministry officials to mainstream osteopathy, they are also working to defend the separateness of the osteopathic profession against its total medicalization and restriction to health care professionals such as, doctors, midwives, and physical therapists. President D explained that this was due to the growing number of non-healthcare professionals getting degrees in private osteopathy schools. At the time of our interview in summer 2017, President D cited the presence of 17,000 non-healthcare professionals with degrees in osteopathy. Despite the restrictions on the market for osteopathy schools that the 2014 accreditation law created, President D stated that, "there remain many schools and osteopathy professionals leading to a saturated market […] this is why 50% of the osteopaths that declare the revenues from their osteopathic practice earn less than 1,500 euro per month. So, if more osteopaths could work in hospitals as salaried employees there would be more possibilities" (2017).

President D's remarks are a direct echo of the "osteopath on every corner" quip made by the Representative of the *Ordre des médecins* in section 1.2. The demand for and interest in osteopathy translated into a large market for osteopathy training schools. When the number of schools got to be big enough, the government was forced to take regulatory steps in order to attempt to organize and limit the number of osteopaths. Nevertheless, there continues to be a growing number of osteopathic professionals that have spent tens of thousands of euro on their osteopathic training and that are attempting to create client-bases for their practice. President D's association is working to defend the "liberal title" of these osteopathic professionals. In order to do so, the association underscores the specificity of osteopathy and its separateness from conventional medical practice citing such things as: the longer consultation time necessary for an osteopath to "listen to a person's tissues"; osteopathy's ability to "treat the psychological manifestations in the body that create tensions and pain" and that are outside of the medical realm; osteopathic liberation of "tissue memories of tensions"; and its stimulation of the body's "auto-regulation through the creation of harmony in the body, which doctors cannot do because they are more mechanical" (President D, 2017). All of these statements firmly and deliberately position osteopathy outside of the realms of conventional medicine and its "mechanical" view of the body; focusing instead on the body's intelligence, memory, and link to the psyche.

This is a deliberate strategy reflecting President D's assertion that, "Osteopathy is a medicine, because for me, medicine means to heal someone and a doctor is a healer; osteopathy is a therapeutic method that allows us to heal people, there are different kinds of medicine" (2017). Thus, we see that President D's rhetoric is another example of the 'separate but equal' logic that positions osteopathy on an equal plane as conventional medicine, but as a separate kind of medicine with a completely different vision of the body and its functioning. As we can see in President D's rhetoric, which was implicitly underscored in the Representative of the *Ordre de médecins*' sarcasm, the logic informing President D's work to maintain osteopathy's separateness throughout the mainstreaming process is to protect the distinct market integration and professional identity of osteopathic practitioners. Thus, while we can see that while some are promoting the 'separate but equalness' of complementary

medicine as a means of exploiting the market value of it as a trendy alternative, others are doing so as a means of giving complementary practitioners a more stable professional identity that allows them to create and exploit a market share in client demand.

The case of osteopathy and the attempt to solidify a professional identity is closely related to a third reason why complementary practitioners are working to maintain the distinctiveness of their practice: as a means of creating an identity for their practice and themselves. Again, I believe this is related to the negative definition of complementary medicine. Identity is a fundamental component of a sense of belonging and one of the ways in which we gain a sense of identity is through definitions. These definitions do not have to be a question of mere semantics, they can include legal definitions and codifications, physical definitions of territory or place; even cultural definitions of basic conceptions all play a fundamental role in helping us to gain a sense of ourselves and our actions. Identity goes beyond the individual and is linked to an individual's embededdness within larger territorial, social, professional, and cultural groupings and communities. Thus, in light of the absence of a definition of what complementary practices are and considering the evidence of the effects globalization mechanisms are having on many of these practices, it is not surprising to find a certain sense of commonality among complementary medicines and their practitioners. Within the academic literature, complementary practitioners are often said to, "consider themselves as part of a common community that usually…stresses treatments that employ physiologic mechanisms of action that are currently unknown to biological science; holistic in nature; noninvasive; natural and nontoxic; applicable to an extremely wide range of medical conditions; and that are individualized to each patient (Bausell, 2007).

While this certainly came out in the context of the complementary medical trade events, I noticed this same trend within the rhetoric of a variety of the practitioners I spoke with. A surprising number of different complementary practitioners emphasized their separateness from conventional medicine as a result of their practice's ontological understanding of the relationship between humans and what was variously referred to as the universe, cosmos, nature, life force, and energy. As such, when asked, "What is the role of your practice?" I often got responses involving the creation of a harmony with that natural force; balancing the body's energies internally and externally with that natural force; initiating the body's natural healing capacities, which are directed by that natural force; and improving the overall quality of a person's life by connecting them to that natural force. As such it is worth exploring this notion of connection, harmony, and balance within the body and with this greater "force" of nature.

Homeopathic Doctor Q made sure to underscore the different logics behind homeopathy and conventional medicine in a way that summarizes what other complementary practitioners discussed in the context of my question about the role of their practices. Homeopathic Doctor Q said:

> "It's not the same logic. In allopathy it is the 'anti', meaning if you are vomiting we give you an antiemetic, if you have heartburn we give you antacids, you have a microbe we give you an antibiotic against the life of the microbe […] What we do is to stimulate the organism in such a way that it is the organism reacts, not the medicine that reacts, but the organism itself" (2015).

This discourse clearly positions homeopathy as something that is separate from conventional medicine and it is not a position that is at all unique to homeopathy and its particular logic. A variety of different complementary medical discourses that emerged in our interviews focused on these practices' ability to stimulate the human body's capacity to respond to illnesses as a

distinctive feature separating them from conventional medicine. Hypnotherapist M presented hypnosis in much the same fashion, focusing first on its distinctiveness from conventional medicine and then on the importance of stimulating the body as a means of relieving suffering:

> "It [hypnosis] is definitely not that [conventional medicine] […] The patient brings to the surface, for example, a sad memory but, it's in the body. The patient isn't well, they are producing adrenalin, and they lose sleep- that is what hypnosis recalls. The body and the mind are not separated; we say that we are going to treat a sad memory, but it's not for the psychologist no! The thought is in the body- that's why our patient has a stomachache, he's not sleeping because he is sad, it's in the body" (2017).

Going beyond activating the body and its natural responses to illness, identifying and treating the source of suffering in the body were also cited by a variety of complementary practitioners in discourses emphasizing the distinctiveness of their practices from conventional medicine. For example Kinesiologist R used this strategy saying, "We can heal symptoms without healing the cause and that is not an approach that interests us at all. That's why kinesiologists don't define themselves as part of the medical world or even in relation to the medical world, because the approach is different" (2015). Doctor J also discussed the importance of arriving at the source of suffering as a distinctive characteristic of Traditional Chinese Medicine stating, "Chinese Medicine always tries to go to the origin of the pathology" (2015).

According to all of the practitioners cited here, the thing that allows them to arrive at the "true" source of the body's suffering is their focus on the globality of the person. For example, Shiatsu Practitioner C observed that:

> "Occidentals have a tendency, and the French have it in particular, to make a distinction between the mind and the body. The mind is for the psychologist and the body is for the doctor and medicines. In truth, they're the same thing, if the mind isn't well the body isn't well and if your body isn't well your mind won't be well- it's a whole. With shiatsu, you become conscious of the link between your mind and your physical state, they're the same thing, the same continuity" (2015).

According to Shaman C, this also constitutes a shamanic approach, "A shaman is a doctor of the soul, I am a doctor of the soul, meaning that instead of going to one part of your body I go and look at its totality" (2016). Doctor J, echoes Shaman C in both the conception of a global approach to a person and in the conception of what a soul is; only Doctor J indicates that this vision is inherent in a variety of different complementary medicines:

> "These global medicines integrate the material with other dimensions of a being and the life-force […] the Chinese tradition, like the Indian tradition and like other traditions, proposes a reading of the living that is much more universal. [Conventional] Medicine only has the version for the human; but *we* talk about the soul, meaning that which animates our life, and not simply about the mechanics which characterize Occidental [society] which is mechanical" (2014, emphasis added).

This notion of the soul as something that "animates" life corresponds to the importance various practitioners place on creating connection, harmony, and balance with the life-force,

nature, cosmos, or universe alluded to earlier in this section. Homeopathic Doctor Q evoked this force in reference to nature:

> "Nature itself gives us the keys to the responses to our illnesses, we should listen to nature, we must understand nature […] there are certain plants, like ginseng for example, it resembles a human body, it is a plant of life. Bamboo resembles the spinal column and it's good for the spinal column- this is what we call the theory of signatures in nature […] Well-being is a balance, balance is health and that is the force and vital energy […] that stimulates the energy in an individual's organism" (2015).

Curiously, Doctor J also discusses homeopathy in a similar fashion, which effectively includes it in the "global medicines" referred to in the previous quote, "I began studying homeopathy to find remedies that functioned […] that went in the sense of the body and the dynamics of life" (2016). Finding harmony by going in the same "sense of the body" was a sentiment echoed by Hypnotherapist M, "hypnosis intervenes when there is a sort of rupture in the harmony of a human" (2017). Often, this "rupture in harmony" is attributed to energetic blockages in a variety of different complementary practices. This was the case for shiatsu, "when you make efforts on the physical plane you create imbalances in the energies, so there is a need to reestablish a good energetic circulation" (Shiatsu Practitioner C, 2015); this was the case for kinesiology, "suffering comes because we are not balanced […] there is this relation with Chinese energies that allows us to use the Chinese symbolism of the five elements and the [body's] organs" (Kinesiologist R, 2015); this was the case for Shaman C, "when we clean and unblock the millions of cells in our bodies we activate the cosmic energy in us so that the energy of our souls can act"(2015); and this was the case for Reiki Practitioner L, "today people don't want to hurt and want immediate results, so we refuse and reject the body […] we're blocking it and this disassociation is not natural, so I try to help people […] in all of the traditions you work on the spirit and consciousness or harmony with your body, your mind, and nature" (2015). This sentiment was also echoed among multiple magnetizers, osteopaths, yoga instructors; and by multiple practitioners of tai chi, qi gong, reflexology, and various forms of meditation.

All of the practices that are mentioned here come from different historical, geographical, and cultural traditions; and yet, all of their practitioners relate suffering and healing as something to do with unblocking the body's energy and reinstating harmony between a person, in their totality, and some wider life force of nature. It is of note that several of these practitioners explicitly situate their practice within a discourse of "all traditions," "global medicines," and "natural medicines," even though, as Doctor M points out, "These medicines are profoundly different, there is no relation between Indian Ayurvedic medicine and homeopathy…at least not when you look at them with an eye that is a little scientific, a little medical and scientific" (2015). So, considering the vast differences in the origins, philosophies, and ages of these practices, it is significant that their practitioners are all using similar conceptions and in some cases purposefully regrouping themselves in this collection of such vastly different practices. Doctor R alluded to this in a discussion about harmonizing discourses:

> "There is a way to harmonize discourses that can be simply accepting the coexistence of discourses […] on different levels. Harmonization isn't necessarily the fusion of various discourses into a commonality […] others can have scientific conceptions that are a little different and founded on energies- we can imagine many other discourses. We have the impression that these kinds of discourses are

> less scientifically validated, but they are discourses that nevertheless create a social tie- create a social tie for those people who adhere to this or that, the people that have a conception of harmony with the world" (2017).

Thus, we can see that despite the differences between their practices, many complementary practitioners are using the negative definition of complementary medicine in two ways: as a means of creating an identity in the absence of definitions for these practices and their practitioners; and as a means of creating social ties and a shared sense of identity, which seems to be an interesting and unintended consequence of globalization and its disembedding mechanisms. Since these practices and their practitioners do not benefit from the "classic" definition by locality or culture, such as those that were theorized by Klienman (1978), and are now a part of the international marketplace, such as in the trade events presented at the beginning of this section; they are using the negative definition of complementary medicine as a means of creating a social identity for themselves as a community of practitioners adhering to a fairly "harmonized" conception of the importance of being in "harmony with the world."

This interesting because it can be interpreted in two ways: 1) that despite the lack of scientific evidence on the health benefits of living in harmony with life, the universe, and nature-a lack that as we shall see is usually attributed to social prejudices and economic power- all of these practitioners and their practices have caught on to an underlying, esoteric relationship between humans and the cosmos that is sorely lacking in conventional medicine and that is essential to human health and well-being; and 2) that due to the fundamental differences between the practices cited here; their mixed use of what are disembedded and financially trendy concepts circulating in the global marketplace is endemic of new age mumbo-jumbo that is merely a means of capitalizing on the huge market potential of these practices- and the gullibility of the general public- despite the glaring lack of scientific evidence demonstrating the efficacy or existence of these practices and their underlying principles. These two interpretations reduce the conventional-complementary relationship to, "a clash between science and belief" (Bausell, 2007). This is essential to this thesis, because these two interpretations embody the most common perception of the conventional-complementary relationship in the academic literature, in the popular presses, and among the hundreds of patients, practitioners, doctors, health professionals, administrators, politicians, academics, researchers, schools, and organizations I spoke to and observed over the last three and a half years. In other words, these two interpretations were embodied in the critiques of conventional medicine as something that is cold, inhuman, overly technical, and overly reliant on pharmaceuticals, which are seen as corrupt; and in the critique of complementary medicine as unscientific pseudoscience that is wishy-washy, laughably ineffective, and a means of scamming desperate and vulnerable people in the pursuit of power and money.

As such, we find ourselves with the Venn diagram image that was discussed in Chapter 1 of this thesis: two separate and largely mutually-exclusive entities that are separated by what is usually presented as irrevocable ontological and epistemological differences; of science and belief. In light of these differences, it is logical that complementary practitioners would seek each other out, band together through a fairly harmonized vision of their underlying ontological frames, and work to create an identity for themselves in a way that separates them from the perceived shortcomings of conventional medicine. However, as we shall see in subsequent chapters of this thesis, this picture is overly simplistic and not reflective of what is actually occurring throughout contemporary France. For now, it is time to unpack some of the interpretations and critiques of conventional medicine that are often used to emphasize the separateness of the conventional-complementary relationship. Then, the next

section of this chapter will analyze the critiques of complementary medicine that are often used to emphasize what will be interpreted as the antagonism in the conventional-complementary relationship.

In analyzing my data, I found that the critiques of conventional medicine were most significantly clustered around: its mechanical vision of the body and disease, which results in its inhumanity, overspecialization, and treatment of the disease or body-part rather than the person; the egoism, closed nature, and rigidity of French doctors; the coldness of its technoscientific character; and its over-reliance on medications that are produced by corrupt pharmaceutical companies. For example, Doctor J emphasized the mechanical nature of medicine and its resulting flaws:

> "Mechanical medicine is the tissue of Greco-Latin thought, which is that of separation. We cut everything into small pieces and we lose the logic of the whole […] it is a medicine that has no sense, it's just a technique of dissimulation and that is not healing […] that's why the most progress is made in surgery, when we can't hide something anymore. We take out what is bothering us, without even knowing where the problem comes from […] that's materialist medicine, university medicine- it's not asking questions about causes" (2015).

Doctor V attributed these materialist aspects of medicine to its inhumanness, "Medicine is overly separated from the human being […] modern medicine has become too inhuman, looking with the computer- and it's true when the doctor receives his patient he looks at the computer to enter in the data, to see if he can find explanations instead of looking at and listening to the patient" (2016). Both its materialist aspects and mechanical nature are said to lead to overspecialization, which is also viewed as problematic. For example, Doctor M said, "We have arrived at an extremely scientific medicine that works by specialty […] the individual care pathways in our hospitals are extremely fragmented […] we don't have such comprehensive care" (2015). Even the Representative of the *Ordre des médecins* both acknowledged and mocked the extent of conventional medical specialization saying, "Oh yes, the specialization of the right toe or the left toe, it's that" (2015).

The overspecialization of medicine was often linked to a perceived hubris and rigidity among French doctors. For example, Clinical Researcher R observed, "It's true, very often doctors have this attitude, this culture, of dismissing when they can't do anything instead of finding someone who can. It's as if the doctor has been put on a pedestal or as if the doctor is the summit of the period (chuckles) as if the doctor is irreplaceable, truly there is a very very great lack of humility" (2015). This was echoed in the reflections of Doctor H who drew a link between the perception of doctors as being the summit of their specialized knowledge and the rigidity and hubris that can result:

> "I can say to people I don't know and that sometimes scares people. When people come to you because you are a doctor you are leading your unit for more than 20 years, they come to you because they think you are just a big professor, you know everything […] and when you say […] 'who knows? I don't know, I'm just going to see another colleague,' perhaps he knows or perhaps he doesn't know but he won't say, 'I don't know'" (2015).

When discussing doctor rigidity, often practitioners related this to the technical nature of their medical training. For example, Doctor T acknowledged the over-emphasis that is placed on technique saying, "Occidental medicine is too technical and doctors don't spend enough time and are not listening enough to their patients" (2017). Anesthesiologist A

reflected on this and provided some explanation as to why admitting, "At the beginning of my professional life, since I was specialized in anesthesiology and reanimation, my motivation was that of technical mastery. I was on a quest to master the technical gestures and particular competencies […] I was really in a dimension […] of advancing my professional competencies in their technical dimension" (2016). Shaman C linked this technicality with the perceived coldness of doctors saying, "The other problem with doctors is that they don't know how to touch human beings, they don't have real contact. Doctors only rely on science and they lose the component of human-warmth. Technology has distanced the doctor from the patient by putting a machine between them" (2017).

It is worth noting that one of the most common and most acute critiques of conventional medicine fell under the umbrella of its perceived over-reliance on pharmaceuticals produced and sold by powerful pharmaceutical companies. For example, at one point in our interview Shiatsu Practitioner C took on a serious expression and said with the shake of the head, "The lobby for medicines in the world; excuse me, but it is monstrous. You know that we make medicines in every country, so that what we are supposed to- and we do- is make people eat medicines. Sometimes now people scare me, they have a genuine pantry full of medicines and they eat medicines" (2015). This sentiment was echoed by Clinical Researcher R who, near the end of our interview, looked at me and said, "To be honest I don't understand the point of your research. Today everything in medicine is controlled by pharmaceutical companies, they're too powerful, so nothing is going to change" (2015).

Going beyond the profit-mongering theories I heard about pharmaceuticals from many advocates of homeopathy and naturopathy, there was a general acknowledgement that conventional medicine places an extremely high value on drug-based therapies. For example Doctor M attested, "Conventional therapy is completely turned towards medicines, it is above all pharmacology" (2015). Hospital Administrator A related this to the "culture" of conventional medicine in hospitals, noting, "The culture in establishments like this one is more based on therapies, on allopathy, we are a short term care facility so our therapies are relatively major, aggressive. We generally use strong antibiotics or powerful vasodilators-major therapies" (2016). Furthermore, there was a general acknowledgement that the French public is beginning to become suspicious of pharmaceuticals. For example, Representative F of the *Ordre des pharmaciens* noted, "In the last twenty years scientific truth has become suspect, it's the notion of a conspiracy, you know. For example I hear people say, 'it's false, pharmaceutical laboratories are just there to sell their vaccine" (2015).

Conspiracy theories aside, a variety of different practitioners underscored the potential dangers of medications. Homeopathic Doctor Q focused on their toxicity, "definitely in the long-term, but in the short-term as well […] toxicity in the long-term is sometimes difficult to quantify, to understand" (2015). Along these lines, there were also several practitioners that made reference to some of the drug scandals that have occurred, such as Doctor J who noted that there are, "people who make medical errors, legal proceedings against doctors, against pharmaceutical laboratories whose remedies […] were in circulation and we learn several years later that they were medications that were dangerous" (2015). Kinesiologist R also pointed out the dangers of the pharmaceutical industry stating, "Today in the world we are realizing that the number one industry in the world is pharmaceuticals. It's really the number one industry in the world, so they have an enormous lobbying power and they influence…today we realize with all of the scandals that are coming out, especially in the medical sphere" (2015). Doctor M also indicated that:

> "There were two big cases in the United States and in France that considerably modified the public's attitude about medications. When you cite Vioxx in the U.S. and Mediator in France, well, you know good and well that people cannot see this kind of news without wanting to turn towards other medicines, it's human. Also, you have all this work in the United States about the secondary-effects of medicines saying that in the United States there were roughly 200,000, or I don't remember, more than 150,000 deaths linked to medications. In France it was evaluated to be 30,000 deaths per year and when you are a patient and you see this information you considerably modify your vision about medicines and conventional medicine" (2015)[49].

The negative publicity surrounding medications over the last ten years seems to have fueled those with negative perceptions of pharmaceutical companies and their lobbies. For example, in their 2015 study on patients with rare diseases, Director Y of a patient advocacy association expressed surprise over the result that, "Almost 10% responded that they were afraid of different types of care, so I didn't anticipate that" (2014). Although at the time of our interview the country-by-country data from this study had not been fully analyzed, French respondents were included in this 10% and one of the types of care mentioned was pharmaceutical-based treatments.

When all of this is taken together, it is not a surprise that some complementary practitioners emphasize their non-use of medications as a means of separating themselves from conventional medicine and its practices. For example, Hypnotherapist M uses the negative publicity surrounding medications as a means of selling the advantages of hypnosis:

> "There are many more incidents with medications than with hypnosis. I mean, with medicines how many suicides have there been? People swallow sleeping pills- there have been lots of deaths and errors, but with hypnosis there have been 0.0 deaths. Ok there are some people who have seen charlatans and of course they were disturbed, but with medicines there have been thousands of deaths, and with hypnosis there haven't been any" (2017).

This sentiment was given further weight by practitioners who indicated that France had particularly high pharmaceutical consumption, such as: Kinesiologist R, "today in France we are the number one consumers of pharmaceuticals" (2015); Hospital Administrator A, "we can say that France is the country that consumes the most tranquilizers and benzodiazepine in the world" (2015); Shiatsu Practitioner C, "the French really like medications, they're not alone, but even so. For example, it's the French that eat the most anti-anxieties to combat anxiety and depression and everything" (2015); and by Shaman C, "a large percentage of my clients in France suffer and take medications for anxiety and depression" (2015). Representative F of the *Ordre des pharmaciens* did not refute these claims about France's elevated pharmaceutical consumption, but did indicate that it was, "Not as much as the United States, yes the United States consumes more than us" (2015)[50].

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[49] The literature on the exact number of deaths from Vioxx in the United States varies considerably, generally ranging from anywhere between approximately 28,000 to 300,000 people. The same is true for the number of deaths from Mediator in France, which generally range from 500 to 2,000 people. It is of note that this quote was given before the outbreak of the 2017 Levothyrox controversy in France.

[50] For those interested in the validity of these claims, see this 2002 article on French antidepressant consumption: https://www.ncbi.nlm.nih.gov/pubmed/12386542 . Also see the 2015 OECD "Health at a Glance" report on pharmaceutical consumption, which places France below the OECD average for the consumption of antidepressants. This report is available at: https://doi.org/10.1787/health_glance-2015-en

Throughout this section we have seen a variety of the common market-based strategies and critiques of conventional medicine that were used to emphasize the perceived separation of complementary medicine from conventional medicine. It is of note that many of these critiques came from medical doctors and healthcare professionals who are aware that, while it is generally effective, conventional medicine is far from perfect and in need of improvement. While this is both logical and understandable, especially considering that as an example of a complex adaptive system, healthcare acts in a sub-optimal performance; it is interesting that different complementary practitioners are using it as a means of constructing an identity for themselves and their practices, both as something that is separate from conventional medicine and its approaches, and as something that is constituted by a highly diverse collection of practices that loosely maintain a fairly "common" discourse and market presence based on the ontological and epistemological premises of the essential health benefits of considering a person in their material and immaterial totality while harmonizing their energies and connection with nature and/or some form of cosmic life-force. This separation between complementary and conventional medicine is often presented in terms of a difference between something that is based on science and something that is based on belief. However, as the previous chapter attempted to show, conventional medicine and the science it is based on, are intricate parts of society and are interconnected with overall philosophical and ontological trends; as such, it is now time to turn to the second facet of the common perception of the conventional-complementary relationship and its embodiement in the perceived antagonism that comes to the surface through an analysis of the critiques of complementary medicine.

## *2.2: Perceived Antagonism in the Conventional-Complementary Relationship*

In the last section we saw that complementary medicine is usually presented as something that is separate from conventional medicine as a means of consolidating its identity, creating a sense of professional identity, and of taking advantage of the popularity and huge economic potential surrounding the complementary medicine market. In order to do so, we looked at different rhetoric that characterized complementary medicine as something that is alternative and innovative in nature; and as something that promotes health and well-being through the use of techniques that view humans in their globality, create inner balance, unblock the flow of the animating life-force, and restore connective harmony between the individual and the cosmos. We saw that these attributes were emphasized in tandem with critiques of conventional medicine and its short comings as a means of strengthening a distinctive identity for complementary medicine as something that is separate from conventional medicine.

In this section, we will now examine the most cited critiques of complementary medicine that emerged over the course of my fieldwork in order to analyze how their use indicates a perceived antagonism in the conventional-complementary relationship. In subsequent sections of this chapter we will see some of the concrete effects of this perception and how together, this creates a negative feedback loop within the French healthcare system that further underscores the perceived separation and antagonism, or incompatibility, of conventional and complementary medicine. As such, section 2.3 will explore how the perceived separation and antagonism color the conventional-complementary relationships with perceptions of fear; which section 2.4 will show further reinforces the stigmatizations

and stereotypes of both sides. As a result, this bolsters the notions of the separation, antagonism, and incompatibility between conventional and complementary medicine that justify the general unwillingness to create definitions for complementary medicine. As such, Chapter 3 will then explore the strategies that conventional and complementary practitioners are using in light of these perceptions and in the absence of these definitions.

In analyzing my fieldwork, I found significant clusters of data pertaining to the following critiques of complementary medicine: that it is not and cannot be scientifically proven; that it is fundamentally unscientific and does not fit in with conventional medicine's "Cartesian" nature; that it is an illegitimate and dangerous competitor of conventional medicine; and that it is an open-door to sectarian aberrations that leads to dependency, destruction, and death. While this can be easily interpreted as a negative backlash in response to the increasing popularity, use, and consolidation of complementary medicine in contemporary France; my fieldwork indicates that doing so would be overly reductionist. Additionally, the vitriolic responses to the emergence of chiropractics and homeopathy in the United States and to the popularity of Franz Mesmer's animal magnetism in France also act as telling examples of the fact that the history of conventional medicine has long been punctuated by distaste for and distrust in curative practices falling outside of the realms of conventional medical oversight and control. Furthermore, when the rhetoric of the historical critiques against homeopathy, chiropractics, and animal magnetism are taken into account; we can see that they use much of the same language and arguments as those used to critique complementary medicine today.

For example, the editor of the New York Journal of Medicine wrote, in 1847, that, "The work on chronic diseases comprising the *materia medica*…of Hahnemann, is a heterogeneous jumble of crude transcendental imaginings, dignified with the name of *facts*" (New York Journal of Medicine, 1847, p. 6). This is a direct, although more caustic, echo of the committee report on animal magnetism that King Louis XVI commissioned in 1784. This Committee, which included Benjamin Franklin and Antoine Lavoisier, conducted a series of experiments and concluded that the fluid Mesmer reportedly used did not exist and that the effects obtained, "are due to compression, to imagination, and to imitation" (Committee of the Royal Society of Medicine, 1784, p.44). Notice how both discourses dismiss these very different practices due to their "imaginary" aspects, or lack of scientific proof. This is not coincidental since the dates for these two critiques situate them in the historical context discussed in section 1.1, during which official, scientific medicine was being established through the creation of its professional societies and its demonstration in laboratory evidence. Thus, not only do these examples provide additional insight into the philosophical and societal aspects of conventional medicine and its contents; they also demonstrate that the negative perception of complementary medicine as nothing more than the product of pseudoscientific imagination is far from a new response to the current popularity of complementary medicine. Furthermore, my fieldwork indicates that these materialist ontological antecedents of 19th century scientific medicine are still commonly cited as the hallmarks of contemporary French conventional medicine. This will be a theme that repeatedly comes to light throughout this chapter; but for now we can consider it through the discourse of School Director L, the managing director of a school for natural and ethno-medicine, who reflected on this longstanding trend by saying:

> "In the 19th century there was a philosophical fight between materialism and vitalism, which considered that the material human body gains life through natural chemical processes that are part of the divine […] Over time, scientific experiments allowed for many discoveries of things like disease and drugs, which

> led to scientific progress, but the other medicine, vitalist medicine, and its consideration of both body and spirit was erased because it lost the fight to scientific epistemology in the 19th and 20th centuries. These winners also created an economic model with research into chemical medicines- so nutrition, meditation, and reflexology were relegated to the obsolete and useless. This really created a parallel current that's always considered as an opposition and university medicine has always tried to stamp out and discredit alternative medicines" (2015).

As you can see this not only does this quote shed light on the reoccurrence of attempts to discredit complementary medicine using the discourse of science and scientific epistemology, it also acts as initial evidence of how this discrediting is perceived of in terms of an antagonism between the 'two sides.' School Director L discusses this dynamic in terms of "a fight" that created "winners" and losers, resulting in the scientific winners attempting to "stamp out" the "opposition" of a wide variety of complementary practices. Also note that while in the previous section we saw a certain commonality in the discourses concerning the ontological premises of complementary medicine, here we are beginning to see what appears to be a certain commonality in the discourses discrediting these "harmonized" conceptions. This is a theme that will be repeatedly returned to throughout this section as it sheds light on the widespread perception of antagonism in the conventional-complementary relationship that subsequent chapters of this thesis will show to be problematic.

As such, with this in mind, we will now begin unpacking the most common critiques of complementary medicine that emerged in my fieldwork, starting with what seemed to be by far the first-cited critique in my discussions with interviewees: that complementary medicine is not and cannot be scientifically proven. In the context of my interviews, when I asked about why it was difficult to scientifically evaluate complementary practices, I was very surprised to discover a particular pattern among the responses. Namely, that homeopathy emerged as the most frequently and passionately cited example used to discuss both the lack of scientific evidence for complementary practices and the difficulty involved in their scientific evaluation. This is understandable in the context of France, since it is a world leader in the production and consumption of homeopathic medications. According to a market research survey conducted for Boiron[51] in 2012, 56% of the French population uses homeopathy and 36% characterizes themselves as "regular" users of homeopathic medications (Ipsos, 2012). Thus, when the popularity of homeopathy in France is taken into account, the significance of the data clustering around homeopathy in my fieldwork data analysis became clear.

From the conventional medical perspective, homeopathy tended to be characterized as difficult to evaluate scientifically because its remedies supposedly do not contain any molecules of active ingredients and because it has not been shown to produce therapeutic results that are more significant than those produced by the administration of a placebo in double-blind trials. This first critique stems from the process for the preparation of homeopathic granules that is based on the principle of homeopathic dilutions. Without delving too deeply into the details of this procedure, the preparation of homeopathic remedies involves the successive dilution of active ingredients with substances such as alcohol, distilled water, or lactose powder. At each stage of dilution, the remedy is vigorously and methodically shaken in order to "dynamize," or unlock, what Hahnemann referred to as the active ingredient's internal, spirit-like medicinal powers (Dudgeon, 1893). According to

[51] Boiron is a laboratory that manufactures homeopathic products that is headquartered in France. It is the largest manufacturer of homeopathic products in the world, with operations in 50 countries worldwide (https://www.boiron.fr/).

Homeopathic Doctor Q, this process results in homeopathic dilutions that are, "very weak concentrations…it's a billionth in a normal concentration, you see" (2015). Among those skeptical of homeopathy, this was frequently explained using a banality: that homeopathic preparations can be thought of as the equivalent of putting one drop of an active ingredient into an entire lake of water and expecting it to work. According to homeopathic logic, these successive dilutions and dynamizations actually increase the strength of the homeopathic preparation[52], even if they are diluted up to extreme factors of $10^{60}$ and $10^{400}$. Conversely, the *Ordre des médecins* indicates that according to scientific logic these, "homeopathic solutions are often so diluted that they no longer contain any molecules of active substances. For scientists, this lack of an active ingredient renders these treatments intrinsically ineffective" (Ordre des médecins, 2015).

One of the theories used to explain how homeopathic dilutions function is known as the "memory of water." This theory contends that water can retain a lasting "memory" of the substances it is exposed to. This memory allows the water to retain the properties of those substances, even once the substance has been physically removed. One of the better-known scientists that attempted to prove the memory of water was Jacques Benveniste, whose 1988 article in *Nature* sparked a polemical wave of sensationalism[53]. The water memory effect that Benveniste's research supposedly demonstrated could not be replicated by other scientists, which ultimately led to the widespread dismissal of its validity. Nevertheless, this theory remains as a point of reference among homeopathy advocates; so much so that Benveniste's *Nature* article is expressly cited under the homeopathy section of the *Ordre des médecin's* online webzine as, "justifying the affirmations of homeopaths," before it is dismissed as, "never having been able to be reliably replicated (Ordre des médecins, 2015). Despite the scientific shortcoming of his 1988 article, Benveniste continued his research, modifying his hypothesis to one based on a theory of electromagnetic frequency. Over the course of my fieldwork, Benveniste and his research were repeatedly cited in the context of discussions about homeopathy. Of these citations, the strongest advocate was Homeopathic Doctor Q, the president of an institute for homeopathic research and a scientist who has spent years working on the scientific evaluation of homeopathy. Homeopathic Doctor Q gave me a lengthy explanation of Benveniste's wavelength hypothesis and related it to his experiments:

> "I worked on brain receptors […] and I blocked these receptors with radioactive markers and I succeeded in displacing these markers with dilutions from homeopathic medicines- concretely I displaced them […] then I saw the work of Benveniste […] I currently work in collaboration with an association directed by the professor Luc Montagnier, who won a Nobel Prize in medicine […] in his research he also found that homeopathic dilutions left an imprint in the brain, there was an imprint of the dilution's wavelength […] in the beginning we thought that it was chemical and clearly if we think it is chemical […] at a certain dilution there are no more molecules so it cannot be chemical, but with quantum physics etc. now we are beginning to realize that there can still be information […] For example, before you had to open your car door with a key and now you open your car with a remote […] you have an emitter and a receptor so it is a question of wavelength and not at all a question of chemical molecules (2015).

[52] According to Hahnemann, dissolving the substance in greater quantities of fluid increased its strength by giving the substance more surface area to be in contact with (Dudgeon, 1893).
[53] See Davenas, et al. (1988), "Human basophil degranulation triggered by very dilute antiserum against IgE", in Nature, 1988 June 30; 333(6176): pp. 816-818.

This citation is interesting because it reflects a variety of different trends. First, it implies the presence of a scientific bias against homeopathic research. While Benveniste may have erroneously attempted to scientifically prove the theory of the memory of water three decades ago, the subsequent focus of his research- which the experimental results of Homeopathic Doctor Q and his distinguished colleague appear to demonstrate- can be interpreted as evidence of progress in the scientific endeavor to evaluate the mechanisms of homeopathic dilutions. Yet, homeopathy continues to be dismissed for being difficult to evaluate scientifically and there remains a lack of interest in homeopathic research among academic and medical scientists so that, "no hypothesis which predicts the retention of properties of starting materials has been proposed" (Chikramane et al., 2010). Secondly, this citation draws an interesting parallel between the progress made in homeopathic science and the progress made in the science of conventional medicine. Conventional medicine's scientific research passed from the molecular scale to contemporary research on the nano and subatomic scales. For example Orcutt et al. (2012) note that, "while subatomic particles are currently used in the fields of cardiology, cardiovascular surgery, radiology and nuclear medicine for diagnoses and therapies, we have yet to determine the role of the atom and subatomic particles on health and disease" (p.1). Thus, it is interesting to see that this same transition is also occurring in the field of the scientific evaluation of homeopathic medicine; which research such as that of Homeopathic Doctor Q and Chikramane et al. (2010) also situate on the nano and subatomic scales. Perhaps as the scientific understanding of the sub-molecular scales continues to advance our understanding of the body, the wavelength theory of homeopathic dilutions will begin to be taken more seriously.

Speculation aside, despite the seemingly serious scientific research cited above, my fieldwork indicated that homeopathy continues to be overwhelmingly regarded as not being scientifically proven. For example, Doctor O noted that, "there are things that are more or less proven […] but homeopathy is more complicated. There are very few studies that prove anything- well in any case we don't have studies that prove it and that is a problem" (2015). Doctor R also found the lack of accepted scientific evidence for homeopathy problematic, citing it as one of the key reasons for wording the title of his DU in complementary therapies in a manner which specifically excludes homeopathy: "we essentially include treatments that are not mediated by substances. It is a choice that allows us to limit our field and to avoid domains that are either in conflict with medicine […] or that can raise questions or create evaluative problems, and that is notably homeopathy and mesotherapy" (2017). Here we begin to see how the lack of scientific evidence for complementary practices translates into their perceived antagonism. Notice how Doctor R implies that certain complementary practices can be interpreted as creating "conflict" and "problems" with the conventional medical domain.

One of the reasons for the lack of scientific proof for complementary practices that is linked to their antagonism with conventional medicine is their purported dogmatic basis. For example, Representative F of the *Ordre des pharmaciens* dismissed homeopathy as being based on dogma rather than on science: "Why did Hahnemann create homeopathy? If we look at it in the context of the time [we see that] there weren't medications or medications were expensive so Hahnemann, based on his observations of plants, went off on a dogma, but is this dogma true or false? I am incapable of saying" (2015). Doctor R also cited the dogmatic basis of homeopathy as another reason for its exclusion from his DU, "We do not include courses in homeopathy because […] if we did a course on homeopathy we would have homeopaths who come to present it with lots and lots of conviction, but if we asked a scientist about the level of scientific proof, they would say, '*bah*, today there is no proof of the specific efficacy of homeopathy'" (2017).

The remarks of Homeopathic Doctor N, who is also the president of an accredited and particularly well-renowned homeopathic school in France, further developed the relationship between homeopathy, scientific evaluation, dogma, and its perceived antagonism with conventional medicine. In this case, the lack of scientific evaluation is attributed to scientific bias and dogma is discussed in terms of homeopathy's methodological specificity. Nevertheless, both are again linked to a perception of antagonism with conventional medicine that is so strong it translates into a fear of persecution among homeopaths:

> "Homeopaths trained at our facility are official and legitimate in terms of the government, but at the same time they have to be careful about the *Ordre des médecins*. In many instances homeopaths are well-regarded, but it is more difficult with the *Ordre* because while they recognize homeopathy and the homeopathic diploma, they also say that it is nothing more than the placebo effect and psychotherapeutic. The *Ordre* says that homeopathic remedies are not scientifically proven because diagnosis is based on a different method that is subjective and not based on objective medical criteria. The scientific criteria they want is proof that a remedy will work in the same way for a pathology with a more marked result than a placebo- double-blind evidence criteria. There is a movement to find evidence using the homeopathic method of analysis, but it is not recognized by the scientific body. Meta-analyses have shown the efficacy and concrete, material effects of homeopathy, but it is not based on the same method as that for allopathy. Also, there is not much scientific evidence because the allopathic system has a different language and a different starting point, so homeopathic meta-analysis is not accepted" (2015).

While the "different language" of homeopathy was an often-cited reason for the "scientific body's" refusal to accept studies of homeopathic evidence, Homeopathic Doctor Q affirmed that even if studies of homeopathic remedies were done using "the same language" they were still not accepted by the scientific community:

> "I speak the same language as them […] I prefer to communicate seriously with scientists rather than using a pompous communication restricted to homeopaths. I'm not here to struggle […] when I speak about my work I use the same language about the same receptors that they use and I don't use abstract, philosophical language at all" (2015).

Notice the use of the word "struggle" in this quote, which when combined with Homeopathic Doctor N's remark about the need for homeopaths to be "careful with the *Ordre*" attests to the strength of the perceived antagonism in the conventional-complementary relationship. Furthermore, consider the repeated presence of "us" and "them" language in both of these discourses, which acts as a direct reflection of the materialist/vitalist duality cited by School Director L at the beginning of this section. Taken together, this gives us a picture that is colored by language that describes this conventional-complementary relationship in terms of "conflict," "struggling," "fighting," and "difficulty"; in short, as a power struggle between what is presented as two opponents, using opposing languages and opposite methodologies. Furthermore, as School Director L and many of my other interviewees indicated, this is perceived as a power struggle that has long been dominated by the power and authority of conventional medicine.

The notions of fear of persecution will be returned to in the next section. For now it is time to explore the methodological and conceptual opposites that Homeopathic Doctor N alludes to, as they can be used to frame the scientific and medical dismissal of homeopathy as

something that is based on dogma rather than science. Going beyond the obvious dichotomy between the "allopathic" and "materialist" approach of conventional medicine and the "homeopathic" and "vitalist" approach of homeopathy, the "different method" that Homeopathic Doctor N mentions actually refers to what was repeatedly cited to me as a doctor's key role in conventional medicine. When I analyzed the data from my interviews, I was intrigued by my discovery that one of the most reoccurring themes mentioned by both conventional and complementary practitioners was the medical importance and exclusivity of diagnosis. Diagnosing the patient was repeatedly presented as by far the most important aspect of a doctor's role. This makes intuitive sense in the theory of medicine: making an accurate diagnosis is the first and essential step to creating an effective treatment plan; if the doctor does not know what is wrong with the patient, it becomes incredibly difficult to treat them effectively. Nevertheless, we shall see that in practice, the doctor's diagnostic role has unintended consequences that are significant in the conventional-complementary relationship.

When I asked, "What is a doctor's role?" many of the practitioners I spoke with immediately identified the doctor's diagnostic role and its basis on the evaluation of clinical examination and tests. For example, Pharmacist M characterized diagnosis as the first, essential step in developing a patient treatment plan, "the doctor does the diagnosis, then the doctor can plan the treatments" (2015). According to my interviewees, the diagnostic process involves successively progressing through a series of well-defined steps. Doctor H and Clinical Researcher R both explained this process using similar language. Doctor H explained, "So when you've got somebody with an illness your first job is just to listen, not to examine just to listen […] at the end of the talk you've got around 90 percent of the diagnosis done just listening and looking at people- and when you ask a few questions- when we examine people it is just because we have got an idea […] and we do complimentary exams to see if that idea is the right thought. That's the way to do medicine" (2015). Clinical Researcher R also focused on the importance on questioning the patient as the first step of diagnosis, "The doctor will receive the patient, he will ask questions about the symptoms that the patient had during chemotherapy, or between two chemo treatments- did the patient have dizziness or headaches etc. So all of this questioning is the doctor's, who also can evaluate biological tests and things like that" (2015).

The Representative of the *Ordre des médecins* characterized this in terms of strategy and procedure saying, "The doctor plays according to his pieces […] there is a whole proceeding- like a pilot that has to do their check-list before- we have a check-list to complete. To say that it's not serious or that there is this or that [the doctor] has done his biological examinations. I would say that it is the pinnacle of deontology" (2015). Notice how all of these interlocutors speak in terms of the importance of the doctor's evaluation of biological and medical test results in the diagnostic process. This alludes to how French conventional medicine is considered as being entirely based on the science of evidence-based medicine; a theme that will be returned to in the next section of this thesis. For now, we can see that Doctor O also spoke about the importance of clinical and biological evidence in diagnosis, "A doctor has to do a clinical examination and if they consider that there are problems they can ask for complementary examinations […] if there is a doubt ask for complementary exams and after you will see" (2015). As we shall see, this consideration of the importance of clinical, complementary and biological evidence- and the doctor's role of formulating a diagnosis based on this evidence- translates into a perception of antagonism on the part of complementary practitioners. However, before developing this point, I feel it essential to include Doctor T's very scientific explanation of the science of medical diagnosis and the supremacy that is given to its codified steps:

> "In defining the different steps that a sick person has to go through- someone who is suffering from a symptom- it is important to distinguish three distinct steps. The first step is the step of semiology- I call myself a semiologist- so there is the clinical scene […] the patient arrives, 'I have a headache, I have a stomachache, I don't feel well, I'm stressed,' these are the symptoms and you have to know how to identify them and then you have to group them into what we call syndromes. Syndromes are the associations of symptoms […] this is the first phase […] and this cannot be nonconventional, it is conventional, meaning that you have to know all of the symptoms that we clinically observe […] all of the symptoms all of the types of pain […] Next, the second part is the diagnosis […] in diagnosis you have to classify the symptoms, whether they be clinical or paraclinical, meaning for example biological samples or X-rays. And next you make diagnostic hypotheses, these diagnostic hypotheses fall into the category of what we call nosology. Nosology is the classification of diseases- it can only be conventional, it is obligatory that diseases are recognized for what they are, and that can only be conventional- there is not, even for one second, a place for nonconventional reflection in this type of description. First we have to know what we are dealing with, which means categorizing the disease in a diagnosis. A diagnosis must be done […] It's very difficult and it takes a long time to learn how, that is why medical studies are so long and we feel that it takes 6 years to learn […] you cannot think anything until you have learned all of this. The third and last part is the therapeutic considerations, this is the aspect of treatment […] Treatment is the end of the process for the patient during which you have to define the […] treatments that have been proven and that are recognized by medical societies […] that is the process" (2017).

Notice how Doctor T underscores the importance of systematically going through all of the steps of the diagnostic process before determining a treatment, which is defined as the "end of the process for the patient" (2017). This is an incredibly significant statement, because from the patient's perspective, diagnosis is generally considered to be an initial step in their illness process, rather than an end point. One of the best examples of this can be found in Susan Sontag's work, *Illness as Metaphor* (1978), which indicates that the pronouncement of a diagnosis can act as the beginning of a social process that associates the patient's disease with their psychological and moral traits. Throughout my fieldwork, I was repeatedly struck by the profound psychological effects a diagnosis can have as the patient and their entourage integrate that diagnosis (or lack thereof) into their conception of the patient's identity and sense of self. In fact, within my participant observation at Shaman C's practice, many patients came seeking to heal the trauma associated with a medical diagnosis. For example, one of the clients that came to Shaman C for the first time said, "The doctors couldn't diagnose my back pain, they said it was all in my head, but I come from a culture that stigmatizes mental illness, so to my parents this meant I was crazy. Over time this destroyed our relationship, they don't understand and they are so mean to me! [begins crying] My life has been difficult ever since" (Client D, 2016). Another one of Shaman C's clients also shared her traumatizing diagnostic and treatment experience saying, "As soon as I received the diagnosis 'breast cancer' my husband became distant. As I lost my hair and my breast he could barely even look at me. We divorced a year ago, but at least now I'm in remission" (Client M, 2016). When I shared Client D's story with Shaman C later in the day he reflected:

> "The doctor doesn't allow the patient to open up to the magnitude of what they have […] the patient waits for the doctor to give them a dictate, a sentence called a diagnosis and when the patient integrates this diagnosis they are even more

> traumatized because they don't know how to differentiate the 'bad' from the seriousness of what they have […] they're left psychologically damaged and mal-informed" (2015).

What this implies, and what my fieldwork confirmed, is the presence of a misalignment between the patient's and the doctor's understandings of the doctor's role. What constitutes the beginning of the healing process for the patient constitutes the end point of the doctor's principal role. While the evidence given above by Clinical Researcher R confirms that the doctor's role can extend to following the patient through their treatment process in some cases, it many cases the doctor's interaction with the patient does effectively end with their announcement of a diagnosis and treatment plan. The discourses presented here- and in the previous section's discussion of the over-specialization of medicine and the fragmentation it creates in the patient care pathway- shed light on one of the reasons for this. If for example, a general practitioner determines that a patient's diagnosis requires surgical treatment, the general practitioner will pass the patient off to a surgeon through referral and the patient's illness process will continue under the supervision of that specialist. Thus, the general practitioner's role in that patient's particular illness process is effectively ended. According to multiple patients I met throughout my fieldwork, this can indeed result in patients that are "left psychologically damaged and mal-informed" as they are faced with a specialist whose limited, diagnostic-and-treatment-plan role means that they are more interested in the patient's symptoms and clinical and biological examination results than in the metaphysical aspects of the patient's diagnosis-inspired identity crisis.

For example, in his discussion of the "clinical scene" that constitutes the first step in the diagnostic procedure, Doctor H repeatedly emphasized the importance of keeping in mind that, "You've got a human being…it's not an animal […] it's not a tree…you've got a human being in front of you" (2015). Nevertheless, Doctor H was very clear that as a specialist, his role was limited to listening to the patient's relevant signs and symptoms; not delving into the patient's psychological aspects: "When somebody comes to me and says I've got a problem I say, 'sit down and tell me just all your life, not since the beginning I am not a psychoanalyst I don't want to know how you've been born that's not the problem […] so why are you coming to see me, what's your problem, do you have pain […]are you bleeding do you have discharge?'" (2015). Thus, we see a contradiction in Doctor H's discourse. Despite maintaining a humanist vision of patients, his interest in hearing about "all" of the patient's life is quickly limited to the patient's signs, symptoms, and biological processes. Throughout my fieldwork, various practitioners repeatedly spoke about the doctor's role as being limited to this scientific process of gathering data about these signs, symptoms, and biological analyses that are necessary for making a diagnosis, determining a treatment plan, and following-up on the efficacy of that treatment plan. Within his previous quote, Doctor H summarized this all very succinctly by saying, "that's the way you do medicine" (2015). My fieldwork indicated that this is an incredibly important aspect of the conventional-complementary relationship because, in many cases it acts as a push factor spurring patients into the realms of complementary medicine in a search of a practitioner whose role does encompasses the "treatment" of the psychosocial malaise engendered in their illness process. This was the case for Clients D and M mentioned above, and for many of the clients who came to see Shaman C. Most of them, like Client M, were not coming to avoid chemotherapy, mastectomies, or any number of other serious medical treatments. Rather, they came looking for someone whose role began where the doctor's role ended. This is an incredibly important theme that will be returned to throughout this thesis.

Returning to Doctor T's discourse defining the steps of the diagnostic process, we can also see that it repeatedly and emphatically defines the diagnostic process as the exclusive domain of doctors and conventional medicine. It emphasizes: the quantity of information about symptoms and diseases that is necessary for being able to competently make a diagnosis; the length of medical study necessary to learn such information; and the characterization of the diagnostic procedure as the fundamental and exclusive role of a doctor. As Shiatsu Practitioner C put it, "in France, the doctors say that, 'diagnosis it's me, you're not a doctor so you don't do diagnosis'" (2015). The Representative of the *Ordre des médecins* explained the importance of both the diagnostic procedure and the necessity of determining a diagnosis before beginning treatment with a reference to medical deontology saying, "If they haven't done the clinical exams and they're content to do naturopathy just like that when a person has a cancer, they'll be condemned. It's not deontological; you have to do exams to verify that people don't have anything" (2015). Doctor T vehemently echoed this deontological concern noting that there are:

> "People who are sophrologists, for example, or osteopaths- or anything that you can imagine as nonconventional medicine- they directly attack the treatment without having taken the time to study the diagnostic semiology […] You have to do diagnostics and try to have a precise diagnosis […] and then apply a conventional treatment […] and somebody who goes to see a guru who immediately tells them what they will do, saying that there is unity between the mind and body because the human body is one, but that is not sufficient. Just because you've said all of that doesn't necessarily mean that you'll give better care […] you have to have done the steps" (2015).

Doctor T went on to explain that the reason for concern over the diagnostic issue in terms of complementary medical practitioners is that, "It creates the risk of not noticing a cancer, for example […] I fear these people who are doing medicine without knowing [what they are doing] because they are often dangerous. I very regularly see sick people who have been going to an osteopath for a long time and in whom we eventually find a cancer that's advanced because they didn't go to see a doctor before" (2015).

Notice how Doctor T uses the word "attack" to describe how complementary practitioners are perceived to approach treatments without first knowing the patient's diagnosis. As a result, "these people" are characterized as "dangerous" and of engendering "fear". This acts as yet another example of the perceived antagonism underlying the conventional-complementary relationship. Not only does the language used by both Doctor T and the Representative of the *Ordre des médecins* demean "these" complementary "people" and their practices; it reduces them into a single category that is disdainfully qualified as, "anything that you can imagine" and stereotyped into having a singular approach to patients that is based on the harmonized notion of mind-body unity we saw in the previous section. Since the themes of danger and fear will be returned to in the subsequent section, for now we will continue with the analysis related to scientific diagnosis. This is important because while Doctor T's concerns are indeed grounded on a very real and serious problem, upon analysis this discourse appears to be prejudicially based on stereotypes. While it is easily arguable that an unknown, but presumably significant, number of patients in France are left undiagnosed and without treatment in the hands of complementary practitioners to the point at which they arrive at a serious or terminal phase of an illness before seeking medical treatment; this same problem also can and does occur in the hands of conventional practitioners.

For example, differences in beliefs, experiences, and approaches among doctors can result in diagnostic differences and misalignments that may lead to undiagnosis, misdiagnosis, and delayed or improper treatment. Shiatsu Practitioner C unintentionally alluded to this by saying, "If you go to a doctor and tell him you don't have energy- if you have a pessimistic doctor they will do analyses to see, because for them the word energy doesn't have a precise meaning. An optimistic doctor will just give you some vitamins" (2015). According to Nurse F, this is precisely how one of her patients went for many months with an undiagnosed cancer, "she had to go to three different doctors before one of them finally figured it out and by then it was fairly advanced" (2018). Furthermore, different doctors have different levels of competency, which can lead to medical error in some cases. For example, even Doctor T admitted that, "We realize that despite the six and sometimes ten years of study, there are doctors who don't perform well and don't know everything" (2017). Doctor J echoed this concern saying, "There are poorly-trained people everywhere and scandals in ordinary medicine. People make medical errors, there are processes against doctors" (2015). Indeed, one of the principal roles of the *Ordre des médecins* is to monitor and take action against medical malpractice, "We have a role in delinquency or grievances vis-à-vis doctors, it's us who takes them in hand by preparing a report that will go to the regional council" (2015). Thus, we can see that while the absence of medical training is a frequently-cited critique of complementary practitioners, the completion of medical school is not a guarantee of great diagnostic prowess and mistakes do occur. Yet, throughout my fieldwork the "dangerous people" list of practitioners associated with preventing proper treatment only very rarely included anything related to incompetent doctors. When it did, such as in discourses like Doctor J's, it was always in the context of a discussion about how conventional medicine is perceived to unfairly persecute complementary medicine and its practitioners.

Another potential source of undiagnosis and delayed or improper treatment- that also serves as an example of the "power" of the pharmaceutical lobby mentioned in the previous section- can be found in the literature of the French Association of the Pharmaceutical Industry for Responsible Self-care (Afipa). Afipa reported that in 2016, 80% of the French population practiced self-medication, constituting total sales over 7 million euro (Afipa, 2017). According to their definition, self-medication involves the use of products that are not prescribed by a doctor, but are recommended and sold by pharmacists. In this section we have repeatedly seen the consideration of the diagnostic procedure as an essential precursor to treatment. Yet, this French lobby for the pharmaceutical industry is actively promoting self-medication as a means of saving the French healthcare system 1.5 billion euro annually; relieving overburdened medical practices; and improving patient treatment time (Afipa, 2017). In my fieldwork, I saw that this situation leaves much room for the same kind of "dangerous" improper or delayed treatment that was attributed exclusively to complementary medicine.

For example, during my fieldwork in 2016, not only did a pharmacist lie to me about the active ingredient of a cough syrup I have used for decades, she emphatically discouraged me from buying it and sold me a honey-based, phytotherapy alterative that was so ineffective my benign cough quickly developed into a severe bronchitis requiring medical attention. Similarly, in 2016 Client O appeared in Shaman C's practice with a severely infected wound that required medical treatment after a pharmacist recommended using nothing but arnica[54] and told her there was "no need" to use an anti-septic to clean it. Considering that these are

[54] *Arnica montana* is a flowering plant from the sun-flower family which is moderately toxic and used in "folk medicine," homeopathy, and herbal medicines. It is used for its anti-inflammatory, analgesic, antifungal, and antimicrobial properties (Koo et al., 2000).

examples from just 2 Parisian pharmacists in 2016, imagine the potential margin for these kinds of medical error among the estimated 53 million people in France that practiced self-medication under the oversight of the 55,580 dispensary pharmacists in France in 2016[55]. Nevertheless, throughout my fieldwork neither pharmacist error nor self-medication was ever mentioned as a potential cause of undiagnosis, delayed, or improper treatments; even though pharmacists may also erroneously recommend complementary treatments, such as phytotherapy or homeopathy, when conventional medicine is needed. Furthermore, pharmacists were also never once included on the list of "dangerous people" who "attack" treatment without diagnosis; even though they do not take patients through the diagnostic procedure with the deontological thoroughness that was repeatedly evoked in this section. Instead, pharmacist-directed self-medication is being actively pushed on the French political agenda through discourses such as one given by Dominique Giuliani, the former Afipa president who is an executive at GlaxoSmithKline: "Considering the current context of health…it is high time for French political life…to take self-care into account through the development of self-medication" (Afipa, 2017).

Where in the previous example we saw that in light of the political and economic agenda of the pharmaceutical lobbyists, diagnosis is not universally considered as an essential component of treatment in the world of conventional medicine; the nonessential nature of diagnosis for treatment was also evoked by a variety of different complementary practitioners. For example, Doctor J explained that:

> "I don't think of a diagnosis in homeopathy or in acupuncture. A 'cold' doesn't say anything because there are ten thousand ways of thinking about a cold- like a cold with clear secretions, for example, or a cold with yellow secretions. So the diagnosis isn't involved in the treatment, because for us, what counts are the symptoms. It is on the basis of the symptoms and their characteristics that we choose a remedy. When someone comes to you saying, 'I have a stomachache,' whether it's a gastric ulcer or a duodenal ulcer, people don't care about that. They come with their diagnosis- such as, I don't know 'hemorrhoids'- it's a diagnosis, but it is certainly not the goal nor the beginning of treatment in homeopathy" (2015).

Notice how Doctor J also reflected on the notion of the "beginning" and "end" that Doctor T associated with the diagnostic role of the doctor. Doctor J's spontaneous evocation of these terms implies that the consideration of diagnosis as a sort of boundary for the doctor's involvement in the patient's illness process is an inherent conception in conventional medicine. Furthermore, notice how Doctor J uses this as a means of further reinforcing the separation and difference in the homeopathic conception of the doctor's role from that of conventional medicine. All of these aspects were also evoked by Kinesiologist R, who reflected on the underlying nature of symptoms, before discussing diagnosis from a different perspective:

> "Dysfunctions, malaise, disequilibrium's- these are symptoms, they're alarms, but often they're not the cause, not the source. We can treat the symptoms without treating the source […] a certain number of doctors send me people who were diagnosed with things like depression […] Indeed we have a certain success with this […] and this success comes from our way of investigating or interrogating the

[55] The basis for the French population and Pharmacist statistics were retrieved from the Conférence Internationale des Ordres de Pharmaciens Francophones and are available online at: http://www.ciopf.org/Fiches-des-pays/France

> body in a search for what is stressful. Once we have found the source of what is stressing the body on some level- whether it be energetic, emotional, genetic, nutritional, structural, or on an ensemble of different levels- once we have located the source of the dysfunction or the disequilibrium, the source of the malaise, we can then look for the particular technique or techniques, that will allow us to return that person to an equilibrium and to reconcile their parts" (2015).

The Kinesiological method of "investigating and interrogating the body" that Kinesiologist R is referring to, is based on the principle of biofeedback. In the context of this quote, Kinesiologist R is invoking the biofeedback method of connecting with a patient's internal environment through the monitoring of changes in things such as heart rate, respiration rate, skin surface temperature, and muscular tension[56]. It is of note that the evaluative process that Kinesiologist R evokes is conceptually similar to the explanations of the diagnostic process in conventional medicine. While it may not use the results of biological analyses, such as blood tests, the process described here alludes to the kinds of clinical scenes evoked by conventional practitioners. It involves listening to a person's symptoms, attempting to group these symptoms into a conceptual frame- here discussed in terms of "levels"- searching for an understanding of the origins of the person's discomfort, and then formulating a therapeutic response. Thus, even though it is not referred to by the term diagnosis, Kinesiologist R is essentially discussing a diagnostic process. Furthermore, the notion of considering a person in terms of the body's unity- that was so easily dismissed by Doctor T- does not refer to a hackneyed metaphysical conception here. Kinesiologist R evokes many of the concrete and material aspects of a patient's globality that are integral components of conventional medicine, such as genetics, diet, and musculoskeletal issues.

Doing a diagnostic process without using the term "diagnosis" appears to be a common strategy among complementary practitioners. For example Shiatsu Practitioner C openly discussed the medical exclusivity of the term "diagnosis" as a form of hypocrisy:

> "In France we are not going to talk about diagnosis, because the doctors have claimed that […] we talk about an energetic assessment. I would say it is hypocritical, but it's like that. So anyway, the energetic assessment is based on an exam, which involves taking the pulse. Taking the pulse comes from the origins of Chinese medicine- you know, you have 12 pulses like the 12 meridians- and so in Chinese medicine you take the pulse in 12 different places on the wrist, it's an energetic assessment" (2015).

This reference to a diagnostic procedure in Chinese medicine is significant because it underscores conventional medicine's appropriation of the term "diagnosis." In the context of a discussion of Chinese medicine this equates to a form of cultural hegemony since it negates the diagnostic logic and practice of other medical systems. For example, Doctor J explains that:

> "Traditional Chinese Medicine first uses a sophisticated diagnostic procedure before deducing the treatment […] the Chinese diagnosis is an energetic disorder, not a diagnosis of organs […] The first time I went to see an acupuncturist I was

[56] Since biofeedback will be discussed in subsequent chapters, we will not delve too deeply into the implications of this particular reference beyond saying that there exists clinical evidence on the efficacy of biofeedback (e.g. McKee, 2008; Yucha & Gilbert, 2004; Frank et al., 2010). Even though this evidence is based on the use of biofeedback in a medical context and the context evoked by Kinesiologist R is not medical, I feel it reasonable to infer that it is possible to gain insights into the patient's internal environment through a "reading" of the physical mechanisms mentioned here.

> in medical school […] The guy said to lie down, he took my name, age, pulse, he looked at my tongue, he palpitated my stomach, he stuck in needles. I thought, 'What's this?! He didn't even ask me any questions.' So I asked him why not and he said, 'I'm not interested, with the pulse and the tongue and the stomach I can diagnose. I don't care which organ, because I don't treat on that level […] I go in search of the cause and once I've fixed that, the symptoms will disappear.' That's the Chinese diagnosis, it's to go to the source of the energetic disorder, the energy between the *yin* and *yang* and between the 5 movements and the 5 elements- afterwards the manifestations are interesting but certainly not essential" (2015).

Notice here how Doctor J's presentation of the information and techniques necessary for the elaboration of a treatment in Chinese medicine is almost a perfect opposite of his presentation of homeopathy. Since Doctor J is a medical doctor who also practices both Chinese medicine and homeopathy, I asked him how this was possible. In response, he laughed and said that he had a very limber mind from doing so many "mental gymnastics." In my treatment experience under Doctor J's care, I found that he practiced a mix of all three medical systems: listening to my symptoms (homeopathy/conventional); checking my tongue, pulse, and stomach (Chinese); asking about my medical history and the diagnoses I had received from other doctors (conventional); asking about what was going on in my life at the time (homeopathy); asking questions about various components of my physiology (conventional). Only after all of this- which usually takes anywhere from 30mins to an hour according to Doctor J- did he insert the acupuncture needles (Chinese) and then send me on my way with a mix of prescriptions for homeopathic and conventional remedies.

While this particular elaborate process does not at all seem like a direct therapeutic "attack;" according to homeopathic School Director L, two of the three practices used in this particular clinical scene are considered in France to be examples of, "charlatanism that don't work and are bad, which can easily turn into a legal battle" (2015). Doctor J shared this sentiment saying, "I have a diploma as a doctor in medicine, so they have a difficult time touching me, but if you're not a doctor then it's very easy and it can escalate very quickly" (2015). The "they" that Doctor J is referring to here emerged as a reoccurring theme in my fieldwork. Different practitioners, both conventional and complementary, made references to a sort of omnipresent 'Big Brother' or Orwellian-type power that is actively pursuing complementary practices and practitioners. One of the most potent examples of this was the Representative F of the *Ordre des pharmaciens*, who referred to this power as, "the inquisition who is going to burn innovation!" (2015). Nevertheless, practitioners did occasionally refer to specific entities or institutions such as healthcare professionals, the *Ordre des médecins*, the police, or the French justice system. For example Doctor J told me about his acupuncture teacher who had, "the police show up at the door of his practice every five years or so" (2015). Shiatsu Practitioner C also evoked several these entities saying:

> "Principally, its doctors I would say […] and physical therapists. Physical therapists don't practice shiatsu and haven't learned about it in their studies, so they consider it as dishonest competition. Physical therapists essentially do medical massages and we do shiatsu, so they say, 'these guys here do shiatsu, they take my clients.' We have to deal with these people, they often attack us with justice- very often- *ah* yes, in France the justice [system] works very well, as soon as something's wrong we go see the judge […]so we have this problem" (2015).

School Director L also echoed this sentiment saying, "In the public health code, the definition of the illegal exercise of medicine is what is most commonly used to attack people.

Only a doctor can do whatever they want with health, healing, and therapy in France, there is no place for other practitioners" (2015). Notice how all of these practitioners discuss the general conventional-complementary relationship in terms of "police," "justice," "battles," and "attacks." Thus, yet again we see that this relationship seems to be popularly conceived of in terms of mutual antagonism. Conventional medical practitioners consider complementary medicine as unscientific and as such, as a dangerous path towards medical error. This perception of medical error acts as a stereotype that is limited to complementary medicine, without reference to conventional practitioners; such as pharmacists, who may erroneously recommend non-conventional products, and doctors who may also make medical errors.

The other interesting theme that is found in the discourses analyzed in this section is their emphasis on the absence of a "place" for complementary medicine in the logic of French conventional medicine. Throughout my fieldwork this notion of "place" repeatedly surfaced in many different contexts, such as in Shiatsu Practitioner C's reference to a "here"/there, "us"/them dichotomy. We saw this same 'us/them' dichotomy throughout the previous section's discussion of discourse focusing on the "separateness" of conventional and complementary medicine and their practitioners. Now, we see this again, but with the added notion of "place." Thus, it appears as though in the absence of a definition for complementary medicine, practitioners on both sides of the perceived dichotomy are using both "identity" and "place" as de facto definitional characteristics instead.

Here, we see the notion of "place" in examples such as Doctor T's repeated affirmations that there is no "place" for complementary medicine in the diagnostic process; even though this section has shown a variety of different kinds of evidence suggesting that this may not be entirely true[57]. This was also reflected in the discourse of Hypnotherapist M, who emphasized the presence of a rightful place for hypnosis in medicine, "Currently [hypnosis] has been evaluated in numerous clinical studies […] and clinical studies continue to regularly appear, so contrary to other things like homeopathy etc., there are many clinical studies on hypnosis, so it has its place in the scientific world and in the medical world" (2017). Despite the presence of scientific evidence for hypnosis, and its partial medicalization, medical hypnosis is still not included in the core curriculum of French medical schools. As such, it is more accurate to amend Hypnotherapist M's statement by saying that hypnosis has a "partial place" in the conventional medical world; just like homeopathy also has a "partial place" in the conventional medical world, evidenced by its booming sales in pharmacies, reimbursement by the national health insurance, and its prescription by homeopathic doctors like Doctor J.

Thus, we find ourselves back to where we started in this section, with the premise that the ability to display scientific evidence is necessary for a complementary practice to have a rightful "place" in the conventional medical world. This is incredibly interesting when we recall section 1.1's discussion of the most common characteristics defining the identity of conventional medicine.[58] This section suggests that we can narrow this list to one defining characteristic: only that which is considered to be scientifically proven has a "place" in French conventional medicine. As such, practices such as homeopathy- which corresponds 2.5 out of the 4 criteria for conventional medicine[59] and represents a multi-million euro

[57] Subsequent chapters of this thesis will provide additional evidence.
[58] Things that are: 1) reimbursed by the national health insurance; 2) taught in core curriculum at French medical school; 3) practiced or dispensed in official medical settings, such as hospitals and pharmacies; and/or 4) scientifically proven and accepted as part of evidence-based medicine.
[59] I say 2.5 because while homeopathy is not a part of the core curriculum at French medical school, it is included in several DUs and DIUs. It is reimbursed (for now) and used in official settings.

industry in France- are not fully-accepted in French conventional medicine. This was attested to by Pharmacist Y who laughed when I asked if homeopathy was used in hospitals, affirming, "No, homeopathic remedies are not generally used in hospital treatments and are only usually prescribed by homeopaths" (2018). The Representative of the *Ordre des médecins* also confirmed that, "there are those who say that homeopathy is *perlimpinpin* powder and that it's useless […] it's never been proven[60]" (2015).

Furthermore, while Hypnotherapist M is correct in that hypnosis is practiced in medical settings and can be reimbursed by the national health insurance; the fact that it is not included in the core curriculum of medical school suggests that the "many clinical studies on hypnosis," are not commonly accepted as definitive scientific evidence. Thus, even though there are studies on hypnosis and it is used by various healthcare professionals; hypnosis continues to be considered as a complementary practice. The same is true for acupuncture, which despite being bolstered by scientific evidence of its efficacy for, "chronic cancer-related problems, such as pain…integration of acupuncture care into a busy and complex clinical environment is unlikely, unless compelling evidence of a considerable patient benefit can be established" (Park et al., 2008). Thus, we can see that overwhelmingly-accepted scientific evidence of efficacy is the gold standard for the consideration of a practice or product as having its rightful "place" in conventional medicine. Anything short of this criterion is doubted and placed into the category of complementary medicine, which carries a negative stigma and is open to "attack."

Interpreting this dynamic in light of globalization's time-space compression and the changes it is creating in our localized sense of place and belonging adds valuable nuances to this discussion. Now that so many complementary practices have become disembedded, globalized entities that are being consumed around the world, it makes sense that their practitioners would seek to create a "place" for themselves and their practices in a given society, such as France. As their popularity and profitability exponentially expands the scope of these practices, it is logical that they would be viewed as antagonistic by the dominant, "conventional medical world." As a result, practitioners from both sides emphasize their separate identity and incompatibility through "us/them" rhetoric as a means of further reinforcing and expanding their respective "places." As complementary medicine's "place" continues to grow, it increasingly encroaches upon the "place" of conventional medicine. Thus, it is perceived in terms of "stealing" patients away from the "proven effectiveness," control, and safety of the conventional medical gaze. This fans the flames of the belief that "those" complementary medicines and practitioners are "dangerous," which reinforces their treatment as such. As a result, this perceptual feedback loop comes full-circle as this negative perception is seized upon by complementary practitioners and interpreted as equally antagonistic. Thus, we again find ourselves with what appears to be a Venn Diagram of two, mutually-exclusive sides with very little overlap between them. As we shall see throughout the next two sections, this dynamic and the perceived separation and antagonism that is perceived to characterize it, ultimately feeds into the fears, stereotypes, and stigmatizations of both "sides" with very real consequences.

[60] According to the National Center of Textual and Lexical Resources (CNRTL) the French expression, *poudre de perlimpinpin*, refers to a powder with imaginary virtues that was sold in the distant past as a panacea for charlatans, an ineffective medicine, or an illusory thing.

## *2.3: The Perception of Fear and Mistrust in the Conventional-Complementary Relationship*

In the last section we saw that there is a notion of danger that is associated with complementary medicine and its practitioners. On the conventional medicine side, we saw that this danger was justified by emphasizing that complementary practices have not been scientifically proven, and thus have no "place" in conventional medicine's diagnostic process and treatment determination. We saw that complementary medicine continues to be regarded as separate from conventional medicine and that incredibly different complementary practices were perceived of as a monolith with a single, and ineffective, approach to understanding a patient's illness. This complementary approach was considered as "dangerous" due to its potential to lead patients away from conventional medicine or to prevent patients from seeking medical attention, even in the case of serious illnesses. We saw that this stigma was focused on complementary medicine with no reference to the potential conventional sources of these same problems. As a result, we saw how complementary practitioners can perceive this as antagonistic, leading to their critique of conventional practitioners and to a rhetoric concerning various forms of an omnipresent power that is actively persecuting them.

Thus, we can see that there is an underlying perception of fear and mistrust in the conventional-complementary relationship. Conventional practitioners fear the dangers that complementary medicine is perceived to pose and complementary practitioners fear the dangers that conventional medicine is perceived to pose. The previous section interpreted this in terms of the antagonism that is related to the critique that complementary medicine has not been proven scientifically. In this section, we will examine some of the other critiques of complementary medicine that were listed in the beginning of the previous section[61] and we will analyze them as a means of bringing to light the fears expressed by both sides of the conventional-complementary relationship. This is an important step in our analysis because, as we shall see, many of these fears are directly shaping that relationship and the strategies that both sides are using as a result.

The first fear that we will examine is the fear surrounding the critique that complementary medicine is fundamentally unscientific because it does not fit in with the "Cartesian" logic of conventional medicine and is thus, irrational. As we shall see, this fear is related to the ontological and epistemological bases of both conventional and complementary medicines, and thus to the perception that conventional medicine is based on scientific fact while complementary medicine is based on belief. While in the previous section we explored the critique that there is no proof for complementary medicine, several practices such as biofeedback, hypnosis, and acupuncture were alluded to in terms of the presence of scientific evidence for their efficacy. As such, this section will explore why scientific evidence related to complementary medicine is not overwhelmingly-accepted enough to allow for different complementary practices be fully integrated and accorded a "place" in the world of conventional medicine.

Throughout my fieldwork, I was surprised to find that many of the reasons for this were related to affirmations that French conventional medicine is "Cartesian." When I asked what exactly that meant, most of the responses provided vague references implying that "Cartesian" was a synonym for conventional medicine's scientific epistemology. For

[61] These critiques were : that it is not and cannot be scientifically proven; that it is fundamentally unscientific and does not fit in with conventional medicine's "Cartesian" nature; that it is an illegitimate and dangerous competitor of conventional medicine; and that it is an open-door to sectarian aberrations that leads to dependency, destruction, and death.

example, Doctor M explained that, "It's Descartes, the method where Descartes said that there is no truth and that we shouldn't just accept things like that- we must ask, we must demonstrate […] and I am struck by how profoundly Cartesian we are in our behavior" (2015). When I asked what exactly that meant Doctor M replied:

> "This is not a scientific response; I am going to respond with a feeling. My feeling is that French conventional medicine is profoundly Cartesian and that once Sackett in the United States created the concept of evidence-based medicine […] he adhered completely to the French Cartesian concept- the discourse and the method […] the concept of evidence-based medicine reapplied Descartes' discourse to science as one and the same […] and we adhered completely, French medicine completely adhered to this concept of evidence-based medicine and it considers medicine only as the application of scientific proofs" (2015).

The "complete adherence" that Doctor M refers to was echoed to me by a variety of different conventional practitioners. For example, the Representative of the *Ordre des médecins* said, "For a doctor, the first thing is to be Cartesian" (2015). This identification as a practitioner or specialist was shared by Doctor H, "Yep I'm Cartesian" (2015); Doctor D, "I am someone who is very Cartesian" (2015); and even by Doctor M, "It's difficult to imagine more scientific, more Cartesian than my specialty" (2015). Doctor O characterized herself using the link between Cartesianism and evidence-based medicine that was evoked by Doctor M, "I am very Cartesian, very evidence-based medicine. That's things that are proven- we have studies and clinical trials and after results and these results show that it is significant" (2015).

Even Kinesiologist R echoed this sentiment noting, "What has happened today is that there is a part of everyone for whom recognition comes from the recognition of scientific validity and scientific proof" (2015). This was taken up by Hospital Administrator A who explained it in the following terms, "To use a psychoanalytic metaphor, it's as if there is a form of Cartesian superego that says that I cannot accept things that are not rational etc […] In France we are Cartesian, we are rational, we are Cartesian" (2015). Thus, you can see that in the context of French conventional medicine, being "Cartesian" refers to the application of the evidence-based methodology to conventional medical epistemology and to a sense of the rationality of what is proven as a result. According to its practitioners, this has become so firmly entrenched that it has been extended to apply directly to the ontology of conventional medicine, which is conceived of as something that is "scientific," "tested," "and proven," and thus, "rational." As Doctor M put it, "medicine is EBM" (2015). When this is taken together with the previous section's discussion, we begin to see that perhaps we can amend the critique that complementary medicine is something that is not scientifically proven; to complementary medicine is something that cannot be proven using the epistemological approach of evidence-based medicine.

Before delving further into our analysis, it is important to make one distinction about the evidence-based methodology described here. The rhetoric presented here, which was representative of what I heard throughout my fieldwork, all directly linked "Cartesianism" with one aspect of the evidence-based methodology, namely the supremacy of, "statistical techniques and randomized controlled trials" (Hospital Administrator A, 2015). This is important because it provides explanation of the relationship between the "French Cartesian concept" and evidence-based medicine, namely that:

> "When you re-read Sackett's articles, EBM is a triangle […] at the summit […] there is the randomized controlled trials, but at the base you have other things, you

> have case studies, you have the consensus of experts […] in other words we retained only one thing, the randomized controlled trial […] but that's not the work of Sackett" (2015).

Following Doctor M's advice I went back and re-read Sackett's explanation of EBM and found that indeed, Sackett underscored the importance of, "both individual clinical expertise and the best available external evidence and neither alone is enough. Without clinical expertise, practice risks becoming tyrannized by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient" (Sackett et al., 1996). Doctor M questioned this tyranny of evidence pondering, "What is the real relationship between efficacy and evidence from a perfectly controlled clinical trial conducted on a small part of the population with people who are perfectly compliant?" (2015). Nevertheless, according to my interlocutors, this is precisely the gold standard for the "rationality" of French conventional medicine.

This deeply philosophical question takes on additional nuance when we consider that one of the most common explanations I received from complementary practitioners about the difficulty evaluating their practices scientifically relates precisely to this notion. Throughout my fieldwork, one of the "harmonized" notions that was repeatedly emphasized by complementary practitioners was their individualized understanding of and approach to treating their patients. Again, homeopathy appears to be the clearest example of this. In the previous section, Homeopath Doctor Q gave us an overview of what seemed to be some "serious scientific" studies of homeopathic remedies with "concrete, material" results. Nevertheless, the section also ended with a derogatory reference to homeopathy as "*perlimpinpin* powder." Thus, in the context of our discussion of the seemingly scientific research presented by Homeopathic Doctor Q, we had the following exchange after I asked, "So you're saying that homeopathy can be very easily evaluated scientifically?"

> Homeopathic Doctor Q- "Yes, I think, yes, yes it can"
>
> Researcher- "So then why does everyone say that it is difficult?"
>
> Homeopathic Doctor Q- "Between you and me, I'll tell you a secret: we can have 50 people who all have pain and in allopathy we will give them all one pain medication, if the pain gets better that proves that it works, but in homeopathy there are 50 ways of having pain- some feel relief with cold, others feel relief with heat, some will only get better with rest, others will only get better with movement, some will get better with wet-heat, others will get better with dry-heat, some hurt more at 4am, others at 4pm- we all have different characteristics- some hurt on the left, others hurt on the right, some only feel pain when they spend too much time where it is damp and cold, others when they are suddenly hit with a cold dry wind […] we don't give them all the same medicines, you see, we will give them medicines based on their individual characteristics and there are so many factors in question that for 50 people who hurt we may give 50 different medicines, whereas in allopathy, unfortunately, we will give one type of medicine to everyone" (2015)

Homeopathic Doctor N echoed this discourse using the example of a headache, "One thousand people can have headaches from one thousand different things and we'll treat each one individually- some have migraines, some have sinusitis, some have allergies, some have stress, and some have a hang-over because they fight with their mothers [chuckles]. Our diagnosis is based on a different method that is subjective and not based on objective medical

criteria. Scientific criteria ask for proof that a remedy will always work in the same way […] but because of the homeopathic method this kind of double-blind scientific analysis does not give the kind of proof that is recognized by the scientific community" (2015).

Indeed, these explanations of homeopathy, when combined with the previous section's discussion of diagnostic theory and method, indicate an inverse conception of its approach to illness and treatment than that of conventional medicine. Conventional medicine was characterized as being based on the comparison of an individual case to objective medical criteria that allow doctors to accurately use symptoms and tests to conceptualize a diagnosis and then to use objectively proven and standardized treatments to resolve, ameliorate, or manage a patient's illness. Complementary medicine, on the other hand, is presented as being based on the consideration of an individual and their symptoms in terms of that individual's totality of body, mind, and environment. The treatments and practices used vary depending on the patient's and the practitioner's specificity. In other words, conventional medicine will give aspirin and will successfully relieve, to varying degrees, all of the thousand headaches referenced above. Complementary medicine, on the other hand, may recommend aspirin to some; activities such as tai chi or yoga to others; plants like Belladonna, Iris Versicolor, or Peppermint to some; minerals like Silica to others; and treatments such as acupuncture, meditation, sophrology, shiatsu, and even shamanism or magnetism depending on the nature of the practitioner and the specificity of the patient's headaches. This makes it incredibly difficult to evaluate using the randomized controlled trial method. Furthermore, conventional remedies are considered to be predictably effective whereas as we shall see, complementary remedies are presented as engendering a different kind of efficacy, if any at all. It is this lack of standardization and predictable effectiveness that conventional medicine and its practitioners cite in terms of a lack of scientific proof and thus, a lack of "rationality" in complementary medicine. As Hospital Administrator A put it, "We become rigid saying, 'No, but what is all this? It's not rational, it's not Cartesian,' you see and then slam! We're blocked" (2015).

Without a doubt, there is a certain rationality in knowing that if a patient is in mild to moderate pain, aspirin will work with a significantly high level of proven effectiveness. Nevertheless, according to my fieldwork, it all comes down to a question of what is being treated and what is the goal of treatment. If relieving the patient's pain is the only goal to treating a headache then the conventional medical approach is by far the most rational: Aspirin is clinically proven to relieve headaches. However, according to all of my complementary practitioners, treating the headache is not necessarily their primary concern. As Homeopathic Doctor Q put it, "For Parkinson's, allopathy treats the illness that is Parkinson's, but in homeopathy we treat the Parkinsonian, which is completely different" (2015). Curiously, Doctor M, who is both a medical specialist and an expert in Traditional Chinese Medicine, also evoked Parkinson's as a means of explaining the differences in treatment outcomes:

> "The outcomes in randomized clinical trials are extremely scientific, extremely 'hard,' but they're not necessarily the outcomes that patients are seeking. Patients seek much simpler outcomes; they're often symptomatic or even intermediate outcomes. When I prescribe qi gong, I am not interested in the evolution of the patient's Parkinson's disease; I am interested in the falls that their Parkinson's causes. I'm not trying to prove that qi gong modifies the evolution of Parkinson's, I'm trying to show that it reduces the falling, because patients have better equilibrium, they feel better in their own skin, they are less afraid of walking etc. You modify the outcomes […] We have to integrate the patient in our clinical

> trials- and what the patient wants- and above all what will help them the most, doctors don't do what they do to make themselves feel better, ok?" (2015).

I found it incredibly interesting and significant that throughout my fieldwork, reflection on this theme was discussed in terms that conflated the following dichotomies: science vs. belief; standardized vs. individualized; quantitative vs. qualitative; Cartesian vs. humanist; evidence-based vs. patient-based, and mechanistic vs. vitalist. In short, that which is considered to be scientific, standardized, and quantifiably proven was characterized as mechanistic, Cartesian, and rational. This was the general consideration of conventional medicine. On the other hand, complementary medicine was presented as belief-based, individualized, qualitative and thus, humanist. In other words, the conventional-complementary relationship was characterized in terms of their opposing ontological and epistemological bases. As a result, in the conventional conception one was conceived of as being "rational" and the other as being "imaginary." At the same time, in the complementary conception one was conceived of as being "dehumanized" and the other as "humanistic." This characteristic was associated with mistrust among complementary practitioners who felt that conventional medicine does not properly address human suffering and instead treats people as inhuman objects.

According to Clinical Researcher R, "Medicine is based on things that are very scientific, there are protocols and a rigor in how those protocols are put into place, but it fails to include the human component. For me, a human is not a walking sack of chemicals; and there is something more to bring and this thing is the non-Cartesian component- psychology, psychoanalysis, sophrology- all that can bring an added component to the Cartesian […] in France we have forgotten mind-body unity and now we only treat the body without addressing human suffering" (2015). As Hypnotherapist M put it:

> "Technique has removed the humanity; the techniques treat people a little like objects- all of the conventional techniques, not just the medications- meaning treatments for the masses, therapies *en masse*. We work in terms of the masses which means we need results, we have to economize, it's not the person that interests us, it's the profits and the budgets, it's economy, society, industry- the person is just an object that we work on, it's dehumanizing" (2017).

The socio-economic references made in this discourse will be returned to in subsequent chapters, but for now; when this is taken in with Doctor M's assertion that French conventional medicine only focuses on the randomized controlled trial aspect of evidence-based medicine, we can see an interesting pattern. Together, these quotes indicate that evidence-based medicine can also be considered as a globalized and disembedded concept. Although it was conceived of by an American with reference to the United States healthcare system, all of the discourses in this section indicate that it has become de-localized. As a result, multiple actors within the French healthcare system have been able to adopt what appears to be a singular aspect of Sackett's theory and to put it into place as a fundamental part of the ontology of French conventional medicine.

For example, various practitioners underscored that the French "Cartesian" version of evidence-based medicine is directly related to specificities of French culture. For example, Clinical Researcher R noted:

> "I think this is a perspective that we have in France that you do not have in the U.S. The Cartesian aspect is not very important in the U.S., you don't ask questions, if it works you go with it and that's all. So which is the good method?

> Is it asking questions for years and years and then finally never putting anything into practice or is it the method of saying if it works we'll use it simply because it can bring well-being? […] In France we ask a lot of questions, but for me the ideal country is the one in which we ask the right questions" (2015).

Hospital Administrator A also gave a similar reflection noting, "In France a young doctor has to be conformist if they want to have a career and be aggregated and have a position- they have to fit the mold […] In France I feel like we are in a culture that avoids errors and failures […] that's why EMB works well here, it makes everyone conform and makes everything fit in the mold" (2015). Doctor M echoed this by saying, "French doctors, in their university training, only know statistics and randomized controlled tests. We are very deeply Cartesian […] even entering in a medical career- in the first year of medical school, they're selected by math and statistics […] there is a scientific rigor, a very very great rigor" (2015). Doctor R put all of this together with the notion of belief saying, "Complementary medicines bring us to confront the problems and the limits of the knowledge of healthcare professionals and users. It is associated with the belief, an important conviction in the efficacy of treatments. Some healthcare professionals in particular are incredibly reticent to use techniques that are less validated scientifically" (2017).

This reflection on the rigor and conformity that are engendered by the French conception of "Cartesian" evidence-based medicine bring us back to Hypnotherapist M's remarks and their relation to this idea of "treatments for the masses," or the standardization that is demonstrated in evidence-based methodology. The remarks above indicate that within French culture, there is a certain sense of security that comes from the kind of scientific standardization and predictability of the evidence-based epistemology. They also indicate that going against the commonly-accepted comfort equates to a social risk. These comments allude to a fear of non-conformity, of making errors, and of going against common beliefs and "important convictions." As we will see in Chapter 4, this is directly related to some important overall trends within the French healthcare system that are having direct effects on the configuration of complementary practices within the system. For now, this notion will be explored in its relation to the perceived "dehumanization" that it creates within what is considered to be "rational" medicine.

It is interesting that various practitioners made a distinction between "humanist" concerns and "scientific medicine." For example, Doctor O, who also practices medical hypnosis, discussed being a doctor and practicing hypnosis as wearing two different "hats" saying, "I think that when I am in hypnosis, I don't really feel as if I am in my position as a doctor. In that moment I am more in a human-to-human position" (2015). Clinical Researcher R also made a similar distinction in reference to his choice to enroll in a naturopathy school saying, "I had a very scientific training, I was very Cartesian, I did fundamental research. I essentially worked with cells, things that have nothing to do with the patient. I finished by opening a little to the human component and once I did, I became interested in man and well-being- both the physical and mental components of man- it happened naturally, it was an evolution" (2015). Notice here how both of these interlocutors underline the "human component" as a fundamental difference between being "Cartesian" and practicing different aspects of "scientific medicine" with being "human," and being interested in both the material and non-material aspects of man. I found it significant that Clinical Researcher R spoke about this in terms of a personal "evolution," which denotes a value-judgment implying that conventional medicine is un-evolved due to its overly-limited clinical gaze. In this sense, Clinical Researcher R is considering naturopathy and its inclusion of a human component as something that is beyond the reach of scientific medicine and that is an important component

in providing care. Doctor O's comment on the human-to-human interaction that occurs when she is "not a doctor" but a hypnotherapist further buttresses this position by implying the presence of a human component that is beyond the medical gaze.

While in the previous section Doctor T made the very correct and astute observation that merely speaking about or conceiving of a human in terms of mind-body unity does not guarantee added therapeutic value, all of these discourses allude to another limit in the role of a doctor in conventional medicine. In medicine, the role of the doctor is to make a diagnosis and then to, "treat the physical body and heal the physical body" (Kinesiologist R, 2015); to, "improve the patient's physical state of health" (Pharmacist M, 2015); or to, "find a solution for the patient's physical distress" (Clinical Researcher R, 2015). Doctor J put all of these themes together succinctly by explaining:

> "Occidental science […] knows how things happen. If there is too much acid in the stomach we give a medication that stops the acid, but we don't care at all where this abundance of acid comes from […] so we talk about the lesion in the organ without seeing that it is part of a movement in life that is perturbed and that manifests itself in different ways in fragile areas depending on the individual. So diagnosis in the Occident is just a way of regrouping signs to say, this is asthma- meaning shortness of breath and mucous, when we have the two it's called asthma- but we don't care where it comes from. We can describe it perfectly anatomically and in all that is material, but we don't know why the bronchial tubes suddenly do that, we just look for something that will open the bronchial tubes up, that's all that we want. So Occidental medicine is really a materialist medicine because it is based on the material world and test results, but it never goes to the source" (2015).

In complementary medicine, throughout the myriad practices I encountered, there was a focus on finding ways to treat the patient's "physical distress" through a search for the subtle causes and means of relieving that distress. In the case of "energy-based" practices such as Traditional Chinese Medicine, Ayurveda, magnetism, and reiki, the subtle causes of patient distress are based on an ontological premise of forces, entities, or energies that do not lend themselves well to the epistemological methods of evidence-based medicine. This is the "movement of life" that Doctor J referred to above that is "not of interest" to conventional medicine. Shaman C described this same movement as a subject of disinterest for conventional medicine by saying, "There are currents inside of the body that are energetic. They're like electric currents and when they cross it stops the cells from properly acting. This blockage continues and generates what we call illness. Doctors don't know about this because they can't believe it" (2016). It is of interest that Shaman C's conception sounds very similar to the meridians and energetic blockages that are the basis of Traditional Chinese Medicine.

In other cases, such as in hypnosis, practitioners admit that it is impossible to understand the practice's exact mechanisms because it connects with an individual's subconscious. As a result, practitioners affirmed that hypnosis is practiced without a specific intention or expectation of results. For example, self-proclaimed Cartesian Doctor O observed:

> "I don't expect- I don't have an intention when I do hypnosis- whereas when I use a pharmaceutical treatment I analyze why I am using that treatment, I analyze the expected positive effects and I monitor its potential undesirable effects […] but despite all of these analyses, I still have an intention to […] respond to the suffering, or to pain, or to a symptom, but when I am in a hypnotic relation, I

> don't know and I don't expect anything for the patient, I don't guarantee them anything, it's just a relational experience and sometimes something happens and sometimes it doesn't" (2015).

This lack of therapeutic intent significantly changes the expected outcome of seeing a practitioner. For example, in the context of a discussion I had with Doctor J concerning the healing mechanisms in Traditional Chinese Medicine, we had the following exchange:

> Researcher- "How does the energy make us heal?"
>
> Doctor J- "*Bah*, we are not obligated to heal [laughs]"
>
> Researcher- "Yes, but when there is suffering?"
>
> Doctor J- "There are people who will never heal their suffering"
>
> Researcher- "So they will just continue to suffer?"
>
> Doctor J- "Exactly. We have to accept that, I mean it's a part of life, we're not the god of the universe- that dates back millions and millions of years- and it isn't any of us who are going to change its path […] There are life cycles and pathology cycles and cycles of balance that we don't understand and probably never will […] Out of compassion we try to relieve humanity's suffering, no one wants to suffer […] but healing that is something else, it's a particular concept and most of the traditions say that God heals […] we can repair but not heal, healing isn't one of the powers of man"
>
> Researcher- "So what do you do with your patients?"
>
> Doctor J- "I do the best I can [laughs]"

As Reiki Practitioner L put it, "I don't do anything really. We create the world and all humans have the ability to control their spirit and change their worlds […] its part of nature and part of our nature and all you have to do is sit and try. I just help connect them with their spirit and beyond" (2015). This was echoed by Shaman C who repeatedly affirmed, "I don't do anything, when I do therapies I am not there. The energy is a super-intelligent force and it is the energy that heals or that gives us what we need to relieve our own suffering" (2016). Kinesiologist R mirrored this sentiment noting, "we balance body's energies and relieve the tensions, once this is done the body does the rest;" as did Homeopathic Doctor Q, "the organism will react as a regulator, it's the organism that is stimulated to regulate itself" (2015); and Osteopath D, "we release tensions in the body which can help liberate tensions in the brain which helps people re-center themselves" (2017). Naturopath E summarized this role nicely by saying, "We accompany, and it is important to have a level of humility. I may have knowledge but I don't heal […] I only accompany" (2015). While all of these practitioners have very different conceptions of what they actually work with, we can see a certain commonality in their self-proclaimed role. Throughout my fieldwork, not one complementary practitioner that I spoke with, observed, or listened to claimed to be able to heal diseases. A few may have claimed that certain diseases, such as cancer or AIDS, do not actually exist; but they did not claim to be able to heal patients from those diseases or even from the illusion of that disease. Although I am sure that there are complementary practitioners in France who do so, my fieldwork suggested that it was not as common as I initially expected. While in the previous section we saw one of the roles of complementary practitioners through the example of patients who had diagnosis-inspired identity crises and

personal suffering as a result, in the next section we will see more examples of what complementary practitioners perceive their role to be.

For now, we can see that all of the rhetoric presented here implies an absence of the kinds of specific therapeutic intents that are the object of conventional medicine. This has two implications: one, it prevents these practices from being evaluated using the principles of EBM, which are entirely based on proving the effectiveness of a treatment's therapeutic objective; and two, it opens up complementary medicine to the fear that it is irrational and based on nothing more than "mental manipulation." French government interest in sects became consolidated in 1996 under the Juppé government, which formed the Interministerial Observatory of Sects. This organization was charged with analyzing sectarian phenomena, coordinating government actions against sects, and informing both the public and the government about sectarian dangers. According to the Representative N of Miviludes, the, "French government action against sects was perceived as being rather exceptional" (2015). Thus, the Observatory was consolidated into Miviludes in 2002- the Interministerial Mission of Vigilance in the Fight against Sectarian Aberrations. This Mission is situated under the Prime Minister and is charged with keeping watch and pursuing sectarian movements that are, "against human rights and fundamental liberties and that constitute a menace to the public order" (Miviludes, 2012). According to a Representative T of an anti-sect association, a group that works directly with Miviludes:

> "In the health domain, aberrations are incredibly important, for example in the case of serious illnesses like cancer, people think that medications have a side that we call *perlimpinpin* powder and that doesn't do anything, so they think it is not very serious for patients to continue their treatment and very often the guru makes the patient stop their treatment […] so that they can have more of a hold on the sick person, we have many cases of this" (2015).

Notice how we see the same derogatory, "*perlimpinpin* powder" remark that was made concerning complementary remedies in the last section reappear, but in reference to conventional medicine. In both cases, it is an association with charlatanism and an allusion to the mistrust that each side has of the other's remedies. This theme will be returned to in the next section.

It is of note that according to Miviludes the types of therapeutic objectives and considerations that were presented throughout this section all equate to, "promises of recipes for healing, well-being, and personal development that are at the heart of practices with risks of sectarian aberrations…the dangers of this alternative market for healing and well-being is that they are based on the absence of independent and rigorous evaluation" (Miviludes, 2012, pp. 5-6). In fact, all of the complementary practices specifically mentioned in this section figure on the Miviludes "most-common methods" list of "potentially dangerous" complementary practices (Miviludes, 2012). The main "danger" and "risk" that Miviludes associates with complementary medicine is a direct reflection of Doctor T's concerns discussed in the previous section; namely that, "they exclude the patient from receiving care in the conventional medical system" (Representative N, 2015). The rationale for this fear can be found in this section's discussion of the epistemological, ontological, and therapeutic bases of conventional and complementary medicine. French conventional medicine is perceived of as resting entirely on "scientific" and "objective medical facts" (Hypnotherapist M, 2015). In other words, conventional medicine relies on the medical authority of clinical studies, university training, test results, and the rigorous diagnostic procedure and its basis on objective medical evidence. Due to their perceived role accompanying the patient using a vast

array of notions that are purported not to be objectively proven, complementary medicines are dependent on the "authority" of the individual practitioner; in other words, on a subjective rather than an objective authority. This lack of objective authority generates a significant amount of fear concerning complementary medicine. For example, in the words of Miviludes and its associates, this makes complementary practitioners "therapeutic gurus" who, "rape the brain of their patients by washing their brains and putting in what they want" (Miviludes, 2012; Representative T, 2015). According to Representative T, the reason for gaining mental control over patients is in pursuit of, "the goal of sectarian aberrations: power, money, and sex" (2015). While to some the complementary medical discourses given in this section attest to the immaterial factors of illness and well-being, to others they constitute nothing more than the falsities of charlatans looking to gain a material or moral advantage over the vulnerable. The Representative of Miviludes summarized the "real" therapeutic intent of "many" complementary practitioners by saying, "They want to make money, they are not altruists, they want money and they want to get a mental hold over people so they can take all they can. They want to control someone's decisions and life so that they can separate them from their families and take more. Not all of them are like this, but many are" (2015).

This is a very real risk associated with complementary medicine that I did experience during my fieldwork. For example, one of the complementary practitioners I consulted charged me 75 euro for session during which she mumbled while tapping my forehead and administered drops from various bottles full of what seemed to be plain water with no taste or textural difference between them. This practitioner emphasized the need to come back for more of these "reprogramming sessions" in which she used my hand like a "mouse" in order to access and reprogram the "computer of my mind" (2015). I left feeling exactly as I had entered; only annoyed for having wasted 75 euro. Another practitioner I consulted proposed Reiki in her home for 120 euro a session, but offered to give me a discount when I gave her the name of the person that gave me her business card. Following an hour-long session on a massage table during which I felt nothing in particular, she recommended I tape a special symbol on my water bottles in order to "improve the frequency" of my water and to continue giving me "therapeutic benefits" even after my session. When I attempted to contact this person in order to ask about the symbol, as arranged, I failed to ever get a response from email, text message, or phone calls. According to the Representative of Miviludes, it is important to be wary of people who, "emphasize beliefs in 'new' ways of thinking and their own 'special' abilities" (2015). I have to admit that throughout my fieldwork I repeatedly found myself among many different people who presented themselves as "something special" and as having "special gifts" or "otherworldly abilities." Some of them organized drum-circles, full-moon circles, and group meditation sessions for around 20 euro a person, which consisted of group songs, dances, chants, and a mix of references to Mother Nature, various "nature spirits" or gods, and the use of instruments, feathers, crystals, oils, and incense. Most of these practitioners recited what sounded like re-hashed quotes from new age books using the same kind of "mind-body unity" discourse that was referred to by Doctor T.

It is of note that these practitioners have developed a sort of self-organized community in which they share polyvalent rooms or spaces available for these kinds of activities; the names of different practitioners with good or bad reputations; and groups of clients that regularly attend a variety of different practitioners and events. This self-organization will be returned to in subsequent chapters. For now, I can say that while many of these practitioners appeared to have an overly-inflated sense of self-"specialness" and performed gestures such as "energetic cleansings" with drums, feathers, incense and great theatrics; few of them seemed to correspond to the money-hungry manipulative stereotype presented by Miviludes. For example, among Shaman C's clients, many were themselves practitioners of a wide

variety of complementary practices. When I spoke with these clients, most of them appeared to genuinely believe in their practices and their personal abilities to help people advance on their "personal path of self-development (Reiki Practitioner L, 2015). At the same time, I did catch one client-practitioner attempting to steal from the personal affairs of Shaman C's other clients in the lobby; so clearly being "energetically gifted" does not always exclude these practitioners from basic human vices. Also, some of the antics of these practitioners made me both question their mental stability and fear for their clients. For example, several energy practitioners seemed to have dependent relationships with various objects of their trade such as divining rods, stones, or magnetic "reading" devices which they refused to be separated from, even for a moment, or would not answer simple questions without consulting. In two instances I saw different practitioners go into a panic when one of these objects was misplaced.

Furthermore, I did encounter practitioners whose ignorance and overly-inflated egos did lead to relationships of dependency with their clients. Some of these relationships did appear to be characterized by the hunger for power, money, and sex that was described by Anti-Sect Representative T. In one case, this kind of dependent relationship did occur with a mentally instable client. Thus, one of the problems with complementary medicine, which Miviludes has rightfully seized upon, is that since the therapeutic approaches and intent of many of these practitioners are based entirely on nothing but their personal authority; they require a great personal commitment to maintaining the "humility" and ethics referred to by Naturopath E. Many clients that I encountered in the complementary medical world, especially those who have had physical or psychological trauma from illness or circumstance, are incredibly vulnerable. Many of these clients came to see Shaman C after having consulted multitudes of different complementary practitioners in a desperate attempt to relieve their suffering. Many of them wanted to speak with Shaman C in order to ask, "What should I do?" about an illness, a relationship, a job, their family, or any other number of serious life-decisions. Much to their dismay, Shaman C repeatedly told them, "I am not here to solve your problems" (2016). Doctor J echoed this sentiment by, "reminding my patients that the best healer is one's self and the universe" (2015). In this sense, Doctor J emphasized a preference for working with patients who come to him, "Not to be healed but […] people who want to be responsible for their own lives […] and can continue to be the actors of their own lives" (2015). The problem is that not all of those who go looking for complementary medicines are so independent. In the context of Shaman C's practice, I often saw clients going to another therapist or to Shaman C's other clients in search of the answers to their life-problems that Shaman C refused to give them; there was much variety in the responses. Some tried not to answer, some tried to offer simple moral support, and others were quick to hand out their business cards and assurances that they could help. Kinesiologist R spoke about this saying:

> "We often send people back to their doctors, we cannot do anything but that. What I mean is that sometimes people come to me and say, 'I am taking this or that medication, what do you think?' and I say, 'You shouldn't be asking me, you should ask your doctor that question. I'm not trained I don't have the knowledge that allows me to say whether a medicine is good or not good, go see your doctor and ask them.' Often people ask me, 'Can you test to tell me if this or that medication is good for me?' I say, 'No, go ask your doctor I can't do that and I won't do that, it is not my role to test for medications […] It is the doctor's role to prescribe, if the doctor prescribed it he has his reasons, so that is who you should ask, address yourself to him, not us […] we don't have that approach, so go see the person in question' [laughs]" (2015).

While Kinesiologist R's response is perfectly correct, it is up to the individual complementary practitioner to reply ethically to patient questions concerning medical authority or concerning important decisions in their lives or treatments. While many practitioners do reply in an ethical fashion, such as in the way Kinesiologist R claims to; my fieldwork indicates that it is safe to assume that some do not. According to the complementary users I encountered there are reasons that people go in search of complementary medicine; throughout my fieldwork rarely did people wander into complementary practices by mistake. Sometimes clients came out of curiosity or with a friend, sometimes it was part of their quest for growth or self-improvement, and other times they came in desperate search of help, relief, guidance, or support for their medical or psychological problems. As was signaled to me by the Representative of Miviludes, "Often people with mental handicaps come to these gurus and without knowing any better, they put their trust in people proposing miracle treatments- or mothers who are told that their children are miracles and that they'll be cured" (2015). Indeed, twice in my participant observation with Shaman C, mothers came in with schizophrenic children. In one case, the mother came with doubts concerning the efficacy of her child's medication. In both cases, I translated for Shaman C. He told the second mother that schizophrenia could not be cured, that it was important to continue with the child's medical treatments, and that his therapy could only help both mother and child to better cope with the symptoms. After they left, Shaman C gave me a much different explanation of schizophrenia that equated it to a spiritual gift. Nevertheless, he told me, "Occidentals are not ready to hear these kinds of explanations and they don't understand what's needed to develop these kinds of gifts. For example, many Occidentals ask me about Ayahuasca, but they don't understand that you have to have grown up in the mountains and be prepared in special ways to use Ayahuasca correctly. So I just tell Occidentals not to take Ayahuasca and to continue taking their medications" (2016).

Unfortunately, not all practitioners are as careful as Shaman C. Following what they considered to be deeply moving experiences, I saw clients look up at supposed exorcists, magnetizers, shamans, and reiki practitioners with expressions of awe and amazement. I saw clients scramble to touch, hold, or hug various types of energy practitioners as they worked through what appeared to be deep-seated emotional experiences evoked by that practitioner's therapy. In their report on Mesmer's animal magnetism, the Royal Commission noted that in group sessions, once one person began to display signs of strong physical or emotional reactions, other participants would follow suit. I personally experienced this phenomenon within my observation of Shaman C's practice. One notable afternoon, one woman suddenly began shaking and sobbing during her therapy. Within minutes five other clients also began crying and eventually so did the remaining two. The entire room was full of crying clients. Shaman C chuckled and said, "They were all contaminated!" After their session, many of these clients hugged one another in the lobby before leaving; however, I cannot say whether they had genuine emotional responses or whether it was merely a psychological mirroring effect. Either way, their shining eyes all displayed signs of a deep impression. While Shaman C made an effort to avoid contact with these clients following these kinds of deep emotional responses, I saw other practitioners bask in their client's awe and stand with chests puffed out and heads held high as they clearly enjoyed being admired and praised by clients who thought they had a significant experience during their care. In these situations, it appeared all too easy to enter into the kind of manipulative and dependant relationships feared by conventional practitioners and institutions such as Miviludes.

Furthermore, due to the perceived separation and antagonism addressed throughout the last two sections, there are also many complementary practitioners who position themselves against conventional medicine and its remedies. In the domain of health and illness I found

that beliefs and convictions ran deep. As Doctor O explained it, "After all there are many beliefs and I have my own beliefs and patients have theirs. Patients have many beliefs and I don't see why, if their beliefs don't have negative effects- I mean if someone thinks that if they eat one chestnut per day maybe their illness will be cured, I will not say, 'Yes your illness will be cured with one chestnut per day,' but I won't stop them from eating their chestnut […] that's my vision of alternative medicine" (2015). My fieldwork indicated that Doctor O is correct, in the health domain beliefs run deep on all sides. Everyone has beliefs and experiences telling them what works, what doesn't work, and what is worth doing; practitioners of all types and patients alike. Where fear comes into play is in the perception that while conventional medical techniques can be proved as "rational" using the methods of evidence-based medicine, the patient-centeredness and subjective approaches of complementary medicine places it outside of the scope of "Cartesian" scientific verifiability and thus, rationality. This irrationality was sometimes perceived as having deadly consequences. For example, Anti-Sect Representative T told me an anecdote about, "A man with cancer that was being followed by a kinesiologist who said they knew someone who organized trips to the Philippines for sick people. Of course it cost lots of money and he was operated on with 'bare hands,' which is a lie because that means that you don't touch the sick person and as a result the man died because the guru only did chants and nothing else" (2015).

Another negative consequence associated with complementary practices was the destruction of families due to what the Representative of Miviludes characterized as the "seduction and charm" of "therapeutic gurus" (2015). For example, Kinesiologist R told me a story about:

> "A man who attacked a kinesiologist because his wife divorced him. If I remember correctly this woman had seen a kinesiologist- but she also did many other things, she did reflexology, acupuncture many things- so she was on a path of personal evolution […] and eventually she evolved and realized that she was married to a man who no longer corresponded to her [laughs] so she divorced him and this man cried victim, victim of kinesiology, and that gave us a lot of very, very bad publicity. We see it all of the time, there's an association for victims of kinesiology that this man is a member of. It's laughable, but it is unfortunate […] the problem is that there are thousands, I believe there are around 2,000 or 2,500 kinesiologists in France and we can't control everything they do, it's just not possible" (2015).

Indeed, since the Miviludes list of criteria for the identification of a sect or sectarian aberration include the rather broad conceptions of encouraging "rupture with the environment of origin" and "the use of antisocial discourses," this anecdote could be considered as meeting the criteria for an encounter with a "therapeutic guru." Furthermore, not only does kinesiology feature in the 2012 Miviludes list of "potentially dangerous" complementary practices, its 2017 activities report specifically cites kinesiology as "particularly worrisome" (Miviludes, 2017).

Thus we see that part of the fear of complementary practices stems from that fact that unlike conventional medicine, there is a limited ability to monitor instances of complementary malpractice. Due to its institutionalization, cases of misconduct in conventional medicine can be easily pursued through the *Ordre des médecins*. According to the Representative of Miviludes and to Representative T of the anti-sect association, it is far more difficult to identify and pursue cases of misconduct in complementary medicine. For example, of the 202 calls reporting suspected sectarian complementary practitioners Representative T's

association received in 2014, only 87 involved callers who were willing to pursue further investigation. The Representative of Miviludes also noted that, "Now there are many small structures of individual therapists with small numbers of clients and in which it is difficult to collect enough evidence" (2015). As a result, it is incredibly difficult to ascertain the true scope of complementary malpractice. In 2016, Miviludes received approximately 1,069 reports of sectarian behavior in the health domain (Miviludes, 2017). This report does not include statistics on the number of these complaints that went to judicial process.

According to the Representative of Miviludes, this breeds fear because, "It is impossible to even reflect on how to collect numbers and information […] there are thousands of types of therapies ranging from legitimate to totally illegitimate to mixtures of the two and we cannot pursue all of them" (2015). As a result, one of the primary activities of Miviludes is "awareness-raising" through publications, training, and conferences. While the Representative of Miviludes assured me that their tactics are changing because, " now that we know a little better what we are dealing with we are trying to be less aggressive;" this Representative also assured me that Miviludes remains, "linked to a notion of repression," and is thus, "seen negatively" (2015). Indeed, Doctor J characterized Miviludes as, "The organism of the inquisition, they are redoubtably closed and narrow and quick to pounce on practices they consider sectarian, for example they consider Bach flowers as a sect […] it's insanity, the fear of sects, the fear of everything like this" (2015). This comment puts the "negative" perception of Miviludes into clearer resolution. Among complementary practitioners, it is perceived of as an omnipresent power that is always ready to "pounce" on them. It is of note that another practice that Doctor J described in our discussion of fear included:

> "Anthroposophic doctors who used the Lecher Antenna […] they were scratched out by the *Ordre des médecins* because they used the Lecher Antenna, even though they prescribed normal things, they just used the antenna to diagnose or prescribe […] that's all they did with the antenna, they didn't even claim to treat with it, they just used it to refine prescriptions but they were suspended for 3 years" (2015).

Within the context of this section, we can analyze this example in terms of perceived fear. According to Miviludes it is often difficult to determine exactly where a given complementary practice lies on the legitimate to illegitimate spectrum. This uncertainty can translate into "aggressive" tactics to "scratch out" complementary practices and practitioners in general or to "educate" the general public on the "dangers and risks" of complementary medicine as a whole. As a result, this can lead to an overall mistrust of all complementary practitioners. This is evidenced by the considerable breadth of the Miviludes 2012 list of potentially dangerous sectarian practices and the following exchange I had with Representative T of the anti-sect association:

> Researcher: "In your opinion is there a complementary medicine that is legitimate?"
>
> Representative T: "No"
>
> Researcher: "Are there any practices that are legitimate?"
>
> Representative T: "No, no. It is not bothersome if someone wants to take something on the side to reassure themselves, but they must definitely not stop their medical treatment"

Researcher: “What about acupuncture for example?”

Representative T: “Well, there are things that are good, but they are open doors for aberrations- like yoga, yoga isn’t bad except that after trying yoga people do other things and then they end up brainwashed” (2015).

This exchange summarizes what turned out to be a theme in my fieldwork. Those that did not “believe” in complementary medicine regrouped all of the thousands of practices under one “dangerous” umbrella that carried with it the risk of “ending up brainwashed” due to their perception as an “open door” leading patients away from conventional medicine and into death or self-destruction. This is interesting because it recalls this section’s discussion of the link that was made between “Cartesian” logic and the notion of “conformity” or “fitting into the mold”. Notice how the Miviludes rhetoric specifically warns against things that sell themselves as a “new way of thinking,” which is echoed in the Representative T’s reflection on practices that “brainwash” people into abandoning trust in conventional medicine. As such, this indicates a sort of fight for an ownership of belief and trust in authority. In other words, this section has given us a picture of a relationship between two different belief systems, with different objectives, points of reference for authority, and shortcomings that generate fear and mistrust on both sides. Conventional medicine is based on the science of evidence-based medicine and what is understood as French Cartesian logic. This is interpreted as being either “rational” or “dehumanized.” Complementary medicine is based on a belief in natural forces or collection of metaphysical entities. This is interpreted as being an “evolved” form of care or a “mental manipulation.” Conventional medicine rests on trust in the authority of medical science, whereas complementary medicine rests on trust in the individual authority of a practitioner. Both of these forms of authority are seen as suspect. Conventional medical practitioners are controlled through the internal surveillance of the *Ordre des médecins*, while complementary practitioners are monitored by the external structure that is coordinated by Miviludes. Both of these forms of monitoring are seen negatively. Throughout my fieldwork, I was repeatedly struck by how diametrically opposed these two categories were repeatedly considered to be and by how the fear and mistrust of both sides mirrored one another. This is important, because as we shall see in the next chapter, the reality in practice is very different than the characteristics presented here.

Thus, when all of these factors are taken into account, it is easy to see why there is a fear and a sense of mutual mistrust on both sides of this relationship. The discourses analyzed in this, and the previous, section suggest that conventional and complementary medicine are perceived of as diametrically opposed belief systems. As a result, there is fear that complementary medicine will take people away from the rationality of conventional medicine and the security of its scientifically proven products and treatments. On the other hand, there is fear that conventional medicine and its associated authorities are prejudiced against all complementary practices, approaches, and objectives and are actively pursuing their practitioners, ready to “pounce” at all times. Both sides mistrust the perceived shortcomings of the other. As we shall see in the subsequent section, this feeds into the stigmas and stereotypes of both sides that prevent the development of definitions for complementary practices with the potential to address some of the concerns raised in this section.

## *2.4: Stigmas, Stereotypes, and Similarities*

Thus far, throughout this chapter we have examined the common perceptions of the conventional-complementary relationship in contemporary France as well as the fear that is related to these perceptions. As such, this section will explore the stigmas and stereotypes that were implied throughout the previous three sections in order to bring to light how these negative representations, fed by the common perception of conventional and complementary medicine as two diametrically opposed systems, detract from the recognition and instrumentalization of the underlying similarities that are common to both conventional and complementary medicine. This is important, because as we shall see in subsequent chapters, it is precisely these similarities that are allowing for the types of conventional-complementary configurations that I ran into throughout my fieldwork.

Throughout the previous sections, we saw a variety of different discourses that were related to the definition of conventional medicine, its role, and its therapeutic objectives. All of these discourses were based on a perception of the rigorous scientific epistemological and ontological basis of contemporary French medicine, which we were told takes its form from a heavy reliance on one of the principles of evidence-based medicine. As a result, we saw evidence that conventional medicine was stigmatized as being dehumanized. Furthermore, we saw how this stigma was used by complementary practitioners to justify an open "place" for complementary medicine to care for the "individual" and "human" aspects of patients. In turn, we saw how this perceived opening was viewed antagonistically by conventional medicine; which stigmatized complementary medicine for its unscientific nature and thus, its inherent irrationality. We also saw how both sides used this stigma as a means of underscoring their perceived separation and antagonism, which was translated into a fear for both sides. Conventional practitioners discussed their fear that complementary medicine deters patients from the rationality of scientifically proven care; and complementary practitioners discussed their fear that they were being unfairly pursued due to their practice of something that is seen as unscientific.

As such, it is now time to recall a critique that was introduced in the first chapter accusing evidence-based medicine of removing the "art" from medical practice. Despite this critique, several of the doctors that I spoke with exalted the ever-present "art of medicine." For example, the Representative of the *Ordre des médecins* pointed out that, "There is a magical side of medicine, that's for sure […] we have a conscious brain and an unconscious brain and in medicine, the conscious is the Cartesian and the unconscious is the magic and the poet" (2015). This quote is interesting, because not only is it a conventional medical echo of the previous section's discussion of the subconscious in relation to hypnosis; it also introduces the notion of irrational "magic" in French conventional medicine. It is of note that the "magical side" of conventional medicine is presented here with overwhelmingly positive connotations, whereas complementary medicine was stigmatized for its "unconscious" side in the previous section. I particularly liked Doctor H's reflection on the art of medicine as well. When I asked, "What does it mean to be Cartesian?" he replied:

> "That one and one makes two, but in medicine if one and one makes a result between 1.9 and 2.10 I think it's a good result- medicine is not- I think I'm an artist not just for music, but medicine is an art. It's not like when you have to build a bridge- one plus one has to make two otherwise the bridge will fall down- when you do medicine you just try to do your best, in medicine what we have do to is to read what our ancestors wrote […] Sometimes, as I've told you, there are some things you don't understand and you won't understand" (2015).

This is an incredibly significant statement, especially in light of Chapter 1's discussion of changes in the limit thresholds for the diagnostic criteria of some illnesses. It shows that there is a grey-area and a place for uncertainty, even in the context of the "Cartesian" science of evidence-based medicine. A comment made by the Representative of the *Ordre des médecins* also underscored the presence of artistic uncertainty in the French context of medicine:

> "You Anglo-Saxons don't have the Latin side, the artistic side. So you tell the patient, 'you're going to die, you have a 50% chance of dying in the next 5 years.' You tell the patient the truth, but in France it's different. In France we say that there are things we cannot explain- well there are certain ways of explaining them, but we haven't found them yet […] there are things that are a little mysterious and for which we haven't found explanations" (2015).

This is interesting because it acts as a counter-point to the previous section's affirmations about the specificity of the rationality and scientific nature of French, Cartesian medicine. Here, this quote acts as a mirror, characterizing French medicine as having an "artistic" side with a widespread acceptance of the "mysterious" aspects of life, illness, and death. Furthermore, this quote suggests that some doctors may instrumentalize the "mysterious" aspects of medicine as a means of offsetting objective medical authority when giving patients a serious prognosis. It is of note that multiple practitioners on both sides discussed a tendency for French doctors to dissimulate mortal prognoses. This implies that the affirmations of the "Cartesian" nature of scientific French medicine are more nuanced than they may initially appear.

Doctor M explicitly underscored this by saying, "One thing of which I am more and more certain is that medicine is not a science, it is the integration of scientific data into acts that aid a person" (2017). Here, we begin to see that conventional medicine is not as "dehumanized" as it was stigmatized for being in the previous section and that the patient is conceived of as more than just a "sack of chemicals." Director Y of a patient association for rare diseases reminds us that:

> "Treatment and care is not just about medicines, there are other things that patients need- medical devices, surgery information, organization of care- we work on all the aspects that are of interest to patients, including social services […] We need to make sure that patients understand […] that there are not arbitrary decisions and that the process is fair based on science, medicines, and other considerations" (2014).

This quote is of note because it emphasizes the "social" side of medicine, as well as the potential for medical decisions to be made "arbitrarily" rather than on the hard scientific fact that was stressed in the previous section. When this discourse is taken into account with Doctor H's previous assertion that doctors need to remember that they have a "human being in front of them" rather than an animal or a tree, we can see that the "social" side of conventional medicine is an ever-present reality; even if some doctors may forget about the "human" aspects of medicine during their practice. Luckily, just as was the case with complementary medicine, conventional medicine is also not a monolith and I was able to observe very different perspectives and approaches among the various healthcare practitioners I spoke with over the last three and a half years. This is an important topic that will be returned to in subsequent chapters.

For now, I can say that I did see evidence of the "social" considerations of medicine within the political realm that governs French healthcare. For example, Politician N, a former

Minister of Health who also served as a director of the ARS, told me that due to the realities of the current French health landscape, "hospitals can no longer guarantee total care pathways, so we are increasingly working with other professionals to create more global care" (2015). Thus, the work of both this patient association and this government agency places importance on addressing some of the "social" considerations of patient care, even if it is largely limited to logistical concerns related to the organization of care. Nevertheless, by working with associations that represent either specific pathologies or general patient considerations, the ARS is encouraging the consideration of some of the "human" aspects of patient care. As we shall see, this consideration, which Politician N links directly to the rise in "chronic illnesses requiring life-long care," is related to changes in the French public health landscape that are expanding the role of doctors, hospitals, and the conventional medical healthcare system (Politician N, 2015). In fact, I found the rise in chronic illnesses to be an incredibly significant factor that is currently shaping the French healthcare landscape. I also saw that for a variety of different reasons, it is precisely the "social" aspects of "chronic illness" that are posing the most difficulties for the healthcare system and the most opportunities for the rise of complementary medicine. This is a theme that will be returned to in this section.

For now it is worth underscoring that doctors are aware that several of these "human" aspects of care are not easy to evaluate using the principles of evidence-based medicine. For example, Doctor R observed:

> "There are many elements that are very difficult to reduce to a scientific point of view, be it the individual that is being treated, the individual that does the treatment, the therapeutic relationship, the context. So we are far from the scientific model that is rigorous, like in physics. In medical science we are already aware of the difficulty to rigorously evaluate the therapeutic procedure, hence why we focus on medications, they're the easiest to evaluate since we have found procedures, notably the placebo procedure, that allow us to clearly see how an individual reacts specifically to a medication that was already tested pharmacologically, but that then gets therapeutically tested because the effects won't be exactly the same in a therapeutic procedure, even if it is well-controlled" (2017).

Again, here we see yet another contradiction to the previous sections' discussion of the perception that conventional medicine is "rational" because it is based on a rigorous scientific epistemology. This rhetoric indicates that despite the stigma that medicine is "dehumanized" the "therapeutic relationship" that is a fundamental component of conventional medicine cannot be reduced to scientific proof and efficacy studies. Instead, this citation implies that there is something that goes on in medicine beyond the mere creation of a diagnosis and treatment plan. Both doctors and patients are "human beings" that are in front of one another in the context of care. There is an interaction that occurs between them that cannot be tested scientifically. Furthermore, this quote indicates that the heavy conventional medical reliance on medications may be, at least in part, due to the fact that they are one of the components of medicine that are among those that are methodologically feasible to analyze in terms of efficacy. Nevertheless, this citation also states that despite the ability to scientifically evaluate pharmaceuticals, their use in the therapeutic context will differ from what is shown in clinical trials. This was alluded to by Doctor M's question from the previous section about the real relationship between clinical trials conducted on perfectly compliant patients and efficacy within a real therapeutic context. According to Doctor M, and a variety of the healthcare professionals that I spoke with, "Now with self-medication, you have an entire population that

uses medications by themselves and they don't tell their doctors what they are using, it's just not possible" (2015). This is significant because, as we saw in section 2.2, self-medication is being actively pushed on the French political agenda by pharmaceutical lobbies; yet, here we see that it can be problematic as patients are not perfectly compliant to their doctors. Furthermore, we also see that there is not a perfect correspondence between the scientific study of medications and their actual use in practice.

Thus, even within conventional medicine there is recognition that not all of the aspects of patient care can be rigorously evaluated scientifically, which lends more weight to the interpretation of there being a "magic" that is inherent to conventional medical care. This "mystery" also extends to a belief in medications, which Doctor M characterizes as, "The domain of shamanism- the relation that patients have to their medications in our system is of a shamanic order, there is a belief that doctors and patients have, a consideration that medications are the only way, the royal way" (2017). One of the "beliefs" that Doctor M is referring to is known as the placebo-effect. According to Ted Kaptchuk, an expert in placebo studies, placebo effects are, "improvements in patients' symptoms that are attributable to their participation in the therapeutic encounter, with its rituals, symbols, and interactions" (Kaptchuk & Miller, 2015, p.8). Notice how this definition of the placebo-effect refers to the "rituals" and "symbols" that are associated with conventional medicine and instrumental parts of the "therapeutic encounter." This is significant within this context because it supports Doctor M's association of "shamanism" with the "belief" that doctors and patients have in medications and their effects. This was supported by Doctor R's definition of the placebo effect as, "A non-specific effect that occurs in any therapeutic procedure undertaken with the intention to care for someone. This can lead to an improvement, even if a technique is not specifically indicated it can produce favorable results" (2017). Here, the positive effect of a therapy is linked to the healthcare professional's "intentions" to care for someone. In other words, this implies that there is a significant therapeutic benefit by believing in the therapy, even if the treatment is not necessarily perfectly-adapted to the patient's medical needs.

This is interesting because it is a direct correspondence to the last section's discussion of the perceived benefits and deep-seated emotional responses that clients got from unscientifically proven complementary therapies. In fact, we saw this in the example of Shaman C's room-full of crying patients. Whether the therapy can or cannot be scientifically proven was unimportant in the therapeutic context. The technique was used by a practitioner whose discourse implies both a strong belief in the technique and a therapeutic intent. Whether the therapy was "rational" or "imaginary" it was strong enough to provoke a powerful emotional response that was in itself strong enough to provoke similar reactions in six other people. The clients who experienced this did not seem to be concerned over whether their reaction was a "non-specific effect" to the therapeutic context and relationship or if the therapy "actually worked," because according to Client C, "I came out feeling better than when I went in" (2016). What is interesting is that in conventional medicine, the placebo effect is an important and proven component; if doctors and patients believe that a medication or treatment will provide positive benefits, patients will feel better. By extension, if doctors and patients do not believe in the medications or treatments, they will have less of an effect; and if doctors and patients believe there will be negative side-effects from a medication or treatment, the patient will experience them through the nocebo effect. All of these mechanisms have been proven to come into play in conventional medicine, yet the previous sections show how these same components are highly stigmatized in complementary medicine and are accepted as an inherent part of conventional medicine.

Indeed, various practitioners discussed the placebo effect as part of their daily lives practicing medicine. For example, Doctor M agreed that the placebo effect was a major part of complementary medicine, but attested that, "It's the same in our conventional medicine, when a doctor writes a prescription or prescribes a pill, it has a fantastic effect that is possibly even more important than the active ingredient- we see that every day" (2015). Representative F of the *Ordre des pharmaciens* also referred to the placebo effect noting, "The principle is that it does the patient well and that their general state improves […] whether it was because […] of the placebo effect or because the product truly had an effect I often can't tell" (2015). Doctor O also discussed the importance of the placebo and nocebo effects in a doctor's daily experience:

> "There are placebo effects and they are something that are very real, it is a non-negligible effect that we even see in evidence-based studies […] I really believe in it and we see it every day, that and the nocebo effect, that's the same. If I have a patient and I use Nurofen without saying anything, nothing happens, but if I tell them that Nurofen can cause nausea, they'll get nauseous. So you see, I think that there are many beliefs and anyway we come with our own beliefs as well" (2015).

This statement from Doctor O takes on additional nuances when we consider it along with the clear differentiation she made in the previous section between her sense of the doctor-patient relationship and the hypnotherapist-patient relationship, which was characterized as being "human to human". Not only does this underscore the "dehumanized" doctor stereotype in the context of a therapeutic relationship, it also suggests that both the conventional and the complementary medical approaches include belief-based components related to patient care. Whether or not they are based on solid clinical evidence of efficacy, "belief" in the form of the placebo effect comes into play in both cases. What is interesting is that the focus on evidence-based medicine downplays the importance of the placebo effect, or "belief," in conventional medicine; while "belief" or the placebo effect, is presented as the mainstay of complementary medicine, which is then stigmatized for its unscientific nature.

For example, Doctor T discussed this using the example of bloodletting saying, "What we are opposed to in nonconventional medicine is very simple, it's that conventional medicines are based on a method whereas nonconventional medicines are based on dogmas and dogmatic positions. Ever since the Enlightenment period, which revolutionized medicine in France […] all of the important French doctors […] enthroned a method for caring for people rather than the dogmatic positions of ancestral doctors […] who transported dogmas from generation to generation, bloodletting is a typical example" (2017).

Indeed, bloodletting dominated medical practice for more than 2000 years before it was finally discredited for most pathologies in late 19$^{th}$ century scientific medicine. For some, such as Doctor T, bloodletting is a prime example of the triumph of scientific medicine over dogma. For others, bloodletting is an example of, "the dynamic interaction of social, economic, and intellectual pressures, a process that continues to determine medical practice" (Kerridge & Lowe, 1995). In this sense it is of note that bloodletting has not completely disappeared from contemporary medical practice. It is still used in the West for certain conditions such as polycythaemia and haemochromatosis; it is still used for various conditions in hospitals in countries like Morocco and Algeria; and leech therapy has come back into use for microsurgeries and reimplantation surgeries to the point where the University of Wisconsin developed a "mechanical leech" to avoid secondary infections (Greenstone, 2010). Additionally, there are clinical studies on the efficacy of bloodletting for various conditions and on the blood products removed using bloodletting techniques (Again, Montazer, &

Namavary, 2016). In other words, perhaps the relationship between dogma and science is not as clear-cut as some would argue. This was reflected in Doctor H's discourse emphasizing the importance of reading "what our ancestors wrote[62]." This takes on additional significance in the case of bloodletting, since its practice largely continued for several hundred years after the validity of the Galenic anatomy and physiology it was based on was disproven. In other words, bloodletting can also be interpreted as an interesting example of how "beliefs" in medicine can easily outlive being scientifically disproven. Throughout this chapter we have seen multiple discourses emphasizing the strictly scientific basis of conventional medicine, yet this thesis began with a consideration of Kuhn's and Koyré's studies on the intimate intertwining of medicine and society; a theme which is now directly coming into play in our practitioners' discourses. This is a theme that runs as an undercurrent throughout this thesis.

For now, it is worth considering Doctor M's reminder that not all doctors are the same and that, "Doctors are not always complicit with the system, the paradigms, the guidelines, and the recommendations of academic societies. Ask them if they follow all the recommendations, because they don't always do so" (2017). Thus, we now see that both doctors and patients are not perfectly compliant to the rigors of the conventional medical system. This assertion was implied in Doctor O's repeated references to the importance of the beliefs that both doctors and patients bring with them into their medical practices. According to Doctor H, many of these differences in individual doctor practice are related to generational differences that shape their beliefs. For example, Doctor H explained that many medical approaches "depend on our age. I think my generation has seen lots of progress in medicine […] we were taught by our professors who had nothing, but current students have got lots of tools. They have got MRI, X-rays, blood-tests, genetic tests […] and sometimes they go directly to the biological and they forget to talk with people and even if you are a great scientist, even if you do the right blood-tests and have the right diagnosis you mustn't forget you have people who want us to take care of them" (2015). Thus, we see that like complementary medicine, conventional medicine is also associated with stigmas and stereotypes that may not always apply. We also see that conventional medicine does have multiple "mysterious," "social," "human," and belief-based components that do not correspond to the pure, scientific "rationality" that is associated with the French "Cartesian" interpretation of evidence-based medicine.

The same is true for complementary medicine, which also does not correspond to all of the stigmas and stereotypes that are attached to it. For example, there are a variety of different complementary remedies and treatments that have been proven using the methods of evidence-based medicine. Acupuncture has been shown effective for a variety of different symptoms and pathologies; as have different phytotherapies. Doctor O also noted that, "there are things that have been more or less proven. For example someone who takes Valerian to sleep, for me that's proven, it's part of phytotherapy, but Valerian has studies that have proven that it is better than a placebo, so it is an example of alternative medicine that is evidence-based" (2015). Acupuncture is one of the strongest examples of a complementary medicine that has been successfully evaluated using the methods of evidence-based medicine. According to Doctor M, "When you look at the scientific literature on acupuncture and the report of Bruno Falissard from Inserm, there are numerous randomized controlled trials that show that acupuncture is effective for certain indications" (2015). Doctor R also cited

[62] It is of note here that the Representative of the *Ordre des pharmaciens* also underscored the importance of reading what our ancestors wrote and showed me an impressive collection of ancient medical text books. Doctor M also insisted I borrow a collection of medical articles from the 1800s. Neuroscientist R made the same emphasis and took me through the History of Medicine museum at the Paris medical school.

acupuncture as an example of a complementary therapy that has been successfully evaluated scientifically, "There are a number of studies which were done on acupuncture- granted it is not always as easy or as effective- but at any rate we are beginning to have a good number of interesting studies that are being done in domains in which it used to be very difficult to have good efficacy studies" (2017). These comments were supported by a literature review on "*Qi* and pain" that was given by Doctor Pierre Miller during a conference sponsored by the French Federation of Chinese Energetic and Martial Arts (Faemc) at the Hospital Saint Antoine in 2017. According to Doctor Miller's presentation there are multiple sources of rigorous studies in *qi* research, although there remains a lack of randomized controlled studies, the golden standard for scientific acceptance. Nevertheless, Doctor Miller underscored the calls, within the scientific research community, for the acceptance of qualitative studies and a higher place accorded to meta-analysis. According to Anesthesiologist A, this is particularly important in the context of pain studies, which are "totally subjective" due to the subjective experience of pain that often makes it, "psychological or idiopathic, meaning that we cannot find its source, so pain must be taken into charge in a multidisciplinary way" (2017).

Indeed, both Clinical Researcher R and Neuroscientist R evoked the problem of a scientific bias against complementary medical research. While Clinical Researcher R related this to the, "general dominance of the pharmaceutical companies who control major portions of the funding available for research" (2015); Neuroscientist R discussed it in terms of a "philosophical problem that creates a general bias against research in complementary approaches" (2017). For example, Neuroscientist R admitted to, "using the scanners on the weekend to do our own, unfunded research on hypnosis and consciousness…just because we can't get funding doesn't mean we can't do research [laughs]" (2017). Much like Homeopathic Doctor Q, Neuroscientist R also discussed the linguistic problem that surrounds complementary research saying, "We need a common language for there to be more scientific opening to these kinds of research" (2017). Doctor Z, a surgeon who has created specialized surgical technique for patients suffering from multiple myofascial retractions, told me, "It doesn't matter that I've been practicing my technique successfully for 23 years and that I have done thousands and thousands of interventions, my technique is still considered as alternative and high-risk because there are no scientific efficacy studies. I tried to organize a study but I was rejected for funding because they said my study wasn't big enough and there are no publications on this technique, even if they were astounded by the results. It's ridiculous, you have to show proof of studies to get funding to do a study to show proof!" (2015). Representative F of the *Ordre des pharmaciens* also discussed the bias against accepting studies on complementary medicine telling me:

> "I once worked in a research center and we had 60 primates that we treated with homeopathy, and it worked. Nevertheless we weren't convinced, even though the primates didn't know if it was a placebo or not, they didn't know anything about what we were giving them. So, I've always been dubious about the notion of proof, but still having seen those primates healed- well, it was curious [laughs] […] anyway, one day we should try to do this kind of research- it seems obvious to me […] I'd be very interested to know if homeopathy really works […] one day the academy of medicine should make a statement, the academy of pharmacy should make a statement, but the difficulty is that if we did, we'd be accused of obscurantism, because ever since Galileo things have maybe evolved in reverse [laughs] Galileo told the truth, it was a scientific truth, and he was condemned for it, and now we have the population encircled with scientific truth " (2015).

Notice how here we yet again see a reference to a notion of an omnipresent authority and a perceived need to adhere to the dominant beliefs related to conventional medicine. Furthermore, we again see this notion of the "tyranny of evidence" and a reference to the use of science for general social control. Taken together, all of this adds significant nuances to the critique that complementary medicine cannot be evaluated scientifically. One particular example of this that I directly encountered in my fieldwork was the practice of biofeedback. As was mentioned in a previous section, biofeedback involves the use of instruments that provide individuals information on their physiological processes so that they may learn to change their physiological activity in order to improve their health or performance (Yucha & Montgomery, 2008). This 2008 literature-review on biofeedback studies indicated that it was efficacious for 10 different conditions and efficacious and specific for one condition. In the United States, biofeedback is practiced in many major medical centers and clinics. In France, neurofeedback, a field within biofeedback that specifically trains people to gain control over their brains' electro-physiological processes, is being studied in the Hospital Pitié-Salpêtrière in Paris for autism and sleep-disorders and at the hospital Sainte-Marguerite in Marseilles for ADHD and epilepsy (Doctor D, 2015). According to several of the patients I interacted with at the *Association Un Sourire pour l'Espoir* in Evry, some private insurance companies are beginning to reimburse biofeedback sessions in France. Nevertheless, despite the scientific evidence and widespread practice of biofeedback in multiple countries, it has not been accepted in France. I spoke about this with Biofeedback Practitioner D, a biofeedback expert from the United States who is working to develop the method in France. Practitioner D comes to France every six months to consult with parents looking for ways of helping their motor-handicapped children. During one of Practitioner D's visits, I acted as a translator for these consultations, after which she explained:

> "Fear is a big problem in France, since biofeedback isn't well-understood here, both doctors and patients are afraid. One doctor got so upset when one of their patients dramatically improved using biofeedback that they wrote an article criticizing it and calling my center in Miami 'horrible'. I have many patients whose doctors have never even heard of biofeedback. Despite good results, in France if you don't follow the official protocol you're out of line. Some of my patients were 'fired' by their doctors and rehabilitation centers because they tried biofeedback and got good results. There's resistance from the scientific community here because they don't understand so they say it is unscientific and it must be bad- they're quick to condemn. Also, French doctors have a high opinion of themselves so if they cannot find an immediate solution to a patient's problem they are quick to give up and say that there is no hope" (2015).

Thus, again we see evidence of a fear concerning complementary techniques that directly stems from the perception that they are "unscientific" and thus, "bad." Here we see various sources of "resistance" to accepting the growing number of studies on biofeedback, as well as several more sources related to the notion of the social control that has been repeatedly referred to in terms of "conformity" to "official protocol." In this case, the main sources of resistance and control that are referred to are "doctors" and the staff of "rehabilitation centers." Also, notice how Practitioner D uses the word "condemn" in her reference to the scientific community. This adds more weight to the Representative of the *Ordre des pharmaciens*' reference to the inverse evolution since Galileo that was made earlier in this section; in which Galileo was "condemned" for speaking scientific truth. Here, we see evidence of the perception of a scientific unwillingness to seriously engage with a complementary technique. Instead of doctors becoming interested by their patient's improvements, they "fire" their patients and refuse to see or treat them anymore,

"condemning" the patient's "unscientific" attempts to improve their condition. This is a point that will be returned to, as it was my personal experience of being "fired" by one of my doctors that led me into the world of complementary medicine and this project. Here, we again see that medicine is not completely insulated from dogma and that the notion of scientific proof is not completely separated from "social" and "human" beliefs and considerations. It is far easier to dismiss them as "unscientific" and "bad" than it is to seriously engage in reflections on potential ways of evaluating complementary techniques. According to my fieldwork, this applies equally to practices such as biofeedback and hypnosis; both of which can be validated with brain imaging and both of which are based on the same scientifically-validated anatomical and physiological notions as conventional medicine rather than on, "unproven dogmas such as acupuncture, for example, which is based on acupuncture meridians that have no anatomical reality" (Doctor T, 2017).

The same is true for Doctor Z, who's non-invasive, outpatient surgical procedure cannot be legally practiced in France, "because it is not accepted […] in France- the only problem is fear, pure and simple" (2015). Much like the case of biofeedback, Doctor Z's technique could also be scientifically proven as it is founded on the same evidence-based medicine as a conventional technique. In this case, Doctor Z is using many years of clinical experience as "evidence." The only difference is that Doctor Z has not been able to gather the:

> "Money, time and resources necessary to do clinical research. It's expensive and it's difficult and I have too many patients. I come to France several times a year to do consultations and then I perform the procedure in my clinic in Spain. I had to get a special secretary who deals exclusively with my French patients because there are so many of them. I've seen 1,100 new patients and have done 500 surgeries in two years" (2015).

I accompanied Doctor Z during one day of these consultations in France and was surprised to see that they were held in what used to be an office space. Nevertheless, despite the unofficial and non-medical setting, Doctor Z examined patients and discussed their cases using the same techniques as those described by Doctor T in the last section. Furthermore, Doctor Z did not appear to be "selling" surgeries to patients. In several cases he informed the patients and their families that his surgery would not be effective and recommended other options for them. In some of the cases I saw that day, patients came for follow-up consultations. All of the follow-ups were positive, except for one family whose son was "fired" by his doctor for refusing Botox injections and going to Spain for Doctor Z's surgery. During the follow-up exam, both Doctor Z and the patient's family were pleased with the child's increased mobility as a result of the procedure. This particular patient case and Doctor Z will be further discussed in Chapter 4 as it represents an underlying theme that emerged throughout my fieldwork, that of the unbalanced power-dynamics between medical authority and patient preference.

For the purposes of this section, I can say that despite the un-official setting, I was impressed by both Doctor Z's and Biofeedback Practitioner D's consultations. They were professional, serious, kind, and efficient. They used the same techniques, the same tools, and the same approaches as any of the healthcare professionals I have seen, interviewed, or accompanied in France. They both had the same basic therapeutic objectives as the other medical specialists following their patients; only with a focus on the patients' and their families' global well-being and daily functionality, an emphasis on avoiding the use of toxic substances, like Botox, and a preference for using non-invasive therapies whenever possible. Yet, according to their rhetoric and the back-room setting they must "unofficially" work in

due to their non-acceptance in France, they are both stereotyped as being in the same group of un-qualified complementary practitioners as the feather-wielding, moon-dancers discussed in the previous section; even though Practitioner D is a certified occupational therapist in the United States and Doctor Z is a certified medical doctor in Spain, and neither of them made reference to anything "energetic." In addition, according to their rhetoric and their multiple patient testimonies of being "fired" for coming to see them and improving, they are both stigmatized as charlatans practicing unscientific techniques by their patients' conventional healthcare professionals. As a result, Doctor Z's patients and their families must find the money and the logistics to travel to Spain in order to receive surgery. Biofeedback Practitioner D's patients can receive care at the therapeutic center created by *Un Sourire pour l'Espoir* in France, but in several cases patients did go to her biofeedback center in Miami for additional care.

Thus, again we see evidence of the way in which globalization and its time-space compression is changing the nature of healthcare practices. Conventional healthcare professionals are coming to France to practice as complementary practitioners and their French complementary patients are travelling abroad to receive these practitioners' care in conventional medical settings in other countries. Also, both Practitioner D and Doctor Z work with patients from other European countries who travel to France in order to receive their pathology-specific care, which has not been mainstreamed and is thus, not available in all countries. This is clear evidence of some of the unintended consequences of globalization; whereas before, patients were obligated to wait for medical research to dictate medical progress, they can now consult with a variety of different practitioners in different locations. Communications technology is facilitating networks of information and patient-exchanges on techniques and practitioners, giving patients increased authority over their care pathways. As such, we see additional evidence of the 'new' networks, movements, and exchanges that are occurring as a result of globalization mechanisms. Not only can practitioners and techniques become disembedded entities in the globalized market; my fieldwork indicates that patients are increasingly disembedding themselves from their localized restrictions on care and are moving more freely around the world as a means of selectively consuming the healthcare practices and modalities that suit their needs. This theme will be returned to in Chapter 4 as it is an incredibly important dynamic that is shaping the healthcare landscape.

Throughout this section we have seen how stereotypes and stigmas are applied to both conventional and complementary medicine and how they take focus away from the "mysterious" aspects of conventional medicine and the "scientific" aspects of complementary medicine. This only further underscores the perceived separation, antagonism, and fear of both sides. Nevertheless, despite the stereotypes and stigmas, my fieldwork indicates that healthcare practitioners are beginning to discuss the development of evaluative methods for various practices. For example, Hospital Administrator B affirmed that:

> "We had a meeting on [complementary] corporal therapies and we reflected on how we could go beyond evaluative difficulties, how we are going to measure, how we are going to work on evaluation, both for the professionals who practice and for the patients. For the moment we haven't worked enough on this, but we need to go much further in these initiatives. For now we are reflecting, the objective is there, but we haven't worked on it enough" (2017).

This citation attests to the fact that among some French healthcare professionals, complementary medicines are not as irrational as was implied in the rhetoric presented in the previous section. Furthermore, it was representative of the sense that I got of the general state

of French reflection on complementary medicine. It is of note that looking back on my three and a half years of fieldwork I did witness a noticeable shift in the general perception of complementary medicine in France. When I first started my research I felt as though using the term "complementary medicine" was like using a bad word. By 2017, I was beginning to see more events and to attend more discussions among healthcare professionals concerning potential approaches for evaluating complementary practices. These discussions, however, perfectly echoed Hospital Administrator B's remarks that, "For the moment we haven't worked enough on this […] For now we are reflecting" (2017).

For example, I attended a closed meeting of the *Observatoire des médecins non conventionnelles* (OMNC) that was held before its conference, "Respiration, consciousness, well-being" at the medical school of Nice in 2017. During this meeting, which included a numerous and broad mix of practitioners who were presenting at the conference or members of the OMNC, there was a general agreement on several themes. Everyone present agreed that there was a considerable market for complementary practices and that there was also a "fear of charlatanism in the conventional care milieu" (Doctor T) that made complementary medicine a "delicate and electric subject" (Doctor V). There was also widespread agreement that "terminology" was a complicated problem that needed to be addressed so that "science could be used to advance slowly with a focus on how to evaluate complementary medicines" (Professor E). The discussion lingered on the problem of terminology for complementary medicine and the importance of resolving this problem through the creation of standardized definitions as a means of facilitating scientific evaluation. In other words, on how it is possible to define something like "yoga" which includes an incredibly diverse aggregation of techniques ranging from "traditional" forms all the way to seemingly-less legitimate "new age" techniques[63]. While yoga is one of the more extreme examples of the definitional problem, it is difficult to define many different complementary practices, such as exactly what practices can be qualified as forms of "neo-shamanism;" how to define which practices actually constitute "meditation;" or how to draw a definitional boundary between "relaxation techniques" and "sophrology."

Within this meeting, there was general agreement that these definitional difficulties are important blockages that are hindering both the development of the scientific evaluation of complementary medicine and its further integration into various "official settings" for conventional medicine, such as in medical schools. Furthermore, according to Doctor T, "The problem is that many doctors do not believe in complementary medicine" (2017). Listening to this discussion brought to mind the observation made by Clinical Researcher R in the previous section about the French method of "asking questions for years and years and then finally never putting anything into practice" (2015). Indeed if all of the thousands of complementary practices and their myriad sub-forms must be defined and catalogued before they can be researched scientifically, it will take many years before agreement can be reached and science can progress. Also, the reference to the lack of doctor "belief" in complementary medicine alludes to the power of stigmas and stereotypes that are further hindering serious scientific engagement with complementary medicine in France. This adds additional nuance to Hospital Administrator B's admittance that there is a reflection on evaluating complementary medicine in France, but at this time there is a need to, "go much further in these initiatives" (2017). This is because while academics, scientists, and specialists- such as

[63] One such "new age" technique that I discovered in a French Hatha yoga class in 2016 is "beer yoga." According to Yoga Instructor S, "beer yoga" combines the pleasure and relaxation of beer-drinking with the mindfulness and balancing of yoga. In some cases beer is consumed after the yoga class and in others, both beer bottles and beer drinking are integrated parts of the yoga positions and exercises. This practice has been spreading worldwide and is currently present in the United States, Australia, Asia, and Europe.

those described here- debate over definitions in the context of meetings like the ones I attended, patients with technology at their fingertips will continue seeking care both from the types of disembedded and ontologically hybridized practitioners that have been discussed in this thesis and from various practitioners abroad. Additionally, as the next chapter will show, conventional practitioners are integrating different complementary practices within their conventional care. As such, we can see the presence a gap between the "time" and "place" that characterizes the methodologies for the advancement of conventional medicine and the time-space compression that characterizes the methodologies being used for the advancement of complementary medicine in France. In many ways, my fieldwork indicated that the tensions leading to the stigmas, stereotypes, and fears surrounding the conventional-complementary relationship stem directly from this gap. This is a theme that will be returned to in subsequent chapters of this thesis.

Within my fieldwork, I found this experience to be the general norm for the development of reflection on potential scientific evaluation of complementary medicine. There is no over-arching structure coordinating the research or reflection efforts. Instead, reflection, evaluation and studies are occurring in an uneven and piecemeal way that is entirely based on the efforts of certain individuals with a specific interest in complementary medicine. As a result of these individuals, a handful of structures and associations dedicated to working on evaluating complementary medicine are present in France. Of these, the three largest that I encountered in my fieldwork are the OMNC mentioned above, the CEPS platform mentioned in Chapter 1, and the *Groupe de l'Evaluation des Thérapies Complémentaires Personalisées* (GETCOP). Much as was the case for complementary practitioners, there is a networked relationship between these associations, evidenced by the fact that all three of their founding members were present at the OMNC meeting and conference, as well as at the CEPS conference I attended in 2017. As we shall see in Chapter 4, it is the networks of practitioners, spaces, events, and patients that are shaping the conventional-complementary relationship in contemporary France. In the context of this section, however, it is useful to analyze a few examples of the individual efforts and interests that have led to the creation of these evaluative structures and associations. For example, when I asked one of the founders of GETCOP about its origins I received this story in response:

> "About 30 years ago, two friends and I- one was the president of the Nancy medical school […] and the other was […] the head of the public health service- […] we decided to create a well-being center in Nancy based on the principle that all of the well-being activities […] were often done under the supervision of people who weren't doctors. Some were very valuable and others were charlatans, so we decided to […] create a big center close to the medical school and the hospital. Nutrition was under the responsibility of the head of the nutrition and diabetes service […] everything cosmetic was under the responsibility of an accredited dermatologist etc. […] we had the plans and the finance and then the *Mairie*[64]of the city joined us because […]the *Mairie* was working to re-discover the [thermal] source and renew Nancy as a thermal city […] Everything fell into place naturally […] Then there were cities where complementary therapies were already well-integrated in the hospital, they were tolerated but not yet official […] so we created GETCOP, the Group for the Evaluation of Complementary and Personalized Therapies" (Doctor V, 2017).

[64] In English, the *Mairie de Paris* is equivalent to the Mayor or elected local official.

Notice how both Doctor V and Doctor T underscore the importance of evaluating complementary therapies as a means of working to prevent charlatanism in the "well-being" domain; this is a theme that will be returned to in Chapter 4. For now, it is interesting to compare this anecdote to the one given to me by Doctor M, the director of an integrated center for Chinese Medicine in a Parisian hospital. According to Doctor M, the origin of his center came from:

> "A request linked to the desire to develop evaluations on Traditional Chinese Medicine, which was an objective situated both at the level of the *Mairie de Paris* and the president of the administration council for public assistance, the person in charge of the AP-HP at the *Mairie de Paris*. There were a few important people […] who were very in favor of developing a reflection in this area […] and at the time, they asked me to reflect on the possibility of inserting Traditional Chinese Medicine in the AP-HP. So it was in conjunction with them that in 2009 we created this center […] a very small structure that attempts to reflect and develop clinical studies on Chinese Medicine" (2015).

It is significant that both of these instances were the result of the individual interests of their founders and the agendas of a few individuals within their local governments. In both cases, these doctors' interests in complementary medicine were noticed by individuals in their local governments, who then encouraged the development of these structures as a means of advancing their own political agendas. This is significant because it brings to light the role that politics play in shaping the conventional-complementary relationship in France. In order to get a better idea of this role, I spoke with the head of health professional relations at the French Health Ministry, Politician C. According to Politician C, the Health Ministry:

> "Makes political decisions. At this level our decisions are based on the macro level and on political concerns […] all of our decisions are political and based on science, which includes studies of morbidity and health economics- so we collect data which allows us to decide what efforts we will make" (2015).

Politician C clearly explained that the government's decision to focus on cancerology or on cardiology is political, because if the government decides to focus on cancer they will put lots of money into it, "which is political" (2015). This was interesting when compared to the discourse of the former director of the ARS who spoke about the role of the ARS in terms of "considering economics, finance, and ethical choices" related to the repartition of government funds and the validation of the "financial strategies" being employed on the territorial level (Politician N, 2015). In other words, the role of the ARS was presented in the same terms as the role of the Health Ministry, only on the territorial rather than the national level. I found it particularly remarkable that Politician C equated the political decisions of healthcare to, "deciding how much money to put into the army and where to deploy your troops" (2015). While this made sense within Politician C's discourse on the factors informing the government's decision to put their weight, and their money, into "fighting" cancer over heart disease, I found that it underscored the notion of "strategy" in French political decision-making for health. Furthermore, this emphasis on "strategy" "politics" and "army" deployment in reference to conventional medical decision-making in the political arena was a reoccurring theme within my fieldwork. For example, Nurse M told me that he retrained in naturopathy because, "The hospital felt like a factory that had more patients than staff and that employed 'nuclear weapons' as a first recourse for everything" (2015). This is significant in within this context because the "nuclear weapons" Nurse M refers to correspond to the "politics" of "reimbursement decisions" on the governmental level.

In other words, due to the "socialist nature of the French government, reimbursement is the primary preoccupation in healthcare decision-making" (Politician C, 2015). While Politician C assured me that this decision-making was done "strategically" on the basis of macro, public health concerns, the repeated emphasis on the "political" nature of these decisions implies that government decisions are not always based entirely on public health statistics. Rather, they take into consideration the political climate that is linked to reimbursement. In this sense, through my fieldwork I discovered that the Health Ministry does have a powerful hand in shaping the conventional healthcare system, and by extension the complementary-conventional relationship. Not only does the Health Ministry work with the Ministry of Education to shape the profiles and contours of French doctors by determining the entry requirements, numbers, and core curriculum for all French medical schools; the Health Ministry plays a fundamental role in working with the French Social Security to determine reimbursements. Reimbursements can be used as a control mechanism, such as by, "stopping the reimbursement of certain medications and forbidding certain practices they restrain people who have the right to practice from practicing in certain ways" (Doctor J, 2015). According to Doctor R, reimbursements can also be used as a justification for avoiding political decision-making for complementary practices or products:

> "Immediately the government and the Social Security see the political problem, in order to reimburse non-pharmaceutical treatments within the regular budget, and that is the absolute rule for them, then we have to stop reimbursing acts that are already reimbursed- economize to be able to reimburse non-pharmaceutical treatments- but what are we going to stop reimbursing? Biological tests, radiology, surgical acts? All the Health Insurance has to say is that they are going to slightly reduce reimbursements for these acts by 1%, which would free up lots of money and allow us to reimburse non-pharmaceutical treatments, but the problem is that then the biologists and radiologists and surgeons whom you told you were going to reimburse less would get paid less and would not agree and that would create a political problem" (2017).

In light of this quote, Politician C's remarks relating healthcare decision-making to army deployment appear much clearer. Any decision that the Ministry of Health makes will have a ripple effect throughout the healthcare system and will touch on different sectors, levels, and actors depending on the nature of that decision. Since complementary medicines are incredibly difficult to define, to test scientifically, and to accept due to the "beliefs" among healthcare professionals that are based on the types of stigmas, stereotypes, and fears that we have seen throughout this chapter; it is not surprising that the French government largely avoids making "political decisions" related to complementary medicine. When they have to, such as in the case of osteopathy- which grew so large a control-mechanism absolutely had to be put into place- these decisions appear to be conservative so as to minimize the "political problems" they create. For example, with osteopathy the decision amounted to putting an accreditation system in place for private osteopathy schools. This created a minimum standard for osteopaths, which is important on the conventional medical side; and it created a third statute for osteopaths who are "*nie-nies*" or non-healthcare professionals from accredited schools. This was important to osteopathic lobbies, such as the one headed by President D, who are actively fighting against the full medicalization of osteopathy. The derogatory "*nie-nies*" reference to the newly accredited osteopaths denotes the political discontent related to this governmental decision springing from the stereotype that all non-health professional osteopaths are inherently unqualified to practice.

These considerations will be further analyzed in subsequent chapters; however they add weight to this thesis' consideration of the French healthcare system as a complex-adaptive system. The evidence that is presented in this section implies the decentralized nature of the overall governance of the French healthcare system in practice. The Ministry of Health only determines the "major outlines" of healthcare including the "repartition of financial resources, the care offerings, and the politics of care-including prevention, care quality, and screening programs- the Ministry mainly determines what is public and what is private and works to ensure equality in care" (Politician C, 2015). These determinations are made on the basis of recommendations and reports furnished by "a complicated arrangement with too many structures," that are "semi-independent" (Politician C, 2015). This role was clear in the way in which the Ministries of Health and Education dealt with the osteopathy problem; by creating accreditations for schools they created a minimum standard for "care quality" while minimizing the creation of "political problems" by avoiding the reimbursement issue.

It is of note that the ARS acts as another key player shaping the healthcare landscape by orchestrating the "financial repartitions" on the territorial and the individual hospital level; however, the examples given by Hospital Administrators A and B suggest that the ARS only has an institutional-level role that does not extend to individual practitioners. This was confirmed by Politician N, a former Health Minister:

> "France upholds the principle of doctors' freedom of installation and freedom of prescription […] culturally, doctors have liberal statutes and liberty in their care […] When the State tries to control various aspects of doctor care, doctors perceive this and have problems accepting that controls are in place. This has evolved over time and is less-strong now than it was before, because there is a general realization that doctors generate public expenditures and now we are attempting to reduce expenditures, but attempting to administrate over doctors creates difficulties" (2015).

As such, we can see how the interplay between individual medical practitioners and, in some cases, of local government officials plays a significant role in shaping the actual landscape of complementary practices within the French healthcare system. We can also see that this arrangement provides a significant "place" for complementary practitioners to work in. This is because, other than the *Ordre des médecins*, which only oversees doctors, and Miviludes, which only looks for cases of sectarian aberrations, there is no centralized entity with a direct oversight capacity of complementary medicine. It seems as this feeds into the fears of an Orwellian-type surveillance that was repeatedly referred to in the previous section; in the absence of a specific authority overseeing complementary practitioners, control occurs in a decentralized case-by-case manner. Taken together, this chapter implies that the structural contours of the French conventional healthcare system have created an environment in which individuals maintain a significant level of agency in their healthcare activities. As we shall see in subsequent chapters, this is resulting in the kinds of self-organizing patterns that were introduced in this section.

Based on my understanding of the conventional-complementary relationship in contemporary France, it seems as though globalization's time-space compression and disembedding mechanisms are unintentionally facilitating what the next chapter will indicate appears to be a general trend towards an opening to and the integration of complementary medicine in French healthcare practices. This section alluded to my finding that while there are stigmas, stereotypes, and fears on both sides that are used to emphasize the separation and antagonism in the conventional-complementary relationship, in actuality both depend heavily

on “beliefs.” We saw that conventional medicine was stereotyped into being entirely based on pure science and stigmatized for being dehumanized; when in reality, there are “mysterious” and “magical” elements in conventional medicine, which remains based on a human-to-human therapeutic relationship. On the other side, we saw that complementary medicine was stereotyped into be composed of a unified body of unqualified practitioners and stigmatized for being “dogmatic” and “unscientifically validated”; when in reality, there is a growing body of scientific work on complementary medicine, that is mostly hindered by beliefs in what constitutes scientific evidence and what procedures are deemed able to be evaluated and ripe for funding. We also saw that there is great variety in complementary practitioners ranging from the theatrical to certified medical practitioners; just as there is great variety in conventional practitioners beliefs, approaches, and competencies.

Thus, according to complex-adaptive systems thinking, we are beginning to see the ample space that the French healthcare system provides for the kinds of interactions introduced here within the diverse collection of agents that are found throughout the healthcare system’s de-centralized and non-linear structural arrangement. We are also beginning to see how the French healthcare system is itself a complex collection of nested systems, all of which are co-evolving within an overall environment shaped by globalization. Chapter 3 will present many of the instances of the emergent patterns that I found within the conventional and complementary practices I encountered during my fieldwork. Chapter 4 will then return to many of the themes that were introduced here- such as the changing role of medicine as a result of the rise in chronic diseases- in order to analyze them as examples of the co-evolution that is occurring within French healthcare as a result of globalization mechanisms.

# Chapter 3: Complementary Medical Trends in France

## *3.1: Evidence of Complementary Practices in Conventional Medical Milieus- Private Hospitals*

Throughout my fieldwork, when I introduced the subject of my research one of the first remarks that people made was that complementary medicine is on the rise due to patient demand. This observation sometimes came in the form of the statistic that, "40% of the French population consults with alternative practitioners, especially in the case of serious diseases like cancer" (Representative of Miviludes, 2015); or in the form of comments such as: "there is a huge patient demand for it" (Representative F of the *Ordre des pharmaciens*, 2015); and "there are many more people who believe and who are getting interested" (Doctor V, 2017). In other words, one of the primary responses that I got from various practitioners reflected the kinds of discourses presented in sections 1.3 and 2.1, attributing the growth in complementary medicine to a growing market of patient use and consumption. These kinds of assumptions characterize the growth in complementary medicine as something that is occurring in a bottom-up fashion with the primary impetus coming from patient/consumer demand. As a result, this seems to further reinforce the kinds of stereotypes, stigmas, and fears that were examined in Chapter 2. For example, in our discussion of the numerous trade events and the booming market for complementary medicine the Representative of Miviludes explained that, "People go to the stands in these salons and they get seduced in a sense, then little by little they become enamored. If the person falls on a predator or someone that has bad intentions it is difficult to tell how they'll take hold of that person, but they will eventually gain psychological control over them" (2015). This discourse underscores the reasons for which I thoroughly discussed the French trade events for complementary medicine, because it acts as a caricature of innocent patients with an interest in complementary medicine navigating through a big room full of stands ranging from the, "innocent, the swindlers, and groups that proselytize, it's very hard to tell" until they fall upon a person with "bad intentions" that "seduces" them and brainwashes them into leaving conventional medicine behind for an uncertain future in complementary medicine (Representative of Miviludes, 2015).

While, to be honest, I had a similar impression of the range in the mix of stands at these trade events as the one given by the Representative of Miviludes, the picture of the data that emerged from my fieldwork seemed to present a more complex view of the growth of complementary medicine in France. On one level, the testimonies of multiple complementary patients that I met at trade events, at complementary events/activities, and in the context of Shaman C's practice attested that there is indeed a booming consumer demand for complementary medicine. This demand seems to be fueling the exponential growth in the number of trade events and practitioners catering to this market. For example, Shamanic Clients C and L told me, "We go to every *Salon bien-être* and every *Salon Zen* and most of the organic salons" (2016). In this sense it is of note that I ran into at least one of Shaman C's clients at every trade show I attended. This implies that there is a complementary medicine client-base that is actively fueling this market as well as a developing network linking complementary consumers and complementary providers.

Nevertheless, one of the things that surprised me the most throughout my fieldwork, was the number of instances in which I discovered diverse complementary practices within various conventional medical milieus such as in hospital services, in trainings for hospital staff, and some interesting initiatives that are developing in various French medical schools. In short, I was impressed by the number of French doctors and healthcare professionals wearing both the conventional and the complementary "hats" referred to in the previous chapter by Doctor O. As such, when analyzing my data, it appeared as though the persistent focus on patient demand as the dominant explanation for the growth of complementary medicine in France overshadowed the importance of the impetus that conventional medical professionals have in this trend. This focus also detracted from the importance that both patient and practitioner associations and lobbies are having in shaping the conventional-complementary relationship; such as President D's osteopathy association and Shiatsu Practitioner C's shiatsu federation. Furthermore, it seems to engender a reductionist, linear, cause-effect vision of the growth in complementary medicine that fed the kinds of discourse that we saw in the previous chapter's discussion of the OMNC meeting, which characterized the interest of conventional practitioners as a response to the growth in patient demand. As such, this and the next section will both focus on a variety of instances of complementary practices that I discovered within medical milieus. All of the examples presented come not from patient demand, but directly from the interests and initiatives of healthcare professionals. This will show itself to be significant throughout this thesis as it acts as an example of the dynamic interplay that is occurring between individual actors that make up the French healthcare system.

As was discussed in Chapter 1, conventional medicine is not a monolith; there are significant differences in the therapeutic objectives, approaches, and priorities of different medical specialties. As such, some of a patient's symptoms may be important to one doctor and completely irrelevant to another. For example the itchiness and discomfort of a patient's eczema could be the central therapeutic objective of their dermatologist, but completely inconsequential to their cardiologist. Furthermore, a general practitioner's most common prescriptions will be dramatically different from those of an oncologist. Following in this logic, I was not surprised to find a certain pattern of clustering in my data concerning the use of complementary therapies in various medical settings and hospital services. This clustering was eventually confirmed by Hospital Administrator B who attested that, "There are healthcare professionals who practice [complementary medicine], so depending on which service we have various different approaches" (2017).

The hospital services in which I found the most interest in and use of complementary medicines included: services related to life and death, such as maternity, palliative care, and resuscitation; services providing care for pain; and services providing care for cancer. The logic behind this seems rather obvious, these are the areas of medical care that are on the fringes of the conventional medical limits during which either many medical treatments cannot be used (maternity), cannot cure or stop the inevitable (palliative care), are on the borderlines of medical knowledge (resuscitation, pain), or involve treatments that are so onerous that they necessitate additional support for patients to deal with their effects (cancer). During my fieldwork, I was able to conduct in-depth interviews and participant-observation with two hospital practitioners who are actively working with complementary medicine in the context of a palliative care service and one in an oncology service. As such, this section will examine these three case studies.

Cases one and two are occurring in a palliative care service within a large, private non-profit Parisian hospital. Within this service I conducted multiple interviews with the head of

service, Doctor O, and with a nurse working in this service, Nurse V. Doctor O is actively practicing and facilitating the use of hypnosis within this service and Nurse V is working to "get little aromatherapy bottles on the carts in all services" (2015). I also conducted participant observation with Nurse V in the context of a "scientific and medical aromatherapy" training course for hospital staff that she helped to organize with Dominique Baudoux's International College of Aromatherapy. It is of note that Baudoux is a Belgian pharmacist who is the founder and president of Pranarôm laboratory, a global leader in health and well-being products derived from essential oils, and an aromatherapy advocate who travels internationally giving aromatherapy training courses to healthcare professionals.

For now, a relevant point of entry into our palliative care cases seems to be beginning with the overlap in both Doctor O's and Nurse V's personal narratives. When I asked Doctor O how she chose her specialty in geriatric medicine and palliative care she replied:

> "I think ultimately it's because of having a global approach to a person […] when I thought about my specialty […] I wanted to do pediatrics when I was young for the same reason, so that I could have a global approach to a person and think of them as a person and not as a sequence or as a collection of organs. So I started in geriatrics […] and it's true that I also felt drawn to this [aging] population which was a little overlooked […] Once I was a geriatric doctor, I wanted to develop on the end of life, so I trained in palliative care and then I wanted to be truly centered on practicing palliative care" (2015).

This is interesting in the context of this case because it contains much overlap with Nurse V's story of how she chose to work in a palliative care service:

> "I became a nurse when I was 20 years old, but after a while I stopped and became the director of a childcare center. I left because I didn't like the strict hierarchy in which nurses didn't have a voice. Also I didn't like seeing patients in pain and suffering and not having any way to help them. For example, with elderly patients who were dying I was left alone with no one to help me- doctors stopped visiting these patients after a while leaving them to the nurses to try and ease their suffering anyway we could […]Palliative care started in France in the 70s and 80s, and eventually I felt that I still had things to do in nursing so I returned to nursing in a palliative care unit […] I chose palliative care because, for me it was the only way to care, because we take the person in a global way and look at them as a person, not as a disease and not as an organ, but as a person with their specificities and psychology. For me, global care is the only right way to care for people and they should do this in all services, but I feel it only happens in palliative care" (2015).

Notice how both of these practitioners specifically chose to work in palliative care due to what they perceive is its focus on the "global care of a person." Also notice how they both use identical language to explain that taking "global care" involves not seeing a person as "a disease," "an organ," or as "a sequence." This is interesting in the context of this thesis because it is a direct echo of Chapter 2's discussion of the negative stigma of conventional medicine as "dehumanized" due to its vision of a human being as a collection of (faulty) components rather than as a complete individual with a body, a mind, and social awareness. It also provides additional insight into Chapter 1's discussion of the developments that occurred in conventional medicine in the 20$^{th}$ and 21$^{st}$ centuries; as these two practitioners are both reacting to the limitations in the scope of the technoscientific, biomedical gaze. As such, they

both selected a medical specialty that goes beyond the disease and the organ to caring for a person and accompanying that person as they pass from life into the beyond.

Another key aspect that is reflected in both these practitioners' dialogs is the notion that the elderly population seems to be treated as being on the fringes of French medicine and is characterized by both practitioners as being "overlooked." While Doctor O makes this explicit, Nurse V's discussion of doctors leaving "elderly patients who were dying alone" implicitly underscores the same notion. This makes sense when we think about the medical gaze, which cannot help a dying patient beyond easing their suffering in any way possible. Despite what the proponents of the "transhumanist" movement are seeking in Silicon Valley, there is no cure for old age. Thus, geriatric and palliative medicines are located at the limits of the medical gaze, because they both involve patients that cannot be cured and symptoms that cannot necessarily be relieved due to their very nature. As Shiatsu Practitioner C put it, "I'm more than 80 years old, I wake up in the morning and I hurt everywhere, so I do an hour of gymnastics and I feel a bit better, but it's like that" (2015).

With this in mind, I asked Doctor O what was the therapeutic objective in palliative care and she replied:

> "Palliative medicine involves care that is meant to bring the most comfort possible to a person in all of their dimensions, knowing that underneath there is an illness that can't be healed. So the most comfort possible obviously means physical comfort with treatments for the difficult symptoms including pain management, but also all of the kinds of suffering that are involved with a forecasted end of life. Naturally this includes the psychic and psychological dimensions as well as the social dimension and the notion of having resolved all our affairs and being in security in this domain- also the spiritual dimension that maybe we don't pay as much attention to in other moments of our lives" (2015).

Thus, we see that the therapeutic objectives in palliative care are very different from those in other medical specialties. This is because the disease cannot be cured or removed and death cannot be avoided. As such, palliative care necessitates the medical care of a person's "psychic," "psychological," "social," and in some cases, "spiritual" dimensions. According to Nurse V, this is because, "You can't cheat death when it approaches, so you become your true self" (2015). This remark adds important nuances to both of these practitioners' interest in taking care of a person in their "globality;" it indicates that palliative care constitutes an interesting mix of physical and metaphysical care, as well as helping a person come to terms with their individuality before passing on. While it seems as though death is the overwhelming preoccupation in palliative care, Nurse V affirms that, "When you're close to death, you're in life!" (2015). This was implied in Doctor O's discourse concerning the need for palliative practitioners to help a person feel as though they have "resolved all of [their] affairs;" meaning that in palliative care the preparation for death involves taking care of that person's life, both in the sense of soothing the discomfort in their lived body and in their lived experiences. This was also further underscored by Doctor O who said, "Even if we are a place for the end of life, we are above all a place of life" (2015). This notion of caring for the "life" of a person was a theme that repeatedly surfaced in my fieldwork among complementary practitioners, thus, it merits further exploration.

These discourses indicate that palliative care can be seen as a medical opening for going beyond the treatment of a person's physical symptoms and ills to treating a person as a metaphysical entity with a sense of self, life, and being in the world. In other words, palliative care can be interpreted as helping a patient to make peace between their living body and their

lived body. According to the work of Bernard Andrieu, the living body can be understood as the body's infraconscious activity that is at work within us before we are consciously aware of it and before we can trigger a conscious physiological or psychological response (Da Nobrega, McStaps, Legendre, & Andrieu, 2017). The lived body, on the other hand, is our conscious experience of being in our bodies. Thus, the lived body directly corresponds to our notion of self in all its aspects including our understanding of our physical and experiential essences. According to the field of emersiology, the living body is constantly at work largely without our conscious awareness of its activities; until the moment comes when an aspect of our living body emerges in our consciousness. For example, some of you may have noticed that sometimes there is a delay between placing your finger on a hot surface and the sensation of pain that makes you pull your finger back. While your finger is in contact with the hot surface, your living body is actively registering the nerve's signals of heat and burning. Your living body is sending those signals to your brain which then translates them into a sensation of pain that emerges in your conscious awareness and stimulates a motor response for you to remove your finger from the hot surface. The delay is the lag between your living body's activity and your lived body's conscious awareness of that activity and subsequent conscious motor response.

This is important in this context because, as Doctor O mentioned, the major aspects of palliative care involve helping patients to cope with both their physical and metaphysical sufferings and symptoms. One of the major symptoms is pain and pain management. As was mentioned in the previous section's discussion of the 2017 "*Qi* and pain" conference at the Hospital Saint Antoine, pain is "totally subjective." This means that what is unbearable to one person could be totally benign to another. It also implies that our pain tolerance varies depending on our lived body's state in any given moment of our lives. For example, consider Shiatsu Practitioner C's comments on waking up every morning with his entire body in pain. Despite that sensation, Shiatsu Practitioner C is able to do gymnastics and "feel a bit better." Notice how he does not say that he feels free from pain or that the pain disappears, only that the exercises help him to tolerate his daily pain. In this sense, the living body can be understood as related to an illness or condition and the lived body to the illness experience. In palliative care, the illness cannot be cured, so peace must be made between the condition and the patient's lived experience with that condition in all of its physical and metaphysical aspects. This is incredibly important within the context of this thesis, because my fieldwork data suggests that this junction constitutes an important "space" for complementary medicine. For example, it is helpful to consider Doctor O's reflections on her use of hypnosis:

> Doctor O: "[hypnosis] entails the relational level for me
>
> Researcher: "Relations between?"
>
> Doctor O: "Between the practitioner and the patient, it involves trying to be on a level of communication with the person so that we can maybe have an action that is not necessarily- it's difficult to explain- so that we are more with the person to help them where they are situated at a given moment […] I feel like hypnosis helps me to be more in communication with the person […] to be present in the moment where the person is in their pain or anxiety without knowing if I'll have a particular action and without wanting a particular result, but in any case being in the instant along with a person and trying to be on their level of communication" (2015).

One of the things that I noticed in particular throughout my discussions of hypnosis with Doctor O was her way of explaining hypnosis in terms of "time," "space," and "place."

In this quote, she refers to hypnotic communication in terms of being with a person "where they are situated at a given moment" and in terms of being "present in the moment where the person is with their pain and anxiety." Thus, this implies that hypnosis allows Doctor O to enter into communication with a person's living body or infraconscious experience of pain. This was echoed to me by various hypnosis practitioners, such as by Hypnotherapist A, who described hypnosis as, "getting rid of the barrier that is between consciousness and unconsciousness so that we can address the unconscious so that it modifies behaviors in consciousness […] It is in the unconscious where we make or conceive of conscious behaviors and in a waking state there is a barrier between the two, like an iceberg, there is the part above the water and a part below the water" (2015). If you substitute "living body" for "unconscious" in this discourse and combine this explanation with the one given to us by Doctor O, the result suggests that hypnosis allows the practitioner to enter into communication with a person's living body.

What is extremely interesting about Doctor O's discussion of hypnosis is that she goes beyond the notion of merely entering into contact with the living body to putting herself on the "level" of the living body in order to "be present" with her patient in the "moment where they are with their pain or anxiety." In other words, Doctor O is situating hypnotic communication not on the lived body level involving the patient's conscious experience of pain, but on the infraconscious level of the living body's physical experience of pain. Furthermore, she situates this as something that it outside of time and place and rather, in a "space" or "moment." This became clear in a follow-up interview with Doctor O, in which she explained:

> "Movement was the first thing that appeared to me in hypnosis, meaning in my first moments where I tried- the symptom wasn't necessarily clearly eased, but what was observable was that something had changed that put the person in movement and that movement was observable in terms of your points of reference. Often it had to do with space- going from the space of the room to the space of a garden and outside of time, meaning that something that was fixed came to the surface and suddenly it was modified in time […] In any case, movement is the thing that determines many things- without me knowing exactly the why and the how of what happens in the person, but I am an observer and I notice this movement- and movement also means change, like a change in the person's position" (2015).

This discourse presents hypnosis as the kind of emersive experiences discussed by Andrieu in his work on emersiology (Andrieu, 2016). In other words, Doctor O is situating the living body as something that is able to exist outside of the lived body's conscious experience of time and place. Thus, a patient is able to simultaneously experience "being" in a hospital room on the conscious level of the lived body, and "being" in a timeless garden on the infraconscious level of their living body. Furthermore, Doctor O is explaining her sense of "being present" with that person on both these conscious and infraconscious levels, as well as being able to observe a "movement" or "change" in the person as a result of the surfacing, or emersion, of something that was "fixed" within the patient's unconscious. This is described as creating a "movement" and a "change" that extends to the lived body's conscious motor actions and a physical change in the patient's body position. Notice also how Doctor O describes the hypnotic therapeutic action in exactly the same terms as many complementary practitioners used to describe their role and action in the previous chapter. That is, she discusses the therapeutic effect of hypnosis as occurring without her conscious knowledge, understanding, or intent.

This is incredibly significant within the context of this thesis because it is a direct correspondence to the surprisingly homogeneous discourse that I heard from a wide variety of complementary practitioners throughout my fieldwork. For example, homeopathic doctors discussed their role in terms of, "going in the sense of the body and the dynamics of life" (Doctor J, 2015); and "stimulating the vital energy of a person as an organism and an individual" (Homeopathic Doctor Q, 2015). A variety of Traditional Chinese Medicine practitioners discussed their work in terms of, "liberating the breath so that it can move freely" (Doctor N, 2017); and "nourishing life within a person" (Qi Gong Practitioner K, 2017). Different corporal and manual practitioners discussed their work in terms of, "taking care of individuals as living beings and liberating the blockages […] on all levels so that energy can freely circulate in the their entire being" (Kinesiologist R, 2015); "reestablishing good circulation of energy along the body's meridians" (Shiatsu Practitioner C, 2015); and liberating tensions in the body's tissue memories to diminish the physical manifestation of problems" (President D of Osteopathic Association, 2017). Along these lines, Sophrologist E discussed his work in terms of, "cutting a person from the external world and helping them to go into themselves in a conscious way" (2017); and Shaman C discussed his work in terms of:

> "Calming the mind so that people can feel […] a subtle energy that communicates through the channel of the mind. Because the mind is an 'ente'[65] in and of itself, it is like a driver, where ideas and information pass through and where we can create a thought. The mind is prepared to recycle and reorder what passes through it so that we can communicate with words. This information becomes incorporated in our minds […] In another way I can say, that it is the intelligence of the soul. This soul intelligence passes through the mind and we cannot differentiate if it is part of the body's mind or if it is the intelligence of the soul. It is very difficult to differentiate. This is why we are very confused, because we are not the masters of our minds […] the true mastery of life is to be the master of the mind and not to be dominated by the mind" (2015).

Thus we see that among these incredibly different practitioners and their incredibly different practices there is a similar emphasis on different descriptions of the living body, of the living body's relationship with the consciousness of the lived body, and on liberating blockages in the living body as a means of easing the conscious mind of the lived body. I found this to be an overwhelmingly common underlying theme among the various complementary practitioners I interacted with. Whether it was discussed in terms of "vital energy," "life," "the sense of life," "breath," "energy," or the "inner self," all of these practitioners are essentially discussing a subtle force that acts on the infraconscious level of the living body. Even President D's reference to the "body's tissue memories," implies that the living body has a sort of infraconscious intelligence that roughly corresponds to what Shaman C terms the "intelligence of the soul;" which is interesting since Shaman C's response is an example of the more esoteric conceptions of the living and lived bodies that I was given in my fieldwork. As was alluded to in the previous chapter, many of these practitioners discussed the connection between the living body and various conceptions of "Nature," "the cosmos," "the universe," or any other cosmological conception of the wider environment we live in. Furthermore, all of these practitioners discussed their work in terms of "movement" and "circulation" both within the living body and between the living and the lived body. This latter conception corresponds directly to Andrieu's notion of emersion, in which information from the living body crosses "the barrier between consciousness and

[65] Here Shaman C is referring to "the mind" in Spanish- *la mente*- of which '*ente*' corresponds to the Latin *entitas* or *entis* meaning "a thing."

unconsciousness" and enters into the lived body's conscious awareness. Even the example of biofeedback that was discussed in the previous chapter corresponds to an emersive process in which machines are used as a means of facilitating the conscious awareness of the body's autonomic physiological processes in order to teach a person how to gain conscious control over these processes.

In this sense, when we hear complementary practitioners discussing their "global" approach to care, we can understand it as meaning caring for both the patient's living body and helping to create harmony between their living body and their lived body's conscious experience. This seems to go beyond the psychological aspects of a patient's diagnosis and illness, extending to an extremely dynamic interaction between their bodies and minds. However, going beyond the reductionist notion of "mind-body unity," the conception that came to light in my fieldwork seemed to correspond to harmony between the patient's body and their conscious experience of their body; which inherently includes their wider social, cultural, and physical environment. Rather than putting these complementary practices at odds with conventional medicine and its conceptions, I found that it seemed to reflect their complementarity. In other words, even accepting Doctor T's affirmations that there is no "place" for complementary medicines within the initial diagnostic process; my fieldwork seemed to indicate that there were various "spaces" for complementary medicine in patients' overall illness experiences- many of which were outside of the "place" and "time" of the conventional medical gaze, such as what Doctor O experiences with patients in hypnosis.

Another good case study of this phenomenon can be found in Clinical Researcher R's personal narrative. Clinical Researcher R works in an oncology service at a private non-profit hospital in Paris. We met at an open house for a Parisian naturopathy school, which Clinical Researcher R attended because:

> "As I said when I came to the naturopathy session, currently the relationship between the patient and the doctor is increasingly reduced on the level of time […] so the relationship is diminishing, the human relation between the patient and the doctor is diminishing and so we see the emergence of complementary tools […] which balance the lack of time that doctors have to spend with patients […] this made me realize the necessity of introducing more things into services that are- *uh*, very Cartesian […] introducing naturopathy for example, a medicine based on plants, luminotherapy, many little things that can bring- they can't cure but they can bring comfort to care that is difficult for patients, especially oncology which is a very, very difficult service" (2015).

Here again we see the same stigma raised in the previous section, that conventional medicine is becoming "dehumanized;" although in this case it is not because of the mechanistic reduction of the body, but due to the lack of time that doctors have to spend with their patients and to deal with the "human" aspects of their care. Notice again how this "human" component is conceived of in terms of the lived body's conscious experience with illness and treatment. Also notice how this experiential component is perceived of as being beyond the scope of the medical gaze; in this case due to the lack of doctors' "time."

According to Clinical Researcher R, as a result of the perceived need for providing care for this "human" component within his service, which he characterized as "fairly modern":

> "Several years ago we introduced psychology units within the oncology service […] to meet with cancer patients who are in chemotherapy and to discuss their

> various problems […] We also have a sophrologist available for patients to provide a complement to their treatments because chemotherapies are treatments that are heavy and so in complement this brings a type of well-being for patients as they go through difficult periods, because they need someone to listen to them and to give them advice […] So that allows us to provide non-pharmaceutical and psychological treatments that even in 'classical' chemical thinking provide an aid that is non-negligible […] I know that it's not all hospitals, but now more and more hospitals are trying […] these complementary tools" (2015).

In other words, here we again see the misalignment between the perception of a French doctor's role and patient needs that was highlighted in Chapter 2. The patient illness experience can necessitate care that extends beyond the doctor's diagnostic and treatment role. According to my fieldwork, this is particularly true for patients with serious illnesses requiring "heavy" treatments, such as cancer and chemotherapy. Indeed, the Representative of Miviludes specifically identified cancer patients as among those most likely to go in search of complementary medicine saying, "Many of the people that consult complementary practitioners have serious diseases like cancer. They are looking for a miracle cure and they want help with their suffering and chemotherapy, which is effective, but may have secondary effects that are hard to deal with" (2015). One such case that was mentioned in Chapter 2 was Shamanic Client M, who discussed the difficulties that her cancer and chemotherapy created in her marriage and sense of self. According to the experience of Nurse V, one of the reasons chemotherapy patients have such difficulties is because:

> "Doctors are specialists and they don't know about other things beyond their specialty. In cancer, doctors don't deal with many patient symptoms, they send them to nurses instead. Doctors treat with chemotherapy, but they don't deal with all that occurs around the patient's chemotherapy or with particularly difficult symptoms […] there's different reasons for this- they're overly limited specialists, they don't have time- sometimes it seems to me that they just don't have an interest" (2015).

According to Shamanic Client M, this is precisely why she went in search of complementary medicine. Dealing with the personal marital and psychological discomfort that resulted from her cancer and chemotherapy fell beyond the scope of her oncologist's gaze; they were thing that occurred "around the patient's chemotherapy" that her doctor either did not have the capacity or the time to deal with. In the case of Clinical Researcher R's hospital, they have brought in "complements" as a means of treating these aspects of a patients' lived body experience; however, as Clinical Researcher R attested, "not all hospitals" have these sorts of "complementary tools." Furthermore, it is interesting that both Clinical Researcher R and Nurse V emphasized that doctors "don't have the time" to foster a "human relationship" with their patients. Clinical Researcher R provided me with several explanations for the reductions in doctor time with patients:

> "Now hospitals have profit-based policies, they have to make the numbers and so the human relationship between doctors-and patients is reduced […] because doctors spend less and less time with patients. I know that in our service, it's 10 to 15 minutes when a patient comes for chemotherapy, for example, that's the time consecrated to their visit […] So the doctor doesn't have time to talk to the patient about their problems, it's become very- how to say it- it's very rapid, they have to get through the numbers and not lose time so that they don't find themselves overwhelmed […] So the doctor has a certain timing with less and less time for

> the human aspect. This aspect is left to the psychologists and the sophrologists, it's them that deal with it now" (2015).

This is a direct mirror of Nurse V's repeated insistences that doctors don't have time to deal with all of their patients' symptoms or issues and that they "send them to the nurses instead." Here, instead of sending them to nurses, doctors are sending them to psychologists, sophrologists- and if Clinical Researcher R's plans get approved- they will be sending them to a naturopath as well. Notice how Clinical Researcher R attributes the reduction in doctor time to "profit-based policies" and "making the numbers." My fieldwork indicates that this is the result of a combination of two factors. The first is related to globalization's time-space compression, in which private hospitals such as this one, have to constantly increase their numbers and profit-margins to satisfy their investors. It is of note that this particular hospital is a grouping of seven different health establishments boasting a 10% increase to 70,000 hospitalizations and more than 190,000 external consultations effectuated in 2017; as well as the successful implementation of both a "Big Data" and an "Artificial Intelligence" (AI) project. Considering that these numbers were featured in the opening lines of this hospital group's activities report, we can see both the importance and scope of the "numbers" that Clinical Researcher R is referring to. The second factor involved, which is evidenced here by this hospital's big data and AI projects, is directly related to the technoscientification of biomedicine. Patients are being reduced to a set of numbers among an ever-increasing "big" database, which is transforming their specificities into being defined by biomarkers and the levels within the biochemical ranges that are tested for in things like blood-tests. In this sense, patient X is better known by their doctor for having something like a consistently low blood platelet range, rather than having a husband who works too much and two children in school. When this is taken together with Nurse V's and Clinical Researcher R's testimonies, we can see that the patients themselves are directly affected by time-space compression, which is reducing them into a number in a series that doctors have to "rapidly" "get through." The time given to them by doctors is reduced to a "diminishing" number, which my fieldwork suggests is somewhere between 8 and 15 minutes; their identity is being reduced to a series of biochemical levels and markers; they're moving through huge multi-sited establishments that are increasingly disembedded from their localities, and which Nurse M referred to as "factories"; and their internal "spaces" are left to be "dealt with" by nurses and complementary practitioners outside of the doctor's medical gaze.

In this sense, even Doctor T admitted, "In the treatment stage there is an opening for nonconventional medicines […] in this third step we can mix and add nonconventional medicines for people's well-being" (2017). According to my fieldwork data, this is precisely what is happening. For example, when Doctor O discussed her hypnosis training she emphasized that it was specifically for medical use according to the professional role of each kind of medical practitioner:

> "There are nurses who practice hypnosis […] a nurse will use hypnosis in the field of their competence to change a bandage or as a means of reassuring and supporting for a painful treatment […] In my training there were psychologists, midwives, surgeons, anesthesiologists, doctors- we were all healthcare professionals" (2015).

Following her training, Doctor O began regularly using hypnosis in her palliative care service and she began encouraging the nurses working in her service to get trained. Similarly, Nurse V began using aromatherapy and massages in Doctor O's service. She told me that it all started because she gave peppermint oil and a massage to one of the doctors suffering from

stress and headaches. The doctor appreciated it and "began asking me to give massages with essential oils to certain patients. It seemed to be doing everyone a lot of good so slowly we began integrating it throughout the service" (2015). According to Nurse V, "More doctors are beginning to follow and are willing to introduce aromatherapy as a new technique in their services […] First, teams must be convinced- both doctors and nurses- you have to find a way to make them believe and train them enough so that they can use it" (2015). To these ends, Nurse V organized an aromatherapy training session with Dominique Baudoux that was open to the entire hospital staff.

This "Initiation to Scientific and Medical Aromatherapy" took place on the grounds of Nurse V's hospital and lasted for 8 hours. It included an initial talk given by Baudoux himself, followed by a series of targeted workshops such as one on "pain" and one on "palliative care" among others. I was surprised to see that there were approximately 100 people present at this particular training session, the majority of whom were women in their 40s and 50s. Baudoux emphasized the scientific nature of his work with essential oils, which is focused on identifying the active molecules and molecular structures in different oils and their interaction with the body. This is interesting because it means that Baudoux is applying the same methodology that is used for pharmaceutical research to essential oils. According to Baudoux, there is a "renewed interest" in aromatherapy that has led him to travel around doing informative workshops and training for healthcare professionals.

It is worth noting that Baudoux actively encouraged nurses to use essential oils with their patients either with or without permission from their heads of service, although he did say that, "It's better to ask permission because of doctors' egos" (2016). When I asked the nurse sitting next to me if this was true she chuckled and said, "I've been using my own mixes of oils to help patients for a long time, the doctors in my service know about it, but no one says anything" (Nurse P, 2016). This is a theme that will be returned to in subsequent sections; evidently there are a variety of different complementary practices being used within French hospital services on a case-by-case basis by individual healthcare professionals. Since these are not "officially" part of the service, there is no need for the authorization or even the knowledge of heads of service or hospital administrators. As such, my fieldwork indicated that there is at least a moderate use of complementary practices in French hospitals; only most of these practices remain "invisible." In other cases, such as in Doctor O's and Nurse V's service, they are attempting to integrate these practices as a "service project," meaning as an "official" part of the service care offering.

Clinical Researcher R made this same distinction and used it as an example of the "novelty" and "luxury" of his oncology service:

> "Within our service it's new and it's a luxury […] We have psychologists in the oncology service […] the psychologists are a part of the oncology team, it's not psychologists who come from another service like neurosurgery, they're part of our team and that is fairly new. Like the sophrologist, the sophrologist also is a part of our team and in addition to taking care of the patients this sophrologist also takes care of the doctors" (2015).

This means, that sophrology is an "official" "service project" within Clinical Researcher R's oncology service. It is known about and supported by the hospital administration as well as by the entire oncology service staff. Doctor O characterized hypnosis in her service as an "official" "service project" as well. Nurse V told me that she is working towards getting aromatherapy officially accepted as a service project, but that at the time of our interview she only had, "a foot in the door. Little by little we will be able to do

more, but for now I just have a little foot in the door […] I've convinced 3 of the 5 doctors in our service about aromatherapy, they don't know why it works, but they see that it works and now they're telling other doctors […] I'm happy to slowly introduce it via protocol so people can learn about it and start practicing" (2015).

Just as in Doctor O's case, Clinical Researcher R underscored the utility of complementary practices for improving the communication and ameliorating the relationship between doctors and their patients. For example, he noted that the sophrologist is "Part of the team […] once a week we have meetings with the sophrologist so that the doctors can discuss the problems they encountered. Sometimes the interactions between doctors and patients can be difficult for the doctor […] in terms of how to interact with a patient […] so it's a moment for doctors to confide in the sophrologist to see how they can improve their relations with patients […] This improves the functioning of the service and it's something that adds to patient care" (2015). Thus, in this case complementary medicine is operating both in the space of patients' illness experiences and as a means of improving doctor-patient communication and by extension, care. This also implies a certain utility for doctors by providing them with someone to "to confide in" and to help them with the stress of working with a patient that is difficult for them. This theme of the dual use of complementary practices in the conventional medical setting as a means of helping doctors and patients reoccurred throughout my fieldwork; however, within the context of this section, it is important to focus on the notion of utility as a means becoming "officially accepted" as a service project.

For example, Doctor O and I had the following exchange about the presence of hypnosis in her palliative care service in 2015:

> Doctor O: "It's a service project, so I think that everyone in the service is very motivated to learn it"
>
> Researcher: "Does the hospital administration know about it?"
>
> Doctor O: "Yes, because they finance the trainings for the entire service"
>
> Researcher: "Was it difficult to convince them?"
>
> Doctor O: "No- why? *Bah*, because it's true that it seems to be fashionable at the moment, hypnosis in the hospitals. There are also several studies that have appeared and even if they're not necessarily on a level of proof that is very significant, some studies have been done- functional imagery in particular added a lot to the scientific argument- even before this service project, there were trainings in hypnotic communication that occurred within the radiology service"
>
> Researcher: "So it is being used in other services as well?"
>
> Doctor O: "*Voilà*. Now do they actually use it or not, I don't know, but they were trained"

This exchange is incredibly rich in terms of its inclusion of many of the themes that have been brought to light throughout this thesis. First, it confirms that hypnosis is being used in a variety of different services within this one hospital; and in the palliative service it is being used openly with the full knowledge and support of the hospital's administration. Secondly, it implies that hypnosis is beginning to be used in other French hospitals and that it is generally perceived as a favorable development to integrate hypnosis into hospitals. Additionally, this exchange provides important nuances to the previous chapter's discussion

of the importance of providing hard "scientific proof" for complementary treatments as a precondition for their acceptance and use in conventional medical settings. According to the case of this hospital, this is not as true or as sure as it was argued to be in the discourses included in the previous chapter. Notice how Doctor O placed the "fashionableness" of hypnosis in hospitals first, with the additional mention of its scientific proof as a secondary support for this claim. Furthermore, she explicitly states that the existing level of proof for hypnosis is not necessarily "very significant" scientifically. Thus, despite the contentions given throughout the previous chapter of the incompatibility of conventional and complementary medicine due to the lack of scientific proof; this exchange indicates that if healthcare professionals have a positive opinion of any given practice, they can take steps towards integrating that practice within their service with the hospital's financial support. Going one step forward, the discourses given by Baudoux and Nurse P indicate that if healthcare professionals personally feel that a certain practice will be useful to patient care, they can integrate it into their individual patient care practices without the need of authorization or support. This is given additional nuances by Doctor O's admittance that she does not know the extent to which hypnosis is being practiced by the radiology service in her hospital; which acts as a further support for the "invisible" presence of complementary practices in conventional medical milieus.

We shall now return to Clinical Researcher R and his vision for integrating naturopathy within his hospital's oncology unit:

> "At the beginning of next year I am going to propose this training to the hospital as part of a project to introduce naturopathy in the oncology service […] I hope to have the support of the oncology service and the hospital so that I can go in this direction, which I think could bring added value to our care […] I believe that this school seems very serious so I think it would be very good to do this training, because with six months of training, if that could lead to a service project in oncology I feel like it would be very beneficial for the patients […] I haven't suggested it to the hospital yet, but I am going to, which would mean that the hospital would pay for the training, because it's fairly expensive. I remember it's about 8,000 euro and I think that if they could pay for it that would be superb" (2015).

Thus, in this case we again see an individual practitioner attempting to create a service project that would introduce naturopathy into his hospital service in addition to the sophrology that is already present. The logic behind this plan is the "added value" that this complementary practice could bring to patient care. According to Clinical Researcher R, this includes things like, "If a patient tells me, for example, that they have lost weight then I could give them remedies and things based on plants to help care for the patient- dietary supplements and things from nature" (2015). In other words, Clinical Researcher R is proposing complementary care for some of the same kinds of symptoms that Nurse V told us "doctors don't deal with." In this case, these symptoms are side-effects of chemotherapy that correspond to patients' lived bodies and their conscious perception of their illness experiences; both of which have been purported as falling outside of the scope of oncologists' conventional medical gaze.

Notice how Clinical Researcher R made no mention of scientific evidence for the efficacy of naturopathy, despite that being the very definition of his professional training and activity. Also, despite his self-qualified "very Cartesian" profession in a "very Cartesian service" he made his selection of a school based on his "belief" in that school's "seriousness."

This belief was based on his experience in the promotional open house we attended rather than on any "objective" criteria pertaining to its reputation for quality. Additionally, notice how the particular training that Clinical Researcher R is interested in lasts for only six months; which means that if his project were accepted by the hospital he would be able to "treat" patients with a huge variety of naturopathy techniques with only one, half-year of training. According to the naturopathy school open house we attended, naturopathy involves the mixed us of approximately 10 different collections of techniques ranging from corporal techniques including movements, sports, reflexology, and massage; to techniques such as hydrotherapy, luminotherapy, and biotherapy; and a heavy basis on all forms of phytotherapy, which includes various uses of essential oils, dietary supplements, and aromatherapy. Within Baudoux's eight-hour aromatherapy "initiation" I was astounded by the potential number of plants, mixtures, and administration techniques that were possible in medical aromatherapy. In this single training we were only able to cover 7 oils in the pain workshop and a handful of administration techniques for aromatherapy use in palliative care. Each oil had very specific uses and, in some cases, warnings. For example, we were instructed to keep the percentage of Tea Tree oil below a 3% concentration for massage use to avoid creating skin irritation. As such, I find it incredibly hard to believe that in only six months it would be possible to cover the absolutely massive terrain falling under this school's conception of naturopathy techniques. Even with Clinical Researcher R's rigorous background in molecular biology, I feel as though a six-month training would barely be sufficient to develop an expertise in Baudoux's scientific and medical aromatherapy; let alone to be qualified enough to practice from among 10 incredibly different collections of techniques in the context of cancer patients.

Furthermore, we again see that proposing a complementary practice as a "service project" implies getting hospital funding for trainings. To these ends, when I asked Clinical Researcher R if he would go forward with his naturopathy training even if the hospital was unwilling to pay for it he replied:

> "I'm not sure. I think this training is expensive, but if the hospital paid half, I could make an effort to pay the other half out of my own pocket. Ideally, if the hospital were highly motivated they would say, 'We'll pay for all of your training because we are going to create a position especially for you.' That's what they could tell me, or it could be a part-time position which would mean I would continue my clinical research activities on the side- part-time could mean that maybe in a half-day I could receive patients and maybe bring therapeutic compliments to these patients" (2015).

Clinical Researcher R went on to emphasize his positive outlook for the feasibility of his naturopathy project. Specifically, he underscored that naturopathy went well with the "very competent team of psychologists and the sophrologist" that were already present within his oncology service. Furthermore, he noted that he "interacts very well with them" and that among his team there was "good feedback and good relations," which made him feel confident about "proposing to join this team as a naturopath so that we would have three elements: a psychological element; a sophrological element; and an element of naturopathy" (2015).

In other words, we see additional evidence for the logic according to which complementary practices are being introduced into French hospitals. Just as in the previous section, we see that the introduction of a given practice in a given hospital or service is entirely dependent on the initiatives of a variety of different agents. Individual healthcare professionals develop a personal interest in a given practice. In some cases, such as Nurse P's,

they simply begin practicing that complementary therapy in the context of their professional capacities. In other cases, such as Doctor O's and Clinical Researcher R's, they then attempt to convince their colleagues that their complementary practice fits into the culture of their service and could satisfy a patient care need. If this is successful and enough of the staff in a service are convinced, then the individual goes to their hospital administration in order to seek funding for training the rest of that service's staff. In some cases, such as Nurse V's, if there are enough people in hospital that are interested, then the individual can seek hospital funding to provide trainings that are open to the entire hospital staff; which was what happened in the case of Baudoux's aromatherapy training that Nurse V organized.

One of the most important aspects in these mechanisms is the notion of the "acceptance" of a complementary practice. In the previous chapter, the acceptance of a complementary practice was presented as being entirely contingent on demonstrated scientific proof in the form of randomized controlled trials. Yet, here, we see that in terms of hospital practice, acceptance really equates to either the adoption of a practice by a significant number of healthcare professionals in any given hospital or service; or to the willingness of a hospital's administration to pay for complementary staff members, such as the sophrologist in Clinical Researcher R's service, or to pay for complementary trainings, such as for the hypnosis and aromatherapy training in Doctor O's and Nurse V's hospital. The incredibly important link between "acceptance" and finance will be developed throughout the rest of this chapter.

For now, we can see that the logic informing all of these cases is clustered on a "relational" level. This entails both engendering "improved" relations between healthcare professionals and their patients, and the individual practitioner's use of their "interactions" with their colleagues to convince them to integrate their complementary practice of choice. In this sense, it is useful to recall Nurse V's case, in which she "convinced" doctors of the efficacy of aromatherapy and those doctors then began discussing aromatherapy with their colleagues. As a result, Nurse V was able to gather a critical mass high enough to justify the financing of a hospital-wide aromatherapy training session with an international expert. This is interesting in the context of this thesis, because despite all of the rhetoric we have examined concerning the "dehumanized" nature of conventional medicine, we see that a very "human" and "relational" communication occurs between healthcare professionals. Furthermore, rather than the "hard scientific proof" that was strongly emphasized among healthcare professionals, in practice it seems as though this very "human" "relational" process is largely responsible for the introduction of complementary practices in French hospital settings.

This is why I have chosen a complex adaptive systems approach to analyzing the conventional-complementary relationship. Throughout my fieldwork I was repeatedly struck by the impact that individual agents had in terms of introducing complementary practices in conventional medical settings. The cases we have examined here are testimonies of that "relational" mechanism, in which the personal interest of any given agent can translate into a hospital-wide training. This was even the case in the previous section, in which we saw complementary medical centers being established as a result of the interests of both local-level politicians and individual healthcare professionals. In the case of Doctor V, this resulted in one of the largest and most active complementary medical evaluation associations in France. In the case of Doctor M, this resulted in a small, but enduring and prestigious complementary medical structure within a major Parisian hospital. Thus, we can see how the personal interests of individual agents throughout the healthcare system can result in significant steps towards the integration of various complementary practices within conventional medical milieus.

In the absence of a centralized authority or oversight body for complementary medicine and in light of the extremely complex organization of the French healthcare system, these kinds of individual actions appear totally uncoordinated, bordering on chaotic. Nevertheless, following complex-adaptive systems logic, we see that patterns do emerge. Rather than following clear, linear pathways, such as the commonly-cited bottom-up flow from patient demand; these patterns follow the personal relational networks of individual agents. For example, in the case of Nurse V, her use of aromatherapy and massage to ease the suffering of one of her colleagues resulted in the lateral spread of aromatherapy interest throughout her hospital. Eventually, a critical mass was reached that was significant enough for Nurse V to go upwards to her hospital administration to seek funding for an aromatherapy training session. The lateral spread of interest and practice of complementary medicine has also been indicated in terms of the networks that are emerging among both complementary practitioners and clients, such as the one that I encountered in the context of Shaman C's practice.

It is of note that Nurse V's hospital-wide training session was conducted by a Belgian aromatherapy expert whose laboratory and activities give him a significant international market presence. This expert has developed his own approach to "scientific and medical aromatherapy" and is actively teaching according to his methodology in multiple countries. This acts as yet another example of how globalization processes are having a direct impact on the conventional-complementary relationship. Baudoux has been able to disembed what started out as a back-room family aromatherapy project into a top international brand that is available in over 13,000 points of sale. Furthermore, he has created a method that he is actively teaching in hospitals in multiple countries, which is resulting in a certain amount of international standardization in aromatherapy practice. In this sense, it is of note that according to Baudoux, "Aromatherapy began about 4,000 or 5,000 years ago in either India or Australia. The Aborigines used aromatic plants to cover wounds and Ayurveda was based on the use of many aromatic plants" (2016). This is interesting for two reasons: 1) it acts as evidence that aromatherapy has become completely disembedded from its ancient locality-contingent origins; and 2) that much as in the case of yoga and various practices from Traditional Chinese Medicine, today we are seeing a renewed interest in the medical use of ancient healing practices in conventional medical settings.

Another globalization-related theme that came to light in this section pertains to the repeated mention of doctors' time-constraints. Both Nurse V and Clinical Researcher R emphasized the "diminishing relationship" between doctors and patients that is occurring because, "doctors don't have time" to deal with certain patient symptoms or their lived body's conscious conception of their illness experience. Following the logic of this thesis, the reduced time for doctor-patient interactions in the hospital setting is what I interpret as an unintended consequence of globalization processes and another example of the effects of time-space compression.

Thus, despite the previous chapter's repeated insistences that there is no "place" for complementary medicine within conventional medicine, we are beginning to see that in practice, there is a very real "place" for complementary medicine in conventional milieus. According to healthcare professionals that are also complementary practitioners, these complementary practices seem to operate in the "space" and "time" that are beyond the medical gaze. In other words, while chemotherapy or changing a bandage can take care of a patient's illness or symptom in the material present; complementary medicines are being presented as able to take care of patients' illness experiences in the past, the future, and even in their personal, inner spaces that are outside of time. Furthermore, complementary medicine

in the medical milieu is being presented as something that is able to help take care of the metaphysical aspects of a patient's lived body experience and to actively cross "the barrier" between patients' living and lived bodies.

In this sense, another theme that came to light in this section is the dual use of complementary medicine as a means of taking care of both the doctors and their patients. In all of the cases presented here, the complementary practices in question were explicitly related to helping the healthcare professionals who are doing the caring. Clinical Researcher R made this very clear in his explanation of how the sophrologists are able to provide support and advice for doctors when they have difficulty with certain patients. Nurse V's use of aromatherapy to soothe the headache of one of her stressed colleagues led to the spread of aromatherapy throughout the hospital. Doctor O also told me within one of our interviews that when they use hypnosis, "what often happens is that the nurses feel more at ease when they take care of patients. They feel better themselves and are much more relaxed- both relaxed and attentive in their care" (2015). Thus we are beginning to see that beyond the potential "added value" that complementary medicine can provide patients in conventional medical milieus, there is also potential for it to improve the "well-being" of healthcare professionals, and by extension, their care.

The cases presented in this section show evidence of the integration of complementary practices in different hospital services. They shed light on how these practices operate in the "spaces" that are beyond the capacity of the medical gaze; both to help prepare patients for the inevitable and to help patients and doctors cope with patients' illness and treatment experiences. It is of note that the cases presented here occurred within a palliative care service and an oncology service. In the former case, complementary therapies are being used to help ease patient symptoms that medicine cannot cure and to prepare patients for their passage out of life and medical applicability. In the latter case, complementary therapies are being used and are of interest due to their ability to help treat the patient discomfort that results from their conventional medical treatments and from their illness experience with cancer. All of the practitioners discussed in this section emphasize the complementarity of their conventional-complementary hybridized practices. As such, none of them corresponded to the aberrational fears that we saw were a common stigma associated with complementary medicine in the previous chapter. Therefore, this indicates that despite the general appearance of two oppositions, in practice there seem to be a variety of different ways in which the conventional-complementary relationship can be characterized as precisely what the appellation implies, as complements. As such, the next section will continue exploring several of the other instances of complementary medicine that I discovered in conventional milieus.

### *3.2: Evidence of Complementary Medicine in Conventional Medical Milieus- Public Hospitals*

Within the previous section we saw three instances of different healthcare professionals with personal interests in a complementary therapy who were working towards the "official" acceptance of their practices as a service project in either palliative care or oncology. The two hospitals concerned were private, non-profit hospitals. In this section, we will examine three more cases of individuals working on the "official" acceptance of various complementary medicines within three different public university-hospitals (CHU[66]), one in Paris and two in other French cities. While in the previous case we examined the introduction and integration of complementary practices as a result of the individual interest and advocacy of single healthcare professionals, the three cases that will be examined in this section will explore individual efforts towards organizing and structuring different complementary practices that are already being actively practiced in multiple services in their respective hospitals. Nevertheless, much as in the previous section, we will see that the "human" and "relational" aspects of complementary practices and the individual efforts of healthcare professionals constitute the major mechanisms driving the structuring of complementary practices.

The first case in this section involves a center for Traditional Chinese Medicine (TCM) that is directed by Doctor M. This center is a clinical unit that works to structure research on and the evaluation of TCM techniques with a vision towards bringing the practice of conventional medicine and TCM together. According to Doctor M, this center works in three ways:

> "Considering that we are a university-hospital structure, I felt as though the first thing to do was to put weight on teaching […] we have developed courses that are both obligatory and optional for students in the second and third cycles [of medical school] and we are in the process of establishing another in the third cycle in the form of what we call a University Diploma (DU) […] aimed at augmenting the knowledge of medical students and doctors […] We also have an orientation in clinical research […] we have done multiple clinical trials […] The themes of our clinical research have made it so that multiple teams in this hospital work on bringing together TCM and conventional medicine […] Indisputably, on the practical side, the therapeutic side, that is the domain in which we have advanced the least for the simple reason that before developing therapies you have to create jobs and things, and that involves a financial engagement that is much larger than what's been made, so this is why we are much more advanced on the university side than on the hospital side. Do you understand the discrepancy?" (2015).

This is incredibly interesting because it is a direct correspondence to our second case involving both a pain treatment and study center, and an interdisciplinary department for care support in cancerology directed by Doctor R. Both Doctor R's pain center and cancer support department use combinations of conventional and non-pharmaceutical interventions as well as some different complementary techniques, such as qi gong. Much like Doctor M, Doctor R has placed a primary emphasis on teaching as a result of what he describes as being:

> "Confronted with the problem of ignorance both among healthcare professionals and users that is also associated with a belief- a fairly significant conviction in the

[66] In French, these are Centre Hospitalier Universitaire or CHU

> efficacy or inefficacy of these treatments. Among some healthcare professionals there is great reticence about using these techniques which have less scientific validation and so we decided that one possible response to these questions or problems was to improve education. So we created a DU in non-pharmaceutical therapies in 2015 […] It was the first generalist DU in France […] and I think we will have more because this one is having a certain amount of success […] Other DUs already exited, but they are more targeted on psychocorporal techniques or on one technique or another such as hypnosis or osteopathy" (2017).

It is important to note that Doctor R simultaneously created two DUs, both of which were accepted by his university. The one he is describing above is a general DU in non-pharmaceutical therapies and the second was in therapeutic supports for cancer. Much like his two hospital structures, both of his DUs cover a variety of different non-pharmaceutical interventions; many of which fall within the "nonconventional" or complementary medicine category. Additionally, it is significant that like Doctor M, Doctor R also found that is was far easier to "officially" advance the integration of complementary medicine on the university side of his CHU than on the hospital practice side. When I asked him about the challenges he encountered creating his DUs he replied:

> "The challenge was a question of whether the university […] would accept my proposal of this kind of a diploma […] I maintained a discourse […] saying, 'Whatever you think individually, these techniques are and will be more widely used, so either we abandon them saying that they are not scientifically validated […] and thus, we abandon our mission to validate or scientifically accompany in terms of teaching; or we incline ourselves to the problem with prudence and try to show students […] what these techniques are, what their strengths and weaknesses are, what their references are, their levels of proof, their indications' […] I encountered people who were sufficiently open […] who listened with a critical and benevolent ear and who accepted […] On the contrary, in my CHU- the CHU in which we created an association of non-pharmaceutical therapies that was linked to this DU[…] in the CHU, certain people were very interested but others were very reticent saying, 'Yes but we don't know how this could evolve, we don't know if we can deal with this issue,' and so you see, you have to have the cooperation of favorable circumstances […] I had the side of the university, but I didn't have the side of the CHU, which is a university-hospital linked to this university, so you see things are not so simple" (2017).

Notice how both Doctor M and Doctor R opted for an educational strategy as a primary approach towards the structuring of complementary medicine in conventional medical milieus- in this case, medical schools and university-hospitals. According to both doctors, doing so was a way of counter-balancing the lack of scientific evidence for efficacy. In Doctor M's case, this was associated with his development of clinical research trials and in Doctor R's case, teaching was a way of presenting complementary medicine's "strengths and weaknesses" and informing students about the current presence or absence of scientific validation for various practices. Another thing that is interesting about this quote is that taken by itself, it seems to characterize the development of the DUs as a direct response to the bottom-up rise in consumer demand for and use of complementary medicine; however, just as in the cases presented in the previous section, Doctor R's primary motivation for developing his DUs seems to be the result of his personal interest in complementary practices. Also, Doctor R's emphasis on the need for "the cooperation of favorable circumstances" indicates that rather than being a systematic or highly organized effort, the proliferation of

complementary medicine in conventional medical milieus is largely dependent on bringing the right individuals together into "favorable circumstances."

The same is true for the case of Doctor M. In the previous chapter, we discussed the development of Doctor M's TCM center as a result of the dynamics created by the individual interest of several local politicians and administrators of the AP-HP. This discussion completely left-out the rationale by which Doctor M was singled out in particular and asked to lead the AP-HP reflection on the potential pathways for bringing TCM into its hospital system. In our initial interview I asked Doctor M how he ended up in his current position and he seemed somewhat reticent about discussing the development of his personal interest in TCM. Nevertheless, he did tell me that:

> "In general you can see that it was a little error because you cannot imagine a specialty more Cartesian, more scientific [than mine] and then finding yourself at the end of your career rubbing up against complementary and alternative medicine- but I think that it very closely corresponds to an evolution in temperament with age and taking a step back from your activities and reflecting on medical activities" (2015).

It is worth noting that this remark came at the end of a 6 minute outline of his 35 year professional career, a career in which claims to have, "evolved a lot." Doctor M said that he, "tried to maintain an open mind," which allowed him to "change directions several times in my career." He told me that one of these changes was his development of, "a public health pole that reflected on hospital strategies," as a result of the hospital restructuration that took place following the "HPST law[67]" for the reform of the French public health system in 2009. According to Doctor M, it was, "At this moment that they asked me, within this public health pole, to reflect on the insertion of complementary and alternative medicine in the hospital and for diverse reasons that we can discuss later, within this complementary and alternative medicine I worked on everything related to Traditional Chinese Medicine" (2015).

Even though Doctor M does not discuss the personal journey that led him to discover TCM, this discourse does imply that he already had an active interest in TCM at the time he was asked to "reflect on the insertion of complementary and alternative medicine in the hospital." His founding of a public health pole within the massive AP-HP system indicates that he was both an active and an influential public healthcare actor at the time; but his remarks concerning his specialty in TCM specifically imply that it was as a result of his personal interest that he was asked to reflect on the potential integration of complementary medicine in the AP-HP system. This is because if he was asked merely due to his influence in the system, he most likely would have developed a similar approach as Doctor R, covering complementary practices in general. Furthermore, in light of the different remarks concerning the history of the development of TCM practices in France, I can safely say that Doctor M was definitely not the only hospital physician in all of Paris who was interested in TCM in 2009. For example, consider Doctor J's discussion of the development of acupuncture in France:

> "The acupuncturist under whom I trained was not a doctor, because the majority of the doctor-acupuncturists were trained by the non-doctors who were the first generation in France. They practiced acupuncture in the 1950s and they were physical therapists or people who had not studied medicine. So the first French

[67] In French, the *loi HPST (hôpital, patients, santé, territories)*. Consultable online at: https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000020879475&categorieLien=id

> doctors who learned acupuncture learned it from non-doctors and then we started having generations of doctor-acupuncturists, but in the beginning it was non-doctors and since there weren't courses in France there were individuals who went to different places, to get trained in Quebec in French or in China in Chinese or in other countries" (2015).

Thus, we can see that considering the 60 years of acupuncture practice in France and the multiple "generations of doctor-acupuncturists" that were trained throughout this time, it is safe to assume that Doctor M was not the only Parisian doctor with an interest in complementary medicine at the time he was asked to develop it. As such, the fact that he was specifically asked by the AP-HP to reflect on complementary medicine coupled with the fact that he chose to reflect specifically on TCM indicates that he had at least a moderate personal interest in TCM before he was asked to "officially" work on it by his hospital system.

Doctor R also had a personal interest in complementary medicine that led him to develop his DUs and to integrate complementary medicine into his pain and cancer support centers; however his interest developed in a different way. Doctor R is a psychiatrist, a domain in which he assures me, "Non-pharmaceutical treatments are therapeutic approaches that are familiar to us, because psychotherapies are part of these non-pharmaceutical treatments" (2017). Doctor R went on to become the head of a pain medicine structure in which non-pharmaceutical treatments also have an "important place." Furthermore, over the course of his work in pain medicine, Doctor R encountered:

> "People with cancer problems that involved pain […] and for some of these patients we proposed non-pharmaceutical treatments […] one of the most well-known of which was physical therapy, but there were also methods like relaxation and physical activities. We noticed that when we cared for a patient that suffered from chronic pain with these treatments […] the patient experienced a global improvement that had an impact on their quality of life, no matter what the disease […] So in oncology and cancerology we developed global non-pharmaceutical therapeutic strategies as compliments to oncological treatments […] and over the years we added relaxation, adapted physical activity […] and also qi gong groups" (2017).

In Doctor R's case, we see that his use of conventional non-pharmaceutical therapies naturally evolved into his integration of complementary therapies for pain management and cancer support. This is interesting because this integration of complementary practices occurred as a result of Doctor R's observation of the "added value" they brought to caring for patients with chronic pain. Recalling the discourses that were analyzed in the previous section, we can see that this is a direct correspondence to the logic that informed Clinical Researcher R's decision to attempt integrating naturopathy in his oncology unit. Clinical Researcher R felt that naturopathy could add a beneficial component to patient care along the same lines as what the sophrologist in his service was already doing. Here, Doctor R found that integrating various complementary practices also added to the benefits provided for chronic pain and cancer patients' overall improvement. What is curious is that it is an inverse logic than the one that informed Doctor M's decision to work on the integration of TCM in conventional care. According Doctor M, rather than seeing complementary practices as bringing "added value" to patient care; he noticed that their integration was a way of off-setting something he perceived of as lacking in conventional care:

> "In the years from 2005-2010, I had a sensitivity to the incompleteness of our medical care […] Within public health, I worked extensively with nursing

> institutes and I realized that there was a difference in the care that was given by a doctor and by paramedicals who worked a lot on empathy and on global care. The medical care was very fragmented, very specialized and very scientific and so this preoccupation [with empathy] and open-mindedness was new [to me]" (2015).

What is interesting is that despite their inverse rationales for the integration of complementary practices in their conventional care- as either adding to or making up for a lack in conventional medicine- both of these practitioners arrived at the same conclusion about the benefits that these practices brought by taking care of a patient in their "globality." Doctor R's discourse implies that providing care that goes beyond the patient's symptoms improves their overall well-being. This is interesting because it is a direct echo of comments that were made in section 2.3 concerning Homeopathic Doctor Q's and Doctor M's use of complementary practices with Parkinson's patients. In both cases, these doctors said that they were not using complementary medicine to treat the illness of Parkinson's, but rather to improve the overall quality of life for the "Parkinsonian;" by helping to improve their balance or helping them to "feel better in their own skin." Thus, again we see that rather than referring simply to a reductionist notion of "mind-body unity," these practitioners discuss treating a patient in their "globality" in terms of going beyond merely treating the patient's symptoms or illness. This is what is implied in the multiple discourses condemning conventional medical over-specialization in which a person is seen only in terms of their "organ," or "illness," instead of as a person. The notion of "well-being" and its relation to contemporary changes in the scope of the conventional medical gaze will be further explored in subsequent sections.

For now, it is important to underscore that rather than being based on the evidence of clinical trials, Doctor R made his decision to integrate complementary therapies in his treatments on the basis of both his clinical experience and circumstance. In other words, there is a strong relational component that informs Doctor R's decisions on exactly which practices he incorporates both in his clinical care and in his DUs. In fact, when I asked him how he selected complementary therapeutic practices he told me that:

> "While you might think that we were guided by scientific data […] many of the developments that we made occurred before the scientific work in these domains was slowly consolidated […] The introduction of new procedures is done largely by personal relations, meaning that professionals in place know about practices that have been recommended by patients, recommended by colleagues. Sometimes they saw them at a conference and they may have been discovered in scientific research, but its all of these things […] If we have the luck of having a healthcare professional who is validated in a certain practice or technique that is scientifically supported we turn towards that professional. That is often how it happens, but sometimes we actively search for a professional if we want to develop an activity […] on one side we wait to see what science brings us, but also according to the testimonies of patients or a fortuitous meeting with a professional who corresponds to what we're looking for" (2017).

This is interesting because it is a direct echo of the same lateral, networked diffusion of information and interest in complementary practices and their integration in conventional medicine that we saw in all of the cases from the previous section. Rather than being based on the hard scientific evidence that was repeatedly emphasized in Chapter 2, we again see that in practice, the mechanisms guiding the integration of complementary practices in conventional medical milieu are only secondarily scientific. In other words, the relational mechanism of information sharing among colleagues and patients appears to be playing a far more

significant role in the integration of complementary practice in conventional medical milieu than the presence of scientific data. Furthermore, in many cases, the integration of a given practice depends on the presence and availability of a certified practitioner in a given healthcare agent's network. It is significant that Doctor R repeats his emphasis on "luck" and "fortuitous meetings," because it underscores how the relational mechanism of information sharing constitutes a spontaneous emergence of a pattern; which is exactly what complex-adaptive systems theory tells us should happen. For example, Doctor R explained that:

> "We have an excellent music-therapist so we […] got that music-therapist to take part. We have someone who is very competent in the domain of acupuncture and Chinese Medicine and it's someone who talks about acupuncture, qi gong, and tai chi- the three of which are corporal techniques that can be used in pain and can also be used in cancer. This man is also competent in Traditional Chinese Medicine so he talks to us about that, which acts as an introduction to traditional medicines" (2017).

So we can see that many of the decisions to integrate a given therapy are made on the basis of the presence of an actor in a given healthcare professional's network. This was precisely how Doctor M was selected to head the TCM center at his hospital; several actors on the local political and AP-HP administration level were interested in complementary medicine, they knew about Doctor M and his interest in TCM, they asked him to intervene and he did. Additionally, as we saw in the previous section, this relational mechanism leads to the emergence of patterns in the types of complementary practices that are proliferating in French hospitals.

According to my fieldwork, Doctors R and M are far from isolated cases of conventional practitioners in French public hospitals with an interest in integrating complementary medicine. For example, when I asked Doctor M if there were complementary practitioners in his hospital he answered: "There are, there are not many but there are more than you'd think, they're invisible from the outside and not often brought to light" (2015). This remark was echoed in another case that will be examined in this section; that of Hospital Administrator B. Hospital Administrator B works in another public university-hospital within a structure for pain, palliative care, support therapies, and complementary therapies. Hospital Administrator B told me that she has been working:

> "For two or three years now on the theme of complementary therapies to see how we can- beginning with the professionals who practice them- how we can structure them a little so that these professionals can exchange and find one another to exchange about these practices and to think about training […] We said, '*Bah voilà*, there are healthcare professionals who practice,' it depends on which service […] We have contacts because there are professionals who come to us in order to ask about trainings and about our structure, so we knew that there was something to do in terms of structuring and so I proposed doing a study and we did an inventory within the institution" (2017).

Thus, in all of these cases we see that there are conventional healthcare practitioners within French public hospitals who are actively practicing various complementary therapies; however, they have low visibility and are not organized in any way. Recognizing this, Doctor M and Hospital Administrator B are working to both boost the visibility of these practices and to organize interested healthcare professionals into a network. Furthermore, in the case of Hospital Administrator B, we again see an emphasis being placed on promoting the education of healthcare professionals in terms of complementary practices. I found it interesting that

despite having conducted an initial inventory study, Hospital Administrator B was still not able to tell me how many healthcare professionals in her institution were interested in or practicing complementary therapies. For example, when I asked about the results of her inventory she told me that:

> "We had approximately 75 respondents, because at the time they were the only ones to respond, but now that we are doing our structuring, today we may have more. If we were to do another study I am sure that there would be a lot more people who would respond to it and the list of people who practiced- the professionals who practice within this CHU- would be much more exhaustive […] We would have a service by service approach, certainly also a practice approach and maybe other practices would emerge" (2017).

When this is considered in light of Doctor M's comment on the "invisibility" of complementary practices in his hospital it adds considerable nuances to Hospital Administrator B's decision to attempt to create a structure that would bring the healthcare professionals with an interest in complementary practices together so that they could "exchange" with one another and find information on training. This attempt can really be interpreted as a means of working to render complementary practitioners and their practices in the hospital visible.

Going further, we can interpret the invisibility of complementary practices in French hospitals in light of Hospital Administrator A's comment from Chapter 1 relating an interest in complementary and metaphysical themes as something that he had to hide in his "jacket pocket" as if they were "pornographic." This notion was implied in Hospital Administrator B's use of the phrase "they were the only ones to respond" along with her confidence that as a result of her structuring efforts she was sure that there would be "a lot more people who would respond" if she were to do another inventory study. In other words, taken together this suggests that by rendering the presence of complementary medicine in conventional medical milieus visible, practitioners would not feel the need to dissimulate their interest in these practices. As such, it acts as further evidence of the incredible power that the negative stigmas and stereotypes surrounding complementary medicine in France have as a mechanism that causes "open-minded" conventional practitioners to hide their complementary orientations. As we shall further explore in subsequent sections, this is creating a dynamic that actually fuels the kinds of concerns that were voiced in the previous chapter by both healthcare professionals and anti-sect agents. As such, this explains why both Doctor M and Doctor R are placing a primary emphasis on complementary education for healthcare professionals. Doing so constitutes yet another approach to rendering complementary practices visible and organizing interested conventional practitioners into a network.

Another interesting point that comes to light in Hospital Administrator B's structuring approach to the complementary practices in her hospital is that she also places considerable emphasis on the "relational" aspects and the lateral diffusion of interest among healthcare professionals' networks. When she was describing her structuring project she gave primacy to "bringing these professionals together so they can exchange" about their interests in complementary practices. This was further underscored by her remark that "professionals come to us in order to ask about trainings and our structure." Together, these statements act as evidence for the relational network mechanism that is fueling interest in and use of complementary practices among healthcare professionals in French hospitals. In the previous section we saw multiple instances of how the contact networks of individual healthcare agents facilitated the spread of interest and training in three different complementary practices. What

is interesting to explore here is the effect this lateral diffusion mechanism is having on the kinds of practices that are entering into conventional medical milieus. As we are beginning to see, there is a certain amount of clustering in healthcare professionals' interest around certain practices. There is also what appears to be a pattern of the kinds of professionals that employ different practices. For example, consider Hospital Administrator B's response to my question about how she recognized that there was an interest in complementary medicine in her hospital:

> "It was by meeting people […] I am vice-president of the committee for pain and palliative care and we deal with and talk about these themes […] There was a group several years ago that was put into place, but it did not last. It was a group of anesthesiologists and anesthetic nurses who wanted to form a group on hypnosis, but they didn't get institutional support. Today we see that it is working because there is institutional support and so the doctors with whom I work are doctors working on pain and we identify- it's by identifying the doctors and professionals. Also I have a nurse who I recruited several years ago for a position in sophrology […] so this nurse is in contact with other nurses in different services in which she does sophrology and she also acts as a bridge to services. She identifies professionals who practice in services of all levels, in pediatrics […] in resuscitation services, and in gerontology" (2017).

Within this quote we see several different forms of interesting evidence. First, Hospital Administrator B's language very clearly demonstrates that the main mechanism guiding her work on complementary medicine is relational. She "identifies" healthcare professionals wearing the "two hats" described by Doctor O. Once she has identified them, she "meets" with these professionals and works to bring them together and to promote their "exchanges" using her pain and palliative care structure as a platform. Furthermore, she is using her sophrologist-nurse as a "bridge" linking her directly to a verity of different services so that she can identify the professionals with complementary leanings in those services. It is of note that much like the previous section, Hospital Administrator B is focused on both pain and palliative care; although her specific mention of pediatrics and gerontology also constitute services in which many times the "heavy" "nuclear weapons" of pharmacology cannot be used or in which symptoms or illnesses cannot always be cured. Thus, much like palliative care, chronic pain, and maternity, both of these services are located on the fringes of the medical gaze. Here, however, Hospital Administrator also discusses the use of complementary practices in "resuscitation" services, which adds additional support to her claim that an inventory study of the presence of complementary practitioners and practices should be done on both a "service by service" basis as well as an a practice by practice basis.

In this sense, it is of note that Hospital Administrator B's structuring efforts seem to be having a direct impact on the growing presence of hypnosis in her hospital. In other words, due to the relational mechanism in which practitioners discuss their experiences and interests with those in their contact networks, the wider this interest network spreads. When this is coupled with Hospital Administrator B's efforts to provide structure and visibility for these practices, a significant impetus is added to the growing number of interested practitioners. According to Hospital Administrator B, this is because:

> "There is a real visibility […] there is a real exchange between professionals and when there are exchanges there is questioning and […] they don't feel as though they are alone in their service confronted with maybe difficulties on the ground or in implementation. In that aspect they can help provide support, supervision. What

> is interesting in structuring is that professionals can meet one another and bring to light positives in terms of the returns on their experience. What is also interesting is that it motivates and interests other professionals to maybe refine their project or to say, 'Look, it's possible because it has already been done, so it's possible'" (2017).

As we can see, in this case Hospital Administrator B is actively working to build a relational network amongst the healthcare professionals in her hospital who are interested in complementary practices. Her language implies that there is already a significant presence of these practitioners, but that due to the invisibility of complementary medicine, they are acting "alone" in isolation. This is exactly what Nurse P was doing with her aromatherapy mixes in the previous section. She was working "invisibly" in her service, administering her own blends of oils to her patients while her head of service turned a blind eye to her activity; ignoring it rather than condoning or condemning it. As such, this adds significant nuances to Doctor M's comment that there are "not many but more than you'd think" in reference to the number of professionals in his hospital who are also interested in or practicing complementary therapies.

Also, much like in the case of Nurse V, we see that Hospital Administrator B is actively working to fuel the integration of complementary practices by offering "support" and "supervision" to those professionals interested in developing or "refining" service projects in their individual services. Thus, again we see that in addition to the bottom-up consumer demand, the individual advocacy, awareness-raising, and structuring efforts of healthcare professionals is clearly having a significant and direct impact on the proliferation of specific complementary practices in French conventional medical milieus, such as in both public and private hospitals. In this sense, we can see the critical importance that structuring the presence of these practices is having. Helping professionals to exchange on their experiences and to know "that it has already been done" seems to create a motivating dynamic that both drives and sustains the individual efforts of these agents. This was implied within the previous section, because it appeared as though Nurse V's efforts were bolstered by the successful and "official" presence of Doctor O's hypnosis service project. In this sense, it seems as though rather than resulting from a simple bottom-up rise in consumer demand, the spread of complementary practices in conventional medical milieus more closely resembles a "hundredth monkey[68]" phenomenon.

This was the same operational mechanism that we saw in the previous section with Nurse V's aromatherapy. As more practitioners became interested, that network of interest grew throughout the hospital staff until a critical mass was achieved that was high enough to justify the hospital's funding of a hospital-wide training session in aromatherapy. In this case, Hospital Administrator B has identified a significant number of professionals using hypnosis and by organizing and rendering this interest visible, she is directly promoting the lateral spread of hypnosis throughout her hospital. For example, consider Hospital Administrator B's discussion of the benefits of her structuring efforts:

[68] The hundredth monkey effect is a hypothetical phenomenon in which a new behavior or idea appears to spread rapidly from one group to all related groups once a critical number of the members of one group exhibit the new behavior or acknowledge the new idea. The story of the hundredth monkey effect was published in Lyall Watson's forward to Laurence Blair's *Rhythms of Vision* in 1975. While the original research that gave rise to the effect has been largely discredited, it is cited here because it seems as through rather than being based on the appearance of new scientific proof for a given complementary practice, its spread through hospitals seems to be directly related to the growth of a "critical mass" of interested practitioners.

> "We follow an action-plan […] we work on training and […] we have identified the person who is in charge of the training office and she is in constant contact with me asking if I validate this or that project. We ensure that the information for the practice is correct in terms of the objectives of the service and this is a real 'added value' so each of us work in our own ways […] Structuring allows us to bring visibility […] so we said, '*Bah* we're not going to stay among ourselves,' and we organized a day- well not a whole day because that's too long and would mobilize too many resources, we're going to do between 12h30 and 14h […] the people from the hypnosis group are going to present their practice […] So with the structuring this is how we are going to do things now, meaning with short actions. Professionals will come, see what hypnosis is, that will incite questions- the structuring allows us to do this" (2017).

Here we see that there is a double importance created through the support of the hospital administration. In one sense, their support brings considerable weight and legitimacy to the visibility of a given complementary practice. In the other, it brings the financial resources that are necessary for both awareness-raising events and trainings. These events then further promote the spread of a given practice among hospital staff. We saw this in the previous section with both the cases of Doctor O and Nurse V. For Doctor O's hypnosis, once the practice was accepted by the hospital administration, her entire service was "motivated" to get trained in it. As such, in this case it is not surprising that the "hypnosis group" did not "last" without the support of the hospital administration; they did not have the resources necessary to create the visibility needed to justify the organization of trainings and events. In addition, the financial implications of getting hospital administrative support may explain why both Doctor R and Doctor M found that it was easier to get complementary projects approved by their respective universities than by their hospitals. Hospital Administrator B gave me some potential explanations for this phenomenon:

> "There are DUs that respond to specific needs, but three-fourths of the trainings are really trainings that are provided by either professionals of the CHU who practice and are prepared to train or by external services- external organisms that do trainings. We prefer to train on techniques that respond to needs, we're not going to do trainings for many different complementary therapy techniques that are not useful, we're not going to put them in place because it requires resources and means […] DUs maybe go a little further or have a wider scope of content in trainings […] whereas the trainings that are given by external organisms have two graduated levels […] So we don't train with lots of DUs because it's expensive and it requires a lot of time […] For services like anesthesiology, for example, we can go for a longer-term training, but for other services that are 'light' we're not going to do a DU when it's certain that conversational hypnosis would sufficiently respond to the need" (2017).

In follow-up to this comment I asked Hospital Administrator B if the hospital paid for all of these trainings and she assured me that, "Yes, yes with the hospital budget, the hospital's budget for training- whether it be for DUs or trainings given by external organisms" (2017). In order to better understand the distinction that Hospital Administrator B is underscoring between complementary practice-based trainings given by a hospital staff member or an "external organism" and the trainings provided by DUs, it is helpful to consider what Doctor M told me about the goal of his DUs in complementary medicine:

> "The teaching that I develop is a teaching for opening minds- by the way on the level of the second cycle for young students it's not TCM, it's complementary and alternative medicine- it's for opening their minds and letting them know that there are other medicines that are used for healing people. That's what I try to teach to the students, that there are other ways for healing people that exist. It's not for teaching them techniques, I'm not going to teach them how to do acupuncture […] For you it seems obvious, you're an anthropologist who well knows that there are other medicines […] you know that, but our students they don't know- for them there's only one medicine" (2015).

Thus, within Doctor M's discourse we are beginning to see what Hospital Administrator B meant when she referred to the "wider scope" of DU formations. In other words, Hospital Administrator B is saying that since the hospital decides which kinds of trainings for complementary practices it will fund with a limited budget, that decision is based on the potential practical applicability of a specific technique. While is some services where the practices involved are both complex and serious, such as in anesthesiology, the hospital will pay for a long-term, in-depth formation that includes both theoretical and practical knowledge; for most other services the hospital will default for cheaper, shorter, technical training rather than a DU. It is important to note that the objective of Doctor R's DUs is essentially the same as Doctor M's and that his formations also do not involve technical trainings in therapeutic techniques. Rather, Doctor R's DU is also a general-knowledge introduction to various complementary practices. For example consider the similarities that Doctor R's following discourse has with the one given to us by Doctor M above:

> "Ours is a DU in information training […] Based on a certain number of general reflections on non-pharmaceutical therapies we define- we try to define as best as possible- what complementary and alternative medicines are […] Our objective wasn't very pretentious […] our objective wasn't to give a therapeutic diploma, just to give a diploma showing that people were […] sufficiently informed on what non-pharmaceutical therapies are" (2017).

Following this explanation, I asked Doctor R, "What can people do with a diploma like this?" and he responded:

> "They can't do anything specific, meaning they can't establish themselves as a therapist, but what they can do is to do what they've already been doing- only much better, meaning they'll have acquired competencies in terms of validation, indication, and recourses to non-pharmaceutical treatments that they didn't have before […] It should be an obligatory teaching, doctors should know what physical therapy, osteopathy, hypnosis, and acupuncture are, what their recommended uses and non-recommended uses are. They should know that, but they don't so our DU completes their instruction […] In our trainings we have workshops so the professionals […] are better able to use them for themselves and their patients- adapted physical activities, relaxation exercises, breathing […] are capable of favoring meditation […] These workshops develop our students' competences […] and they can use them with their patients, but they can't call themselves a relaxologist or a specialist in therapeutic breathing or a professor of adapted physical activity, they just become competent in these therapeutic strategies" (2017).

This discourse reflects the rationale behind Hospital Administrator B's assertion that "three-fourths of the trainings" in complementary practices in her hospital are organized with a

"professional of the CHU who practices and is prepared to train" or by an "external organization." For example, when I asked Doctor R if his students would be able to perform techniques such as acupuncture following the completion of his DU he assured me that:

> "They can't do acupuncture […] if they wanted to get trained in acupuncture we'd tell them to enroll in a training […] or we'd ask the professor who comes to do a one-hour class on acupuncture […] we'd ask who they thought was the best or what was the best place to train if someone wanted to train in acupuncture- that's how we'd respond" (2017).

Considering all of the evidence that we have heard thus far, this comment brought to mind Doctor J's discussion from the beginning of this section about the first generation of French doctors who were getting trained in acupuncture. Doctor J told us that this first generation of doctor-acupuncturists was trained by "non-doctors," such as Doctor J's own teacher who:

> "Was not a doctor, he was a physical therapist […] He said, 'I have the right to practice acupuncture because it's recognized as a Chinese therapy and since there aren't diplomas in France, I did my studies in China,' and it's true, he was a man of great quality in acupuncture and he knew his profession well" (2015).

In other words, we see that curiously the current state of the training in complementary practices for French healthcare professionals is an echo of Doctor J's description of the "first generation" of doctor-acupuncturists. This is because many of the current hospital professionals with an interest in complementary practices are being trained by non-doctors. For example, within Hospital Administrator B's hospital, the nurse-sophrologist that she hired, "does trainings, it's organized […] She does trainings with people in pediatrics and also with people in all of the acute care services" (2017). The same is true in the context of Doctor R's DU- not all of those who come to teach about a specific practice in his DU are medical doctors. Instead, the instructors are chosen because they are, "competent […] they have a reputation that is locally recognized" (2017).

Going further, just as among Doctor J's "first generation," there continues to be French healthcare professionals who are travelling abroad to places like China and Canada in order to be trained in specific complementary practices. For example, when Doctor M became interested in doing, "work on qi gong and cancer," his colleague, "went to China because there was a qi gong technique that is based on walking" (2017). When I asked him why people continued going abroad for complementary trainings he told me that, "there are not a sufficient number of courses" available in France. In fact, according to Doctor M, this lack is precisely why he felt it was of critical importance to develop introductory courses on complementary medicine in French medical schools.

This is interesting because it further underscores the disembedded nature of the complementary practices that are being pursued in France. While in the previous Chapter we saw a few examples of instances in which patients were willing to travel to different countries in order to receive a specific complementary therapy, such as to receive Doctor Z's surgical technique in Spain or to go to Biofeedback Practitioner D's therapeutic center in the United States, here we are seeing that French healthcare professionals are willing and able to travel abroad in order to receive complementary training. As such, the competencies and practice that they bring back with them are the disembedded versions of what they have learnt abroad and applied to the French context. According to Doctor J's discourse, this is not a new phenomenon, but rather something that has been occurring for over fifty years in the specific

case of acupuncture. In other words, despite the long-standing presence of various complementary therapies in France, we see that in some ways they are still perceived of as "new" and the same "first generational" "non-doctor" trainings that marked the early years of some complementary practices in France are still being actively used by healthcare professionals in conventional milieus. In this sense, we can bring back Doctor R's confirmation that his DU on non-pharmaceutical therapies was created in 2015 and was, "the first generalist DU in France" in complementary medicine (2017). In other words, there is a considerable lag between the arrival of a complementary practice in French healthcare and its "official" acceptance within conventional medical milieus.

For example, according to my fieldwork, it appears as though Doctor R's DU remains the only "generalist DU" on complementary interventions in France. While some medical schools do have a DU or DIU in the use of non-pharmaceutical treatments for specific illnesses, such as Alzheimer's; or a DU or DIU in specific complementary practices, such as acupuncture; there are not any other French university diplomas providing a general introduction or overview of complementary practices. Furthermore, for some practices, such as homeopathy, the handful of DUs or DIUs in French medical schools remains both limited and controversial.

In fact, the medical school of Brest was the first French medical school to create a DU in homeopathy in 2014 and it was not without polemics and "insulting mails from liberal doctors" (Berrebi-Bonin, 2013). Up until this point, homeopathy was not recognized as a medical specialty and thus, it was only taught in pharmacy schools rather than in medical schools. Curiously, the rationale of the Brest medical school president closely aligns with the rationale that was given to us by Doctor R; namely that it is important for doctors to have at least an idea about complementary practices so they avoid reacting to patient queries, "with a lack of knowledge either saying, 'I don't know,' or stigmatizing it" (Le Télégramme, 2014). I found this to be incredibly interesting considering that as Homeopathic Doctor Q reminded us in the previous chapter, homeopathy is intrinsically "recognized" since it has "been in the French pharmacopeia since 1965" (2015). In this context it is of note that despite an interest in acupuncture among French doctors that dates back to the 1950s according to Doctor J, there are currently only about 20 DUs or DIUs in acupuncture in French medical schools. This is significant because acupuncture appears to be the most common complementary practice currently being taught in French medical schools. Thus, we can see that despite the long-standing presence of certain complementary practices in France, their entry into medical schools remains extremely limited, which according to Doctor M, is fuelling the movement of French healthcare professionals to go abroad for trainings.

The other significant theme that was raised in Doctor M's and Doctor R's discussion of their complementary medical course development is the influence and interest that foreign governments and healthcare professionals are having in French medical school trainings in complementary medicine. In the case of Doctor R's DU, he was contacted by:

> "Doctors, nurses, and physical therapists from francophone countries, including the Ivory Coast and Madagascar […] They asked us if there was a possibility for them to follow our instruction by internet […] after all if 50 colleagues from Madagascar want to register for the course they can register and follow by internet […] So I think maybe we'll film and then the people in other countries who want to can follow the course" (2017).

I found this comment to be a telling example of one of the ways in which globalization and its time-space compression is coming into play in the case of the conventional-

complementary relationship in France. Throughout my fieldwork, I was struck by the mobility involved on the part of complementary users, practitioners, and the practices themselves. Furthermore, this quote reflects another element that I repeatedly encountered throughout my fieldwork; that of a tendency for individual agents in one country to refer to developments in complementary medicine in other countries.

As an example of this, we have already seen a variety of different practitioners who made comments comparing developments in France with those in the United States. In the context of the international conferences concerning complementary medicine that I attended throughout my fieldwork I encountered academics from multiple countries who were interested in developments occurring in France. I found it remarkable that everyone seemed to think that other countries were making more progress and advancement on complementary medicine than their own. For example, multiple French practitioners told me how France was, "a bit late compared to the United States" (Clinical Researcher R, 2015); or that in comparison to, "the United States, Germany […] Great Britain […] we are always indisputably late in this domain" (Doctor M, 2015). In this context, many practitioners also qualified Switzerland and other countries as being more advanced in terms of integrating complementary medicine into their healthcare system in comparison to France. For example, I heard comments such as: "the Swiss, they're very advanced in this area" (Shiatsu Practitioner C, 2015); "it already exists in Switzerland and Germany" (Doctor V, 2017); "in Germany, England, Switzerland there is no problem" (Doctor J, 2015); or, "in most other countries there's been a strong evolution in terms of recognition […] notably in Switzerland, Germany, Belgium, England, Spain, Greece" (Kinesiologist R, 2015).

All of these comments characterized France as being "behind" other countries in terms of its development of complementary medicine, yet here Doctor R is giving us evidence of a strong interest among healthcare practitioners in other francophone countries in the possibility of following his course. This suggests that France is not as far "behind" as all of these comments imply. I found that this seemed to underscore the importance that perception and belief have in shaping the conventional-complementary relationship in France. Not only was this discussed extensively in the previous two chapters, this and the previous section have both included comments to this effect. In the previous section, we saw that Nurse V and Clinical Researcher R both discussed their efforts to "convince" people and get them to "believe" in the potential "added value" that their complementary practices could bring to their respective services. Here, we have seen how the "perception" of a practitioner's "competency" and "reputation" were listed as among the key factors guiding Doctor R's selection of the complementary practices and instructors in his DU. In a similar vein, the case of Hospital Administrator B also discussed the importance of boosting the "visibility" of complementary practices and practitioners as a means of strengthening the network among the professionals in her hospital who are practicing. Additionally, the logic behind Doctor R's and Doctor M's DU as well as in the DU on homeopathy that was developed by the president of the Brest medical school all demonstrate that informing doctors about complementary practices is an important step towards changing the perceptions of complementary medicine among healthcare professionals.

Going further, here we are seeing that not only are the efforts of the individual healthcare professionals discussed in this and the previous section raising the visibility of complementary medicine among French healthcare professionals, it is also having an impact on the international visibility of French complementary medicine. The statements presented above demonstrating the perception that France is "behind" the complementary medical developments of other countries attests to the presence of a shared interest in the growth of

complementary medicine worldwide. When these are coupled with Doctor R's discussion of his plans to allow healthcare professionals in multiple countries to follow his courses on-line, we see that different agents in other countries are watching the developments in France just as agents in France are watching the developments in other countries. For me, this only further emphasizes the disembedded character of complementary practices and attests to their movement on the international level. Practitioners, practices, and patients are all moving throughout the world in order to get complementary medical information, training, or treatment. The feasibility of allowing healthcare professionals in other countries to participate in a DU on complementary practices in a French medical school is also significant in this regard. Namely, it is evidence of the effects that globalization's information technology and time-space compression are having on the development of complementary medicine in different countries. I feel as though this is also another interesting reflection on the emergence of patterns among complementary practices. In the previous section we saw how Baudoux's aromatherapy training is contributing to the emergence of a certain amount of international standardization in aromatherapy practice and knowledge due to his international teaching efforts; and now we are seeing how Doctor R's DU carries the potential to advance this same standardization.

In this sense, another important example of these kinds of emergences of an international organization or patterning in the development of complementary medicine came in the form of Doctor M's admittance that:

> "It's at the limit of a crazy idea, but I have the financing, I practically have the Chinese financing, so we just need- it's the organization, but you have a good prototype in what is being done in Barcelona. A hospital in Barcelona has created a care center in Chinese Medicine and we have everything we need to do it- the mayonnaise simply has to rise" (2017).

Not only does this comment act as additional evidence of the emergence of a pattern in complementary medicine on the international level as agents in one country watch and draw from the developments that are occurring in other countries, it brings to light the important role that foreign governments are playing in shaping the development of complementary medicine in other countries through financial investments and cooperation. This topic was introduced in the context of the first chapter in terms of France's significant international presence and engagement in global public health initiatives and the Foundation of the French Academy of Medicine's organization of international best-practice sharing at its *FAMx* conference. Now, we see the same trend specifically applied to complementary medicine in the form of a foreign government investing in the promotion of their traditional medicine in French healthcare practices.

According to the 2016 Activity Report for Doctor M's TCM structure, he is actively developing cooperation with the Chinese government as a means of advancing TCM in France. In 2007 a "Protocol for Cooperation on Traditional Chinese Medicine between the Government of the French Republic and the Government of the People's Republic of China" was signed; in 2012, the AP-HP signed a protocol for cooperation on Traditional Chinese Medicine with the Chinese State Administration of Traditional Chinese Medicine (SATCM); and in 2016 Doctor M's center developed research agreements with four Chinese university-hospital groups and organized three Franco-Chinese conferences on the subject of TCM. In addition to these formal instances of Franco-Chinese cooperation and finance for TCM research and development, Doctor M's 2016 activities report provides multiple examples of exchanges in which Chinese representatives and healthcare professionals came to France for

conferences and diplomatic meetings on the subject of TCM and French representatives and healthcare professionals went to China for similar visits and exchanges.

This acts as very clear evidence of the direct impact that the international level is having on the development of complementary medicine in France; even if Doctor M remarked, "this edifice is fragile and rests on the intellectual engagement of certain individuals and volunteers" (2017). Thus, we see how the lateral networks of individual agents in the French healthcare system are not only instrumental in shaping the conventional-complementary relationship within France; they are also shaping the organization of this relationship internationally. As a result of the diffusion of information through these globalized networks, healthcare professionals in Francophone Africa found out about, contacted, and may be able to participate in Doctor R's DU training. The direct efforts of "certain individuals and volunteers" are fostering bi-lateral cooperation between the governments of France and China in terms of promoting the development of French TCM practice. Doctor M was inspired by a TCM center that was created in Spain and is reflecting on using Chinese financing, to develop a similar kind of center in France. French professionals are discussing what is occurring in terms of complementary medicine's acceptance in other countries and advocating similar developments in France. Likewise, professionals and academics from multiple countries are watching the developments of complementary medicine in France and are advocating doing similar actions in their countries.

All of these developments are occurring in the absence of a single organizing or oversight entity. Instead, they are based on the informational diffusion and exchanges that are occurring throughout individual agents' relational networks, both in their individual localities and abroad. Rather than occurring in a simple bottom-up fashion and being exclusively the result of an exponential rise in consumer demand, or occurring in a simple top-down fashion as a result of either international or national trends and mandates; these kinds of patterns are spontaneously emerging as a result of complex and lateral exchanges among the relational networks of individual agents. I argue that this could only occur in tandem with globalization's disembedding and time-space compression mechanisms, which are nullifying traditional time and space constraints. For example, in this section we have seen how Traditional Chinese Medicine is no longer an exclusive Chinese tradition. Instead, it is present and practiced throughout the world and it is being actively promoted as an international commodity by the efforts of the Chinese government and healthcare agents in multiple countries. We also saw how a French DU that includes various complementary practices has the potential to become a part of the medical training in multiple countries in Francophone Africa. Furthermore, we saw how the structuring and awareness-raising efforts of one Hospital Administrator are having a direct impact on the diffusion and development of hypnosis and sophrology training and use throughout her hospital.

In subsequent sections of this chapter, we will see how Hospital Administrator B's efforts also carry the potential to have an impact in the territory-wide diffusion of complementary practices in French public hospitals. For now, we are beginning to see how the individual actions of healthcare agents is creating a self-organization that is rendering complementary practices more visible and, as a result, promoting their diffusion through lateral relational networks. I found it fascinating that these efforts are fostering the emergence of patterns that go across scales stretching from the individual hospital to the international levels. This acts as an interesting reflection on the dynamics of a complex-adaptive system and the unexpected non-linear co-evolution that the "nesting" of a healthcare system can have

in terms of the international "healthcare environment" populated by different national healthcare systems.

### *3.3: The Notion of the "Acceptance" of Complementary Medicine in the French Healthcare System*

In the previous two sections we have explored six different cases involving the presence of complementary practices in French hospitals and medical schools. All of these cases were interpreted in terms of the dynamics they are engendering in promoting the visibility and structuring of complementary practices and practitioners. We saw that these dynamics were characterized by the diffusion of interest and information among the relational networks of individual agents, which promoted the growth of a critical mass of interest that was high enough to elicit various forms of hospital and governmental financial support for the organization of awareness-raising events and trainings. We also saw that these trainings included instruction from both doctors and non-doctors. Nevertheless, the evidence from Chapter 2 on the negative stigma and stereotypes surrounding the perception of complementary medicine suggests that despite their growing presence in both consumer demand and conventional milieu, these practices are still not fully "accepted" in France.

As such, we must deepen our analysis of the notion of the "acceptance" of a practice in the French healthcare system. This is particularly interesting in the context of this chapter, because it will provide additional insight into how the mechanisms that have been introduced in the previous two sections interact with some of the structural and political components of the French healthcare system. Furthermore, it will also shed additional light onto the how all of the dynamics identified here are contributing to the emergence of both self-organization and patterns within the conventional-complementary relationship. In this sense, while in the previous sections we have looked at the movements and dynamics that are being created by individual healthcare agents; we will now look at how the logic and organization of the healthcare system are enhancing these dynamics. We saw an initial example of this in the previous section's discussion of how Doctor M's and Doctor R's individual efforts are having repercussions on the international level; now we will examine the interactions between the representative groups for individual complementary practices and different levels of the internationally nested French healthcare system.

At the outset of this section, it is useful to recall the four criteria that emerged throughout my fieldwork concerning the definition of conventional medicine. As described in Chapter 1, these criteria told us that conventional medicine was popularly presented as including practices or products that are 1) reimbursed by the national health insurance; 2) taught in core curriculum at French medical school; 3) practiced or dispensed in official medical settings, such as hospitals and pharmacies; and/or 4) scientifically proven and accepted as part of evidence-based medicine. This is important because throughout this thesis, we have seen that even when a complementary practice, such as acupuncture, meets all four of these criteria, it is still not "accepted" as part of conventional medicine and remains considered as a complementary practice. As such we will now explore several of the structural elements underlying the French healthcare system as a means of better understanding what this notion of "acceptance" constitutes and how it is affecting the dynamics and efforts of different agents with an interest in complementary medicine throughout the system.

In Chapter 1, we saw an initial outline of the structure and logic of the French healthcare system; namely, we saw that it was a highly complex structure full of intertwined, nested systems. Within the discussion of the French healthcare system as a complex-adaptive system, we also underscored the decentralized nature of healthcare governance. These two elements will be taken back up in this section in order to shed more light on their details. As was mentioned in section 3.2, the HPST Law allowed Doctor M to create a public health "activity pole" that ultimately led him to his current position directing a TCM integration and evaluation center. It is of note that the 2009 HPST Law constituted a substantial overhaul of the organization of the French healthcare system. Namely, it was a major step towards its decentralization. This was done by creating the activity poles, such as the one mentioned by Doctor M, which concretized a new hierarchy in the definition of the roles of individual healthcare agents on the sub-national levels. Additionally, this law gave individual hospital administrations more autonomy and, by extension, hospital teams gained more responsibility in fostering dialogue with their administrations in order to fix objectives, to elaborate "establishment projects" for the hospital and to seek financial resources for those projects.

Most importantly, the HPST law created the ARS, the Regional Health Agency, which was given a mission to coordinate health policy on the territorial level in dialogue with individual hospitals. The ARS also brought together the financial resources of the State and the Social Security and was given a key role in determining the allocation of those resources for individual hospitals. This was part of the logic informing the HPST law, which was intended to modernize the healthcare system by reorganizing its structure along decentralized lines that were defined by the regional and territorial lines. To do so, it brought together various sources of State resources with the ARS, planned for the eventual creation of Territorial Hospital Groupings (GHTs), and gave hospital administrators, service teams, and staff more autonomy and responsibility in the management of their establishment.

This law was intended to modernize healthcare management as a means of better responding to the French public's healthcare needs. In the specific case of Doctor M, we saw that this law did give him the ability to create a public health activity pole and to engage in dialogue with representatives from both that AP-HP management and his local government. This dialogue led to the creation of an establishment project for TCM and the multi-level dynamics we considered in the previous section. In other words, in the Case of Doctor M, we can see how the HPST law and its reorganization of the national healthcare system had a direct impact on the conventional-complementary relationship with implications stretching from the individual agency level of Doctor M, to his establishment, to the AP-HP system, to the national and international levels. In short, we saw how changes in the organizational structure of the healthcare system as a whole interacted with and enhanced the dynamics that arose from Doctor M's perception that something was lacking in conventional medical care and individual interest in TCM.

The decentralized, regional, and territorial reorganization of the French healthcare system continued through the 2016 Law for the Modernization of the Healthcare System, which put into place the 135 GHT that were anticipated by the 2009 HPST law. These GHTs acted as a means of coordinating patient care pathways along graduated levels of collective care strategies shared among the multiple health establishments in a given territory. In other words, it introduced the notion of a medical project on the territorial level that is shared among multiple hospitals. Not only was this a direct territorial extension of the "regional vision" and organization of French healthcare that was put into action through the HPST Law and the creation of the ARS, it also promoted the pooling of resources amongst multiple hospitals and further decentralized the organization of care adapted to the health needs of the

population in a given territory. Along these lines, the 2016 healthcare law also created the Regional Schema for the Organization of Care (SROS), which Healthcare Administrator A told us constituted a territorial map of the specific healthcare services offered within the hospitals in different regions. This is important, because as Hospital Administrator A discussed, the SROS have a direct impact determining the types of services, practitioners, and equipment that any given hospital can formally establish or obtain. In this sense, it is helpful to recall that Hospital Administrator A told us that the SROS constituted the, "planning, organization, everything is inside it. You see it's signed by Claude Evin, the director of the ARS, it's the strategic plan […] for the organization of care […] and the orientation and cooperation between establishments" (2015).

Notice how Hospital Administrator A specifically mentions that instead of being signed by the Health Ministry or any agent on the national level, the SROS is "signed by Claude Evin, the director of the ARS" at the time of our interview. This means that it can be considered as evidence of the further decentralization of the management of the French healthcare system. In the 2009 law, the ARS was created and the system was reorganized according to a regional logic; and in the 2016 law, the system was further decentralized and organized according to a sub-regional or territorial logic. Since the SROS for a given territory and the authorizations for equipment and services are approved on the regional level by the ARS, it sheds light on the current structural organization of the healthcare system. As was implied in Hospital Administrator A's explanation, the GHT necessitates cooperation and exchange among the administrators from the different hospitals included in any given GHT. They must work together in order to define the "orientation" and "organization of care" in their region, as well as the division of care offerings, medical equipment, and services. Using the terminology that is being employed in this thesis, we can say that the GHT organization creates networks of healthcare establishments and administrators on the territorial level.

Indeed, when I attended a closed meeting for healthcare administrators and public officials in the Essonne territory that was organized by the ARS, I found that the promotion of the notion of a local network was precisely what the ARS was advocating. According to Claude Evin, the territorial approach to healthcare was a means of creating health democracy, equality in the access to care, and addressing departmental differences in the health of the population. Throughout this meeting and its workshops, the major themes that came to light involved promoting the territorial organization of care as a means of pooling hospital resources and better directing the distribution of State resources; as well as empowering local establishments and elected officials to develop their own strategies for meeting the specific healthcare needs of their populations. Within this meeting, we heard from a member of the CRSA[69], the Regional Conference for Health and Autonomy, a consultative organism that was created through the 2009 HPST law in order to assist with the definition and implementation of ARS policies. The CRSA is charged with promoting dialogue between the collection of actors that are involved in healthcare and the Director General of the ARS. It is of note that this collection of actors includes the lobbies of both healthcare professionals and patients. This representative emphasized the need to overcome the "compartmentalization" of healthcare professionals who, "don't know how to work together with medico-social actors," and to promote the creation of a "health teams" approach to the regional and territorial organization of care (Representative E, 2014). I felt as though this was an accurate summation of the main themes that were covered in this event; namely the importance of both empowering local-level actors and facilitating their exchanges as a means of developing territory-based strategies to healthcare needs.

[69] In French, the *Conférence Régionale de Santé et de l'Autonomie*

It is important to note that at the time of this meeting, the 2016 healthcare law had not yet been passed and the GHT organizational structures had not yet been put into place. This acts as evidence demonstrating the anticipation of the GHT and the political emphasis that was being placed on promoting their implementation in 2016. In this regard, when I reviewed my notes and interviews from this event in the post-2016 reform, it appeared to be a means for the ARS to advocate and encourage the development of the 2016 healthcare decentralization reform. Considering that this conference was organized by the ARS, with the inclusion of discourses provided by the ARS Director General and representatives from its CRSA members, implies that we can interpret it as a sign of both the scope and power of the ARS. This is because this meeting gave clear evidence of the ARS management over the territories and the GHT. This meeting acted as a means of informing hospital administrators, local officials, and the lobby groups of healthcare professionals and patients about the upcoming territorial restructuring of the healthcare system.

In this sense, it is helpful to return to the cases of Hospital Administrators A and B as a means of further exploring the interactions that these actors have with both the GHT and the ARS, as well as the dynamics that these interactions create in the conventional-complementary relationship within their respective hospitals. To begin with, in the first chapter, Hospital Administrator A repeatedly alluded to the direct and powerful oversight authority that the ARS has over his hospital's care offerings and orientation. For example, Hospital Administrator A discussed the relationship between the SROS and ARS authorizations for hospital services or equipment using the examples of a maternity service and an MRI machine. In the context of our interview, when I asked Hospital Administrator A about the modalities for acquiring an MRI machine he explained:

> "You have to create a dossier […] everything is regulated and that's the work of the ARS. All of it is completely regulated, not only in what you can and can't ask for, but in addition we can only submit in periods that are strictly defined- it's during two months twice a year that we can submit authorization requests, I have to do it within the fixed terms. Then to obtain the authorization I have to have submitted a standardized dossier that shows our motives, who will be attached, show that it fits in the SROS […] I have to describe everything to be authorized for them to tell me the conditions in which they authorize me to implement […] afterwards the ARS will come to verify that I have implemented the authorization in the conditions they asked for or gave me. You see, it is a system that is completely defined and there are things we can do without authorization, but they're extremely marginal" (2015).

Notice how this discourse reflects the strict regulations and direct oversight that the ARS has over individual French hospitals. What I found incredibly interesting, was the powerful and instrumental role that the ARS maintains in the management of the healthcare system. In this sense, we can recall the discourse that Politician C gave us in section 2.4 describing the Health Ministry's role in terms of the "army" and "deciding where to deploy troops," which she told us were "political" decisions (2015). Here, we see that if the French Health Ministry can be compared to the leaders of an "army," then the ARS acts as a sort of general within that army deciding how to allocate State resources and organize healthcare decisions on the ground. As such, it is significant that within Hospital Administrator A's discourse we see that the ARS is described in terms of its highly regulated approach to hospital oversight. This was embodied by Hospital Administrator A's repeated references to the ARS using language such as "strictly defined," "standardized," "completely defined," and

so forth. In other words, Hospital Administrator A presents the ARS role in terms of its total oversight of all major hospital activities.

Nevertheless, despite this characterization, Hospital Administrator A went on to say that it is precisely within the "extremely marginal" areas of hospital activity not requiring ARS authorization that complementary medicine is practiced in the hospital. In fact, when I asked him what were some example of these "extremely marginal" things falling outside of the scope of ARS oversight he told me: "we decided to propose osteopathy […] in our maternity;" and that, "our anesthesiologists propose hypnosis […] for certain patients," neither of which requires authorizations. As a point of clarification for these examples Hospital Administrator A told me that:

> "It's a little complicated, but for example, surgical activity is submitted to authorization […] we can't do surgery if we are not authorized, but after, the way in which we put people to sleep in order to do that surgery […] because we have to put them to sleep to do a surgery- so whether we do hypnosis or general anesthesia or a local or regional anesthesia or a local-regional mix of anesthesiology and hypnosis- all of that is left to the free choice of the doctor […] on this level nothing dictates that a doctor has to choose this or that technique" (2015).

This remark shed more light on this chapter's on-going exploration of the invisibility of complementary practices in conventional medical milieu. In this case, we see that they are present just outside of the scope of the State-sponsored oversight of the ARS. As we have shown throughout the beginning of this section, the decentralizing healthcare system reforms that led to both the creation of the ARS and the territorial organization of the system occurred along with the provision of additional responsibilities and role for hospital administrators in the management of their establishments. Thus, here we see that that role is allowing for the practice of complementary medicine within hospitals that falls outside of the oversight capacities of the ARS. This is given additional nuance when we recall Hospital Administrator A's previous discussion of the individual agency that doctors have to decide what techniques they will use in their individual practice. This was how Nurse P was able to use her own blends of aromatherapy oils without any authorization from anyone, including her head of service.

What is incredibly interesting is that in addition to leaving room for the invisible practice of complementary techniques in French hospitals, the decentralized and multi-layered structure of the French healthcare system is simultaneously enhancing a networking effect. Indeed, the networked, territorial structure linking departmental hospitals together in a shared reflection, organization, planning, and pooling of resources and experiences also demonstrates potential to bring complementary practices in hospitals to light. For example, consider the following exchange I had with Hospital Administrator B:

> Researcher: "Are you working on the structuring of complementary practices with other hospitals and is there an interest among them in your experiences?"
>
> Hospital Administrator B: "That will come, because in the GHT we will be incited to reflect on it, that is sure. For the moment I'm not working with other hospitals, but I will be led to work together with them now that we have the GHT […] So on this departmental level there are 13 public establishments and we will be regrouped and brought together and I will certainly be brought in to work with

[two other hospitals] and at that time we will definitely work on this theme, that is sure" (2017).

Here we see that despite the lag in the actual implementation of the GHT reorganization, Hospital Administrator B had already identified the active role that she will eventually play within the GHT structure. Furthermore, she also admits that within this role on the territorial level she expected to "work on" aspects of structuring complementary medicine with two other hospitals in her department. This is interesting because it mirrors the work that Hospital Administrator B is already doing in her hospital. In the previous section she told us about how she was working to create a network of complementary practitioners within her hospital so that they could "exchange" about their experiences, questions, and facilitate trainings. Now we see that she is anticipating doing this same work, but on the departmental level within the GHT system. One of the reasons for this is Hospital Administrator B's admittance that, "In terms of complementary therapies […] I have understood that in effect there are sectors in big hospital centers that are practicing them, but in terms of structuring evidently we are really advanced" (2017).

It is relatively safe to assume that Hospital Administrator B's experience can bring an "added value" to at least one of the hospitals she will be working with in her GHT, CH Saint-Nazaire, because it is a hospital of comparative size. Furthermore, I found no less than 45 different listings for osteopaths in the Saint-Nazaire area, equating to roughly one osteopath for every 1,550 inhabitants or twice the national osteopathic density[70]. I also found listings in online practitioner databases for 133 individuals practicing hypnosis and 41 practicing magnetism. This means that we can safely assume that there is both a significant consumer demand for and use of complementary therapies in this city and that it is very likely that there are healthcare practitioners using those therapies in that city's hospital; especially when we recall Doctor R's emphasis, in the previous section, of the important role that the "presence" and "local reputation" of complementary practitioners had on creating the "fortuitous meetings" that led to their integration into his DU and conventional medical activities. In the case of Hospital Administrator B's interactions with CH Saint-Nazaire, we see that there is considerable potential for these kinds of "fortuitous meetings."

The logic informing this particular assumption is based on the previous two sections' discussions of and my own personal experience with the dynamics of complementary medical networks. Considering the population size, the potential density of complementary practitioners in its city, and the size of the hospital that Hospital Administrator B is expecting to work with, I feel as though it is safe to assume that there is also a network among both the patients and practitioners using complementary medicine in this hospital. This was implied by Hospital Administrator B's discourse; because she explicitly cited this particular hospital as one of the ones she would "certainly be brought in to work with" and assured me that she would "definitely work on this theme." Considering all of this together, it is logical to assume that this hospital also contains an informal network of complementary practitioners and/or patients. In this regard, I found it of significant note that the ARS described the GHT project in terms of creating "networks" among the hospitals and their respective resources on the territorial level. Within the ARS event I attended, this clearly showed through the discourses that were included, all of which focused on empowering local actors and fostering their cooperation, joint work, and exchanges. This appears to provide the "fortuitous"

[70] This calculation is based on the 2015 Insee population statistic for the commune Saint-Nazaire totaling 69,784 inhabitants (Insee, « Dossier complet, commune de Saint-Nazaire (44184) : RP2015 (géographie au 01/01/2017) », Available online at : https://www.insee.fr/fr/statistiques/2011101?geo=COM-44184).

circumstances that Doctor R identified as important to promoting the structuring of complementary medicine within Hospital Administrator B's particular GHT network.

With this in mind, I asked Hospital Administrator B if the ARS or other "national structures" were interested in what she was doing. In response she laughed and said:

> "I don't know, honestly. I don't really think that we have this visibility […] No, no I'm not sure. *Bah*, I think that they are aware to the extent that they […] know that there is an instance that is our committee on pain and palliative care, it's certain they discussed that, just as in all of the hospitals, but I don't think they have a detailed knowledge of our structuring [activities], no" (2017)

This indicates that not only does the current organizational structure of the decentralized system seem poised to enhance the complementary networking dynamics that Hospital Administrator B is engendering in her own establishment on the departmental level; there is considerable room for complementary integration beyond the scope of ARS oversight. As such, it further underscores the principle of self-organization and the emergent patterning that complex-adaptive systems theory identifies. In this case, we see that not only is Hospital Administrator B working to self-organize the complementary therapies in her own hospital, she is also preparing to share her experiences with other hospitals in her department; one of which clearly carries the potential for having a presence of complementary therapies within its services. Not only could this raise the visibility of complementary practices in both establishments, according to Hospital Administrator B's above rhetoric, it also carries the potential of raising the visibility of her structuring efforts and/or of the complementary medical presence in hospitals on the national level. This is because should enough hospitals in any given GHT begin to structure complementary practices in the same way that Hospital Administrator B is doing, it could gain enough of a critical mass to draw the attention of the ARS and by extension, the Ministry of Health. It will be interesting to see if this emerges in the future.

For now, we shall now turn to an examination of some other instances, involving individual efforts to raise the visibility of complementary practices and their potential for being "accepted" as playing even a marginal role in conventional medicine. In addition to data clusters around the four criteria I listed in relation to the "acceptance" of a given product or practice in conventional medicine, I also found data clusters surrounding a variety of different "channels" towards acceptance that different complementary agents are employing as a means of raising the visibility and perceived legitimacy of their practices. Before doing so, however, it is important to make one point of clarification. As we saw in the previous sections on the hospital level, the "acceptance" of a complementary therapy really equated to a decision for the hospital administration to pay for trainings or practitioners. We saw this in Doctor O's and Nurse V's hospital and its decision to pay for trainings in hypnosis and aromatherapy; we saw this in Hospital Administrator B's hospital with hypnosis and sophrology; and we saw this in Hospital Administrator A's hospital with osteopathy and hypnosis. We also saw that Clinical Researcher R was attempting to secure his hospital's funding for his naturopathy training. Likewise, we also saw that on the hospital level "acceptance" was equated to raising the visibility of a practice and its practitioners to the point where it could be structured or "officially" integrated as a service project. This is what Clinical Researcher R referred to when he emphasized his "good relations" with the sophrologist and psychologists in his service and assurances that he would discuss his integration with their "team" as a means of supporting his proposal to the hospital administration for funding. As in the case of Doctor O and Nurse V, and as was explained by Hospital administrator B, once a complementary

practice is "officially" visible within a service or among a large enough group of practitioners, it motivates others to attempt to do the same with the complementary practice of their own interest. Hence, it is useful to recall her statements related to organizing a hypnosis event in her hospital so that healthcare professionals could see that "it's already been done so it's possible" (2017).

As such, we can see that the notion of the "acceptance" of a complementary practice carries two components: that of sufficient visibility to give it a perceived legitimacy; and that of receiving various forms financial support. What I found to be incredibly interesting is that there is evidence of both of these components on every level of the conventional-complementary relationship in the context of the French healthcare system. Furthermore, I found that these two components were the drivers behind the self-organizing and awareness-raising efforts of various complementary agents who are attempting to "mainstream" their preferred complementary practices as a means of rendering them visible enough to receive funding or various forms of financial support or reimbursement. Therefore, throughout the rest of this section, we will examine several of these cases.

On the local hospital level, the previous two sections have shown us multiple instances in which an individual complementary practitioner has worked both to render their practice visible, to convince a sufficient number of their colleagues that it brings an "added value" to conventional patient care, and then to seek funding for integrating that practice through trainings or as a service project. Furthermore, we saw multiple cases in which these efforts of an individual agent had repercussions that are shaping the conventional-complementary level on the territorial, national, and international levels. Another aspect of raising the visibility of a complementary practice that we saw included attempts to structure complementary teachings in the form of DUs and DIUs in French medical schools; these attempts were characterized as a means of raising-awareness about a variety of different complementary practices as a means of changing the medical perception of these practices and their potential "added value" to conventional care.

In this sense, it is important to highlight the specific nature of the teaching that the sophrologist-nurse who is working with Hospital Administrator B is doing. This is because this sophrologist-nurse, "responded to a project that is what we call a simulation project from the ARS. So she does trainings that respond to the very specific obligations imposed by the ARS in the frame of a pedagogic approach using simulation" (2017). In other words, this nurse received funding from the ARS in order to conduct simulation-based trainings to healthcare professionals. This is important because it acts as evidence of how the individual efforts of Hospital Administrator B led her to hire a sophrologist-nurse and to encourage that sophrologist-nurse to organize trainings for healthcare professionals with State financing, given out on the regional level by the ARS. This also further underscores her above-mentioned potential both to work with other hospitals on the departmental level and to get the attention of the ARS; which, when coupled with the ARS support that her sophrologist-nurse colleague is receiving, carries within it the potential to develop into an approach to complementary medicine on the regional level. Just as in all the cases that have been discussed in this chapter, we see that the sophrologist-nurse and Hospital Administrator B are choosing to seek ARS funding to structure and render visible training in a complementary practice for healthcare professionals. This demonstrates the double visibility-funding components that are involved in promoting the "acceptance" of a complementary practice. In this case, receiving support and funding from the ARS provides both funding for trainings and a sense of "legitimacy," because the ARS is an extension of the national government in healthcare oversight.

In this regard, Doctor M told us that he was actively developing and implementing clinical research projects on different aspects of complementary medicine and that these projects were helping to bring professionals from different services together. This was a different approach to the same ends of promoting the "acceptance" of a complementary practice. In this case, Doctor M is doing clinical research in a pluridisciplinary way among his hospital's services, which both raises the visibility of the practices and results in funding for the research project. While he did not let me know who was funding this research, his emphasis on the importance of bringing different healthcare professionals together through joint research efforts involves the same dynamics that we have seen throughout this chapter. It is a networked-approach to both raising the visibility of TCM and gaining funding for clinical research on it. While in the previous case the source of the funding, the ARS, gave Hospital Administrator B's nurse-sophrologist a certain amount of perceived legitimacy for sophrology; in this case, the clinical research findings that are resulting from Doctor M's funded complementary research are providing this component of legitimacy. In both cases we see that the notion of "acceptance" is being pursued both through raising visibility and gaining funding. Furthermore, in both cases these efforts are having a direct impact on strengthening the networked interest among conventional practitioners and further providing impetus to this visibility-funding dynamic.

On the national level, I encountered a variety of different complementary practitioners who were pursuing very similar attempts to both raise the visibility of their practices and to gain or facilitate funding for trainings through their associations, federations, or lobbies. I found this to be particularly strong in the discourses of osteopathic association President D, Kinesiologist R, and Shiatsu Practitioner C- all of whom are active members of their respective representative organizations and all of whom seem to be pursuing incredibly similar strategies towards raising the visibility of their respective practices by structuring trainings on the national level as a means of facilitating the receipt of funding for these trainings for interested individuals.

Before discussing these specific cases, it is important to explain one aspect of the national French structure concerning education and training. In France, a "diploma" is an educative title that is given in the name of the State. For example, once a medical student has successfully completed their medical studies, they are given a national Diploma in Medicine. As part of their continuing or non-core education, healthcare professionals can enroll in the DU or DIU that are offered by their universities. Upon completion they receive a diploma that is given in the name of their university, or the university partnership sponsoring the DIU. This is a university-level diploma, not a State-sponsored diploma. The non-medical equivalent of a DU or DIU is a "professional title," which is a certification that is given by the Ministry of Employment. Just as in the case of a DU or DIU, a professional title justifies that a professional completed training for specific competencies or qualifications that are applicable to their professional activities. There are hundreds of professional titles available in France and all of them are included in a National Repertory of Professional Certifications (RNCP).

In the previous section, we can assume that since both Doctor M and Doctor R developed their DUs in complementary medicine as a means of raising-awareness about their preferred complementary practices, they did not yet have enough visibility and perceived legitimacy to make a case for the integration of their trainings within the core curriculum of French medical schools. As such, they were limited to developing information-based DUs and DIUs that only provided a very limited technical training, if any at all. While the case of the establishment of a DU in homeopathy in the Brest medical school did indicate that once one medical university accepts the inclusion of a complementary DU others will follow; the angry

emails that the Brest medical school president received, and the small handful of other universities that followed suit indicates that this is a slow and uneven process. In other words, despite the nation-wide proliferation of acupuncture DUs and DIUs, the introduction of homeopathic DUs and DIUs, and Doctors R and M's DUs and DIUs, the "official" acceptance of complementary medicine in French medical schools has not yet occurred. Instead, instruction in complementary practices is merely tolerated on an individual university basis. Nevertheless, just as the ARS is beginning to get an awareness of the growing presence of complementary practices in hospitals; the *Conference des Doyens* is also aware of the growing presence of interest in complementary practices in medical schools. This is evidenced in the following discourse given to me by Doctor T- one of the founders of an observation group monitoring and investigating complementary medicine who created a DU in meditation for his medical school:

> "The *doyens* know what I created […] and that we are the first medical school to have created- they asked me to write a text that will be the position of the *Conference des Doyens*. So I wrote a text that I presented at our meeting saying that it could be the position of the universities, but we are not going to go any further for the moment […] For the moment we prefer not to release it because there are other reforms occurring that are important […] So for the moment we haven't taken an official position, I'm not sure we're really ready, one day or another we'll release it when we think that it's expedient" (2017).

This discourse indicates that the *Conference des Doyens* is monitoring the proliferation of DUs and DIUs in complementary medicine and are making steps towards taking an "official position." In this case, we again see that Doctor T's individual efforts to structure complementary practices and to render them visible drew the attention of the organization of medical school presidents that represents all of the medical schools in France. We saw that just as in the case of Doctor M, as a result of Doctor T's interest and efforts he was asked by a higher administrative level to develop an "official" position on complementary practices in conventional milieus. Similarly, just as in Doctor M's case, Doctor T is also working to evaluate complementary practices as a means of developing their "legitimacy." Furthermore, just like Doctor M, Doctor T has also instituted a DU in a complementary practice in his medical school; that of meditation. In other words, we again see the same dynamics occurring, only this time with repercussions on the national level; in this case, the national representative body of French medical schools. It is of note that all of these dynamics are based on the same relational and networked mechanism that we saw throughout the previous two sections. Just as countries are watching and copying the actions of other countries concerning complementary medicine, here we see French medical school presidents watching, and in some cases, drawing inspiration from the DUs and DIUs in various schools. Since Doctor T's efforts and interests became visible, he was asked to take initial steps towards developing an "official position" on complementary medicine for French medical schools as a whole. This further indicates that raising the visibility and structuring of complementary practices are both important mechanisms that favor its "acceptance."

As such, it is useful to look at the case of President D and the results of his association's efforts to get osteopathy instruction "accepted" on the national level. Osteopathy gained national "acceptance" through its official structuring as a result of the Law n° 2002-303 of 4 March 2002, which created the official title of osteopathy for individuals possessing a state-sanctioned diploma from a nationally-accredited school. As was mentioned in Chapter 1, the osteopath title applies equally to three different categories; that of doctors, healthcare professionals, and "*nie-nies*" or non-healthcare professionals. National Decree n°2007-435 of

25 March 2007 created a regulatory frame defining the "authorized acts" in osteopathic practice, which officially defined osteopathic practice. It is of note that there was a four year lag between the creation of accredited schools and the official definition of exactly what maneuvers qualify as legitimate osteopathic practice.

According to the interpretive logic of this section, it appears as though despite the creation of accredited osteopathic schools and the regulatory definition of its practice, osteopathy has not been fully "accepted" on the national level. This is because, as we have seen throughout this chapter, the notion of acceptance includes two components; that of a significant visibility and that of finances. In the case of osteopathy, there was enough of an interest in osteopathic trainings, or enough visibility on the national level, that the State was required to create an official structure for those trainings by accrediting schools. Nevertheless, President D specifically told me that, "The government doesn't like recognizing new healthcare professionals because doctors don't like it, so osteopathy is not specifically reimbursed by the Social Security" (2017). In other words, according to President D, while osteopathy is officially included as being present in the "healthcare field," it is not recognized as a "healthcare profession." This is evidenced by the fact that while there are now nationally-accredited osteopathy schools, they remain private, and osteopathic training is not included in the core curriculum of French medical schools. Instead, it is taught as a DU or a DIU in some, but not all, universities. Furthermore, the osteopaths that are graduating from the accredited schools are far from being "accepted" by what President D describes as, "many healthcare professionals who are anti-osteopathy, they want it to be exclusively practiced by doctors, if by anyone at all" (2017).

Despite the mixed opinions surrounding who should be allowed to practice osteopathy, it clearly has achieved the critical mass of visibility on the national-level that was necessary for its partial acceptance in the form of accredited schools. In fact, President D specifically mentioned this by saying that, "It's all about the size. The rationale for the law was that there were high enough numbers of osteopathic practitioners and patients. This gave the osteopathic syndicates the size and weight needed to successfully lobby- our association was the first to be recognized by the Ministry of Health because we have more than 1,200 members" (2017). Thus, we see that yet again, the notion of acceptance is directly related to the level of a practice's visibility. Despite its "acceptance" through the accreditation system, President D made it clear that osteopathy was far from being fully-accepted as a conventional practice or healthcare profession. He described this gap in terms of his association's ongoing work to:

> "Politically defend the profession against healthcare professionals who don't want it and don't accept it as part of the socio-economic tissue. We are working to structure osteopathy in hospitals by creating a statute for employees that would allow more exclusively osteopathic professionals to be placed in them. Doctors don't practice the same osteopathy as we do. Doctors and physical therapists have a more symptomatic approach, so osteopaths are more effective osteopathic practitioners […] but, the population wants it so we are heading towards reforming healthcare- it will take decades because of the tensions between osteopaths and healthcare professionals" (2017).

Within this rhetoric it is important to highlight President D's remark about the unwillingness of healthcare professionals to "accept it as part of the socio-economic tissue." Following the analytical logic of this chapter, we can interpret this as justifying my inclusion of two components included the notion of the "acceptance" of a complementary practice; that of visibility and finance. In this case, osteopathy can be characterized as not being fully

"accepted" as a part of conventional medicine both because it does not receive the financial support of the State through Social Security reimbursement, and because it is not recognized as a legitimate professional competitor in the French healthcare market. The creation of the accreditation system for private osteopathic schools thus constitutes an official step toward structuring osteopathic training that resulted from the achievement of a critical mass in the visibility of osteopathic practitioners and consumers. Nevertheless, its failure to gain State financial backing through either Social Security reimbursement or inclusion in the State-sponsored core-curriculum of French medical schools is evidence of its partial, but not full acceptance. Doctor R made this clear in his explanation of the financial concerns that he says are the reason for which the State chose to create an accreditation system rather than to integrate osteopathy training within the medical school curriculum:

> "I think it had to be because of the economic and financial concerns of the procedure. Schools were created, or they already existed, and the Minister had to either create a diploma- but that would have cost us a fortune in the State budget- or leave the private schools in place. People would pay to register for these new trainings and the French attitude of not paying anything for the first years of university in France […] the first years of university in France cost almost nothing, but this attitude doesn't exist for osteopathy. People are ready to pay 1,000 euro, 2,000 euro, 3,000 euro per year if they have to. Meanwhile the Ministry of Health and I think also the Ministry of Education had to have taken a look at the labeling […] the Ministry makes a specification list and *viola*. It was not easy in the beginning because these schools already existed […] I met some of the people in the Health Ministry who were in charge of labeling these schools and they told me […] determining the evaluation criteria and all that was very, very difficult"(2017)

This discourse clearly relates the "acceptance" of osteopathy to the financial considerations of the state, telling us that it was less expensive for the state to develop the accreditation system for the private osteopathy schools that were already in place than to create a state-sponsored diploma for osteopathy in the university system. In this context, it is important to note that DUs and DIUs are not paid for by the university, it is up to interested individuals to secure their own funding for these courses; funding which Hospital Administrator B told us can come from a hospital's continuing education budget in some cases. The individual willingness to pay for osteopathic training allowed the State to structure osteopathy without actually accepting it as a healthcare profession or as an integral part of conventional medicine. It is significant that Doctor R specifically mentions that "people are ready to pay" thousands of euro for training at a private school, because it sheds light on the State decision not to pay for the costly integration of osteopathic training in French universities. Furthermore, it adds to the visibility component of the "acceptance" of a complementary practice. Here, Doctor R's statement about how individuals are willing to pay for expensive private formations, despite being accustomed to "not paying anything" for their public university diplomas, suggests that part of the reason that osteopathy gained the critical mass of visibility was that the general public accepted it enough to finance their own trainings. In other words, it again displays evidence of the dual dynamic that is related to the notion of "acceptance."

We can now turn to Kinesiologist R, whose kinesiology syndicate is working towards the same professional recognition, structuring, and acceptance that President D's association is lobbying for in the case of osteopathy. In one of my interviews with Kinesiologist R, we

discussed the efforts that were being made by kinesiology lobbies to increase the visibility and the structuring of kinesiology on the national level. Within this discussion he told me that:

> "A dossier was created for the recognition of kinesiology to obtain a RNCP number. This RNCP number will allow training organisms to pay for the employees that use them and that chose to do trainings […] In general if we are not listed with a RNCP number training organisms systematically refuse the employees that want to get trained in areas that are not recognized and don't have a RNCP number- so the employees can't get trained unless they have enough personal resources […] This is a big blockage in the evolution, in the development of these soft medicines in general and for kinesiology specifically" (2015).

The dossier that Kinesiologist R is referring to was created and submitted to the RNCP by the French Federation of Kinesiology (FFK) in 2014. It was refused due to the lack of representation, so the FFK worked with the National Syndicate of Kinesiologists (SNK) to develop a second dossier in 2016. This dossier was also refused, although I do not know the reasons that were given by the Ministry of Employment for this refusal. Both the efforts and the difficulties that these kinesiology syndicates are having in terms of getting recognition as a profession are significant because they are a direct correspondence to the case of shiatsu. According to Shiatsu Practitioner C, who is a member of the French Federation for Traditional Shiatsu (FFST), shiatsu organizations are also actively pursuing the structuring, visibility, and the professional recognition or acceptance of shiatsu on the national level. Similar to kinesiology, Shiatsu Practitioner C told me that:

> "Shiatsu is not recognized in France […] as a profession, it's something- it's a denied labor *voilà.* We find it everywhere, including in the hospital milieu and in clinics and in homes for the elderly, but we don't yet exist as a profession. So that's one of our goals and that's why we created a federation. It's precisely to get our profession recognized by the State, by any ministry […] to get us recognized simply as a profession with rights and responsibilities- that means obligations and limits and that's why we created a deontology code that is imposed on all of our adherents. It's very important to have a deontology code so that people don't do nonsense under the pretext of shiatsu […] We also do lobbying, we were received by the Ministry of Health and I've met with politicians and deputies and senators […] but I won't hide anything, currently the political class doesn't care at all" (2015).

Thus we see that in both the cases of shiatsu and kinesiology there is an active self-organization into representative groups that are lobbying on the national level. In both cases, their syndicates are working towards getting their practices recognized as a "profession with rights and responsibilities," and thus, as a legitimate form of employment for interested practitioners. This was demonstrated in the efforts to get kinesiology included in the RNCP, which would equate to professional legitimacy allowing interested practitioners to get financial assistance for their trainings. In both cases, we see that there is a persistent resistance on the part of the State and it's ministries to accept either of these practices as a profession, as a component of healthcare, or in any "official" way. Thus, much like the complementary practices that we saw in French hospitals in the previous sections, we now see examples of complementary practitioners that are "invisibly" present in the French healthcare landscape. This was evidenced in Shiatsu Practitioner C's discourse characterizing shiatsu as a "denied labor" despite its presence in multiple conventional medical milieus. It was further underscored by his description of the FFST mission to get recognized "by *any* ministry,"

which implies that they are making efforts to get recognition from the Ministry of Employment, like kinesiology; by the Ministry of Health, like acupuncture; or by the Ministry of Education, like osteopathy.

Furthermore, in the case of kinesiology we saw that facing State resistance; two major kinesiology organizations began working together as a means of increasing both the scope of their membership networks and the overall visibility of kinesiology. The FFK manages those involved in teaching and training while the SNK gathers kinesiologists together as professionals. The SNK included 344 kinesiology practitioners in 2016 and the FFST currently includes 93 shiatsu schools, 490 practitioners and a total of 1,712 members. Another important reflection on the self-organization that is emerging in both the cases of shiatsu and kinesiology is their development of their own deontology codes. While we saw this clearly in the rhetoric of Shiatsu Practitioner C above, Kinesiologist R also emphasized the importance of a deontology code for kinesiology:

> "We have a professional syndicate that made a deontology code. Since we're not recognized by the State and we can't oversee every person that calls themselves a kinesiologist, but who isn't or who hasn't been properly trained- and if they're not attached to either the FFK or the SNK then that can damage us, but we can't regulate this situation when kinesiology isn't recognized. So […] we have this goal to let the Ministry know that this is blocking us, despite all our efforts. We are obstinate, so we're going to continue to ask for a form of recognition that will allow us to act so that there is as little misconduct as possible. That is our primary concern, to be able to strictly tie people calling themselves kinesiologists to deontology, to make sure they have adequate training" (2015).

What I found to be very interesting within this discussion with Kinesiologist R was that he went on to equate the current invisibility, or lack of recognition, of kinesiology with the developments that have occurred in other complementary practices. The language that he used to do so reflected the same emphasis on education and awareness-raising efforts that we saw in the examples from the previous two sections. To see this more clearly, it is worth considering the following discourse from Kinesiologist R:

> "I think that this is an issue for all young professions that being to grow and evolve in the shadows […] This was the case for acupuncture, for osteopathy, chiroproactics, sophrology, reflexology, and for a certain number of practices of this type. At one point they were demonized but then they evolved and played the game of recognition as a means of no longer being seen as charlatans- or as certain words that often appear on the internet and that have no basis, because people don't even know what they're talking about, talk about a profession without knowing what it is and what it comprises and this is a great shame. So today we are armed with a sort of service that is allowing us to create a dossier so that all of those that don't really know what kinesiology is will know- we are communicating and trying to make ourselves known" (2015).

Again we see the reoccurring notion of the invisibility of complementary practices, here described as growing and evolving "in the shadows." This was exactly what we saw with the proliferation of complementary practices in hospitals beyond the oversight of the ARS and in some cases, beyond the oversight of the hospital administration or even the heads of service. In all of these cases, we see that to remedy the situation there is a self-organized structuring that is occurring in tandem with efforts to raise awareness about and the recognition of certain complementary practices and give them enough visibility to be

"accepted" in some form or another. While in the previous section the acceptance that healthcare professionals are seeking was largely limited to individual hospitals, here we are seeing efforts among complementary practitioners to get recognized by some form of the French State apparatus.

In both the cases of kinesiology and shiatsu, my informants spoke about the political resistance against accepting or recognizing their practices. We saw this clearly in the case of kinesiology through the repeated refusals to include it in the RNCP, as well as in Kinesiologist R's description of the kinesiology lobbies as "obstinate" in their continued efforts to gain recognition. In this context, Shiatsu Practitioner C gave a more nuanced explanation of his experience with the political resistance facing shiatsu:

> "They receive us very kindly. Often politicians have received shiatsu at one time or another- in the big hotels there are often shiatsu specialists that work and in between meetings politicians go to have shiatsu and they find that it is very good, but when I go to see them they say, 'Yes, yes I know what shiatsu is and it's very good, I received it in a hotel one time and it was very good.' So I say, 'Great, are you going to recognize us?' and they say, '*Ah*, well, you know, you understand it's delicate *niah niah*' and we don't get anywhere. The truth is that there are lobbies […] that are doctors and mostly physical therapists- physical therapists, if they don't practice shiatsu and don't learn about it in their studies then they consider it as dishonest competition" (2015).

This perception of shiatsu as a competitor to physical therapists is significant because it was also given to me by Kinesiologist R, only in reference to their non-use of pharmaceuticals. According to Kinesiologist R there is, "A will to ostracize us […] our wrongdoing is that we don't prescribe medications […] so people come to see us and that is seen as a black market by people who prescribe" (2015). While the language used is considerably different than the language that Shiatsu Practitioner C used above, the implications are the same. We see that Kinesiologist R is referring to the political resistance against recognizing kinesiology or to "ostracize" it because of it is perceived as a direct competitor taking clients away from the business of healthcare professionals. Within the analytical frame that is developing throughout this chapter, we can see that while in the previous two sections "acceptance" or recognition was interpreted in terms of a hospital's acceptance to finance trainings in that practice; here we see that political resistance to complementary practices is equated to an unwillingness to "accept" these practices as financial competitors in the healthcare market, just as we saw with osteopathy.

In light of the difficulties they have obtaining the "recognition" of kinesiology on the national level; Kinesiologist R told me that his lobby group began working with other organizations on the European level to raise its visibility. Specifically, they worked with a European-level organization lobbying for complementary therapies and in particular on:

> "The role and the recognition of naturopathy in Europe, we did a large project with them in order to create a European curriculum that would create pathways between naturopathy and kinesiology. In fact today there are more and more naturopaths that are choosing kinesiology as one of the techniques in their practices- it's not just kinesiology there are other techniques like reflexology, iridology etc. So kinesiology enters, in a certain way, as being among their optional practices, and so in this type of course a person can start their studies of naturopathy in a school and then come to do a course in kinesiology and then go

back to their school and continue to practice- they're pathways we can say, with levels of equivalence in the diploma they obtain" (2015).

The efforts described in this quote provide us with a valuable insight into the self-organization and multi-level networking that is being pursued by different kinesiology lobbies. In the absence of national recognition of kinesiology trainings, its lobbies are going to the European level in order to work with other complementary organizations to structure kinesiology trainings. These kinesiology representatives are organizing themselves into a multi-level network of complementary groups in order to work towards an international standardization of training. These networking efforts are creating the same kind of dynamics that we saw in the previous sections by raising the visibility of kinesiology and integrating "pathways" to kinesiology trainings in naturopathy schools. It is of note that Kinesiologist R's rhetoric is focused on the same themes that were of primary interest to the healthcare practitioners we saw earlier. Namely, there is an emphasis placed on the key role that complementary training and education play and the corresponding importance of structuring that training. I also found it interesting that when faced with unwillingness to "accept" kinesiology on the national level through the Ministry of Employment, kinesiology organizations began working with representatives of other complementary practices to promote the recognition of kinesiology within the context of naturopathy. This is due to what Kinesiologist R describes as the "systematic refusal" by professional continuing education organizations to pay for employees interested in training in kinesiology. Thus, by linking themselves to naturopathy, the kinesiology organizations are increasing the chances for people to obtain funding for training; in this case, because naturopathy is a much wider complementary practice that includes a diverse collection of techniques.

Much like in the case of kinesiology, Shiatsu Practitioner C assured me that as a result of the difficulty in gaining national recognition for shiatsu, his shiatsu federation is also working to raise their visibility and presence on the European level. Specifically he explained:

> "Externally there is another possibility to get recognized and it's called Europe. We are part of an association […] if you go on-line you'll find that the German, Italian, Swiss, and French federations are part of a group that is called the International Shiatsu Network that regroups four federations from four European countries. So this group fights in Brussels in the European Parliament for the recognition of shiatsu- there also things don't move quickly, but personally I'm counting more on Europe for recognition than on France, because if Europe imposes it- there was a young law that was in the European Parliament called the Lannoye/Collins […] they voted on a law recognizing shiatsu as something positive for health, but this […] wasn't imposed on countries, the European Parliament said that it was good, but we French were not obligated to say that we accept it" (2015).

Thus in the cases of osteopathy, kinesiology, and shiatsu we see the emergence of a pattern. In all of these cases, the representative groups for these practices are working to raise their visibility and to get them accepted as recognized professions. In order to bolster their efforts, these groups are self-organizing both by creating their own deontology codes and by bringing practitioners and interested agents into their professional networks. They are using these professional networks to communicate and to raise-awareness about what their practices are as a means of changing the negative stigma and perception of these practices. They are working to self-organize and to structure their respective trainings. Furthermore, in all of these cases, we see that their representative groups are working with other groups on both the

national and the international levels as a means of gaining even more visibility and adding weight to their lobbying through the lateral extension of their networks. Just as we saw in the previous two sections, the notion of "acceptance" not only includes visibility, it also includes finance: either gaining enough people willing to finance their own private trainings, such as in the case of osteopathy; being accepted as a profession as a means of helping those interested to gain finance for their trainings, as was the case for kinesiology; or as being accepted as a legitimate financial competitor in the healthcare market, which has still not occurred for any of them. Furthermore, throughout all of these cases, we again see the importance that the relational dynamic is having in the "evolution" of these practices. All of the movements that we have been exploring in these cases involve the meetings and relations that these representatives are having with government officials, medical school presidents, ministries, and with other representative organizations.

It worth repeating that these dynamics towards the "acceptance" of these complementary practices is occurring despite the overwhelmingly negative perceptions, stigmas, and stereotypes that were associated with complementary medicine in the previous chapter. It is also occurring without the clear definition of exactly what these practices consist of; except for the notable exception of osteopathy which was officially defined several years after its schools were accredited. Thus we see that rather than needing outstanding scientific proof of efficacy to be accepted, complementary practices really only need both significant visibility and willingness for financial investment.

### *3.4: Specific Cases of Complementary Self-Organization*

Throughout this chapter thus far, we have explored evidence of not only the presence of complementary practices in various conventional medical milieu, we have also examined how the dynamics engendered by these cases are resulting in emergent patterns and multi-level self-organization ranging from the individual, local, territorial, regional, national, and international levels. In the first two sections, these cases focused on the local efforts of individual conventional practitioners to render the complementary practices in their establishments visible as a means of promoting their structuring, perceived legitimacy, and funding. In the previous section, we explored several cases in which groups representing some specific complementary practices were making the same kinds of efforts on the national and international level. As such, within this section we will now examine two cases in which the efforts of groups representing patients with specific pathologies are also making efforts to raise the visibility of, structure research and education on, and promote the financing of work advancing complementary treatments within the context of these pathologies. This is important within the logic of this chapter, because they are all conditions that are also largely "invisible" in conventional medicine. Therefore, much like we saw in the previous sections, in which hospital services that operate close to the fringes of conventional medicine turn towards complementary treatments, here we also explore the same dynamic, but from the perspective of the patients and their families living with pathologies that are at the borderline of conventional medicine; either because of their incurable nature or because of the limited population sizes affected by them. As such, just as we have seen in the previous sections of this chapter we shall again see that these efforts are also contributing to the emergence of patterns and self-organization within complementary practices for the specific health needs of certain populations. These populations include patients living with rare diseases and patients

living with motor handicaps. Additionally, within this section I will delve more deeply into what I observed among the clients that came to Shaman C's practice; namely, the presence of these same emergent patterns of networked self-organization. Upon analysis, we shall see that these dynamics are operating in parallel with those that we have seen in the cases throughout this chapter. Therefore, when all of the cases presented in this chapter are taken together, it sheds considerably more light on the complex, multi-level, and multi-directional dynamics that are driving the exponential growth of interest in and practice of complementary medicine.

In this section, it is useful to recall our discussion from Chapter 2 about the role of the doctor. Within this discussion, we saw that according to various healthcare professionals, the pinnacle role of the doctor is to evaluate the patient using a combination of clinical and complementary exams and analyses, and then to determine a treatment plan for that patient. Doctor H put it succinctly by saying, "My job is just to take care of people […] and I have got a lot of tools to do that […] our job is to have the right tool for the right person" (2015). While this is perfect in theory, in practice there are a variety of different cases and pathologies that are not as simple as finding evidence of a specific bacteria in a patient and then giving them antibiotics to treat it; or of finding a cancerous growth in another patient and removing it with surgery. In many cases, such as with elderly patients, patients with chronic or incurable diseases, or patients suffering from rare diseases that only affect very small proportions of the overall population; the patient care pathways involved in determining and delivering "the right tool for the right person" are long, complex, or even inexistent. As such, in these cases, the role of the doctor, healthcare professional or healthcare establishment may not be clearly defined, which makes treating and caring for these patients within the healthcare system challenging.

For example, within the ARS meeting for the Essonne territory that I attended in 2014, there was a thematic workshop dedicated to healthcare pathways for the elderly and handicapped patients. The overall theme of this workshop was on the difficulties related to caring for these patients in conventional care. The difficulties identified related to the importance of accurately evaluating a patient and their needs. In this sense, Representative N of the Association *APF France handicap* underscored the difficulty involved in creating synergy between evaluation, the certification of a patient's illness and needs, and their placement in the proper care setting when healthcare professionals are faced with patients suffering from handicaps or degenerative conditions. Representative N even underscored difficulties in getting doctors to make thoughtful evaluations of these patients noting that, "Sometimes doctors just don't pay attention to what they're doing and will say a patient is independent even when it is not true" (2014). Additionally, since there can be many different healthcare professionals involved in the case of a single handicapped individual, there is a great need for coordination, which is often lacking. As an example of this, the mother of an autistic child raised her hand and recounted an anecdote related to finding basic care for her son. She explained that her son's autism is so severe that each time he gets sick with a minor illness; she is refused care by multiple general doctors and sent to the emergency room instead. This story led to a general discussion among the workshop participants about the "unclear role" that hospitals have in caring for handicapped individuals. In response, one of the hospital administrators present evoked the need to create some form of "hyper specialization" for these cases in lieu of the transversal care policy that characterized hospital policy at the time of this meeting. When an audience member emphasized that handicapped individuals deserve the same level of care as anyone else, another hospital administrator responded that hospitals "do the best they can" when they receive handicapped individuals.

This discussion sheds light on the kinds of difficulties that are faced by families caring for handicapped individuals. All of the comments that were made in the aforementioned workshop reflected the interplay between the structural realities and organization of the healthcare system and the specific case of handicapped people. Namely, as a result of their nature these cases require a global view of the patient's illness and care needs; which was referred to in terms of creating "synergy" and "coordination" among the diverse healthcare workers that may be involved in a single handicapped patient's case. Unfortunately, as this discussion indicates, finding these forms of "synergy" is difficult, even in light of the healthcare system's emphasis on providing "transversal" care. This is why one hospital administrator evoked the possibility of "hyper specialization" for these cases. Going further, this reference to a "hyper specialization" for handicapped patients also identifies their "invisibility" within the healthcare system. For example, Representative N's reference to doctor error in the evaluation of handicapped patients because of their "not paying attention to what they're doing;" can be interpreted as saying that doctors do not fully "see" the handicapped patients they are in the process of evaluating. This notion of the general invisibility of handicapped patients in the healthcare system was further underscored by the recognition among the entire audience of the unclear "role" that hospitals have in caring for handicapped patients; a comment that was further underscored by the mother in the audience's story about her difficulty finding a general practitioner to care for her son's "regular" health needs. Taken together, all of this indicates that there is a gap within conventional medicine that is created by the system's specialty-based organization that can limit the long-term and complex healthcare pathways needed by some patients and their families.

In fact, it was precisely these healthcare limitations and the care challenges that she faced for her handicapped son that led Antonie Moradel to create her association *Un Sourire pour l'Espoir* (USPE) in 2003. Moradel's son is severely handicapped due to a cerebral anoxia that occurred at his birth. According to Moradel, she was unwilling to accept the doctors' affirmations that her son would never be able to walk or have any autonomy; so she went in a search for alternative therapies that led her to multiple countries. While her son, Aris, remains in a wheelchair, he is now able to walk and has gained significant mobility and additional autonomy as a result of the complementary therapies he received with his mother abroad. As a result, Ms. Moradel created the association USPE in order to provide accompaniment and support for other families faced with caring for handicapped individuals. When asked, she explains that she began noticing that many families with handicapped members were unsatisfied with the lack of available medical and social care options in the French healthcare system. While many of these families went abroad looking for alternatives like Ms. Moradel, other families cannot afford to do so. As such, she is working to make USPE a structure that brings together various complementary care options and makes them available for as little money possible in order to handicapped individuals and their families. To these ends, USPE recently opened its own therapy center, *La Maison de l'Espoir*, with the goal of regrouping different complementary therapies from all over the world that are not currently available in France; thereby facilitating access to them for those in need. It is of note that all of the actions pursued by USPE are focused on helping to improve the autonomy of handicapped individuals, not to cure them of their conditions. Thus, we can see that the care component that Ms. Moradel is providing goes well beyond conventional medicine's role of addressing an individual's disease or illness. It also goes well beyond the doctor's perceived role of evaluating, diagnosing, and treating that disease or illness. Rather, Ms. Moradel intention is to improve the overall quality of life for handicapped patients and their families, especially when conventional medicine or its practitioners are unable or unwilling to do so. To these ends, USPE is working to offer diverse complementary therapies for handicapped

individuals such as music therapy, equine-assisted therapy, dance, theater, biofeedback, neurofeedback, shiatsu, and light therapy.

Furthermore, and of particular relevance to this paper, USPE is actively working to build and strengthen networks between families caring for handicapped individuals. According to Ms. Moradel, this is intended to help them by, "bringing them out of the isolation that comes from being excluded by society" (2015). Doing so not only helps to raise the visibility of handicapped individuals and their families, it also brings families into a network in which they can share their good and bad experiences with different complementary practices. Ms. Moradel told me that this is incredibly important, since in the absence of the acceptance and scientific evidence for the effectiveness of many complementary therapies, families often have to make decisions on what therapies to pursue based on reputation alone. To do so, many look to online forums and chat groups, which Ms. Moradel said can provide very mixed accounts of a given complementary therapy. Since in many cases, such as Ms. Moradel's personal experience, families must take their handicapped members abroad to try expensive therapies at great cost, she hoped the *Maison de l'Espoir* would help make it easier, more accessible, and less expensive for families to try complementary therapies. She also hopes that bringing families together into a sort of network will help advance the reputation of good therapies so that they will eventually be recognized and reimbursed by the French health insurance for handicapped individuals. During the scientific committee meeting for USPE, Ms. Moradel summarized this all by saying:

> "I had heard about biofeedback in other countries, but it didn't exist yet in France, so I was able to take Aris abroad so we could try it. Eventually, we ended up at a center in Miami and it is remarkable how much it improved Aris. I had results in one week that were so good we were able to take off his back-brace, but not everyone can afford to go to Miami and sometimes the therapists that come to France are too expensive. For example, I've heard good things about a Brazilian therapist who comes to France occasionally, but it's 70 euro per session and that's too expensive. I want to put various techniques together for a good price. Once we start practicing, we can do research on them and then we can try to get these practices recognized" (2014).

Thus we can see that in addition to working to create a network and improve the visibility of handicapped individuals and their families, Ms. Moradel is also actively promoting the structuring of scientific research and the evaluation of complementary therapies. The USPE scientific committee is comprised of different healthcare professionals, doctors, and researchers. At the scientific committee meeting I was invited to attend in late 2014, the focus was on the upcoming opening of the *Maison de l'Espoir* therapy center and on their advancements in researching biofeedback. Ms. Moradel emphasized the lack of biofeedback's recognition and reimbursement in France. She shared her experience with her son's biofeedback in the United States and her amazement to see him dramatically improve after only one week of intensive sessions. Following her discourse, there was general agreement among the scientific committee that the American biofeedback practitioner that Ms. Moradel brought to France should continue practicing and training a full-time practitioner in France. Furthermore, they decided that they would continue providing biofeedback treatments and that they would conduct research on biofeedback in tandem with an intention to raise the visibility of biofeedback research. The committee confirmed their plan to produce a study on biofeedback within two years and then discussed the best way to organize the plethora of practices that would be offered in the *Maison de l'Espoir* therapy center. This discussion is interesting because it brings to light the exact same dynamics that have

characterized all of the efforts we have seen throughout this chapter; different agents across the conventional-complementary spectrum are all working individually to raise the visibility of various complementary practices in tandem with the creation, fortification, and extension of interest networks. They are working to structure training, education, and research in these practices; and to promote the legitimacy of these practices with a specific emphasis on seeking financial support for them in one form or another. Furthermore, in this particular case, USPE is working to bring together a variety of complementary therapy options in one place and to make it as cheap and feasible as possible for families from around the world to come to this center with the hopes of improving the autonomy of their handicapped loved ones.

Two of the therapies that are offered by USPE are the biofeedback technique practiced by American Biofeedback Practitioner D and the myotenofasciotomy technique[71] developed by Doctor Z. While I was waiting in the lobby to shadow Practitioner D and Doctor Z in their on-site consultations, I spoke to a handicapped individual waiting to see Doctor Z. She told me that after being diagnosed, her doctors told her that there was nothing they could do and that she just had to "accept my condition" (2014). As a result, she went to go and see Doctor Z in Spain and after four months her condition was "much, much better." This patient told me that she had discussed both Doctor Z and his procedure with her neurologist before going and that, "He told me not to go, but I went anyway" (2014). In fact, Doctor Z's procedure worked so well she told me she wanted, "to go see my old neurologist and show him how well it worked, because my doctors offered absolutely no support of any kind" beyond saying that she should just "accept it" (2014).

I found this case in the waiting room notable, because I heard the same thing from a different family that same day. That afternoon, I sat in on one of Doctor Z's consultations with the family of a five-year-old girl who is in a wheelchair with spastic muscles that prevent her from walking or standing. During their consultation, this girl's family also said that, "Her doctors told us that there was nothing to do except to accept that she'd be in a wheelchair her whole life, but she wants to walk" (2014). They explained that in light of their daughter's desire to walk they continued seeking other therapeutic options and that they had seen Biofeedback Practitioner D for the first time that same morning at USPE. They said that it was on Biofeedback Practitioner D's recommendation that they were now consulting with Doctor Z, even though they were skeptical of both techniques because, "Our doctors and our daughter's special school staff told us not to do this. They asked us why, if this all works so well, it isn't practiced or promoted in France" (2014). According to Biofeedback Practitioner D, the reason she recommended that this family consult with Doctor Z was because:

> "They were going to start giving her Botox injections in a week and I strongly advised against it because [Botox] only works temporarily, so it must be done every six months forever, and its toxic- it causes kidney problems later. I really feel that between biofeedback and Doctor Z's procedure we can get this girl to walk, obviously she'll always have brain damage, but at least she'll be able to walk. Also, you know, the doctors haven't been able to diagnose her, they say it's a genetic anomaly, but anyway, biofeedback can teach her how to use her front muscles instead of her back muscles. It's unbelievable how often French doctors seem to say there's nothing to do except to 'accept it,' they promote no alternatives. I know the family is skeptical and it's entirely up to them, I just

[71] Myotenofasciotomy is a minimally invasive, out-patient surgery developed by Doctor Z. It involves making small percutaneous incisions severing shortened or dystrophied fibers of the fibrous tissue in fascias, muscles, tendinous tissue, and other tissues due to the excessive contraction or spasticity following brain injury.

wanted to give them the information- although I'd really like to help her to walk, but they can always try Botox and see" (2014).

Four months after this visit with Doctor Z and Biofeedback Practitioner D I returned to USPE for another round of their on-site consultations. In both cases, I was surprised to hear similar stories of patients and their families being told that there was "no hope," that there was "no help" that could be given to them, and that they should just "accept" their loved ones' conditions. Likewise, in multiple instances families were told that Botox injections were the only possible therapy available. In one case that I sat in on, the family recounted the saga of their daughter's diagnosis with Lupus. According to her family, "One doctor didn't even know what that was, it took six months of doctors for us to even get a diagnosis and then we get a doctor that doesn't know what it means" (2015). The family explains that eventually, doctors did propose Botox injections for their daughter, but they decided to go to Spain for Doctor Z's surgery instead. They said that the results were so good their daughter's re-education center became interested in what they were doing, "They want to know about it but they won't recognize it since there's no publications on it and they keep recommending Botox" (2015). When I asked Doctor Z about this he confirmed that, "In France, for most cases of muscle spasticity they want to do Botox injections, but they're expensive- they're 1000 euro per shot- and they require repeated use, also it does put a serious toxin in the body" (2015).

What struck me most about the consultations I sat in on with Biofeedback Practitioner D was the nature of the families' motivations. Listening to their stories and concerns, it seemed clear to me that most of them have effectively "accepted" their loved ones' conditions. Throughout my fieldwork at USPE, I spoke with or observed consultations with approximately 20 different families and not one of them ever said that they were searching for a miracle cure. Rather, they expressed hope for the simple autonomies that most of us take for granted on a daily basis. In most cases, these patients and their families just hoped they might be able to turn over in bed by themselves, to make it through the night without muscle spasms, to hold themselves upright, or to take even one step. These families were looking for small triumphs or improvements with the potential to dramatically improve their daily lives; like being able to make it through a night without having to wake up to help their child roll over in bed or rush to the emergency room for intravenous medications in order to calm muscle spasms preventing them from breathing. As such, I was surprised by how many families reported that their doctors had "given up" trying to help their children resorting to the just "accept it" attitude that almost all of the families I spoke with experienced. Frankly, while I understood this conventional medical attitude within the context of the 'one-size-fits-all' organization of the healthcare system; hearing these handicapped children and adults saying that their doctors told them just to "accept" the realities of their debilitating conditions and to give up hope for even the smallest of improvements that can dramatically ease their suffering in their daily lives sounded terribly uncompassionate. The more time I spent with them, the more I understood why they were willing to go anywhere and try anything if they thought it could ease their suffering, even a little. The more of these stories I heard, the more I understood why USPE has grown to its current international proportions; with patients and practitioners coming to France from different countries and French patients going abroad with the coordinating assistance of USPE's practitioners. Furthermore, the more time I spent with these patients and their families, the more Ms. Moradel's personal quest to help her son make even minor improvements began to appear not as a single fight, but as part of a larger pattern; a pattern that she is actively working to transform into a network.

In only two cases did I hear of physical therapy centers or special schools that were aware of and accepting of a family's recourse to complementary therapies at USPE. In this sense, it is of note that all of the practices that are integrated into USPE's activities are approved by its scientific committee and all of them are non-invasive. While in some cases families were advised against using the specific treatment of repeated Botox injections, they were never told to abandon conventional medicine or their conventional medical treatments completely. All of the complementary treatments and practitioners that I observed at USPE were presented as compliments to, not replacements of, conventional medicine. These complements were related to possibilities for improving one or multiple aspects of patients' conditions as a means of helping to improve their overall autonomy or to ease some of their suffering, even if only in small ways. It appeared as both Biofeedback Practitioner D and Doctor Z were both realistic and honest about the expected outcomes that their treatments could potentially bring; they seemed to be open about the limitations of their treatments and in several cases explicitly told families that their expectations were unrealistic. In this sense, I feel it important to recall the discussion about complementary medicine and its potential to prevent patients from seeking proper conventional care. Here, however, we see cases that go beyond the conventional medical ability to ease suffering. Instead, patients and their families are being told just to "accept" that there is nothing to be done. Rather than giving them alternatives, or even hope for small improvements, these handicapped individuals are placed into a long-term conventional care structure that, according to various patient families, is sometimes characterized as a maintenance option with no potential for improvement.

When I thought about this in the face of families' simple hopes for a step, a communicative sign, or even rolling from the left to the right side; it became clear that in addition to the "pull factors" for complementary medicine that are embodied in its growing demand and popularity, there are also "push factors" that are coming from within conventional medicine. These "push factors" most often appeared when an illness or condition involved the types of long-term or incurable conditions that were spoken about in the Essonne meeting of the ARS. In these cases in particular, once the limits of conventional medicine were reached, healthcare professionals told patients that there was nothing more that could be done and just to "accept" the inevitable and give up hope for any improvement. According to what I observed at USPE, this seems to push families and patients of this kind directly into the world of complementary medicine. In this light, Ms. Moradel's case begins to resemble the other cases that we have seen throughout this chapter, she recognized that she was not the only parent willing to go anywhere and try anything if she thought it could help give her son more autonomy. As such, she began working to both structure and to raise the visibility of various complementary therapies and their potential to improve the autonomy of handicapped individuals. She used her personal network as a means of raising interest to the point where she achieved the critical mass necessary to start the association USPE and to receive some funding. Once this happened, she began structuring trainings, education, and outreach as a means of furthering the reach and strength of her network. Again, once she had raised enough visibility, she was able to get enough funding to open her therapy center, the *Maison de l'Espoir*. Additionally, Ms. Moradel's network now spans multiple international borders including both patients and practitioners from various countries. This was evidenced by her affirmation that she specifically chose complementary therapies that are "not available in France" as a means of bringing together different therapies from different countries into one place and working to make them as accessible as possible. Thus, here we again see the same international self-organization dynamic in which in the absence of any national or international directive, practitioners from different countries are watching the complementary medical developments in other countries and making efforts to work together.

I found a fascinating parallel to these trends within my interactions with Eurordis, a European alliance of rare disease patient organizations that works to improve the lives of the 30 million people living with rare diseases in Europe- diseases affecting less than 1 in 2,000 people. There are currently approximately 6,000 rare diseases in Europe, however Eurordis Director Y told me that Eurordis was created in 1997 when:

> "Some European lawmakers realized that […] there was a need for a special economic case to favor the development of medicines for small populations and rare diseases are defined by small populations, which is really an obstacle to everything- they have few experts because clinicians, doctors, students don't necessarily imagine that they can base their careers on rare conditions. Industry is rarely interested because until that time they did not see how they could make profit selling products in small populations […] The care pathways for patients with rare conditions are not optimally organized and patients simply didn't know where to find experts- even when experts existed- plus the case when no experts existed" (2014).

According to a closed Eurordis meeting I attended, in practice this most commonly translates into delayed diagnosis, long wait times for specialists, a lack of access to specialists when they exist, the lack of medications, limited or non-existent treatment options, and a lack of knowledge among healthcare professionals. In other words, rare diseases are also largely invisible in conventional healthcare systems; namely because there is not a critical mass of affected patients that is large enough to be of financial interest to the healthcare industry. This is evidenced in the above discourse given by Director Y, in which he outlines the lack of interest in rare diseases among "clinicians, doctors, students" as a result of their career ambitions. Director Y explicitly cites the general lack of interest in the pharmaceutical industry as a result of the limited financial returns on rare disease medications and then goes on to identify the sub-optimal organization of "care pathways for patients with rare conditions." As such, the Eurordis mission is to work across borders and diseases and to improve patient care throughout Europe. According to Director Y, one example of this role is addressing a problem that is common to all their member states:

> "Issues with cross-border care, care is not available in their country, but is available in another country- in theory. According to the law they can ask to be treated in the other country and still be covered in the member state where they are affiliated, but it doesn't seem to be working […] So this is what we need to analyze now, to make proposals in member states to try to solve the difficulties, knowing that the set of difficulties that we received is only part of the iceberg- but […] when you can solve the situation or difficulty for one patient you can apply the solution to all patients and then help many more patients based on only one report of a specific difficulty so […] Then we analyze in each country if there are issues that are specific to the country and then with local actors and local organizations we make reports to empower local organizations so that they can negotiate with local authorities to solve the issues that we have highlighted" (2014).

I found this quote to be relevant to the context of this section because it acts as an interesting parallel to the activities of USPE, which is also attempting to organize cross-border care for patients with motor handicaps. Here, when care is not available, Eurordis works with patients to assist them with the organization of their care in other countries. In order to do so, it leverages local networks of patient organizations and associations, helping

patients to work with these groups. In other words, Eurordis works by strengthening and structuring local patient representative groups in order to increase both their visibility and the visibility of specific difficulties faced by rare disease patients. Doing so "empowers" these groups so that they are able to "negotiate with local authorities." Not only is this a parallel to USPE's work to bring therapeutic practices to France and to assist families both to come to France and go to other countries for therapies, it is also an echo of the same dynamics that we examined in the previous section. In that section, we saw that complementary medicine organizations were mobilizing in order to address the professional difficulties faced by their practitioners as a result of a lack of national interest in addressing their professionalization. Here, we see the mobilization of patient organizations as a means of addressing the care difficulties faced by rare disease patients as a result of a lack in national interest in optimizing the care pathways for these patients. While it is important to recognize that here we are discussing the organization of care for rare disease patients rather than the organization of complementary practices, I find it significant that the underlying dynamics driving both of these movements are the same: strengthening and leveraging individual networks to raise visibility, attempting to structure and optimize education and training, and attempting to promote the financial incentives for integrating the practice, or in this case disease, into the national healthcare system.

Furthermore, in addition to displaying evidence of these same underlying dynamics, rare disease patients also have an interest in various forms of complementary medicine; just as in the cases of the other non-curable conditions that we have looked at throughout this chapter. Director Y explained this by saying:

> "Whereas often in alternative medicines there is a reluctance to apply scientific methods to evaluate them, even though there are large numbers […] There are other situations where the disease is so severe and the prognosis is so poor that evaluated or not- or even evaluated and evidence says it's too dangerous or not efficient- people will still try, even if it has a huge cost […] We don't know exactly to what extent people are willing to do anything they can […] and [rare disease patients] have listed something like 15 different types of care which are not at all evaluated that doctors themselves prescribe […] or that they don't want to prescribe but patients still access them. We realize that this is the case in many, many rare diseases so our intention is to conduct research on a certain number of rare diseases to try to quantify the frequency of that kind of use. We call it the therapeutic behavior of patients who have […] no efficient option- or sometimes they have a treatment which is more or less satisfying but they still want to do something more- so we'd like to document the frequency of this kind of access to not-yet-validated care that encompasses natural medicine, alternative medicine, traditional medicine, complimentary medicine and others" (2014).

Thus, here we again see that just because the limits of either conventional medicine or the healthcare system are reached, patients will not necessarily just "accept" that there is nothing more to do and live with their condition. Director Y confirms that in "many, many rare diseases" patients are ready to use "not-yet-validated care" no matter if it has "a huge cost" or if it has been evaluated and shown to be "too dangerous." This quote acts as the direct confirmation of the fears that were raised by the Representative of Miviludes in the previous chapter. When faced with a severe or debilitating disease that conventional medicine cannot easily remedy, patients and their families are willing to go just about anywhere and try just about anything if they think there is even a remote possibility for it to help them. Nevertheless, just as we saw in the previous case of handicapped individuals, often this is not

the exclusive result of the "proselytizing" pull of complementary practitioners. Rather, here we see that in some cases where the nature of the illness places it beyond the reach of conventional medicine's treatments, "doctors themselves prescribe" or push patients into complementary medicine; either out of a desire to help patients or an unwillingness to recommend anything beyond the limits of conventional medicine.

Indeed, according to Eurordis' Preliminary Results of their Survey on Complementary and Alternative Therapies (2017), 9 out of 10 rare disease patients among the 1,900 surveyed reported the use of at least one complementary therapy; the vast majority of which included physiotherapy and massage or dietary supplements. Eurordis found that their survey results indicated a "significant interest" in complementary therapies and that the overwhelming majority of rare disease patients using complementary therapies got information about those therapies from their medical "doctor/center" (Eurordis, 2017). This is what Director Y meant when he referred to the "types of care which are not at all evaluated that doctors themselves prescribe" in the quote cited above. Less than 20% of those surveyed found that complementary therapies had a negative effect and 68% reported that their complementary therapies had either a "very significant" or "fairly significant" impact on their household budgets (Ibidem). This finding supports Director Y's assertion that, "people will still try, even if it has a huge cost." Two of the rare disease patient quotes that were included in the Eurordis complementary medicine survey also act as implicit supports for the efforts that USPE is making to bring multiple complementary therapies into one, accessible therapeutic center. Specifically, a woman from Poland said that, "The problem is that even if we find something it is very expensive;" and a woman from Hungary said that, "I was treated during 13 years with the Dévény Gymnastics Method…However, I am no longer treated with it because there are few professionals that know this method in my country, and I need the treatment" (Cited in Eurordis, 2017, p.17).

In light of these findings, both Eurordis itself and several of its associated organizations are emphasizing the need to collect data about what complementary practices rare disease patients are using, what their experiences are, what issues they face with reimbursement or payment for these therapies, what factors are influencing their choices from among the plethora of complementary therapies available, and general calls for research on complementary medicines. Director Y described this in terms of the complementary medicine survey that has been cited several times within this section, but that was still in development at the time of our interview. Nevertheless, I feel as though it remains useful to analyze his description of this research project:

> "We'd like to document the frequency of this kind of access to not-yet-validated care […] and see which sources of information doctors use when they prescribe these products, what kind of information patients could use when they wish to learn more on this, and which kind of ICT tool to help getting information or asking questions or documenting on the positive or the negative aspect and cost aspect of this kind of treatment. Plus, a sociologist proposed that we sort of analyze the different behaviors that patients may have- some who are always willing to take any risks and try anything, those who will first wait for the first category and then decide, or with more information will decide, and the other category, the followers that simply follow the direction of the wind. So they're interested in categorizing patients according to their behaviors in these situations. The idea is if patients are willing to do things anyway then there is no need to try to better inform them, whereas if they are more hesitating and would like to first have the information and then decide, then there is a rationale to do everything we

> can to give them the information they need or to generate that information" (2014).

Like much of what we have seen throughout this chapter, this rhetoric again emphasizes the need to structure research on complementary medicine according to both rare disease patients' sources of information about different practices and the factors that go into their decision to pursue a particular treatment. There are several particularly important aspects included in this discourse. First, notice how Director Y cites doctors at the beginning of his discourse, thus placing a primary importance on investigating the factors that are influencing doctors' decisions to recommend complementary treatments to rare disease patients. This acts as a nice counter-weight to the multiple citations throughout this section of doctors telling handicapped patients that there is nothing more to do beyond "accepting" their condition. Instead, here we see that in the case of rare diseases, where conventional treatment options are often scarce or non-existent, doctors are recommending complementary treatments. Additionally, this adds even more nuance to the frequent identification of patient demand as the main driving factor behind the growth of complementary medicine, by showing us that it is an overly-simplistic reduction. However, it is important to recall that Eurordis research is Europe-wide and thus, not exclusively in reference to France. Unfortunately, I was unable to obtain the country-by-country breakdown of this particular finding. Nevertheless, considering that the medical "doctor/center" response as the primary source of information for complementary medicine was cited more than twice as often as any other sources in the Eurordis survey; I feel that it is safe to assume that this reply must have also been significantly included in the responses collected from rare disease patients in France.

Secondly, it is of note that following his remark on the need for collecting information on the factors determining doctor recommendations, Director Y immediately cited the need for determining what type of "ICT tool" could be used to promote the sharing of information on complementary medicine use throughout Eurordis' massive network including 810 rare disease patient organizations from 70 countries. Within the context of this thesis, this is particularly notable because it acts as yet another example of the potential that promoting, structuring, and sharing research can have in advancing a sort of international standardization in complementary medicine. According to Director Y, this standardization is needed, because without it there are country-by-country differences in the accessibility of different complementary treatment options:

> "In alternative medicines […] there are exceptions, for example there are vitamins which are reimbursed to treat some rare diseases because they could be scientifically evaluated and there are cases in between where everybody assumes there is a benefit, but it has not been tested so in some countries it's reimbursed and in others it isn't" (2014).

Thus, we see that in the particular case of rare diseases, having a minimum international standard for information on complementary medicine could ameliorate access to care. Again, this gives us a different perspective on the same issue that USPE is working to address. In this case, Eurordis is actively working to raise the visibility of complementary medicine use throughout its network as a means of both promoting and structuring complementary medical research. This is having an effect that is enhancing the international dynamics of complementary medicine. For example, the subject of rare disease patient use of complementary medicine was raised at the 2017 Eurordis Membership Meeting in Budapest. This meeting was attended by Dr. Ali Davoudian, the Managing Director of the Rare Diseases Foundation of Iran, whose foundation published a summary his experiences at the meeting on

their website. Included within Dr. Davoudian's summary was the remark that, "It is urgent to collect data about [complementary medicine], share experience and work towards a strategy to generate research and robust knowledge on [complementary medicine]" (Rare Diseases Foundation of Iran, 29 May, 2017). Thus, we again see evidence of the network dynamics that are shaping complementary medicine as a category internationally, as well as additional evidence of agents watching what agents in other countries are doing as a means of deciding what to do about complementary medicine in their own countries.

In this context, it is important to underscore Directory Y's division of patients into three groups: those that will "take any risks and try anything;" those that look for "more information" either from "the first category" of patients, or from other information sources; and those that "follow the direction of the wind" and will try whatever seems to be the overall trend. In other words, we see that not only are different countries watching and following one another in advancing complementary medicine, rare disease patients are doing the same thing. In order for this to occur, it means that there must be networks established between rare disease patients in addition to the networks that Eurordis is creating among rare disease patient advocacy organizations. Thus, we see that information about complementary practices is circulating on multiple levels going across continents within networks of individual patients and doctors, local patient associations, and international organizations. This creates a multi-dimensional interest in complementary practices for rare disease patients that cannot be reduced to a simple bottom-up flow in patient demand. Eurordis and the organizations within its vast network are promoting complementary research as a means of improving care for rare disease patients who are often left on the fringes of the conventional medical gaze. Using the language of this thesis, they are advocating the structuring of complementary research related to rare diseases and mobilizing their network as a means of raising the visibility of complementary therapeutic behaviors. The hope is that this structuring will lead to enough visibility to allow patient advocacy groups in different countries, such as France, to lobby for reimbursements for specific complementary treatments in the case of rare diseases. Since Eurordis is an international organization, this movement is having international reach that goes well beyond the confines of Europe.

On a more local level, I also found evidence of these same individual self-organization and network dynamics occurring, in a more informal sense, among the clients that came to Shaman C. Throughout my participant observation with Shaman C, there were two elements in particular that repeatedly struck me. The first was that a significantly large number of his regular clients were themselves practitioners of a variety of different complementary practices. Many gave "energy treatments" using various forms of magnetism, massage, reiki, sounds, and/or dance. Many practiced as shamans, or mediums, and a few as exorcists, or clairvoyants. Many practiced, taught, or were actively involved in associations for practices including reflexology, osteopathy, sophrology, shiatsu, tai chi, qi gong, and hypnosis. Some of the practitioners that came led their own groups of followers or were members of groups that followed the teachings of a guru or the practices of a specific sect. Additionally, a few claimed to work with their clients using the divinities of various traditions, angels, nature spirits, dragon spirits, and/or fairies. The second thing that struck me about Shaman C's clients was the rapidity with which information would circulate among them. For example, when Shaman C would announce a change of address; within a few days to one week the majority of his "regular" clients would know about it, even if they had not yet come in for a session since the announcement was made. When taken together in practice, both of these aspects indicated that there was a dense informal network and self-organization that was in place among Shaman C's clients. As such, I feel that it is important to attempt to describe and

analyze the dynamics surrounding this network; as in many ways, they resembled the dynamics and emergent patterns that we have repeatedly seen throughout this chapter.

When I asked these complementary practitioners why they came to see Shaman C as clients, all of the responses that I received involved their seeking self-care in relation to their own complementary practices. Thus, some came to receive "energetic cleansings" or a means of cleaning and re-balancing their own energies after working to "cleanse" the energies of their clients; others came to work on an issue that surfaced as a result of their practice, such as the emergence of a bad memory; and still others came to work on their personal issues in order to advance their competency as an energetic practitioner. These issues often involved family or childhood-related traumas, emotional difficulties, or difficulties with the client's professional advancement as a complementary practitioner. I found it of note that none of Shaman C's complementary practitioner-clients came in order to work on a technical aspect of their practice; although in one case, there was a woman who claimed to be able to see the auras, or personal energy fields, of individuals. She came repeatedly over the course of a year in order to observe and make sketches of Shaman C's practices and told me that doing so was improving her ability. At the end of the year she gave Shaman C a copy of her completed sketches and stopped coming. This was the only instance of a complementary practitioner coming for their own "technical advancement" that I encountered over the course of the three years I spent in Shaman C's practice. I found this to be particularly interesting, because rather than coming to advance their techniques, most of these practitioner-clients were coming for treatments for "energetic blockages or imbalances" that do not exist in conventional medicine. Nevertheless, it seemed as if many of Shaman C's clients who were themselves practicing a diverse collection of spiritual or energetic techniques were coming for treatment for this specific malaise.

It is of note that while "energetic blockages or imbalances" feature in the ontologies of various complementary practices such as Traditional Chinese Medicine, Ayurveda, yoga, tai chi, qi gong, shiatsu, reiki, magnetism, and kinesiology; many other complementary practitioners had also integrated this notion into their personal conception of their practice including osteopaths, sophrologists, reflexologists, and different spiritual healers. This adds more nuance to the discussion of the disembedded nature of complementary practices. Specifically, it sheds more light on how this creates a dynamic in which people are able to integrate these disembedded practices into their personal belief systems. As these practitioners interact and exchange with one another and their clients, it fosters interest in these hybridized conceptions. My fieldwork in the context of Shaman C's practice indicated that the self-organizing network dynamics that occurred among his clients facilitated the permeation of these hybridized conceptions into the wider community of practitioners in a given practice. As such, it is useful to further explore these dynamics within the context of Shaman C's practice.

Among his complementary practitioner-clients, I noticed the presence of a network between them that grew denser over time. I felt as though this was facilitated by the organization of Shaman C's practice. This is because Shaman C always made sure to have a waiting area in which clients could enter and prepare for their treatments. Following their treatments, the waiting room served as a sort of intermediate area in which they were offered a cup of tea and a space to take a moment before returning to their daily lives. On busy days or when there was a "fortuitous meeting" of clients, this waiting area resembled a tea house in which clients would sit, sometimes for hours, sipping tea and talking with one another. Since I was generally positioned in this waiting area, I had many opportunities to listen to these discussions and I began to notice patterns emerging in the inter-client dynamics. For example, I noticed that the complementary practitioner-clients would often discuss both their practices

and the techniques or reputations of other practitioners with each other. Many of them either knew one another when they came in or got to know one another over time. In this sense, many of Shaman C's clients would make arrangements among themselves to come at the same time so that they would meet each other in the waiting area.

Over time, I began to recognize that some of these practitioner-clients would use the waiting area as a place to network, pass out their business cards, and to get new clients for their own practices. In some cases this occurred passively by their meeting another of Shaman C's clients who spontaneously spoke about an issue that their technique could help with. In other cases this was an active strategy in which practitioner-clients would remain in the waiting area in order to strike up conversations with those around them and to advertise themselves and their practices. In this context it is of note that many of these practitioner-clients came to Shaman C as a result of the recommendation of another one of his clients. Thus, there was a lot of cross-pollinating in which practitioner-clients would recommend that their own clients come to Shaman C for a complementary treatment and then would hang around Shaman C's waiting area in order to try to incite his clients to come to them. Shaman C made no attempt to either encourage or discourage this behavior and would generally avoid the waiting area as much as possible. I also noticed that the waiting area was used by clients as a meeting space in which they would discuss the development of ideas and projects. Sometimes these exchanges led to the spontaneous self-organization of a group of Shaman C's clients who would all go to another complementary event together. On multiple occasions this event involved a conference or one of the complementary trade events that were discussed in Chapter 2.

These dynamics resulted in the emergence of what appeared to be a loose, self-organized "community" of both clients and practitioner-clients. This is because as clients began to recognize one another due to their repeated meetings and exchanges in the waiting room, their individual networks began to develop links and overlaps between them. Often I heard conversations in which clients identified a person that they both knew from the context of a different complementary practice. This took on the contours of a self-organized community in which multiple clients began coordinating their complementary interests and activities. For example, many of Shaman C's clients actively spread information promoting the events or activities of other complementary practitioners. One of the best examples of this occurred each year when the Indian spiritual leader, Amma[72], came to France; I would hear about it being discussed in the waiting area before, during, and after Amma's visit. Shaman C's clients would plan their participation so that they would meet, inform other clients about the Amma event, share stories from their past experiences at Amma events, and answer other clients' questions about it. As such, I heard multiple new clients in Shaman C's practice tell me that they had heard about Shaman C while visiting Amma and vice versa. The same was true for the complementary medicine trade events. Anytime one of these events would occur, many of Shaman C's clients would attend, meet one another, bring flyers, and share

[72] Amma is an Indian guru who travels the world giving hugs to people and leading chants and meditations. She is revered as a saint by her devotees and she comes to France each year for two programs of three days. Approximately 50,000 people come to see her during her stays in France and the free, three-day event is organized entirely by more than 1,000 volunteers; including food and a variety of different side-events. Amma has a network of charity organizations that operates in 40 countries providing food, housing, medical services, and education for the poor (www.etw-france.org). This is interesting within the context of this thesis because it acts as additional evidence of the potential international reach that an individual's participation in complementary medicine can have. It is also a parallel- of much larger scope- to Shaman C, because in both cases all of their activities are organized by groups of volunteers, involve treatments en masse, and conduct programs including meditations.

information about it with other clients coming to see Shaman C. I also saw these same self-organizing and networking dynamics occur in relation to complementary conferences, workshops, and trips.

With this in mind, it is important to take a moment to describe Shaman C's advertising strategy. While Shaman C did advertise his activities on social media sites such as on his Facebook page, this was the only advertising he did. The overwhelming majority of his clients came from word-of-mouth or the recommendations of those who had heard about him or visited his practice. This is precisely how I first heard about Shaman C. One of the doctors I was interviewing told me that he had heard about a shaman in Paris with a good reputation and thought it might be interesting for me to meet him for my research. This doctor handed me Shaman C's card, which he told me one of his patients had given him. To these ends, Shaman C would always provide flyers with the dates and addresses of his activities in Paris that clients could take with them and pass among their contact networks. Shaman C came to Paris once a month for approximately ten days. Anywhere from 30 to 150 of these flyers would get taken by his clients each month and many new clients came with these flyers in hand. It is of note that in Paris Shaman C saw an average of 30 clients per day, gave approximately 200 treatments per month, and received an average of 25 new clients each month. Each month before coming, he would send an email announcement with the dates, activities, and addresses for that month to a list of approximately 1,400 clients. This gives an idea of the scope of Shaman C's practice and the density of the network among his clients in Paris.

One of the key factors that enhanced the self-organization of a network among Shaman C's clients was linked to his use of multipurpose spaces available for rent in the Paris area. Over time, I saw that there are a limited number of available multipurpose spaces that are open to complementary activities in Paris. As such, whenever Shaman C would change to a new space many of his clients discussed the different complementary events they had attended at one of these spaces, what they had heard about the space from others who had used it, the space's overall reputation, or the events they had sponsored in one of these spaces. As a result many of these multipurpose spaces became hubs of complementary activity hosting diverse practitioners in dance, music, yoga, energy practices, workshops, and complementary themed conferences. With this in mind, many of these multipurpose spaces provided an area for practitioners to leave their flyers, advertisements, and business cards. While all of the events held in any given space were independently organized and separate, the common use of these spaces turned them into points of reference which seemed to reinforce the links between Shaman C's clients.

For example, at one point when Shaman C announced that he would be moving his activities to a new space, I heard Client C and Client L have an animated exchange about what practitioners they had visited in that space and what conferences they had attended there. They both agreed that the space was well-situated and well-lit, but had heard that the proprietor could be troublesome for complementary practice renters. This conversation gave them a shared point of reference that resulted in a larger discussion and their exchange of phone numbers. After that, Clients C and L began to come to many of Shaman C's events together, which further reinforced their connection and by extension, the overlapping links in their respective personal networks. In another instance, a workshop participant using a different room of a shared space picked up a flyer for Shaman C during her break and then became one of his regular clients. On multiple occasions, Shaman C's clients would enquire about the price and availability of the space he was using and tell me about the event or activity that they were interested in organizing there. In my own case, I was surprised to find

that one of the "sacred sound" circles I attended in the context of my fieldwork took place in one of the spaces that Shaman C had previously used. When I told this to the person who brought me to this event, the organizer of the circle overheard and asked us about Shaman C. She eventually became one of Shaman C's relatively regular clients saying that it was because she did energy therapies and needed someone to clean out the "negative energy" that she "picked up from her clients" (2016). Taken together these anecdotes indicate that these multipurpose spaces with an openness to complementary practitioners are developing their own reputations and acting as links in the loose self-organized networks that I encountered among Shaman C's clients. This implies that there are links between the networks of complementary practices and practitioners in a given location. It also provides nuance to Doctor R's discussion of the "fortuitous meetings" that led to his integration of a given complementary practice into his DU and DIU. Here, as practitioner networks grew, there were mutual recommendations of practices and practitioners. In this sense, it was not uncommon to hear one of Shaman C's clients tell me that they were also receiving treatment or practicing the complementary technique of another one of Shaman C's clients.

This implies the presence of a self-organizing pattern forming among complementary practitioners, their clients, and the spaces available for their shared use. Thus, as Shaman C's clients sat in his waiting room and exchanged information about their practices and their experiences with different spaces and practitioners, business cards and phone numbers were exchanged as connections were made. I found it incredibly interesting that their exchanges were a direct echo of the kinds of information that were included in a Eurordis presentation to its 2017 Membership Meeting in Budapest (Houÿez, 2017). Specifically, I heard Shaman C's clients discuss the emotional pressures that their families and friends imposed on them as a result of their complementary medicine use; their compliance and non-compliance with medical recommendations; their uncertainty about the progression of their various conditions; and in some cases, the illegal procurement of complementary products. This implies that whether people are using complementary medicine as a form of care for their rare disease, their motor handicap, or their "energetic cleansing," they all may face negative consequences associated with the stigmas and stereotypes surrounding complementary medicine as a category.

Nevertheless, my fieldwork experiences indicate that complementary practitioners and consumers are banding together and spontaneously organizing themselves into different networks. This seems to form very loose and informal communities that grow denser as interest and exchanges among complementary practitioners increase. These communities are characterized by networks of individual complementary practitioners and the overlaps and links between them that emerge through their interactions and exchanges with each other in a collection of spaces that are available for their use. These emergent patterns provide impetus to the self-organization of complementary practitioners, which then further strengthen the links and overlaps between their networks. While they are all very different, the cases that have been examined in this section shed light on the same dynamics. In all of these cases networks, links, and exchanges go from the local to the international levels. Furthermore, it is of note that all of the cases presented in this section intersected in the context of Shaman C's practice. This is because both a practitioner from USPE and a rare disease patient were among Shaman C's clients.

I found it incredibly interesting that the three cases examined within this section appear to act as parallels. Despite their different concerns and perspectives, all three display evidence of the same dynamics: using networks to increase visibility; promoting the structuring of research and information-sharing; promoting the accessibility to complementary

practices; and ultimately attempting to raise the interest in different complementary practices to give them legitimacy, and by extension, funding. In this sense, the cases throughout this chapter have repeatedly shown us that the interest in complementary medicine in France is growing in an uneven, multi-directional, multi-level fashion that spans scales ranging from the individual to the international. We have seen that there are both pull factors coming from complementary medicine and push factors from within conventional medicine that are enhancing the links between the two "sides" of the complementary-conventional relationship. In all of the cases presented in this chapter, we have seen that complementary medicine is being used as a compliment to conventional medicine, and that there is a clustering of complementary medicine use among the cases of patients living with incurable, long-term, or illnesses affecting a small portion of the overall population. Additionally, we have seen evidence of a certain clustering of complementary practitioners who seek complementary treatments for issues that are related to their own practice, but that are not at all included in the realm of conventional medicine; such as "energetic cleansings or re-balancing." In other words, in all of the cases that have been explored in this chapter, we have seen that complementary medicine is operating in the "spaces" that are on the fringes or beyond the limits of conventional medicine's role and therapeutic tools.

Furthermore, in all of the cases examined in this chapter, we have seen how the notion of the "acceptance" of a given complementary therapy is linked to both its visibility and its financial interest in one form or another, rather than to the overwhelming presence of scientific proof of its effectiveness. Likewise, it is of note that we saw the same dynamics and patterns emerging on the part of different kinds of agents, including: individual complementary users or practitioners; individual doctors or healthcare professionals; patient advocacy groups; the lobby groups for complementary practices and practitioners; private individuals; healthcare establishments; government agencies; and international organizations. I found it incredibly significant that in all of the cases examined in this chapter there was evidence of the multi-level effects that an individual agent or group of agents could have with implications extending to the international level. Similarly, all of the cases explored in this chapter displayed evidence of the disembedded nature of the complementary practices they involved. As such, we saw how these practices are able to become hybridized as they are integrated into the personal belief systems of individual users, and how by extension, those hybridized conceptions are able to permeate the networks of those individual agents. This globalization mechanism will be further explored throughout the rest of this thesis. For now, the cases in this chapter all perfectly correspond to complex-adaptive systems theory and display evidence of its properties, including large numbers of agents that are interacting in a dynamic fashion, yet are affecting and effected by each other's actions. As a result, we were able to bring to light the patterns and dynamics that are emerging among these individual agents, which seem to be changing their behaviors and appears to be slowly changing the behavior of the healthcare system as a whole. This particular aspect will be the focus of the subsequent chapter on the wider trends that are influencing and shaping the conventional-complementary relationship. Furthermore, while within this chapter we were able to examine evidence of the importance and influence that the wider globalizing environment has on the conventional-complementary relationship in France; in the subsequent chapter we will explore this more fully.

# Chapter 4: French healthcare trends and the patterns and dynamics of complementary integration

## *4.1: Trends in French Public Health and Healthcare System*

Thus far, throughout this thesis we have seen that despite the complications in the definition of both conventional and complementary medicine; the lack of accepted scientific evidence for complementary practices; the negative stereotypes, stigmas, and fears that both sides of the conventional-complementary relationship have concerning each other; and the political difficulties surrounding the acceptance of complementary medicine in the conventional healthcare system; there continues to be an exponential growth of interest in and use of complementary practices that is permeating the French healthcare system on multiple levels. To these ends, we have explored several cases involving the presence of complementary practices in a variety of different conventional medical milieus; attempts by conventional agents, complementary agents, and among patient and complementary associations to increase the visibility and acceptance of complementary medicine in the French healthcare system; and the parallel emergent patterns for the self-organization, structuring, and finance of complementary practices that are being effectuated by agents on both sides of the conventional-complementary relationship. As such, this chapter will explore a variety of different trends that are currently occurring within public health, conventional medicine, the French healthcare system, and among both doctors and patients that are working together in order to provide the context in which the kind of integrations of complementary medicine in conventional medicine that we have examined in this thesis are able to occur.

As we shall see, all of the trends that will be presented in this chapter are directly related to globalization mechanisms and the wider environment within which the French healthcare system is nested. The first set of trends that we will observe in this context are related to French public health. Namely, the rise of chronic diseases, the ageing population, health inequalities, and the subsequent attempt to use healthcare reforms to shift the medical gaze from an exclusive, curative focus on "illness" to a much wider conception of preventive and behavioral health. Within this section, we will explore the role that these trends are playing in the redefinition of both healthcare and the conventional medical role. In so doing, they are subsequently creating new spaces for the entry of complementary medicine into conventional medical care and facilitating the kinds of conventional-complementary arrangements we saw in the previous chapter.

At the outset, it is useful to provide a general overview of the state of health of the French population. According to international indicators, the French population appears to be in an overall state of good health in comparison to other countries of similar economic standing (Drees, 2017a). Among the European Union member states, France is ranked as having an overall high life expectancy, which is approximately 85 years for women and 78.9 years for men (Drees, 2017b, p.2). Between 2000 and 2014, France has also shown evidence of a considerable reduction in all-cause mortality, as well as a reduction in the death rate of people under 65 years of age (Ibid, p.3). The two leading causes of death in France are cancer, which was responsible for 27.6% of the 567,000 deaths in metropolitan France in 2013, and cardiovascular diseases, which were responsible for 25.1% of these deaths (Drees, 2017a,

p.14). Within this trend, there has also been a decrease in the mortality rates for most chronic diseases. The mortality rate for cancer in France has decreased by 1.5% on average per year for men and by 1.0% for women (Drees, 2017b, p.3).

Improved health management and treatment in France has helped to substantially increase the survival rates for most types of cancers and for cardiovascular diseases. According to French demographic studies, the aging of the French population began accelerating in 2005 and is projected to continue into 2050, with an estimated 30.6% of the population expected to be above the age of 60 by 2035 (Robert-Bobée, 2006, p.2). According to these projections, this exponential growth in the aging rate of the French population is inevitable, as it is already inscribed within the population pyramid and will only be augmented by the increases in the overall life-expectancy rate. By extension, this trend is contributing significantly to the high prevalence of the chronic disease rate and its exponential increase (Drees, 2017b). This is because, according to the WHO, as many as 25% of 65-69 year olds and 50% of 80-84 year olds are affected by two or more chronic health conditions simultaneously (WHO, 2008, p.8). In addition to population ageing, there are both positive and negative factors that are enhancing the increasing prevalence of chronic diseases in France. These positive factors include improvements in diagnostic techniques and imaging technologies, which are improving the diagnosis rates for chronic diseases; and the negative factors include overdiagnosis[73] and behavioral risk factors among the population such as sedentary lifestyles, increased obesity, tobacco use, and the health concerns that are associated with social inequality (Drees, 2017b).

All of these population and health trends in France are directly related to and interlinked with globalization processes. This is because globalization involves much more than an economic model for the production and consumption of goods, extending into a movement of ideas, lifestyles, and developments with far-reaching consequences. Indeed, the improved diagnostic and imaging techniques that have become integrated into French conventional healthcare are representative of the circular causal relationship between globalization and technological development, diffusion, and the increasing standardization that results (Chareonwongsak, 2002). Furthermore, the WHO attributes the "negative health factors" listed above directly to the, "loss of social cohesion and globalization of unhealthy lifestyles" that contribute to an environment that is unfavorable to good health (WHO, 2008, pp.7-8). Indeed, these "globalized lifestyles" refer to the growth in the prevalence of a globally dominant culture that is directly influencing the dietary patterns, employment and working conditions, healthcare structures, and social behaviors in all countries. According to

[73] Overdiagnosis is the diagnosis of a medical condition that would never have caused symptoms or problems. This is incredibly prevalent in terms of cancer due to the emphasis that is being placed on cancer screenings. Not all tumors grow and become life-threatening; some may grow so slowly that a person dies of another condition before the tumor ever becomes problematic. In other cases, tumors may not grow at all or may disappear on their own. People can live long and healthy lives with tumors without having any idea they have or had cancer. In some cases, overdiagnosis is harmless, but in other cases overdiagnosis can have serious negative consequences on a person's life and may lead to unnecessary or risky treatments or surgeries. For example, imagine a 68 year-old man with a small, slowly growing prostate tumor he does not know about. This man dies at the age of 78 due to a heart attack, not cancer. Now imagine that this man went for cancer screening at age 70, he would have been diagnosed with cancer and faced psychological stress and serious treatments. Even if those treatments worked and the man's cancer was cured, his life would not have been prolonged due to his heart condition. The only difference is that as a cancer patient, he would have had a considerably lower quality of life and well-being and he may even have died earlier due to the negative effects that cancer treatments can have on the heart. Furthermore, as a cancer patient receiving unnecessary treatments his medical care would have cost considerably more. Thus, we see that preventive medicine and screening is a double-edged sword. For an interesting study on overdiagnosis and cancer see Welch and Black( 2010), "Overdiagnosis in Cancer," in *Journal of the National Cancer Institute,* 5 May 2010; 102(9): 605-613. Available at: https://doi.org/10.1093/jnci/djq099

the WHO, the global trends towards increased urbanization, ageing, and "globalized lifestyle changes combine to make chronic and noncommunicable diseases…increasingly important causes of morbidity and mortality" worldwide (WHO, 2008, p.8). Indeed, in 2017 the WHO reported that these diseases are responsible for 70% of deaths worldwide and that they "continue to be a public health challenge in all countries" (WHO, 2017a, p.7). In other words, the French public health trends that have been identified in this section are actually local expressions of a much larger, global public health trend. This was alluded to in the theoretical and definitional overview that was presented in Chapter 1, in which we saw the integral intertwining of society, health, healthcare, technology, and medicine. As such, this chapter will bring theory and practice together in relation to the movements and dynamics that were identified in the previous two chapters.

For now, it is important to note that as a result of the population growth, increased life expectancy, increased ageing population, increases in chronic disease, and the increased cost of care, French heath care expenditure is outpacing the growth of the economy as a whole rising from 10.4% of the gross domestic product (GDP) in 1995 to 11.6% in 2013, which was well-above the European average of 9.5% (Chevreul et al, 2015, p.59). As a result, cost-containment measures for health insurance expenditure have intensified. This is important since, in France, 77% of total health expenditure is publicly funded through the national social health insurance, which was at a deficit of 5.9 billion euro in 2012 (Ibid, p.67). In this context, it is essential to note that the French healthcare system operates on a medical activity-based payment system with tariffs set by the social health insurance, following its negotiations with representatives of healthcare professionals. Once determined, these tariffs are sent to the Ministry of Health for final approval.

Thus, we now have a more nuanced view of the medical tariff process that both Doctor R and Hospital Administrator A discussed in section 1.1 in terms of the significant authority that the Social Security administration has on the determination of the therapeutic acts and their reimbursement in the French healthcare system. In fact, this authority was recently commented on by Patrick Bouet, the President of the *Ordre des médecins*. In an article in *Le Point* magazine in April 2018, he said, "The health economy and its disciples imposed their dictatorship on the ministerial cabinets, the high authority of health, to the detriment of the requirement for solidarity and therapeutic innovation" (Le Point, 29 April 2018). This use of the word "disciples" in reference to those in the "health economy" is a direct echo of Hospital Administrator A's reference to the "guardians of the health insurance temple" in section 1.1. Here, Bouet went even farther in his interview by calling on the government to make global reforms to the healthcare system, which he qualified as being, "short of breath" (Ibidem). Bouet's reference to the need for "global reforms" constitutes a critique of government attempts to make changes to the reimbursement schedule for individual medical activities and the shift to the GHT system, which was supposed to create shared medical resources on the territorial level. However, Bouet indicates that this is not generating the cost-saving benefits that were intended. According to Bouet, the regrouping of healthcare establishments on the territorial level was, "A false good idea to share resources and ensure higher profitability by removing services and organizing grouped purchasing. In practice, it is not working" (Ibidem).

What is incredibly interesting about this discussion of the current attempts to reform the French healthcare system is that it provides a picture of the context within which the developments in the conventional-complementary relationship that we have explored throughout this thesis are occurring. This is because, as we shall see, these politically and economically driven debates on healthcare reforms shed light on the tensions that are created

by the differing characterizations of conventional medicine and its role among different actors. As such, this is a theme that will now be developed. To begin, we shall consider what emerged during my interview with Representative P of the National Agency for Performance Support for Health Establishments and the Medical-social (ANAP). When I asked Representative P about ANAP's role, he first drew a distinction between the mission of ANAP and that of the High Authority for Health (HAS). He told me that:

> "The HAS makes recommendations related to the quality of medical treatments, whereas ANAP is not interested in therapeutic acts themselves, but rather in the optimization of care pathways. We focus on those that are not covered under standard 'care,' such as the elderly, handicapped, or those with mental disorders. This is the result of a strong historical distinction that has been traditionally made between the 'medical' and the 'medical-social.' The idea is to include both the 'very medical' and the 'medical-social' in regular healthcare services, because often, in mental health for example, hospital services have small numbers of professionals who are dealing with the care of many people with specific problems that can't be treated in regular services. Hospital services are very particular, but the medical-social patients require heterogeneous care with good coordination among small, more specialized staffs" (2016).

In other words, according to Representative P, ANAP was created in order to render this "historical distinction" transparent and to reorganize these sectors, which have been historically separated throughout the development of French medical care. It is of note that this discourse explains the kinds of blockages to care that prompted the motor handicap and rare disease patients in the previous chapter to supplement their standard care with complementary measures. In other words, it relates the challenges in their care pathways directly to the organizational and structural logic of the French healthcare system. Representative P added nuance to this by pointing out that as a result of this "strong historical distinction":

> "Typically, the big financers such as the Social Security deal with the 'very medical' questions in a 'treat the disease and send them home' logic. They don't deal so well with the specific problems of populations that have 'untreatable' problems and that are in need of care that helps their lives in a general sense. All of this was organized separately and now we are seeing that this separation is causing problems" (2016).

Indeed, in the previous chapter we saw that it was precisely this lack of "care that helps their lives in a general sense" that opened a pathway to complementary medicine for patients in this "untreatable" category. Representative P explained that the realization "that this separation is causing problems" came as a direct result of the increases in the prevalence of the ageing population and the incidence of chronic diseases. As such, this implies that the cases which we saw in the previous chapter constitute a small portion of a much larger share of the French population that is living with "untreatable" problems and in need of a broader conception and care offering than is well-organized in the French healthcare system. As a result, these populations are actively seeking complementary medicine. This trend was confirmed by the Representative of Miviludes who told me that:

> "We know that in health we have 40% of the population that consults with practitioners in alternative medicine, many with serious diseases like cancer […] Health has become a key sector for us, when I arrived it was only 25% but, in the past few years it has grown to 40% […] These practitioners take 'health and well-

being' in the large sense to include both treatments and personal development" (2015).

Taken together, these quotes imply that despite the favorable international ranking of the French healthcare system in terms of quality, the "historical" French conception of the "medical" role as something that is separate from the "medical-social" role of public services has resulted in a structural organization that is unfavorable to the provision of "global" care that the rise in "untreatable," chronic conditions requires. This can be understood as a direct manifestation of the interplay between medical science and society. As such, here it is useful to recall that Kuhn reminds us that the "normal science" that constitutes a paradigm in a given moment of time is "predicated on the assumption that the scientific community knows what the world is like" (Kuhn, 1970, p.5). As was shown in section 1.1, the initial rise of public health in France was directly related to an understanding of disease transmission in the domain of "scientific medicine"; while the larger social considerations in health were viewed as a separate domain that was organized by the general councils of individual municipalities. In other words, the "world" in which French medicine was organized into its modern form did indeed include the "separation" between the "medical" and the "medico-social," just as Representative P tells us. Today, however, the "globalized world" has changed our lifestyles, our illness profiles, and our health needs. Many of these changes are the direct result of medical advancements, which have allowed us to both live longer in general, and to live longer with our health problems. As such, just as Kuhn's theory indicates, the medical paradigm inscribed within the French healthcare system is no longer able to adequately address the health needs of the population because it does not reflect the health realities of the contemporary "world." As a result, we see that both the healthcare system and certain segments of the population are each working to re-organize the system to address an expanded "medico-social" conception of "health and well-being."

In the previous chapter, we saw evidence of this movement in terms of the attempts among various agents to self-organize in order to raise the visibility and structuring of complementary medicine. In this section, we will see that the conventional healthcare system is also concurrently attempting its own reorganization. In fact, according to Representative P, the 2009 HPST Law was intended to re-structure healthcare nationally by strengthening the territorial level, "With the hope that this would create better coordination on the local level […] towards helping people with specific needs, which we decided would be better organized on the territorial level as a response to the specific needs in territorial populations" (2016). He said that this reorganization led to the creation of ANAP, which was conceived of to help foster the best possible service offerings by focusing exclusively on facilitating coordination between healthcare establishments and actors and to "define good practices."

With this in mind, it is interesting to return to and explore the significant differences between Bouet's critique and Representative P's overview of the 2009 and 2016 healthcare reforms that led to the current arrangement of the French healthcare landscape and its collection of structures such as ANAP, the ARS, and the GHT. First of all, notice how Bouet discusses these two reforms in terms of their intent to create "higher profitability" and cost-saving through "shared medical resources" and "group purchasing." Bouet focuses on the GHT regroupings as a means of "removing services" that were redundant or unnecessary for meeting the healthcare needs of a given population. This language clearly reflects the "business of healthcare" perspective that has repeatedly surfaced throughout this thesis' analysis. Representative P, on the other hand, focuses on the relationship between the 2009 and 2016 healthcare reforms with ANAP's role to work to coordinate better care pathways for "people with specific needs" by empowering local actors to work together in order to

optimize the healthcare services needed on the territorial level. This can be seen as a difference in the interpretation of the role of medicine. Bouet's concerns and critique of the attempted reforms to the Social Security reimbursement schedule for individual medical acts corresponds to a curative interpretation of the healthcare system. This is evidenced by his focus on "therapeutic innovation." While Bouet does say that healthcare reform should not be "restricted to grooming the T2A[74]," his discourse remains centered on financially empowering healthcare professionals and establishments so that they can provide better care. He makes no mention of the need to expand the definition and approach of medicine from the acute and curative to the model of long-term, complex, and coordinated care that is the focus of Representative P's discussion of the healthcare system's structural reforms.

Ultimately, both Bouet and Representative P are referring to reforming healthcare expenditures and the organization of the system in a way that optimizes healthcare costs; only it appears as though they are each focused on the reforms in relation to two different outcomes. This is evidenced explicitly in Bouet's characterization of the French healthcare system as being "out of breath," and pursuing reforms that further limit "therapeutic innovation." While he does not say what kinds of "therapeutic innovation" he would like to see, this goal is clearly curative in nature and focused on further improving the "medical" side of the healthcare system. Representative P, on the other hand, discusses the financial limitations of the healthcare system in terms of the difficulties that the "big financers such as the Social Security" have in addressing the "specific problems of populations" that are in need of care that "helps their lives in a general sense." Thus, Representative P is focused on making reforms that improve the integration of the "medico-social" side of medicine into healthcare organization so that the system can address an expanded conception of the populations' specific medical needs that are beyond what can be cured. This is fascinating, because it adds considerable nuances to the previous chapter's discussion of the self-organization of complementary medicine within the conventional system. Specifically, it alludes to tensions between the perceived role of healthcare professionals, the healthcare system, and the needs of increasing numbers of patients with specific pathologies requiring complex and coordinated long-term care. According to all of the evidence presented thus far, it appears as though these tensions are hindering reforms that are necessary for the healthcare system to adequately address the growing "needs of specific populations." As such, this appears to create an increasingly large "space" in which complementary medicine is able to expand.

In this sense, Representative P's presentation of the distinction between the "very medical" and the "medical-social" is incredibly helpful. Essentially, it sheds light on a disconnect between the perceived roles that we have seen throughout this thesis. In Chapter 2, a variety of different individuals assured us that the doctor's role was to examine, diagnose, and determine a treatment plan for a patient's condition; not the patient, but for the patient's condition. This was underscored through multiple critiques of this perceived role and discourses concerning the need to have a "global" approach to patients rather than seeing them as a "sequence of organs" or a "walking sack of chemicals." Thus, clearly, the doctor's perceived role in France is relegated to the "very medical" side of the care spectrum. Within this section we see that the structure of the French healthcare system as a whole is based on this same acute, curative role and largely oriented around the "very medical." This is directly reflected in Bouet's remark about how the financial considerations of healthcare system management have created a detriment to "therapeutic innovation," among other things. It is logical for the President of the *Ordre des médecins* to seek advancements in therapeutic

[74] In French, « T2A » means *tarification à l'activité* or activity-based payment in English

innovation, as doing so will only improve doctors' abilities to better treat their patients' illnesses.

Representative P, a government employee of a national agency that works, "on the basis of national priorities, which include access to care, the democratization of care, the ageing population, and preventive medicine," clearly has a different perception of the role of conventional medicine (2016). This role is defined by the underlying logic of the French healthcare system, which according to Politician C, who was highly placed in the Ministry of Health at the time of our interview, is based primarily on the "equality of care for all French people" (2015). We can see how the national priorities that guide the work of Representative P at ANAP are directly related to the national government's attempts to create a large-scale "equality of care." As such, the difficulties experienced by patients that are beyond the doctor's role to diagnose and determine treatment, and beyond the hospital's role to "treat the disease and send them home," have translated into the national priorities that led to the two recent healthcare reforms and the creation of agencies such as the ARS and ANAP. Nevertheless, there remains a disconnect between doctors and their representative *Ordre*'s micro-level vision of needing to reorganize State finances in order to provide better care for individual patients and pathologies; and state representatives such as Representative P and Politician C's macro-level vision of how to best organize State resources in order to provide the best care possible for pathologies affecting large portions of the population. As is implied in Bouet's discourse, this gap creates political tensions that make reforms difficult.

According to Politician N, a former director of the ARS, these tensions have increased due to both the rise in chronic diseases and advancements in medicine. Politician N explained that this is because, "Today you can live with cancer or chronic diseases for a long time, so we must ensure long-term treatment in the face of inequalities in access to care" (2015). Politician N was so cognizant of the advancement of chronic diseases that he has integrated it into his personal conception of the definition of illness. When I asked him what an "illness" was he replied:

> "A state of fragility, it is a state that can be reversible or it is a state that manifests as a situation necessitating long-term social accompaniment. It is a disturbance necessitating accompaniment, and chronic diseases are progressing the most now. The most important are cancer, diabetes, respiratory problems, and mental health. AIDS is still problematic, but it has become relatively controlled in Paris" (2015).

This indicates that the public health trends described at the beginning of this section are having a direct and very real impact on the evolution of the perceived role of conventional medicine and healthcare. By extension, this is directly shaping the reforms being made to the organization of the French healthcare system in an attempt to better address the specific health needs of the population. Nevertheless, both Bouet's discourse and Chapter 2's discussion of the role of doctors and healthcare professionals indicate that this vision of the perceived role of the healthcare system and its professionals is not necessarily shared on the individual practitioner level. Furthermore, the discussion of the therapeutic behaviors of patients with motor handicaps and rare diseases indicates that these political reforms have not yet translated into real benefits and the creation of the kinds of "global" "complex" and "heterogeneous" care pathways that their pathologies require. In light of the population projections and the exponential increase in chronic diseases, the ageing population, and the medical advancements that are lengthening life spans; Bouet's characterization of the overall system being "out of breath" and on the verge of collapse appears in sharper relief. Taken together, this suggests that while there is a political vision for how to better meet the healthcare needs

of the population, this does not necessarily translate directly into better care for individual patients and their pathologies. Indeed, Politician C confirmed this disparity by saying that, "In public health the biggest concerns are the ageing population, the dramatic increases in cancer, obesity, addictions, and mental health- the problem is that the pathologies are there, but on the ground doctors do whatever they want" (2015).

According to the evidence that surfaced through my fieldwork, it appears as though in cases in which patients do not feel as though the healthcare system is able to sufficiently respond to their needs, patients and their families are willing to take charge of their own care pathways by turning to complementary medicine and by working to invoke the dynamics that we outlined in the previous chapter. As we saw, this was due to patients and their families' unwillingness to accept their characterization as "untreatable" in cases when doctors declared that there is "nothing to be done" and that they should just "accept" their condition without offering any potential options for their improvement. In other cases, we saw that patients went looking for complementary treatments when they could not access care in their country or when care for their condition does not exist or was not easily accessible. This can be interpreted in terms of a trend towards an evolution in the current conception of the role of healthcare and the difficulties involved in implementing that reinterpretation. Politician C explained this by saying:

> "The question is whether the population is ready to turn towards well-being rather than focusing on illness- this means a change from viewing them as two different things to viewing them as a single spectrum between illness and well-being. The problem is that defining well-being is difficult, because it is different for everyone- illness, health, well-being are different- and we must differentiate between well-being in terms of health and well-being in terms of happiness" (2015).

Politician N also discussed this shift in the vision of care and stated that, "The role of hospitals is changing because of chronic diseases […] hospitals can't guarantee the total care that is needed so we must work with other professionals" (2015). He went on to explain that this was the consideration that informed the 2009 HPST reform and the move towards making "this mutation happen territory by territory." Specifically, Politician N underscored the need for an evolution in hospital activities, and explained that this was difficult to do in light of the activity-based payment method that is currently used by the Social Security. In fact, according to Politician N, these considerations are precisely what are informing the overall mission of the ARS. He characterized this by saying that the ARS is working with hospitals to evaluate their spending and to determine if their "financial trajectories are valid in order to respond to the health needs of a territory" (2015). This suggests that the ARS is acting as an intermediary that is attempting to harmonize the Ministry of Health's "macro-level politics" with the Social Security's activity-based reimbursements and individual hospitals' micro-level responses to the health needs of their territorial population. According to Politician N, the ARS does this almost exclusively through finance, namely by "evaluating hospital spending […] discussing if financial trajectories are valid […] refusing budgets if expenses are not aligned […] optimizing regroupings between multiple establishments" (2015). This was corroborated by Hospital Administrator A's explanation of the ARS role in authorizing his establishment's activities in previous chapters. Furthermore, Politician N made it very clear that the ARS functions according to a curative, "very medical" vision. In our interview he underscored that:

> "Well-being is not medical, it is not taken under the charge of the Social Security […] the Social Security is 100% based on health spending- spending on medicine

and doctors' interventions which are reimbursed based on good evaluations of the medical market" (2015).

Thus, we can see that the ARS has its own role and vision concerning how best to optimize the healthcare system that is explicitly curative and "very medical" with no recognition of a potential role for "well-being." Furthermore, it is characterized as being "market based" and guided by a logic of how best to allocate state funding as a means of responding to the population's medical needs as best as possible. According to the picture painted for us by Politician N, the ARS and by extension, the population, are not ready for the "turn towards well-being" that was evoked by Politician C. This was evidenced through his very clear statement that the role of the Social Security is to reimburse "health spending" on medical interventions, not "well-being." This implies that Politician N considers "well-being" as something that is related to "happiness" rather than "health."

This rhetoric from Politician N and the ARS takes on more interest when it is compared to that of Representative P and the mission of ANAP. Rather than focusing on the structural reforms of the healthcare system in terms of the financial optimization of the business of healthcare, the GHT were conceived of as a means of optimizing patient care pathways in the face of the complex, long-term healthcare needs that are exponentially developing among different segments of the population. Representative P gave us a non-curative vision of healthcare reforms that were intended to facilitate the system's response to "medico-social" needs of "untreatable" patients. The interesting thing is that Representative P also characterized ANAP as a direct intermediary charged with, "coordinating national-level centralized objectives that were focused on helping people with specific needs with the organization of care on the territorial level" (2016). Notice how both Politician N and Representative P describe the respective missions of their government structures in terms of being an intermediary between "macro-level politics" or "national-level centralized objectives" and the "health needs" or "organization of care" on the "territorial level." Despite these similarities, these agents have individual objectives that are on opposite sides of the "medical"/"medico-social" or "illness"/"well-being" dichotomies. In other words, both of them are working on optimizing the shared medical resources on the territorial level that were structured by the creation of the GHT system, but with completely different objectives in mind.

Despite these differences, when these two agents are viewed together within the healthcare landscape that is being depicted here, we can see that changes in French public healthcare needs are translating into a shift in the perceived role of conventional medicine. Whereas there was a "strong historical distinction" between that which was considered to be "very medical," such as a disease, from that which was considered to be "medico-social," such as mental illness; all of the rhetoric presented in this section thus far indicates that a "mutation" in this dichotomy is occurring. For example, even in light of Politician N's hard-lined rhetoric characterizing "well-being" as something that is "not medical," his personal definition of illness as "a state that manifests as a situation necessitating long-term social accompaniment" clearly falls on the "medico-social" side of the spectrum. Going further, the ARS funding of the sophrologist-nurse working with Hospital Administrator B in the previous chapter acts as additional evidence that the ARS is not as exclusively "medical" as Politician N attempted to characterize it in his previous discourse decrying "well-being."

Thus, it seems as though the French medical gaze is shifting from an exclusive focus on "disease" to a wider, more complex vision of a "spectrum of well-being and illness." Furthermore, rather than medicine being completely dominated by a centralized, national

determination of care, we see that the French healthcare system was decentralized in an attempt to give local and territorial actors more agency in determining individual care pathways. Nevertheless, it appears as though this evolution is occurring unevenly and in a non-linear fashion that is marked by tensions. Not only did Politician C confirm that there is evidence of a disconnect between the national vision of healthcare priorities and the on the ground activities of individual healthcare professionals; we have also seen discourse suggesting that the medical activity-based payment organization of the system, which is financed by a Social Security system operating in a deficit, makes it complicated to create coordinated, long-term care pathways for patients with "untreatable" illnesses falling on the "medico-social" of the medical dichotomy. One of the reasons for this was given by Politician C, who confirmed that there are "too many government structures and it is not clear how to get them all to act together" (2015). As we saw within this section, the differing visions, means, and ends of these structures adds to the difficulty in fundamentally reforming the structural organization of the decentralized French healthcare system.

The problem is that not only is the French healthcare system as a whole a complex bureaucracy involving "too many government structures" that are difficult to effectively coordinate in order to "get them all to act together," the shift in the disease burden towards noncommunicable and chronic diseases is translating into an increasing need for instituting the shift towards the "medico-social" vision of illness in France. This is compounded by another French public health trend, the enduring presence of significant social inequalities in the health of the French population. Despite advancements in the overall average state of health, France has one of the highest rates of social inequalities in life expectancy and health in Europe (Lang & Ulrich, 2017). Rather than decreasing with medical advances, the social inequalities in health and mortality in France have become so marked in the past thirty years that it has been dubbed "the French paradox" by the ARS (Basset, 2008). Indeed, despite the high-quality medical care that is available in France, in the period from 2009-2013, "A 35-year-old man belonging to the highest socio-economic category can expect to live an average of 7 years longer than a man in the 'labor' category and 3 years longer than a man in the 'artisan, commerce, business-owner' category (Lang & Ulrich, 2017, p.8). Beyond life expectancy, the social inequalities of health in France are marked by a 10 year gap in the well-being of individuals from the highest and lowest socio-economic strata. This means that a 35-year-old man in the highest socio-economic stratum can expect to live 10 years longer without functional limitations than a man in the lowest socio-economic stratum (Danet, 2010). These social inequalities encompass all health indicators (life expectancy, perceived health, healthy life-style behaviors, use of the healthcare system, etc.) and worsen in direct correspondence to the social gradient from rich to the poor, from white-collar to blue-collar professions, and according to educational levels. Furthermore, these social inequalities in health are often present during pregnancy and birth and can be seen in early childhood (Lang & Ulrich, 2017).

In the last ten years, various French healthcare policies and reforms have attempted to address these health inequalities, but they have had little success. This is because, according to the WHO, social inequalities in health are the result of multi-factorial, complex chains of causes that begin at birth and accumulate throughout an individual's life. Additionally, most of these factors, such as education level, income, housing and work conditions are beyond the direct control of the healthcare sector and are the result of the shared outcomes of environmental, educational, and economic policies (WHO, 2015). For example, in France geographical studies in mortality before 65 years of age show both regional and infra-regional disparities, some of which are directly linked to inequalities in exposure to atmospheric pollution from industrial sources (Basset, 2008). According to the WHO, there is a direct link

between household revenue and household proximity to industrial sources of pollutants (WHO, 2015). It is for this reason that the WHO is currently advocating a "health in all policies" approach to reducing the social inequalities in health worldwide (WHO, 2015). Unfortunately, due to the enduring structural cleft between the "medical" and the "medico-social" in French healthcare, instituting the kinds of transversal policies that the WHO is calling for remains a challenge in France; even though the notion of health inequalities began appearing in French healthcare policy as early as 2003 and was a focus in the 2015 healthcare reform known as the "Touraine law."

Specifically, the Touraine law focused on promoting access to care and prevention as key national healthcare priorities. To these ends, the government began developing educational programs on aspects of behavioral health that are linked to social inequalities, such as promoting healthy eating, hygiene, and the reduction of high-risk behaviors including smoking and alcohol consumption. Furthermore, it attempted to increase the availability of health care information and to address the problem of "medical deserts," or areas in which there is limited access to healthcare due to the presence of low concentrations of healthcare professionals. It is of note that this law focused on a limited perspective concerning preventive health; namely that it could be best promoted by working to influence individual behaviors rather than targeting the overarching structural causes of health inequalities beyond unequal access to care. This was clear in the Touraine law, which included provisions such as transportation for rural women to get breast cancer screenings or financial incentives for doctors to practice in underserved areas rather than provisions for better coordination between different government ministries and structures as a means of reducing the overall rate of socioeconomic inequality as advocated by the WHO. As such, even though the French government has made several attempts to address health inequalities, they remain a persistent problem that is not being adequately treated on the ground. In other words, just as in the case of the other public health trends that we have seen throughout this section, social inequalities in the health of the French population correspond to both the enduring gap between advancements in the "medical" and the "medico-social" domains as well as a disconnect between national health objectives and territorial realities in health and well-being.

This was evident in my interviews with both healthcare professionals and politicians. Indeed all of those that I spoke to about national healthcare policies clearly identified prevention as a key component. They also all associated it with the national educational initiatives for reducing individual high-risk behaviors and the promotion of cancer screening that were encapsulated in the Touraine law. For example, in her explanation of the role and priorities of the Ministry of Health, Politician C characterized the priorities of national health policies in terms of, "all that is prevention, quality of care, and screening" (2015). This was directly echoed by the Representative of the *Ordre des médecins* who characterized French public health policies in terms of, "all that is in the domain of prevention, vaccinations, health prevention, and all that is in the domain of drugs, alcohol, and tobacco" (2015). Yet, despite the national political emphasis on promoting the screening and educational aspects of preventive health, my interviews with healthcare professionals indicated that this has not translated into the widespread adoption of an emphasis on prevention on the sub-national level. For example, Hospital Administrator B expressed doubt over the future of prevention in French healthcare saying, "It's that, you know, it's tertiary. I don't know how that will continue developing" (2017). The Representative of the *Ordre des pharmaciens* also expressed concern over the efficacy of preventive policies saying, "Actually, prevention isn't really organized by the State in an effective way" (2015). According to Shiatsu Practitioner C, the difficulties creating effective policies for prevention in French healthcare stem from the blockages elucidated in this section, namely that, "prevention is definitely beginning to enter,

but medicine is primarily oriented around illness" (2015). Thus, we again see the difficulty that the French healthcare system as a whole seems to be having in implementing public health policies that are able to foster significant reductions in the social inequalities in health among its population. The explanation that Shiatsu Practitioner C gives us here indicates that this is because doing so would involve overcoming the gap between the "medical" and the "medico-social" domains though an expanded vision of the role of French conventional medicine.

This implies that there is an ideological blockage preventing the kinds of structural reforms that would be necessary to adequately address the changing medical realities in French public health. Rather than necessitating the "therapeutic innovations" that were called for by the President of the *Ordre des médecins* or the aspects of preventive medicine that were included in the 2015 healthcare reform, the trends presented in this section imply that the rise in chronic diseases and the ageing population, coupled with the increasing awareness of the socio-economic components and inequalities in health, mortality, and illness are all related to a need for a considerable evolution in the scope of the French medical gaze and the conception of the role of conventional medicine. This shift can be characterized as moving from an exclusive consideration of the "very medical," to a primary focus on the "medico-social." Doing so would require a "mutation" from the logic of an acute, curative, illness-based approach to a long-term, "well-being in terms of health" approach that takes socio-economic factors into consideration. According to the public health trends that are currently developing, this shift is becoming increasingly necessary as more people are living longer lives that are punctuated with long-term illnesses and social inequalities in health. Nevertheless, it appears as though the long-standing ideological gap that is inscribed in the structure of the French healthcare system and the complexity of the sprawling government bureaucracy that deals with health through the non-linear efforts of its myriad of structures is preventing this "mutation" from occurring.

Within my fieldwork, it appeared as though the government's inability to effectively overcome the separation between the "medical" and the "medical-social;" to coordinate preventive care; and to foster the kinds of complex, coordinated, long-term care that trends in public health are identifying is facilitating the growing interest in, use and presence of complementary medicine in France. This is because while the overall healthcare system remains oriented around a "medical"/"illness" axis, all of the complementary practices and practitioners I encountered over the past three years included a focus on various notions of "well-being" and the "medico-social" aspects of health. Throughout this thesis, we have been discussing this in terms of the complementary medical focus on the "globality" of a person, which involved treating both the physical and the metaphysical aspects of an individual. We also discussed this in terms of the complementary medical focus on the "living body," which was defined as the infraconscious animating aspect of a human being that brings together their mind, body, and environment. Throughout this thesis, we saw evidence of the presence of these expanded conceptions of health, illness, and well-being that seemed to act as a commonality underlying a surprising variety of different complementary practices. We also saw that all of the complementary practitioners that were included in this thesis openly accepted the non-curative role of their practices. When this is combined with the analysis in this section, it appears as though these complementary practices fit perfectly into the "space" beyond acute, curative care that is expanding in conjunction with chronic diseases and the social inequalities of health. This implies that one of the reasons for the exponential increase in the presence of complementary medicine in France is due to their positioning within the "medico-social" and "well-being and health" side of the French medical dichotomy. Considering the public health trends that have been examined within this section, this explains

some of the growth in consumer demand as more people live longer lives with more physical discomfort, and the efforts that we saw in previous chapters made by healthcare practitioners attempting to integrate complementary medicine into their conventional medical milieus. As such, we will now turn to an examination of these elements within some of the discourses of the complementary practitioners I spoke with.

One of the clearest examples of the wider complementary conception of health and illness that I am referring to here was given to me by Shiatsu Practitioner C. Within our interview he told me that:

> "Shiatsu is more interested in people in good health- that is the primary clientele and in my opinion those are the most interesting […] what I mean to say is that we should first address people who are in good health, why? Because when the body is in good health it should stay that way […] the Chinese have a proverb about this that is fantastic, they say that 'Those who dig wells when they are thirsty are crazy, you have to dig wells before you're thirsty.' If you're in good health you have to stay that way and use techniques that will allow you to stay in good health- yoga, jogging, eating correctly, you won't go to the discotheque every night because it is not good for you" (2015).

Thus, here we see that shiatsu is a complementary practice that encompasses both the "well-being in terms of health" and the "well-being in terms of happiness" that were identified as separate by Politician C earlier in this section. It is of not that Shiatsu Practitioner C's discourse focuses on how shiatsu can act as a preventive measure that is not restricted the kinds of health education programs that are currently being pursued within the French preventive medicine policies that were described in this section. Shiatsu Practitioner C explained that:

> "Shiatsu can bring a formidable well-being because it helps maintain the body in an energetic state that is both physical and mental. This state is favorable to the maintenance of good health because as soon as you feel good in your body and your mind, you will naturally go towards a discipline in life that will help you to stay in this good functioning state" (2015).

This is a direct expansion on the notion of "globality" that we have seen repeatedly throughout this thesis. Here, rather than educating people on how to stay healthy and moralizing against high-risk health behaviors, Shiatsu Practitioner C is saying that by helping to maintain a global state of well-being that includes both "health" and "happiness" in terms of physical, emotional, and mental comfort, people will naturally change their behaviors as a means of staying in that state. Doctor J also gave me a very similar account in terms of his combined practice of acupuncture and homeopathy. When I asked what the goal of his treatment was he said:

> "I try to relieve the person and bring them to themselves. There is no better doctor than one's self […] but sometimes there is a need for someone outside of ourselves to bring us relief and a little energetic assistance, to help us to realize something about our suffering- because that person has knowledge and has been studying for many years" (2015).

In other words, like Shiatsu Practitioner C, Doctor J is saying that by bringing people "a little relief and energetic assistance" he returns people to a "good functioning state" that helps them to realize what they need to understand about the source of their suffering and to

be their own doctor. In other words, Doctor J implies that we are all able to take care of ourselves, but that occasionally we may have recourse to someone who has studied health and illness as a means of getting "a little energetic assistance" that helps us to make sense of our suffering. This is based on the same logic that was given to us by Shiatsu Practitioner C, namely that once someone has brought us back to a state of harmony within ourselves, we will naturally take steps to maintain this state of being. Shaman C also discussed this same process within a conference by saying:

> "I activate the energy of the cosmos that is in you. If a person feels bad and is sick, they will get better and they will resolve the problems in their life. They will calm down and realize what they are doing in their life. This is how we change our lives […] we can only calm anxiety and desperation when we calm our minds. So this energy calms our minds. It puts us into an alpha-omega state and leaves us calm. Then we start to reflect […] and our spiritual intelligence begins and we realize many things that we are doing and we start changing life without realizing […] we find the solutions and the cells that are activated start to communicate to us like a memory of who we are and why we do things. It is a consciousness that speaks to us and guides us […] this is the energy of the body that we experience when our cells have changed" (2014).

Here we see that Shaman C's discourse encompasses both the notions of treating a person in their "globality" and the "living body." Namely, he suggests that taking care of a person involves both taking into account their illness and their overall well-being. By calming their minds and giving them "a little energetic assistance," Shaman C says that people will "realize many things" that they are doing and "start changing life" as a result. He then incorporates in the notion of the living body, which he refers to as "the energy of the body" that activates and guides "our cells." I found it curious that even Homeopathic Doctor Q discussed these same dynamics in terms of prevention, stimulating the energy of the living body, and in terms of the body's biochemistry by saying:

> "Well-being is an equilibrium, and I feel it's better to stimulate a person and their defenses than to suppress their defenses, which can provoke problems- take an anti-inflammatory and after have a stomach ulcer, that's not very nice […] So for me it's better to do prevention instead of only treatment. There is a proverb that says 'it's better to prevent than to heal,' and for me, equilibrium is health, it's force, it's the vital energy that stimulates an individual's organism […] energy is the potential of an individual to react in all situations, stress is a stimulation of energy […] positive stress will make us secrete adrenaline and negative stress will paralyze us. Stress is a form of adaptation and adaptation involves the search for a reactional mode that will induce good energy or a good way of reacting" (2015).

Again, within this discourse we see similar references to the importance of taking care of a person by restoring a physical and metaphysical equilibrium as a means of promoting both good health and prevention. Moreover, we again see a reference to the role that stimulating the "vital energy" of a person's living body is perceived to play in inducing "a good way of reacting" to the stresses in life. In other words, in all of these complementary discourses we see a pattern emerging: restoring a person's global harmony with their physical and metaphysical selves is believed to stimulate their living body, which will guide them into reactional and behavioral modes that are inclined to promoting healthy behaviors and preventive health. Hypnotherapist A talked about hypnosis in similar terms, only he called it a

"training" for people to resolve their own problems that favors their staying in a state of overall well-being:

> "I help people to face a problem that they have encountered, I accompany them. […] The ability to talk about changing one's behavior can favor a process that makes it so that they go from, 'I felt bad today' to 'I feel better, maybe even good.' […] We can say that it is a training, simply to be better, that prompts us to better use our capacities, to do things differently and starting at that point the person can decide if they want to change or if they don't want to change. If they want to change and they ask me to, then I'll accompany them, that's why I talk about accompaniment […] Also I work with a lot of doctors, they send me their patients that have problems […] like stress- once they send a patient over to me, I make sure that the doctor is aware of what we're doing" (2015).

Here we see the presence of a striking similarity in the conception of the role and approach of these very different complementary practitioners. All of them talk about their role in terms of helping restore people's connections with themselves and then accompanying them through a self-directed process of change that naturally leads them towards altering their behaviors in such a way as to allow them to remain in an overall state of "well-being." In order to better understand this shared conception, it is useful to consider the body ecology that Andrieu & Burel (2014) relate to the intelligence of the living body, which acts before our conscious awareness. This adds further weight to the need for the expanded conception of the body and health that is discussed within this section. Notice how none of these practitioners make the kind of distinction between "well-being in terms of health" and "well-being in terms of happiness" that Politician C was careful to make. Here, all of these conceptions link the physical and metaphysical as essential to creating a "global" state of well-being that encompasses the physical, the mental, and the emotional- on both conscious and unconscious levels. Also, notice how within Hypnotherapist A's discourse there seems to be a fairly smooth coordination that is maintained with that person's doctor. When this is coupled with the previous chapter's multiple cases of the pathways that are developing between complementary and conventional medicine, it indicates that these complementary practices are able to bridge the gap between the "medical" and the "medico-social;" albeit in a way that is different from the conceptions we have seen in terms of French healthcare policy. Furthermore, I found it interesting that all of these practitioners discussed a direct correspondence between their practices and stimulating a natural orientation towards healthier behaviors and preventive health.

Thus, we are beginning to see that in face of the healthcare system's inability to address and coordinate complex, individualized, long-term care; preventive medicine; and the kinds of behaviors that lead to health problems; a "space" has been opened for complementary practitioners that conceive of themselves as playing that role. As these negative public health trends continue to grow, it appears as though these complementary practitioners are operating and expanding within this "space." Curiously, much as we saw with the dynamics between the ARS and ANAP, these dynamics are acting as an interesting parallel. Earlier in this section, we saw that these two government structures are both working towards differing conceptions of the same ends using different means. Both are working to optimize French healthcare, only the ARS is doing so on the "medical" side and ANAP is doing so on the "medico-social" side of the healthcare dichotomy. In order to arrive at these ends, both are acting as intermediaries of the state; although the ARS is employing financial management strategies and ANAP is employing coordinating and communicative management strategies to do so. Within this section, this was analyzed in terms of its

maintenance of the gap between the "illness" and "well-being" dichotomy that we saw is inscribed in the French healthcare system.

Here, it appears as though both conventional and complementary agents in the French healthcare landscape are working towards promoting health and preventive medicine. Conventional medicine appears to be having difficulty expanding beyond the "medical"/ "illness" side, while the complementary practitioners are operating on the "medico-social" side of the dichotomy. Conventional medicine is being guided by a perceived separation between "well-being in terms of health" and "well-being in terms of happiness" and a focus on the "health" side of the equation. Meanwhile the complementary practitioners cited here are all pursuing a "global" vision of "well-being and health" that incorporates both aspects of this equation. Both French conventional and complementary medicine are working towards instilling health-promoting preventive behaviors in the population; although the conventional medical side is pursuing an educational policy to reduce high-risk behaviors while the complementary medical side appears to attempting to stimulate healthy behaviors through the activation of people's living bodies.

According to complex adaptive systems theory, these cases and their dynamics correspond directly to the properties of a complex adaptive system. Namely, we see that the French healthcare system is populated by a large number of agents and structures that are all working according to their own visions, conceptions, and missions. These agents are apparently interacting in different non-linear ways with significant differences in both their perceived means and their conceptions of the same ends. Clearly, the overall system is functioning in a sub-optimal way; since as we have seen throughout this thesis, there are significant "spaces" beyond the medical gaze and the care possibilities of the healthcare system in which complementary practices are flourishing. These "spaces" appear to be created through the conventional medical system's inability to overcome the separation between the notion of the "medical" and the "socio-medico" and to address the growing public health issues of chronic diseases, an ageing population, and health inequalities. As we saw in Chapters 2 and 3, these complementary practices are growing in this "space" in an uneven, non-linear fashion as a result of the different actions of different agents that extend from the individual to the international levels.

When the number of agents and their individual missions and actions are considered, it seems as though the entire healthcare system is operating on the edge of chaos. Nevertheless, throughout this thesis we have seen a vast variety of different examples of both patterns of dynamics and self-organization that are emerging within the overall system. In this section, these patterns concern the emergence of healthcare system reforms and their associated structures- such as the ARS, ANAP, and the GHT- that are all working towards optimizing the care offerings of the French healthcare system on the territorial level. Within this section, we have also seen the emergent pattern of the clustering of complementary practices in the "space" that has been created by the gap between the "medical" and the "medico-social" sides of French healthcare. Within this space, we saw that different complementary practitioners using diverse practices all evoked the same unified conception of "well-being" that takes into account both the "health" and "happiness" aspects that were presented as irreconcilable by multiple agents in the healthcare system. We also saw a similar dynamic that was associated with their care, namely the creation of a global harmony in a person that is able to stimulate the intelligence of their own living bodies and to foster changes towards healthier behaviors.

In the previous chapter, we saw patterns related to the ways in which different agents on multiple levels are attempting to integrate complementary practices into the healthcare

landscape in different ways. Moreover, we have seen multiple cases that demonstrate the nesting of the French healthcare system within a wider environment of globalization and its influences on the health profile of the French population and the multiple interactions that the French healthcare system has with the international, globalized healthcare business and public health arena. Specifically, we have seen two interrelated trends: the global increase in the chronic disease burden and social inequalities of health, both of which are very present in French public health; and a shift towards an expanded notion of healthcare that goes beyond curative care to include preventive care. This was discussed in the context of Chapter 1 and developed within this section. Going further, the focus on the financial aspects of French healthcare also seems to be linked with larger, globalized trends in which healthcare has become a business that is marked by the same quest for profitability, cost-containment, and financial optimization that is driving global businesses. This was first suggested in Chapter 1 in terms of the buy-out of Hospital Administrator A's hospital by an international Australian healthcare company with links to the United States. It was further corroborated here through the President of the *Ordre des médecins* call for the financial optimization of the healthcare system as a whole.

Taken together, all of these trends seem to be both helping and hindering the proliferation of complementary medicine in France. While the system's overall inability to overcome its own structural dichotomy and to create the kinds of transversal and coordinated actions that are necessary to fully address the current public health challenges is creating a "space" that complementary medicine is readily filling; the complex bureaucratic structure and lack of transversal coordination throughout the healthcare system is preventing the development of national policies for complementary medicine. Instead, complementary medicine is developing "in the shadows" in a piece-meal fashion that is resulting in an uneven development. This paradox will continue to be the focus of the subsequent sections in this chapter.

## *4.2: Globalization, Mental Health, and the French Healthcare System*

In the previous section we looked at how the current trends in both French public health and the reforms of the French healthcare system are creating a "space" in which complementary medicine is developing "in the shadows" and largely in the absence of any concerted national policy; with the notable exceptions identified in previous chapters concerning specific regulations for the medicalized practice of acupuncture, the accreditation for osteopathy schools, and the reimbursement for homeopathy. Aside from these three exceptions, the evidence in this thesis suggests that complementary practices are developing on a case-by-case basis through the individual efforts of a large range of actors in a near-chaotic fashion. Nevertheless, we have also seen that despite the uneven and non-linear character of these efforts, there are some patterns and dynamics that are emerging; such as the self-organization, visibility-raising, and structuring efforts among different agents attempting to bring their preferred complementary practices out of the "shadows" and into the "light" of recognition and finance in a variety of different ways. The previous section provided additional nuances to the context in which these efforts are taking place, by exploring the "space" for complementary medicine that is being created as a result of the ideological and structural blockages for expanding the perceived role of conventional medicine and healthcare beyond its exclusive focus on the "medical"/ "illness" side of the "medical"/ "medico-social"

dichotomy. In other words, in terms of the difficulty in harmonizing national objectives with individual actions as a means of addressing the current public health trends necessitating healthcare that goes beyond the acute and curative to provide the long-term, complex, and coordinated care that chronic diseases, the ageing population, and health inequalities require. In the previous section, we characterized this difficulty in terms of the need to enlarge the conventional medical role to include a notion of "well-being in terms of health." This difficulty was further underscored through various discourses that opposed the inclusion of a notion of "well-being in terms of happiness" within the French conventional medical paradigm. As a result, the previous section ended with an exploration of what appears to be a surprisingly common underlying component of different complementary practices; namely, their acceptance and inclusion of a "globalized" vision of "well-being" that includes the components of "health," "happiness," and what we refer to as an activation of the living body that is believed to prompt individual shifts towards healthier behaviors.

Furthermore, within the previous section, we identified the "historical separation" of the "medical" and the "medico-social" as the primary stumbling block that is creating difficulties for the expansion of the perceived role of French conventional medicine. We saw that this is because the "medical"/ "medico-social" dichotomy permeates the structural organization of the overall French healthcare system, evidenced by the activity-based reimbursements for medical care and the multiple examples that were cited concerning the difficulty the French healthcare system has in developing effective complex, long-term and coordinated care pathways for the increasing instances of ageing, chronic disease, and long-term pathologies in the French population. This reality, when coupled with the examples given in previous chapters was characterized as a "push factor" that was pushing people into the realms of complementary medicine. As such, within this section we will now further explore the ideological separation that Politician C demarcated between this notion of "well-being in terms of health" and "well-being in terms of happiness" in relation to another set of contemporary public health trends as a means of bringing to light both: another "push factor" fueling the growing patient demand in complementary medicine; and the underlying logic of French conventional medicine that I interpret as creating resistance to the expansion of the French conventional medical gaze. Doing so, we shall see that this seems to be helping the development of complementary medicine in France by further expanding the "space" that complementary practices are flourishing in; and, at the same time, feeding into the conventional medical resistance to "seeing" complementary medicine as a complement rather than as a competitor.

One global public health concern that is becoming increasingly prevalent worldwide is the overwhelming presence of a mental health burden. Indeed, as early as 2001 the WHO began making urgent calls for all countries to make improvements to their mental health services as they found that four of the ten leading causes of disability worldwide were neuropsychiatric disorders, accounting for 30.8% of total disability and 12.3% of the total burden of disease at the time (WHO, 2001b). The WHO projected that this latter figure would rise to 15% by the year 2020. In 2010, a global burden of disease study found that mental and substance use disorders were the leading cause in the global non-fatal burden of disease, with depressive disorders, substance use disorders, anxiety disorders, drug use disorders and schizophrenia identified as the most prominent contributors (Whiteford et al., 2013). According to the WHO in 2001, one in four persons who sought health services suffered from mental or behavioral disorders, which continue to be frequently misdiagnosed or incorrectly treated.

While mental health issues have always been a part of society, historically it has generally been separated from mainstream healthcare services in many different countries. Within the previous section, we discussed this separation in France in terms of the enduring "medical"/"medico-social" dichotomy that has fundamentally shaped the structure and logic of its contemporary healthcare system. Hypnotherapist M explained this separation in terms of the distinct educational structures for medicine and psychology by saying: "It was modern medicine that separated- really deeply separated as I have said […] by making universities for medicine and universities for psychology, which is completely stupid" (2017). Hypnotherapist A complemented this explanation by clarifying the relationship between psychologists and medicine:

> "I'm a hypnoanalyst […] it is a non-medical healthcare professional. We're considered as healthcare professionals because the trainings are reserved for healthcare professionals in which psychologists can enter, but we are not medical in the sense that we don't give treatments" (2015).

Thus, in both of these discourses, we see the translation of the French separation of the "medical"/ and the "medico-social" in terms of the educational and professional separation of psychologists from doctors and "medical" healthcare professionals. According to the WHO and the structural implications that are implied within these two discourses detailing the exclusion of psychology and psychoanalysts from the "medical" profession, this translates into the sub-optimal development of healthcare services and pathways for the increasing number of people living with mental health and substance use disorders. Going further, the WHO has cautioned that there is also a tendency for assigning mental health a low place in individual governments' political healthcare priorities. Within France, I found evidence supporting this claim within a 2016 report detailing the overall national consumption of and spending on healthcare services (Drees, 2017c). While in addition to the information on general healthcare spending there were specific mentions of the same political health priorities that were identified in the previous section by Politicians N and C; mental health medication and service consumption were only marginally featured in this report. Specifically, this report contained entire sections dedicated to detailing the healthcare expenditures on long-term care for the elderly and for handicapped persons, both of which were clearly identified as political priorities in the previous section. Yet, mental health was only discussed in terms of overall hospitalization rates. There were no statistics on the specific kinds of mental health issues that were the cause of those hospitalizations and no numbers showing national spending on psychotropic medications. I did find a report from the Social Security presenting its recommendations for policies in 2018 that emphasized the "important weight of mental health" (Assurance Maladie, 2017, p.13). This is because mental health care and reimbursements of psychotropic medications cost the French Social Security 19 billion euro in 2015, which was 5 billion euro more than the system's cancer related expenses (Assurance Maladie, 2017, p.13). Nevertheless, in consistency with the Drees report cited above, despite the considerable financial weight that mental healthcare costs put on the overall Social Security spending, there were no specific recommendations made concerning strategies to contain these costs or to improve mental health service delivery.

In fact, it is of note that I was largely unable to locate many exact statistics on the overall national spending specifically for mental health patients in French government reports other than the reports cited above and a 2018 Social Security report stating the national objectives for health insurance expenses; although the only mental health issue this report did specifically include was for spending on Alzheimer's disease among the ageing population (PLFSS, 2017). I also managed to find a report from a National Assembly Session on 22 June

2006 discussing concern over the increasing French use of psychotropic medications; however, the statistics within this report were from 2003 or before[75] (Assemblée Nationale, 2006).Taken together, all of this implies that even the "medical" side of mental health remains a relatively low priority in terms of French healthcare politics and concerns; despite its considerable presence among the French population evidenced by the Social Security report on mental health costs in 2015. As such, this confirms the local French expression of the WHO claim that mental health remains largely marginalized from mainstream healthcare services and of low political priority (WHO, 2001b). It is interesting that even though the 2001 WHO report is now incredibly dated, the concerns it expressed appear to still characterize the place of mental health in the French healthcare system.

This is significant because, while mental health issues such as anxiety and depression may not feature as specific healthcare priorities in the French political arena, there is a variety of different research that indicates that they are having significant economic and social consequences for an increasing number of individuals. Furthermore, the WHO indicates that not taking mental health into consideration negatively impacts the effectiveness of the kinds of preventive health measures concerning substance abuse and high-risk health behaviors detailed in the previous section. Indeed, the WHO conceptualizes mental health as being an integral component of one's "overall well-being," playing a role in whether "the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2007). Notice how the WHO discusses mental health and substance abuse in terms of "overall well-being," which is a mirror opposite of the previous section's analysis of Politician C and N's clear separation of "well-being in terms of health" and "well-being in terms of happiness;" the latter of which was clearly situated as being outside of the role of the French healthcare system. This nuance sheds light on one of the reasons why mental health remains "marginalized" in French healthcare; its association with a notion of "overall well-being" can be interpreted as placing it on the "medico-social" side of the French dichotomy.

One of the reasons that mental health and substance abuse are growing components of the global disease burden is the result of globalization mechanisms. Indeed, the European Agency for Safety and Health at Work (EU-OSHA) indicates that, "global socio-political development" including "increasing globalization" is causing significant changes in European working life and a marked increase in "work-related psychosocial risks and stress, together with their associated negative health and business outcomes" (EU-OSHA, 2014, p.4). In other words, globalization has been creating significant changes in workplaces over the last several decades, resulting in new occupational safety and health challenges. These changes have been directly linked to global socio-political developments such as the increasing globalization of businesses, developments in the free market, advances in information and communication technology, new types of contractual and working-time arrangements, and significant demographic changes (EU-OSHA, 2007). This means that in the wider sociological context, working life is being negatively affected by time-space compression and the general acceleration of the pace of life. These factors are contributing to work intensification, constant time pressure, increased multitasking, and the need to learn new things just to maintain the status quo (Rosa, 2013). In addition to these changes, global economic crises have increased the pressure on both employers and workers to remain competitive.

[75] It is of note that according to this report, French Social Security spending on psychotropic medications in the period 2003-2004 equated to 1 billion euro and was expected to continue rising.

France and its population have not escaped these trends. In 2017, Stimulus, a French consulting firm with a specialty in occupational health and well-being published a report analyzing more than 30,000 French employees working in a variety of different employment sectors in France. Their study focused on the stress levels, instances of anxiety and depression that resulted from these stress levels, and the principal stress factors that were faced by these employees. They found that 24% of these employees lived with so much work-related stress that they could be characterized as living in a state of "hyperstress;" a state that put their health at risk (Stimulus, 2017). This state of "hyperstress" affects female employees more than male employees (28% and 20% respectively) and it equally touches both managerial and non-managerial staff. Furthermore, in correspondence to the health inequalities findings presented in the previous chapter, the Stimulus report found that employees over 40 years of age generally had higher stress levels than their younger counterparts. Going further, Stimulus found that 52% of the total employees studied experienced elevated levels of anxiety, 16% of which appeared to be suffering from anxiety corresponding to the medical definition of an anxiety disorder (Stimulus, 2017). Additionally, 29% of the total employees studied are living in a state of depression, 6% of which had depression corresponding to the medical definition of the term (Stimulus, 2017).

According to a 2007 study conducted by Inrs, a non-profit association focused on occupational health and safety in France, the social cost of stress (including healthcare costs, costs linked to absenteeism at work, the cost of stopping work, and premature deaths) in France equated to between 2 to 3 billion euro in the year 2007 alone (Inrs, 2007). Going further, Inrs used data collected by the 4$^{th}$ European study of working conditions and its epidemiological literature review to find that exposure to elevated stress is directly linked to the following health pathologies: various cardiovascular illnesses, including ischemic heart disease, cerebrovascular disease, and hypertensive heart disease; depression; and musculoskeletal disorders such as chronic back pain (Trontin et al., 2007). Thus, whereas in the previous section we discussed how the French difficulty in overcoming the chasm between the "medical" and the "medico-social" is becoming increasingly problematic to the healthcare system's ability to effectively address the current public health concerns that are created by the increasing ageing population, increases in chronic disease, and pathologies that involve long-term, coordinated care; we now see that even if the "medical" and the "medico-social" were effectively combined, the perceived separation of the notion of "well-being" according to its "health" and "happiness" aspects would still act as an important blockage to the French healthcare system's ability to address the growing significance of stress and its corresponding health consequences among the French population. In other words, the research presented in this section indicates that "well-being" should be considered as a global notion that reflects the clear links between mental, emotional, and physical health; separating it into "well-being in terms of health" and "well-being in terms of happiness" appears to be both short-sighted and artificial with the potential to seriously limit the healthcare system's potential to care for the increasing occurrence of stress-related pathologies such as those mentioned in this section.

Going further, in an interview given in *La Libération*, Bruno Falissard provides significant nuance to the difficulty in medicalizing mental health. His comments are significant, because they bring to light important questions concerning the medical role in identifying and treating mental health issues that are commonly on the fringes of the pathologic:

> "At some point we have to decide: at what point do is there a [mental health] problem, and at what point is there not? It's complicated: what is it that

> constitutes a mental health issue? Some say that not all suffering should be medicalized: in life it is normal to be unhappy, even to suffer; in a mourning period or after an emotional break, for example. It can even be considered as an essential element of human life. Others remark that some people in mourning suffer terribly and that there is no reason to refuse to treat them and ease their suffering if they would like. It's difficult to distinguish. But what is good, is that everyone is talking about it and there is a debate" (Falissard cited by Favereau, 9 May, 2013).

Indeed, Falissard's remarks clearly include stress as a mental health issue that is difficult to medicalize and to fully integrate into French healthcare services. This is significant within the context of this thesis because, the data I collected during my fieldwork supports this claim. Indeed, not only did a variety of different practitioners from both sides of the conventional-complementary relationship clearly identify stress as a growing concern among the French population, they also identified the difficulty surrounding its medicalization and directly related it to the exponentially growing interest in and use of complementary medicine in France. As such, it appears as if this globalization-related trend towards increased stress, mental health problems, and substance abuse is playing an important role driving interest in complementary medicine. Furthermore, as indicated in this and the previous section, my fieldwork suggests that the conventional healthcare system's inability to expand its role in order to encompass these globalization-related public health trends is further increasing the "space" in which complementary medicine is expanding. Therefore, we will now turn towards an analysis of these aspects within my fieldwork data.

One of the most interesting examples of these interrelated phenomena that I encountered in my fieldwork emerged during my interview with a Representative of the *Ordre des médecins*. While this particular interview has been repeatedly cited throughout this thesis, this representative's specialty within the *Ordre* is now particularly relevant for consideration. This is because, the representative I spoke with was a national head of the *Ordre*'s section dedicated to "public health and medical demography" (2015). The Representative of the *Ordre* clarified that this section dealt with:

> "All that is in the domain of the number of doctors in France and public health, which is everything in the domain of prevention, vaccinations, preventive health, and all that is in the domain of drugs, alcohol, tobacco- that is the domain of our section" (2015).

Recalling that the *Ordre des médecins* is a professional order that is "made up of and managed by doctors" as an "intermediary between patients and doctors" and between "doctors and the national administration;" it is important to keep in mind that in addition to their oversight of the medical profession in France, the Representative of the *Ordre* described the *Ordre*'s role as, "a role of information and mediation" (2015). The existence and scope of the public health section that our representative works in attests to this "informational" role in terms of the *Ordre*'s activities counseling the "national administration" on healthcare priorities; as such, our Representative of the *Ordre* provides us with an interesting insight into the "official" French medical position on the trends that are being addressed within this chapter. With this in mind, I found there to be some very telling nuances within this representative's discourse concerning the French population and the public health trends that are being discussed here. For example, as was cited in Chapter 1, the Representative of the *Ordre* referred to the rise in complementary medicine using the French expression about people wanting, "to have the butter, the money from the butter, and the mouse from the

creamery" (2015). It is of note that he followed this statement with the following clarifying remark: "[French people] want to be in good health, want to be in good form, they want to be serene, they want to be happy and all of that- people want everything now" (2015).

Clearly, when coupled with the French expression he used to introduce this remark, our Representative of the public health division of the *Ordre des médecins* views the same separation between "well-being in terms of health," and "well-being in terms of happiness" that Politician C demarcated in the previous section. Furthermore, he views people's search for "well-being in terms of happiness" in the conventional medical realm as being overly-demanding and identifies it as the primary reason why complementary medicine is on the rise, saying that doctors are:

> "Overwhelmed now with normal care, and then everything that is well-being now they don't have time to deal with it all- and thus, *bah* there are others who have taken the niche, so there's alternative medicines […] people who treat the healthy" (2015).

I find it of significant note that the Representative of the *Ordre* categorizes people's contemporary search for well-being in terms of being a burden on the healthcare system that is causing doctors to be "overwhelmed" with patient demand for care that is not "normal" or habitual. The disdain that the Representative of the *Ordre* had for this trend was palpable in our interview, evidenced by the reference that he made characterizing complementary medicine in terms of people who "treat the healthy." Indeed, he went on to further underscore this non-medical nature of complementary medicine by comparing it to the "Dr. Knock" character from Jules Romains' 1923 satirical play: "*Voilà*, you're in good health, and as Dr. Knock says […] 'those who are in good health are sick people who aren't aware of it' [laughs]." In the context of Romains' play, Knock or the Triumph of Medicine, Dr. Knock is a charlatan who takes over a medical practice in the country. Due to the population's good health, Dr. Knock begins convincing healthy people that they are sick as a means of making business for his newfound medical practice. Thus, within this context, the Representative of the *Ordre* is characterizing complementary medicine in general as charlatanism with a focus on treating "healthy" people. This is incredibly telling considering that this representative works within the *Ordre*'s public health division and thus, plays a role in informing the French government on public health priorities in the context of the increasing mental health, substance abuse, and the stress-related chronic diseases that have been identified in this chapter. This is given additional nuance considering the remarks this representative made approximately 30 seconds after his reference to Dr. Knock, specifically that:

> "We are in a society now that is much more- well, admittedly we maybe work less, but people are more stressed now, they work less but they have to do in less time what they did before in more time, so they feel pressured and so they are stressed and so they have problems- somatic problems *hein*- digestive problems and all of that, so they look for things that will relax them, they do sport, zumba, aquagym, they go running, they do yoga, the go to see the psychotherapist, the sophrologist, the iridologist and company- because they want to relax and all that" (2015).

Notice how this Representative of the *Ordre* recognizes the mental health trends that have been identified in this section, yet dismisses them as "non-medical" by referring to them in terms of going to see "the psychotherapist" and complementary practitioners in order "to relax and all that." This indicates that clearly, the *Ordre des médecins* is aware that stress is a growing issue in society. It also further underscores the nature of the "medical"/ "medico-

social" divide by grouping psychotherapists in with the complementary practitioners this representative compared to "Dr. Knock." Additionally, just as was suggested in the beginning of this section, the Representative of the *Ordre* recognizes the relationship between globalization, time-space compression, and increasing stress. He then links that stress to the rise in complementary medicine; which 30 seconds earlier he belittled as "treating the healthy" and related to an infamous literary charlatan. Nevertheless, the Representative of the *Ordre* does associate increased stress with "somatic problems," which means that he recognizes that there is an intertwining between stress and physical health. Yet, it appears as though the *Ordre* does not readily consider this negative relationship between stress and health problems as significant enough to be included as legitimate in conventional medicine. Rather, he dismisses it as part of a perceived need "to relax and all that," vilifies it as "overwhelming" conventional care with "everything that is well-being" and relates it to the rise in complementary medicine. He then discredits this rise in complementary medicine in terms of charlatanism and a practice of "treating the healthy" that merely caters to people's search for "well-being in terms of happiness" or relaxation.

This indicates that while the *Ordre des médecins* is aware of the increasing stress and its potential health consequences, it remains squarely situated on the "very medical" side of the "medical"/ "medico-social" dichotomy and upholds the separation of "well-being in terms of health" and "well-being in terms of happiness." This implies that French conventional medicine is unable to fully accept increasing stress as a medical issue that merits full conventional medical attention. As such, we again see evidence of the "space" or "niche" that these divisions are creating and in which complementary medicine is expanding. What is extremely curious about this discussion is that while the *Ordre des médecins* clearly recognizes this dynamic; it neither fully rejects nor supports the "complementary" role that complementary medicine is playing in light of increased stress and mental health issues as larger globalization-related public health trends. Rather, the discourse that is given to us here can be characterized as ambiguous. The Representative of the *Ordre* recognizes the limitation of conventional medicine's role and its subsequent inability to address the rising "somatic" needs of the French population in the globalized environment, but still characterizes these needs as "non-medical" and downplays them as being the problems of "healthy people" who are overly-demanding and greedy by wanting to be "healthy," "in good form," "serene," and "happy" all at one time. In other words, as people who want "well-being in terms of happiness," instead of just being content with the "well-being in terms of health" that the French medical system is tasked with providing. Thus, while the Representative of the *Ordre* recognizes that there is a demand and a role for complementary medicine to address the global well-being of the population, he characterizes this role as being outside of the scope of conventional medicine; and thus as something that does not deserve a serious place in French healthcare. Furthermore, he does not relate the globalization-stress-health dynamic to the kinds of socio-economic costs that are being emphasized by entities such as the WHO.

Following my fieldwork with Shaman C, I can attest that the Representative of the *Ordre*'s assertion that complementary practitioners are merely "treating the healthy" or convincing healthy people that they are sick like Dr. Knock, did not correspond to the clients I interacted with during my fieldwork. Indeed, very few of the clients that came to see Shaman C during the three years I spent in his practice could be classified as "healthy." A significant proportion of his clients were either living with or recovering from various forms of physical illnesses. I found clusters around the following conditions among Shaman C's clients, listed in order of significance in occurrences: chronic pain; cerebrovascular accidents; cancer; various forms of colitis; assorted gynecological or prostate conditions; and motor handicaps. Additionally, an overwhelmingly large proportion of his clients were living with or suffering

from mental health and substance abuse issues including: stress; anxiety; depression; histories of abuse and psychological traumas; phobias; alcoholism; drug use; schizophrenia; and all of the personality disorders defined in the DSM-5[76]. When I asked Shaman C about my observation of these trends among his patients he laughed and responded:

> "Yes, it's true, a large percentage- the majority- of my clients have anxiety, anguish, depression. Anxiety comes from the desires of the mind and it provokes problems, anguish is the impotence that comes from not actualizing things in your life, and depression is the resulting illusion of nothingness. All of the people that come to see me have problems- people that are well, happy, and healthy generally don't come to me, why would they?" (2016).

This quote is particularly interesting because not only does it act as a direct counterpoint to the assertions that were made by the Representative of the *Ordre des médecins* above, it also supports the link between stress and its associated health conditions that were identified in the Europe-wide epidemiological analysis cited by EU-OSHA. Notice how all of the conditions that I observed as significantly reoccurring within Shaman C's clients figure on the EU-OSHA list of stress-related conditions (EU-OSHA, 2014). This is not to say that all of Shaman C's clients were suffering from stress; just that it is of note that there was a significant clustering of stress-related health conditions among them. This is remarkable when coupled with the remarks given to us by the Representative of the *Ordre*, because it implies that since French conventional medicine does not appear to consider stress and stress-related health problems as falling in its domain, people are going into the realms of complementary medicine for treatment of these conditions. Going further on this theme, I found it incredibly telling that Shaman C characterized "a large percentage" or "the majority" of his clients as suffering from "anxiety, anguish, depression" or mental health conditions. He underscored this by noting that there was no reason for people who are "well, happy, and healthy" to come seeking his services; a logical conclusion that is in direct opposition to what the Representative of the *Ordre* told us about complementary medicine. Not only does this further underscore the French manifestation of the WHO claim that most medical systems do not adequately treat their populations' mental health needs, it also indicates that the Representative of the *Ordre*'s derogatory comments about complementary medicine can be considered as evidence of the *Ordre*'s view of complementary medicine in terms of the stigmas and stereotypes that were analyzed in Chapter 2.

When Shaman C's statement and my field observations of his clientele are considered along with the ambiguity that the Representative of the *Ordre* expressed, we can see that the position of the *Ordre des médecins* appears to be in contradiction to the global public health trends that international entities such as the WHO and the EU are characterizing as vital concerns meriting priority in conventional medical systems worldwide. The current literature on the anthropology of public health in the globalization era argues that the public health vision that is being propagated by the WHO is transforming the "object of health" into a "social body" that is "normalized" (Hours, 2001). In other words, the WHO discourse concerning the rising mental health, stress, and chronic illnesses around the world

[76] This is the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) that contains the standard classification of mental disorders and is the principal authority for making psychiatric diagnoses used by mental health practitioners in the United States and in much of the world. While none of the clients that came into Shaman C's practice while I was there admitted to having been diagnosed with a personality disorder, considering the evidence about my personal background in mental health that was presented in the introduction, I feel I have enough lay-knowledge to spot a personality disorder when I encounter one. I often discussed these clients with my psychiatrist father who also confirmed my suspicions of personality disorders in most all cases.

reconceptualizes health as an integral component of social capital. As a result, this makes illness appear to be a sort of rupture in the social order, which informs the logic behind the kind of preventive and behavior health approaches that focus on promoting healthy lifestyles as a way of limiting the risks of illness. We can see this clearly in the global public health evidence that was presented in the introduction to this chapter. Notice how the all of the WHO and EU-OSHA rhetoric focuses on the socio-economic costs that are created by increases in mental health, stress, and substance abuse.

What I found remarkable within my fieldwork and research is that the French government both does and does not acknowledge the importance and socio-economic consequences of the public health trends being discussed in this and the previous section. In 2017, the French Ministry of Health published a position paper presenting its strategy for preventive health. The document opens with an emphasis on the importance of promoting good behavioral health in terms of the socio-economic costs related to obesity (20.4 billion euro), alcohol (15 billion euro), and tobacco use (26.6 billion euro) in France (Ministry of Health, 2017). It specifies that the national preventive and behavioral health policy extends to "all living environments" including schools, workplaces, and both "medical and medico-social establishments" (Ministry of Health, 2017, p.11). This policy document specifically covers the importance of preventing substance use, promoting healthy nutrition, promoting physical activity, promoting sexual health education, preserving functional mobility, promoting good hygiene and hand-washing, and ensuring healthy housing conditions. It then moves on to cover work-related health issues, namely: minimizing exposure to interior and exterior pollutants, excess noise, and preventing musculoskeletal issues related to physical labor and repetitive motions. The report covers insect-borne infectious diseases, vaccinations, preventing antibiotic resistance development, cancer screening, and ended with a section emphasizing the importance of creating proper care pathways for chronic diseases (Ministry of Health, 2017). Thus, we can see that while French healthcare acknowledges the socio-economic costs of current public health trends that encompass behavioral, lifestyle, and work-related health pathologies, it remains limited to the material, "medical" side of the dichotomy. Reading it, I was struck by how this strategy was largely limited to the same kinds of classic public health concerns that have been around since the 19$^{th}$ century origins of public health initiatives. Other than its inclusion of substance abuse, there was no mention of the mental health and stress issues that global public health entities are emphasizing.

This indicates the presence of a contradiction in French conventional health care. The rhetoric that was presented in this and the previous section from the Representative of the *Ordre des médecins* and Politicians C and N all underscore the clear boundary that prevents the conventional medical gaze from expanding to a wider notion of global well-being that includes both the health and happiness components that are being implicitly advocated by international public health organizations. This contradiction evidences the French healthcare system's inability to truly expand the conventional medical gaze to address a global vision of health and well-being. This contradiction was brought to light in the rhetoric of multiple conventional medical healthcare professionals who all responded to my questions, "What is the definition of health?" with conceptions that were closely related to the WHO definition of health: "A state of complete physical, mental, and social well being and not merely the absence of disease or infirmity." For example, Doctor O defined health as: "A state that allows you to be well […] in all dimensions of one's physical, intellectual, professional, social, spiritual life and to be in harmony with one's environment and with others" (2015).

Hospital Administrator B directly echoed this conception of health saying that it was, "That of the WHO […] it is being […] in balance between […] the bio and the psycho and the

socio, meaning […] that there has to be a balance between the three with this possibility of feeling well" (2017). In fact, even our Representative of the *Ordre des médecins* gave me a definition of health that was completely oriented around this sense of global well-being:

> "There are various kinds of health, there is physical health and moral health […] One can be in good physical health, but feel tired and after various exams they are all normal, because morally they aren't well. Good health is a certain serenity, it's evident in life […] Even if we have good physical health, morally we can have troubles, it's fragile all of this and it can evolve, but all of this together is health. I would say it's a machine that works well- so all of this is good health, it's the combination of a state of serenity in a perfect body" (2015).

To me, these comments perfectly encapsulate the contradiction in French medicine that I am referring to in this section. Healthcare professionals, the *Ordre des médecins*, even the health policy of the Ministry of Health includes both "physical" and "moral" components of health; yet the evidence in this section suggests that they do not consider "health" as falling within the conventional medical gaze. This was underscored by Politician C who responded to my question on the definition of health by saying, "I don't have a definition for health, I would just use the one given by the WHO" (2015).

Within my fieldwork, much of the discourse that was given to me by complementary practitioners seems to shed light on a potential reason behind the difficulty the French medical gaze has in expanding to include the well-being and "health" components of public health trends identified in this chapter. Namely, it can be understood in terms of the conventional medical desire to maintain its authority over both patients and their bodies. My fieldwork indicates that this has to do with the conventional medical dominance over the notion of "illness" that does not extend to the conceptions of "health" given to us by both the WHO and conventional healthcare professionals. For example, consider how Kinesiologist R discussed the relationship between illness, stress, and the "success" that kinesiology has in helping patients suffering from stress and mental illness:

> "It's medicine that defines illness, *hein*. I would say that it is symptoms of dysfunction that are the opposite of a state of well-being, symptoms of imbalances […] We can heal the symptoms without healing the cause, but that is not at all the approach that interests us […] That is why we have a certain amount of know-how concerning stress management, which is particularly important in our epoch, for example ameliorating the state of people who suffer from depression […] It's not our role to diagnose or to say that a person doesn't feel well or is suffering, people come to see us because they feel they don't have well-being and we see that after our sessions their state is improved, effectively it's us that have a certain success with what people call stress management" (2015).

This quote follows perfectly in line with Foucault's (1973) conception of the authority that the medical gaze gains by filtering or defining the objects that are considered as legitimate for inclusion within the conventional medical paradigm. Here we see that Kinesiologist R acknowledges the authority of the medical gaze by specifying that it is "medicine that defines illness." In other words, he is saying that conventional medicine does not "see" the globalization-stress-negative health dynamic within its limited gaze. His discourse implies that the reason for this medical refusal to "see" stress and depression is because conventional medicine remains oriented around its curative, illness-based logic that defines the conventional medical role in terms of diagnosis and the treatment of the symptoms that are linked to illnesses. In other words, French conventional medicine does not readily

accept stress, depression, or anxiety as an "illness" or as integral parts of "illnesses." Instead, these "medico-social" issues are seen by the conventional medical gaze as components that are outside of its domain and related to a person's general state of overall "health" and "well-being."

Kinesiologist R's discourse indicates that rather than operating according to the dynamic that the Representative of Miviludes associated with complementary practitioners convincing patients to come and see them through proselytizing, patients are being "pushed" into complementary practices as a result of their sense that they "do not have well-being" due to their increased stress and mental troubles. Since conventional medicine does not consider these as falling within the definition of "illness," and thus, as being within the realm of "health" and "well-being" that is outside of the conventional medical role, my fieldwork indicates that these patients go in search of complementary practitioners that are willing to treat these "sources" of patient discomfort. This is specifically evidenced by his remark that "patients come to see us" and Shaman C's remark that "people come to see me." This implies that these complementary practices are oriented around a global vision of "well-being" and its relationship to "health." As a result, according to Kinesiologist R and Shaman C, their practices are able to effectively treat the stress and depression that they consider to be the "source" of patients' malaise. Doctor M added important nuances to this discussion by stating:

> "We have a lot of difficulty- in my opinion as a conventional doctor, a hospital or university doctor- saying that health is not only the absence of illness. We only treat this work very incompletely, we stay in a very small part of the determinants of health and we work on our illness, we don't work with well-being and the quality of life and there is still this dogma that is funny in intensive care that 'illness is a death that is healed' [laughs] meaning that the important thing isn't whether the illness is healed, it's only if the patient dies or not that is important" (2015).

Notice how here, Doctor M explicitly identifies conventional medicine's total appropriation of and control over "illness" by saying that "we work on our illness" using the possessive pronoun "our." The "dogma" that he cites is exactly how Doctor H explained his role in Chapter 1, namely that his job involved "taking care of people and not letting the patient die" (2015). It is also worth recalling the multiple cases in Chapter 2 in which we were told that "dogma" is not associated with conventional medicine; we now see that the reality is far more nuanced. Doctor M's discourse clearly states that conventional medicine is not interested in "well-being and the quality of life," rather it is fixated on acute, illness-related care that keeps the patient alive with no regard whatsoever for how the patient feels in their life. This sheds light on the reasons why so many of the rare disease and motor handicapped patients in Chapter 3 were told by their doctors that they needed to just "accept" their conditions. According to what Doctor M tells us here, this can be understood in terms of the "very incomplete" scope of the French medical gaze, which remains focused on "a very small part of the determinants of health." The limitation of these parts was reflected in the Ministry of Health policy concerning preventive and behavioral health that was presented earlier in this section; namely, only the material aspects of health that are clearly and directly related to illness were included, such as nutrition and obesity. This document made no mention of the immaterial and more subtle aspects of overall health such as depression, stress, and anxiety; because they're not easily "seen" within the French medical gaze.

In order to understand why this is the case, it is helpful to examine a comment that was made about the nature of health within my discussion with Hospital Administrator B. After defining health in terms of a balance between the "bio and the psycho and the socio" that gives us "this possibility of feeling well," she noted that this balance involved, "definitions that are subjective. It's true that there needs to be an equilibrium, but it follows one's own- it depends on where one places the marker of balance [chuckles] on which level" (2017). The key here is that Hospital Administrator B emphasizes that one's "balance" or "health" is "subjective." Whereas illness can be measured according to objective indicators such as blood-levels, health is based on an individual's subjective feeling about their state of "balance," "serenity," "harmony," or "well-being." Due to its subjective nature, a person's overall or global state of health cannot be fully appropriated by conventional medical authority. This explains why, in Chapter 1, so many complementary practitioners defined their role in terms of accompanying people, not healing them. In other words, since they are generally focused on health and well-being or the "medico-social" rather than on illness or the "very medical," they tend to conceive of their role in terms of going to the "source" of a patient's suffering rather than healing their illness. The source of the patient's suffering was described in terms of notions such as "balance" and "harmony," which we now see are associated with an overall state of health and well-being, not illness. Hence why Kinesiologist R specifies that people come to see kinesiologists because "they feel they don't have well-being," rather than because they feel that they are ill.

As a example, we can reconsider Anesthesiologist A's emphasis on the subjectivity of pain in Chapter 2. He told us that pain is a "subjective experience" that is often "psychological or idiopathic" (2017). Within the context of this chapter, this is significant because it supports both the discourse given to us by Kinesiologist R and the epidemiological evidence linking mental health factors, like stress, to musculoskeletal issues such as chronic back pain. As we saw in Chapter 2 through the story of Shamanic Client D, the conventional medical inability to "see" the kinds of "medico-social" "dysfunctions," such as stress and depression, as a "source" of complex pathologies, such as pain or cerebrovascular accidents, is pushing patients into the realms of complementary medicine. The discourse that was given to me by all of the complementary practitioners I spoke to indicates that complementary practices, such as all of those that have been cited throughout this thesis, readily include the metaphysical and "medico-social" elements that contribute to a patient's overalls sense of "well-being" into their complementary role and gaze. I interpret this as a key explanatory factor for the data clusters I found in which complementary practices were significantly grouped around specific medical conditions. These were put forth in Chapter 3 and identified as: birth, death, pain, cancer, life-long handicaps, and rare diseases. We can now add the stress-related conditions and mental health conditions that we have explored in this section to that list. While in Chapter 3 these clusters were explained in terms of conditions that were on the fringes of the conventional medical gaze, we can now see that they can also be interpreted as falling on the "medico-social"/ "health and well-being" side of the conventional medical boundary. This implies that while the role and gaze of French conventional medicine struggles to expand its conception of "illness" to include both "health" and "global well-being," complementary medicine is readily filling the gap that is created. Kinesiologist R's discussion of this can thus act as a nuance on one of the sources of the increasing patient demand for complimentary practices: "they feel they don't have well-being" and conventional medicine is unwilling and/or unable to cater to their well-being; so patients gravitate towards the complementary practitioners that are playing this role.

What I found to be very interesting throughout my fieldwork was that this was not at all limited to the specific practice of kinesiology. Rather, a surprising variety of different

complementary practitioners all seemed to express their adherence to this shared conception of the complementary medical role and gaze. Furthermore, when I asked the complementary practitioners I spoke with about the major changes they have seen in their clientele; almost all of them identified "stress" as a key factor driving their increased client volume and the subsequent demographical characteristics of their clients. For example, Shiatsu Practitioner C told me that:

> "The current context is a context in which modern men and women are increasingly faced with diverse stresses, anxiety-related stresses, bad food. So big problems are beginning to occur, people don't exercise, well some people do thankfully, but others don't do much and they become obese and then they have problems […] and for all of these people shiatsu does formidable good, because it puts the body back into an energetic state that is good physically and emotionally and that promotes the maintenance of good health" (2015).

Thus, here again, we see the reference to the wider globalizing context and its relation to the "globalizing sedentary lifestyle" that results in a chronic health problem that has been repeatedly identified by organizations such as the WHO as being a significant part of the global health burden. In other words, we see another complementary practice that seems to easily adhere to the "socialized" concept of "health" that is promoted on the international level of public health discourses, such as those that were presented in the beginning of this section. Shiatsu Practitioner C acknowledges the negative health consequences that are associated with increasing stress and obesity and cites them as a factor that is increasing the general interest in shiatsu. What I found to be particularly interesting in my fieldwork with complementary practitioners was that most all of them saw this connection between increased stress and the negative health consequences that resulted as falling squarely within their role, which they described as ameliorating stress in order to promote a global notion of well-being with positive health impacts. Yet, the evidence in this chapter indicates that conventional medicine views this as falling outside of the scope of the conventional medical role.

Taken together, all of this can be related to a claim that was made by Kuhn concerning paradigm shifts, namely that, "no part of the aim of normal science is to call forth new sorts of phenomena; indeed those that will not fit in the box are often not seen at all" (Kuhn, 1970, p. 24). Notice how, like Foucault, Kuhn uses the verb to "see" in reference to what is considered as legitimate for inclusion in a paradigm. Within this chapter it appears as though the current relationship between conventional and complementary medicine can be interpreted in terms of two paradigms: that of the "normal science" of the dominant conventional medical paradigm which this thesis has shown is limited to the purely "medical" domain; and the complementary medical paradigm, which has been shown to maintain a global vision of an individual that is focused on their overall "well-being" in such a way that it takes into account the "medico-social" domain in its totality. Following the logic of Kuhn's theory, the trends that are being identified within this chapter imply that French conventional medicine is currently in "crisis," which Kuhn defines it terms of the, "the breakdown of the normal puzzle-solving activity of the paradigm and the proliferation of alternatives," or in terms of the, "failure of the existing rules [that] precedes a search for new ones" (Kuhn, 1970, p.69). In this case, the increasing prevalence of stress can be interpreted as a "new sort of phenomenon" that the discourse in this chapter indicates does not "fit into the box" that French conventional medicine defines according to that which is "very medical," or related strictly to "well-being in terms of health." As such, we have seen repeated rhetoric on both sides of the conventional-complementary relationship that place things such as anxiety, depression, and stress as things that are not easily "seen" or included in the French

conventional medical paradigm[77]. Going further, I found it of note that the rhetoric that was given to me by multiple complementary practitioners in the context of my fieldwork indicates that contemporary French complementary medicine seems to embody the "two essential characteristics" that Kuhn identifies in terms of a "new" paradigm, namely that complementary medicine shows "achievements that are sufficiently unprecedented to attract an enduring group of adherents away from competing modes of scientific enquiry;" and that it is, "sufficiently open-ended to leave all sorts of problems to be solved by their new practitioners" (Kuhn, 1970, p. 10).

All of these characteristics were clearly identified in the above discourse given to us by Kinesiologist R. He says that "medicine defines illness" and then goes on to give his personal definition of illness in terms of being the "opposite of well-being." This is the inverse of the conventional medical vision of illness, which we have been told is limited to a very narrow conception of "well-being in terms of health," or the absence of illness. In an echo to what Shiatsu Practitioner C tells us, Kinesiologist R indicates that kinesiology has "a certain success" with "stress management," a phenomenon that he identifies as "particularly important in our epoch." Taken together, the discourse of Kinesiologist R and Shiatsu Practitioner C indicate that complementary practices represent the "proliferation of alternatives" that Kuhn tells us occurs in light of the "breakdown of the normal puzzle-solving activity of the paradigm." In this case, this "crisis" in conventional medicine is occurring as a result of its inability to move beyond the "very medical," to include the "medico-social" concerns, such as stress, which are increasing as a result of globalization mechanisms. According to Kinesiologist R and the Representative of the *Ordre des médecins*, this is driving people who feel that they do not have "well-being" into the realm of complementary medicine.

This overall dynamic was also identified by Doctor J within our discussion of the changes he has noticed in his patient base. Doctor J told me that:

> "What I see more and more is a reflection of what is occurring in society and it is retained in the life of individuals. It's that work-related suffering is being increasingly expressed, harassment and suffering at work. Yes, this is also expressed in other forms of suffering, but it is the most evident, the most flagrant in terms of restraints caused by work-related suffering- and in a clientele that is particular […] is the will to understand and to master one's life in the sense. Like Bakunin[78] says, when I go to the bootmaker I know that he knows how to make my shoes, but I'm the one who chooses the color of my shoes and I go to someone who has more knowledge, but I'm the one who decides what I do- and that is a great pleasure because that is the goal, the goal of medicine is to restore, with your knowledge, the autonomy of the person so that they can choose what they are going to do or what they want to be. We are only a force of suggestion because we have studied a specialized sector, that's all" (2015).

[77] According to the WHO reports cited in the beginning of this section, this seems to be a relatively global phenomenon, but as this thesis is focused on France, I will limit this discussion to the "French conventional medical" paradigm.

[78] The actual quote that Doctor J is referring to is from Mikhail Bakunin's work God and the State, published in 1882.

Here again, we see a complementary practitioner describing the increase in their client base directly in terms of both the increase of work-related stress, and the desire of his clients to actively search for "someone who has more knowledge" that can help them "understand and master" their own lives so that they can find their own well-being. This is a direct echo of the various discourses we have seen from complementary practitioners suggesting that their practices help patients to change their lifestyles and behavior towards healthier patterns. What is interesting here is Doctor J's reference to his perceived role in terms of restoring "the autonomy of the person so that they can choose what they are going to do." This can be seen as the direct opposite of the role of doctors that was given to us in Chapter 2 in which doctors told us that they make diagnoses and then determine the treatment path for the patient. In Chapter 2, Shaman C referred to this process in terms of, "the patient waits for the doctor to give them a dictate, a sentence called a diagnosis." The fact that Doctor J uses Bakunin in order to frame this discussion here is significant, because it refers to the imbalanced authority that doctors wield over their patients due to their extensive knowledge of "a specialized sector." Clinical Researcher R referred to this by saying that it is "as if the doctor is on a pedestal where he is the summit of the pyramid" (2015). When I asked Doctor J about doctor authority he responded:

> "I have never allowed myself to impose a treatment or to say that, 'It's this or nothing,' or that 'If you don't take this you are stupid.' That happens, I have had patients tell me about their consultations with doctors who have a fist of violence that is incredible towards their patients, it's unimaginable. I'd flip a table over the head of that kind of person saying, 'By what right do you have to speak to me like that?!' […] Yes it's the absolute knowledge, 'I know, you don't know, and you are my object, I discharge all initiative and liberty' […] there is pride in this, we take ourselves for the all-powerful, it's complete pride and it's terrible, *viola.* The doctor is the place of knowledge and the other, the patient, is the place of ignorance and the roles are assigned like that […] Doctors take themselves for gods and patients remain as babies, dependent babies" (2015).

Within this quote we see the perceived medical authority or "absolute knowledge" about illness. The "fist of violence" that Doctor J refers to explains why Shaman C discussed a diagnosis in terms of a "sentence" or "dictate," by characterizing the doctors diagnosis and treatment plan in terms of removing "all initiative and liberty" from the patient. Within this medical vision, the patient is objectified, or seen in term of a "sequence of organs" or a "sack of chemicals." They are seen as an "other" that is a "place of ignorance." This representation of doctors as "all-powerful" "gods" and patients as "stupid" or "dependent babies" brings to light the imbalanced power dynamic within the doctor/patient relationship. Here, doctors are portrayed as having "complete pride" due to their "absolute" authority over illness.

This imbalanced power dynamic and the imposition of a medical treatment on a patient was a reoccurring theme that repeatedly surfaced within my interviews with both conventional and complementary practitioners. For example Shaman C told me that:

> "Doctors don't give alternatives because they don't believe in them and they don't have authority over them […] Many times they tell patients, 'You have cancer […] you have to have chemotherapy,' and the patient is cornered with no escape. Imagine if a patient were to say, 'I'm going to do an alternative therapy,' the doctor would reply 'Fine, try and arrange that with your family so that they don't put the responsibility on me when you die.' So I'd go to my family and try to tell them, but they'd say, 'You're crazy! You have to have chemotherapy because the

> doctor says.' So doctors and medicine have robbed me of my dignity because there is no alternative other than chemotherapy and since they have the power I will listen to my family and submit myself to chemotherapy, but because I'm very fat chemotherapy destroys my heart. In many cases the heart can't withstand chemotherapy, but doctors don't say that chemotherapy was the problem, they say I was- and this is the problem, many human beings are violated by medicine- I'm only telling you what my patients talk about" (2014).

Within this vignette, Shaman C provides us with a highly nuanced insight into medical authority. Like Doctor J, he begins by emphasizing the conventional medical authority over and imposition of treatment determinations on their patients. Also, much like Doctor J, Shaman C indicates that if a patient were to attempt to refuse that medical treatment plan, the doctor replies with a threat of certain death. Just as was the case with Shamanic Client D, we again see that in addition to their "absolute" authority over illness, diagnosis, and treatment, doctors have an indirect authority over their patients through the pressures that a patient's family can exert over them in relation to their illness and/or treatment plan. Susan Sontag (1978) discussed these social pressures in terms of the shaming, discouraging, and silencing of patients in her work Illness as Metaphor. In a direct echo of Doctor J, Shaman C also refers to doctor and medical authority of "robbing" patients of their "dignity" by making them entirely dependent, since doctors have "the power." It is also extremely significant that Shaman C concludes his vignette with the patient being blamed for the heart damage that resulted from the chemotherapy due to their obesity[79]. This perfectly underscores Hours' (2001) reference to the "normalized, social body" and public health's moralizing component that "marginalizes the sick" or blames them for their own poor health (p.5).

Doctor H also referred to his insistence on patients respecting the supremacy of his authority over their treatments using the same "it's this or nothing" language referred to by Doctor J. Specifically, he told me that his patients should:

> "Feel at home when you are in my hospital but never forget, it's my home. When you are in Rome do as the Romans do, so when you are in this hospital you do as we do, if you don't agree with that just go away. One very easy example is Jehovah's Witnesses. They don't want to have blood transfusions and when they come here they say, 'We come because you've got a very low rate of blood transfusion' […] So they come here and say, 'We are a religious sect,' and I say, 'Come, but if the woman has a risk of death I will do a blood transfusion, do you agree, yes or no? There is no gray answer, it is white or black, there is no perhaps- if you don't agree just go away, it's not my problem it's yours.' I can't take care of people that don't want to be involved in what we are doing if you don't want it, just go away" (2015).

[79] According to a *Harvard Heart Letter* entitled "Cancer treatments may harm the heart," published online in August 2012 by Harvard Health Publishing, Cancer treatment is a "double-edged sword" that can "damage the heart or peripheral blood vessels, or cause problems with clotting or blood lipids" with symptoms appearing even long-after the cancer has "become a distant memory." This letter goes on to cite Dr. Mandeep R Mehra, executive director of the Center for Advanced Heart Disease at Brigham and Women's Hospital and a professor at Harvard Medical School saying, "Almost every chemotherapy drug has some effect on the cardiovascular system, and most are not good." Indeed, this letter states that, "The cardiovascular side effects that arise from cancer therapy are frightening." (Available online at: https://www.health.harvard.edu/heart-health/cancer-treatments-may-harm-the-heart). This supports Shaman C's claim; considering his more than forty years of experience treating clients and the volume of his client base, Shaman C has indeed encountered numerous cases such as the one he describes here.

This quote adds nuance to this discussion of medical and doctor authority. In an echo to the vignette given to us by Shaman C, Doctor H is imposing his medical authority on his patients as a way of ensuring their safety and preventing them from dying under his care. In this sense, it explains why, in Shaman C's reference, a doctor will insist that a cancer patient undergoes chemotherapy. Namely, it is because the hypothetical oncologist in Shaman C's story believes that chemotherapy is the only option for healing the patient's cancer; just as Doctor H will do a blood transfusion if it necessary, despite the patient's personal belief, because he believes that it is a means of keeping them alive. Thus, we now have some insight into the intensive care "dogma" about "a death that is healed" that was given to us by Doctor M. When this dogma is coupled with these remarks from Doctor H, we can see the logic underlying a doctor's primary role in terms of keeping their patients alive. Beyond healing illnesses, if doctors do not do their upmost to keep their patients alive they have no reason for existing; why would a patient go to a doctor that will not do everything in their power in order to preserve their life?

Nevertheless, the global public health trends that have been identified within this and the previous sections all indicate a shift that is occurring in the primary nature of both health and illness. The burden of disease has been evolving in conjunction with the phenomenal conventional medical advances in the last century. We are now able to heal more conditions, prolong life, and give people the opportunity to live longer lives, even if they have certain health conditions. Concurrently, globalization and its mechanisms are changing lifestyle patterns, working conditions, and all aspects of human life on a global basis. As a result, there is now increased chronic diseases, increased stress and anxiety, and the mental health disease burden is fast eclipsing that of communicable diseases. These changes bring to light a limitation in the medical gaze, authority, and ability. As Homeopathic Doctor Q explained it:

> "Now we give medications to treat, certain medications don't heal they treat. We give medications to treat diabetes, but we don't heal it and so there are many medicines that treat, but not heal" (2015).

I feel as though this citation encapsulates the shift that is occurring in terms of patient expectations and trends. In the era of communicable diseases we went to the doctor to be healed; but in the globalized epoch of longer lives, increases in chronic diseases, increases in mental health issues, and increases stress and anxiety, doctors and medicines are treating more than they are healing. This constitutes a fundamental shift in the role and nature of conventional medicine. Yet, due to the historical antecedents of contemporary medicine that have become structurally integrated components of conventional healthcare systems, conventional medicine must adapt to expand the scope of its gaze. Unfortunately, the fundamental curative and illness-oriented basis of conventional medicine makes it so that integrating notions such as health and well-being into its practice is difficult. As was identified in this section, this is due, in part, to the absolute medical authority over illness and the patient that defines the doctor's role. Health and well-being, on the other hand, are subjective and dependent on an individual's sense of balance in all aspects of themselves and their lives. They are outside of conventional medical authority, and thus, outside of the conventional medical scope and role. While it is easy to demonize conventional medical authority, the discourse given to us by Doctor H and Shaman C both indicate that the reality is far more nuanced. As such, this theme of doctor authority and resistance to complementary medicine will be returned to in the next section.

For now, it is important to note that due to globalization's information technology advancements, patients now have unprecedented opportunities to inform themselves about

their conditions and potential treatment options. This gives them the possibility of having more autonomy and of taking more responsibility for maintaining their own well-being. When this is coupled with the current international public health discourse normalizing healthy bodies as integral components of social capital, and the public health trends that result in people living longer lives with health conditions; we can see that there are new and unprecedented pressures on individuals to take care of themselves and to find a state of well-being in their lives. Since the limited conventional gaze seems to be experiencing significant difficulties expanding its sights beyond its deeply anchored historical and structural ideological role, my fieldwork indicates that complementary medicine is expanding as a means of picking up where conventional medicine lets off. As we shall see in the next section, this is not occurring without considerable resistance.

### *4.3: The Specificity of France and Deep Sources of Resistance to Complementary Medicine*

Within Chapter 1, a citation was given confirming what my fieldwork indicated was the presence of an "apparent paradox" within the relationship between conventional and complementary medicine in contemporary France. This citation characterized France as distinct for, "its institutionalized hostility to unsanctioned forms of medical practice," despite the fact that it, "is a major producer and consumer of nonconventional remedies, and by certain measures its use of alternative medicine ranks among the highest of Europe" (Ramsey, 1999, p. 286). In the paragraph following this citation, I stated that this thesis would attempt to explain what my fieldwork suggests is a surprising prevalence of complementary medicine in France, despite the fact that the vast majority of these practices are not acknowledged, regulated, or legally sanctioned. To these ends, Chapter 1 began outlining this "paradox" through a consideration of the scope of complementary medicine in France. Chapter 2 added nuances to this picture by exploring the considerable amount of evidence I gleaned throughout my fieldwork concerning the stigmas, stereotypes, and fears coloring the perceptions of both sides of the conventional-complementary relationship. Chapter 2 introduced the presence of several State and professional structures with specific missions to combat the illegal practice of medicine, charlatanism, and sectarian aberrations. Chapter 3 then put the form of this "paradox" into sharper relief by presenting multiple examples of instances in which complementary medicine is being integrated into conventional medical milieus; exploring how this was done, and introducing an expanded notion of what the "acceptance" of complementary medicine entails within the French healthcare system. Finally, the first two sections of Chapter 4 attempted to provide some initial insights both as to why this integration is occurring and why such integration is complicated in the context of the French healthcare system. This was intended as a means of going beyond the rather pronounced presence of the kinds of stigmas, stereotypes, and fears that permeate the conventional-complementary relationship.

Nevertheless, despite what my research identified as the remarkably wide-spread presence and popularity of complementary medicine and the rational factors that appear to both help and hinder its expansion within contemporary French healthcare; I must admit that as an American, I was deeply affected by the repeated emphasis on themes related to sectarian aberrations, charlatanism, and the absolute authority of science and medicine that continually

emerged throughout my fieldwork. As a result, I kept finding myself asking questions in my interviews such as: How is it possible for something to be so present for so long and on such a large scale; and yet, for it to be actively considered as a threat against society? How can something this substantial exist without being acknowledged? What is it about France that makes this possible? Why does everyone keep calling themselves "Cartesian"? Where does this focus on charlatanism come from? These questions sprang from the fact that despite my fairly medicalized and highly academic background in the United States, I had never heard the terms "sect," "charlatan," and "Cartesian" liberally employed in commonplace use until I began researching complementary medicine in France.

As such, I feel it essential to turn towards a consideration of several of the remarks that were made throughout my fieldwork as a means of shedding light on my questions concerning the specificities of France and how those specificities are shaping the contours of its contemporary conventional-complementary relationship. This analysis will attempt to contextualize these remarks in order to bring to light what will be interpreted as some rather nuanced sources of resistance that are hindering the acceptance, regulation, and/or reimbursement of the ever-expanding panoply of complementary practices in contemporary France. In order to do so, we will examine the social position and the nature of the authority of science, medicine, and doctors in relation to what my research identified as case studies corresponding to key instances in France's historical trajectory. This particular analysis informed my understanding of the depth and strength of what I interpret as significant historical vestiges in the French social memory that are having very real effects on its contemporary conventional-complementary relationship. In the next section, this analysis will be extended in order to explore the polemics that are currently unfolding around the case of homeopathy.

The need to consider a bit of French history within my analysis became apparent as a result of the multiple instances in which my interview participants evoked France's incredibly "historical culture" in reference to resistance against the "official acceptance" of complementary medicine (Hospital Administrator A, 2015). For example, within our second interview, Hospital Administrator A related the growing interest in complementary medicine to one of the factors that was cited in the previous chapter; namely, "psychosocial risks and tensions at work- in the end work-related suffering is a reality today" (2015). He then went on to link these tensions with the mentality and perception of his fellow healthcare professionals in relation to complementary medicine, concluding that:

> "We have the impression today […] that there are constraints, there is pressure, there is no liberty- *phew* it's heavy, the climate is heavy- but *voilà*, we don't have a magic wand, we can't change, we can't […] If you take Plato's cave allegory […] we have the impression that we're rigid, that we aren't able to let go- our country, like an individual- we don't have enough self-confidence to properly go out into the light […] I have a tendency to say that it's a symptom of a society that is ageing, and we often talk about old Europe" (2015).

In other words, Hospital Administrator A framed his colleagues' resistance to complementary medicine within his impression that French society as a whole remains shackled to some form of historically-based beliefs. This was made clear by his reference to Plato's cave allegory and what he identifies as a certain cultural rigidity that comes from "a society that is ageing," which he related to the notion of "old Europe." Taken together, this implies the presence of some form of a historical vestige in the French social memory that can be related to contemporary developments concerning complementary medicine. This was further

underscored by Doctor M who expressed a similar impression using different terms; saying that, "In France you say that we're a conventional country- old Europe, *hein*- in my opinion old Europe is above all old France in a way" (2015).

I felt that it was extremely significant that both of these healthcare professionals, working in hospitals with different statutes in different cities, spontaneously identified the notion of "old Europe" as a source of resistance within the French mentality that is blocking the advancement of complementary medicine in contemporary French society. They also both went further to specifically characterize France as an "old" or "ageing society," which they both linked to a form of cultural rigidity that they both felt was hindering the "acceptance" of complementary medicine as a whole. Furthermore, within their discourses surrounding this theme, they both gave me different reasons emphasizing what they felt was the importance of further developing complementary medicine within their respective conventional medical milieus. As such, we can see that there is something within this shared conception that merits exploration.

Curiously, as a precursor to Hospital Administrator A's aforementioned comments, Doctor J also referred to the notion of a "collective ego" as a means of explaining his perception of the continuing influence that French history has on the contemporary French mentality:

> "I think that our society is holding on to its past, so it is a decadent society because it refuses to die in order to transform. Society is like an ego, society is like a collective ego that doesn't want to let go, because it thinks that the current way is the only way it can identify with itself. So there are many new things that are emerging, but our ancient way of thinking doesn't want to nourish itself on these new things as a means of rejuvenating itself. The powers of the king were recuperated during the Republic, they didn't fade away completely, they were just given a different form, but the essential things are still there- there are those who obey and those who govern (2014).

Again here we see a much different type of healthcare provider- this time a mixed complementary-conventional general practitioner in private practice- presenting the current resistance to complementary medicine in terms of a "collective ego that doesn't want to let go" of its "ancient way of thinking" in order to accept "new things as a means of rejuvenating itself." Thus, Doctor J shares the impression that current resistance to complementary medicine is related to the presence of a long-standing and deeply rooted historical vestige. While Hospital Administrator A discussed this in terms of a contemporary lack of "liberty," here Doctor J presents it in terms of obedience to a form of authority. In both cases, this authority is characterized as being historical.

In what can be interpreted as a direct validation of Doctor J's sentiments, the Representative of the *Ordre des médecins* clearly identified the *Ordre* as being one of "those who govern." However, instead of invoking royal authority, he does so with a reference to another prominent authority that played a significant role in French history; the Catholic Church. Specifically, the Representative of the *Ordre* said:

> "We are 54 doctors on the National Council in Paris and so, 'What is the role of those councilors?' I always say that the *Ordre des médecins* is the Vatican- the Pope is the President of the National Council" (2015).

By reinforcing Doctor J's remark that within French society there are still "those who obey" and "those who govern," and by echoing Doctor J's reference to a historical power that was involved in the governance of France in the pre-revolutionary era, we see that historical forms of authority remain active in the contemporary French social memory. Before moving on, it is worth taking a moment to contextualize the Representative of the *Ordre des médecins* comment. This is because this particular quote was given to me as part of the Representative's explanation of the *Ordre*'s role and responsibilities. Specifically, this remark occurred exactly one minute after his explanation of the *Ordre*'s internal jurisdictional chamber, which is "where you can have a penalty or sanction […] going from a warning to the removal from exercise" (2015). Considering the proximity of his explanation of the *Ordre*'s power to ban a doctor from medical practice to his characterization of the *Ordre* as "the Vatican," we can interpret the *Ordre*'s power to ban a doctor from the medical profession as a contemporary re-interpretation of the Vatican's power of excommunication.

When this is taken into account along with the collection of rhetoric analyzed here, it becomes clear that the authorities and their powers that characterized pre-revolutionary French society remain deeply entrenched in the contemporary French mentality. Specifically, the historical roots of both church and royal authority remain intact in the contemporary social memory; even if they have been re-imagined and given a different "form." For example, notice how the Representative of the *Ordre* tells us that he "*always says*" that the *Ordre*'s National Council "*is* the Vatican;" rather than sometimes saying or occasionally thinking or any number of possible constructions for this phrase. The Representative of the *Ordre* "always says" this; which gives this reference an explicit regularity in use. Going further, we can underscore that he declares that the *Ordre*'s National Council "*is* the Vatican;" instead of saying that it is like the Vatican or can be thought of as the Vatican etc. In other words, this was not just a single-handed comment made within the context of our interview; rather, it a full-fledged component within this representative's perception of the *Ordre*'s role. As such, it adds additional weight to Doctor J's, Doctor M's, and Hospital Administrator A's claims that the collective French "ego" or "self" remains steadfastly attached to the "ancient way of thinking" that made up "old France."

The first chapter of this thesis began with a discussion of the 19th century establishment of the French Academy of Medicine and its implications for the professionalization of French conventional medicine. In reality, this establishment was the fruit of a significant transformation in the relationship between the French State, medicine, and the population with historical antecedents that reach as far back as the Middle Ages. Indeed, during the 14th century, the medical faculty of the University of Paris was actively engaged in consolidating the French medical profession and playing a direct role in the administration of matters concerning the health of the population of Paris. For example, the medieval medical faulty aided during, "periodic outbreaks of pestilence and plague from 1348 onward;" was zealously, "attempting to stamp out charlatanism;" and endeavoring to, "establish an effective surveillance over apothecaries, herbalists, and surgeons" (Kibre, 1953, pp. 1-2). As such, we can see that in many ways, the 14th century faculty of medicine served as a historical antecedent to the contemporary powers of the *Ordre des médecins*- which also has a section working on epidemics and public health; responds to deontological complaints against doctors; and oversees all doctors, including surgeons.

It is of note that the faculty of medicine's right to do such work came from both its own issuance of statutes and regulations, as well as from the aid of the Bishop's court in the prosecution of charlatans and the illicit practice of medicine. This means that the faculty of medicine of the University of Paris was in concertation with the authority of the Catholic

Church in terms of medical governance. As such, "official" medieval French medicine in Paris was regulated, overseen, and operating under the double authorities of both the church and the university. Therefore, the 14th century is an interesting starting-point for our analysis of the "ancient ways of thinking" about contemporary conventional medicine that multiple interview participants identified as remaining in the French social memory. Furthermore, since there are historical records of the faculty of medicine's attacks of "charlatans" during the 14th and 15th centuries, we have a rich historical record upon which we can base our analysis. What is particularly interesting about this period of French medicine is that while the faculty used language emphasizing their protection of "the public interest," it also characterized charlatanism as the, "shameful and brazen usurpation" of medical practice (Kibre, 1953, p. 5). This implies that rather than being uniquely an attempt to ensure public well-being, the faculty of medicine was actively working to professionalize medicine and to secure its sanctity. As a means of doing so, the faculty utilized the Bishop's court in order to prosecute "charlatans" or anyone who was exercising without university-regulated licenses and approval. This makes a brief consideration of this 14th century medical authority a fitting starting point for an analysis of the historical roots of the contemporary French interest in pursuing "charlatanism."

One of the most telling cases acting as evidence to this point was the 1322 trial of Jacqueline Félicie de Almania for illegally practicing as a physician without a license. During her trial in the Bishop's court John of Padua, a key witness of the prosecution who had been a surgeon to King Philip IV, cited the 60 year history of excommunication and prohibition from practice as penalties for the illegal practice of medicine (Green, 1988). Since she did not have a license, the faculty claimed that Félicie was ignorant of the art of medicine and did not know the causes of diseases; a farcical argument since she had a reputation for being a skilled and experienced healer and was unable to obtain a license since women were excluded from university training at the time. The Archbishop claimed that Félicie's ignorance could result in the death of a patient, which would put her soul at risk; this was also punishable by excommunication. Most notably, the faculty expressed their deep offense at Félicie's use of techniques that they viewed as the exclusive right of university-trained doctors (Minkowski, 1992, p. 293). This claim implies that the faculty was significantly motivated by protecting the regulation of medical practice rather than in solely preserving the health of the population.

In response, Félicie's defending counsel cited her record of successfully treating many patients and explained that she consistently refused to take money until the patient was healed. Furthermore, it was argued that in many cases, she had cured patients only after the treatments administered by prominent and licensed physicians proved unsuccessful. Court records of the trial include the testimonies of 6 witnesses all attesting to Félicie's skill and use of successful treatments. Her defense counselor attacked the legality of the university statute, which had been invoked solely by the university and only bolstered by the mandate of the Bishop of Paris. Her counsel also insisted that the university statue blocking women healers from becoming licensed practitioners was "contrary to the public good," since only a woman could effectively examine and treat patients of both sexes- male physicians did not have the right to physically examine female patients or to "inquire into the hidden secretes of a woman's being"(Kibre, 1953, p.11).

Nevertheless, the court ruled in favor of the university. Félicie was found guilty of willful disobedience, excommunicated, banned from the practice of medicine, and heavily fined. As various medical scholars have indicated, not only did this case attest to the strength of the male-dominated hierarchy that was emerging in the medieval European medical community, it also showed the growing power of the university and its ability to effect

medical culture (Minkowski, 1992; Green, 1988). Indeed, shortly after this particular case, the university wrote directly to the Pope asking for aid preventing charlatans from practicing illegally in Paris. In June of 1325, Pope John XXII complied, ordering the Bishop of Paris, "to find out the truth calling a council of learned men in medicine whose advice he should then follow" (Kibre, 1953, p. 12). Furthermore, the Pope's letter to the Bishop of Paris directly cited the university's petition, stating that "charlatans ignorant in the medical art…were presuming to practice medicine…and that these charlatans were causing many deaths" (Ibidem). Thus, we can see that the Pope clearly deferred to university authority in medical matters, which further underscores the concretization and extent of medieval academic authority in Paris.

One of the aspects of the Jacqueline Félicie de Almania case that makes it of relevance here is its striking similarity to various elements that emerged in my fieldwork. Not only does this case shed light on the historical roots that feed into the continued emphasis on combating "charlatanism" in contemporary French society, it can also be interpreted as a historical vestige informing the stigmas, stereotypes, and fears that were evoked in Chapter 2. Additionally, it is worth noting that some of Félicie's 14th century curative methods are still used in contemporary French complementary medicine. Specifically, during my fieldwork, I came across the following methods listed in her trial's court records: steam baths (homeopathy, hydrotherapy); massages with oils (Ayurveda, aromatherapy, naturopathy); and applications of herbs including leaves of chamomile and melilot[80] (phytotherapy, aromatherapy, homeopathy, nautropathy). Not only are these remedies still being actively used in contemporary France, in the next section we will see that the practitioners that employ them are currently being publicly attacked by doctors using the same language that was used against Félicie.

Another concrete aspect of this medieval case that is still be relevant to the conventional-complementary relationship in contemporary France is that much as we saw in Chapter 3, Félicie was reported to have successfully treated numerous patients after their physicians had given up or reached the limits of their efficacy (Kibre, 1953). Thus, this serves as an interesting historical antecedent to the presence of complementary medicine in what we defined as the "space" beyond the scope of the conventional medical gaze. Indeed various witnesses in her trial provided testimony using similar language to the motor handicapped patients I encountered in my participant-observation at *Un Sourire pour l'Espoir*. For example, one of Félicie's patients, Johanna de Monciaco had been seen by several prominent physicians, none of whom were able to ameliorate her condition. De Monciaco testified that Félicie picked up where the other physicians left off, successfully curing her kidney condition with the same clear liquid that Félicie had effectively used in the cases of other witnesses (Kibre, 1953, p. 10). This reminded me of the patients I saw during their follow-up visits with Doctor Z. All of these patients had seen a variety of different doctors and were told that there was nothing more to be done to ameliorate their conditions; yet, they all reported significant improvement after receiving Doctor Z's procedure. In this context it is worth recalling that in the case of Félicie, "faculty members were deeply offended by her use of what viewed as techniques only for licensed doctors" (Minkowski, 1992, p. 293). This same offense was

[80]*Melilotus officinalis* is a flowering plant of Eurasian origin. Commonly known as melilot or sweet clover it is known for its anti-oedematous effects and is used to improve vein tonicity, circulation, and the functioning of the lymphatic system. It commonly used as an antispasmodic for various abdominal troubles, for "heavy legs," as a sedative, to calm the peripheral nervous system, as an anti-inflammatory, and in relation to a variety of conditions including, but not limited to: hemorrhoids, menopausal symptoms, conjunctivitis, and bruising. Melilot figures in the 11th edition of the French pharmacopeia.

reported to me by some of Doctor Z's patients who were "fired" by their doctors for undergoing a surgical procedure from an unsanctioned practitioner.

Furthermore, much as was evoked in Chapter 2 characterizing the diagnostic procedure as the exclusive domain of licensed medical doctors, Félicie was condemned for "usurping" the role of the doctor by using techniques, "such as taking the pulse, examining the urine, touching the body and using potions, digestives, and laxatives (Minkowski, 1992, p. 293). Curiously, all of these elements correspond exactly to what was described in my fieldwork as the clinical exam and treatment determination in the diagnostic procedure. In an echo of the prosecution in the Félicie case, Doctor T emphasized that this procedure could be "only conventional" (2017). Indeed, in Chapter 2 the Representative of the *Ordre des médecins* explained this process as the doctor's:

> "Playing according to his pieces […] there is a whole proceeding, like a pilot […] we have a check-list to complete. To say that it's not serious or that there is this or that [the doctor] has to have done his biological examinations- I would say that it is the pinnacle of deontology" (2015).

Recalling the discussion in Chapter 2, the testimonies given in the Félicie case indicate that she followed the same deontological protocol that remains as the backbone of contemporary medicine: she conducted a physical examination, including biological analysis; she ascertained the nature of the illness; and only then did she administer what witnesses testified was an effective treatment. As a result, she was condemned for the illegal practice of medicine; just as contemporary complementary practitioners who attempt to make "diagnoses" become vulnerable to prosecution for the same offense. In Chapter 2, Shiatsu Practitioner described this using the following formulation: "In France, the doctors say that, 'Diagnosis it's me, you're not a doctor so you don't do diagnosis'" (2015). He then went on to comment on how he avoids using the word "diagnosis" in reference to examining a person before beginning a treatment:

> "In France we are not going to talk about diagnosis, because the doctors have claimed that […] we talk about an energetic assessment- I would say it is hypocritical, but it's like that- so anyway the energetic assessment is based on an exam, which involves taking the pulse. Taking the pulse comes from the origins of Chinese medicine- you know, you have 12 pulses like the 12 meridians- and so in Chinese medicine you take the pulse in 12 different places on the wrist, it's an energetic assessment" (2015)

It is now time to add the second part of this same discourse:

> "This energetic assessment [is] in the famous deontology code, which makes it so that some things are not possible- the deontology code, you will find it on the Federation's website […] In the deontology code it says that you have to do an assessment of the person before starting Shiatsu, we try to know what we are dealing with" (2015).

Notice how Shiatsu Practitioner C emphasized the importance that conducting a preliminary physical exam before administering Shiatsu plays within his federation's deontology code; just as the Representative of the *Ordre* described this procedure as being the "pinnacle of deontology." Nevertheless, in contemporary France only doctors have the right to refer to the physical examination, causal determination, and treatment decision procedure in terms of a "diagnosis." When this is coupled with the additional evidence on the medical

control of the diagnostic procedure that was given in Chapter 2, we can see that it is an instance of medical appropriation that has endured since it was put into statute by the faculty of medicine of the University of Paris as early as 1271. Even though several contemporary complementary medical practitioners emphasized the importance of conducting "semiology" and "etiology" as necessary precursors to their therapeutic activities, and have worked to codify this in the deontological codes of their self-organized representative bodies; calling the results of their assessments a "diagnosis" is still considered to be the illegal practice of medicine. While in the case of Félicie church authority was used to bolster medical authority, we shall see that today this has been merely replaced with the double force of scientific and state authority. This transition will be explored in the next section.

For now, it is worth noting that beyond the contemporary evidence of similarities in the remedies used and in the evaluative procedure that led to their employment, I also ran into yet another of Félicie's medieval strategies that proved to be of equal importance in a contemporary case of complementary practice. Namely, her insistence on only accepting payment for her services following their success rather than charging an outright fee them; which appears to be one of the key factors that led to her escaping some of the more severe punishments utilized in the Middle Ages. Within my fieldwork, I was struck by the fact that Shaman C used exactly the same payment strategy. In other words, Shaman C did not charge a fee for his services. If his clients were satisfied with their results, they were invited to place voluntary donations in a collection box or into a marked or unmarked envelope. None of Shaman C's clients were ever refused service for non-payment; and after opening the collections box and the envelopes on multiple occasions, I can attest that their "donations" regularly included pocket-change, empty envelopes, used metro tickets, or hand-drawn hearts and smiley faces. Furthermore, I found Shaman C to be highly sensitive to his clients' financial difficulties. In some cases, if he knew that one of his clients was in a state of financial difficulty, he would categorically refuse their donations. In other cases, he continued seeing clients even though he knew that they took money out of the collection box rather than putting any in. While I cannot say whether Félicie's payment approach was a deliberate strategy, a sign of her benevolent intentions, or a mark of her confidence in her results; I can say that in Shaman C's case my observation of his practice indicated that it was a mix of all three of these factors.

In both cases, their reliance on voluntary donations following their successful services rather than their use of a fixed-rate turned out to be an incredibly important strategy for the same reasons. In the case of Félicie, it was because the faculty specifically characterized charlatans as treating the sick, "based only on the whims of chance and fortune" and questioned all of her witnesses on "whether she had attempted to extort money from them" (Kibre, 1953, p.9). Contemporary rhetoric surrounding charlatanism and sectarian aberrations in France remains largely centered on this same notion of financial extortion. For example, in their 2012 guide to sectarian aberrations, Miviludes cites "exorbitant demands for money" as second on its list of sectarian characteristics; identifying it as one of the primary goals of the "submission" of a person to the charlatan's will (Miviludes, 2012, p. 18). This was clearly stated by Representative T of an anti-sect organization who said that, "the goal of sectarian aberrations is power, money, and sex" (2015). Thus, in both this medieval and modern instance of unlicensed practitioners in France it appears as though distancing themselves from charging up-front fees for their services was a strategy insulating them, even if only partially, from the wrath of medical authority.

In hindsight, we can interpret this medieval charlatanism case as a display of the initial establishment of the French medical profession and its authority. Since science was not yet an

authority in and of itself at the time, the medical profession was constructed on the authority codified in the university's statutes and teachings with the validation and support of the Catholic Church and its structures. Thus, the first legal regulation of French physicians was based on a powerful mix of academic and religious authority. In light of remarks that several practitioners gave me concerning the specificity of France in terms of the contemporary contours demarcating the conventional-complementary relationship, I felt as though this antecedent of French medical authority informed remarks such this one made by Doctor J:

> "France is very psycho-rigid in terms of the mind. France is the eldest daughter of the church, so there is one law, one right, and one truth- the university truth- it's the only truth, there's no discussion. It's the old French mentality and it's a very French way of seeing things […] we're the eldest daughter of the church and there is a totalizing dogma- so what is not in the dogma is heretical and must be burned- we've never gotten away from that" (2014).

In the case of Félicie, the authority of this "university truth" was so powerful it shaped the court's ruling against her in which it was declared that "medicine was beyond 'hearsay'" (Minkowski, 1992, p. 293). It is not a coincidence that medical historians associate her particular case with the growing power of university medical faculties and a change in the consideration of female healers that ultimately led to "women who had been called healers in the 13th century [being] branded as charlatans and witches in the 14th and 15th centuries" (Ibidem). Thus, Doctor J's direct association of complementary practitioners with heretics, witch hunts, and burning at the stake attests to a perception that there is a continued relevancy both of this early form of medical authority and the vestiges of its relation to the church, even if the two have been largely separated since the Enlightenment. As such, before turning to the examination of a specific contemporary case against a complementary practice in France that is being compared to a modern-day witch hunt with references being made to a "Ku Klux Klan" against it in the popular presses[81]; it is worth taking a moment to continue considering the transformations in French medical authority that led to its contemporary form[82].

Throughout this thesis, we have seen a wide array of different rhetoric that emphasizes the "scientific" nature of contemporary conventional medicine. As such, it is important to examine a particular historical instance that significantly impacted the role of science in French society. This is essential to this thesis, because throughout my fieldwork the "unscientific" nature of complementary medicine was by far the most-commonly cited reason against its mainstreaming, regulation, and "acceptance" within French conventional medicine. Thus, we will now explore one concrete case that significantly affected the shift in the role of science in historical French society; namely, the establishment of the Royal Parisian Academy

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[81] This remark was made by Christian Boiron, the current Director General of Boiron Laboratory, in *Le Progrès* on 15 July 2016 (available online at: https://www.leprogres.fr/sante/2015/07/16/homeopathie-christian-boiron-riposte-face-aux-attaques ). It is significant because in 2014, Boiron had sales revenues amounting to 609.75 million euro, 51% of which were in France. In the context of this discussion, it is worth noting that in this 2016 article, Boiron referred to homeopathy's "*original sin*, which is small infinitesimal doses that are beyond the current understanding of physics" (emphasis added). Thus, not only do we again see a contemporary remark referencing the church authority that bolstered French medicine in the Middle Ages, we also see additional evidence supporting the scientific claims that were made by Homeopathic Doctor Q in Chapter 2.

[82] Although it falls well outside the scope of this thesis, it is important to underscore another significant transformation in medical authority that took place during this medieval period: the secularization and proliferation of hospitals that occurred beginning in the 12th century. While up until this time "convents and monasteries served as early medieval medical clinics," (Minkowski, 1992) the development of 12th and 13th century hospitals and institutionalized lay nursing in Western Europe marked an important shift towards the contemporary predominance of secular medical authority as a "social guardian of morality" and the hospital as a significant lieu of social control over the body, life, death and illness (for example see Turner, 2008; Zola, 1972).

of Sciences in 1666 and its effects on the professionalization and establishment of scientific authority in France during the Enlightenment era. Rather than being viewed as a simple consequence of the transformation instigated by Newtonian science, the establishment of the Parisian Royal Academy of Sciences can be seen as an instructive reflection on the relationship between French scientific thought and social organization. This is because its creation effectively reorganized amateur circles into an established and professional learned society that was attached to the crown and that would eventually rise to be the pinnacle of scientific authority in French society. Without getting too far into the intricacies that led to the creation of the French Royal Academy of Sciences, it is worth noting that it was the result of a partnership between scientists and the crown that was based on mutual self-interest. Scientists needed government patronage in order to finance their increasingly expensive experiments and the state could and did reap the benefits of scientific inquiry as a result (Hahn, 1971).

While the Academy did not condone dogmatism, over time it did develop an official character for science that can be interpreted as based on "phenomenological positivism" (Hahn, 1971, p.32). Considering the rationalist ideological tenets of the Enlightenment, the Academy's subsequent success throughout most of the 18th century does not come as a surprise. This is because as Koyré (1957) indicated, the shift towards the "mechanization of the worldview" resulted in a cosmology based on a "hierarchy of perfection…unified only by the identification of its ultimate and basic components and laws" (p.xiii). Thus, not only did this ontological shift transform the scientific imagination, it also redefined the standards by which knowledge or a solution to an accepted problem was deemed legitimate; and defining this legitimacy became the exclusive domain of the Royal Academy of Sciences.

As such, this can be interpreted as a social reorganization in which demonstrable scientific knowledge became "enthroned…as the universal solvent of ignorance and prejudice" (Hahn, 1971, p. 36). This use of the word "enthroned" is particularly relevant here, since this place was occupied by the newly professionalized scientists of the Royal Academy with the full patronage of and symbiosis with the crown and royal authority. Furthermore, I feel as though "enthroned" describes the place of reverence that scientific authority grew to have beginning with the establishment of the Royal Academy and continuing throughout the 19th century. As Hahn (1971) explained it beginning in 1699, "to be an academician, or to have one's views discussed favorably by the Academy, was in fact to receive the supreme accolade of that loosely knit community of scientists known as the 'Republic of Science'"(p.25). This quote is interesting because it evidences the fact that although the Academy was contingent on royal support, over the course of the 18th century, the codification of scientific practice translated into its powerful authority that eventually began to take on a life of its own; much as we saw in the precedent case concerning the faculty of medicine's authority that was created through the standardization resulting from its statutes.

According to my fieldwork, the combination of the Enlightenment era shift in worldview coupled with the supremacy of scientific authority in French society has proved to be both profoundly rooted and enduring in the French psyche. Indeed, histories depicting French advancements in science and medicine often present a representation in which "Enlightenment thinkers put a new time marked by science and reason in opposition to the *Ancien Régime* impregnated with beliefs, bias, and obscurantism needing to be banished" (Faure, 2012, p7). Faure (2012) goes on to provide the same conclusion that I drew from my general research on medical history; specifically that, "this 'progressive' vision, strongly rooted in our unconscious, has structured historical research which has in turn, legitimized this vision. From the middle of the 19th century and long after, medical historians describe the heroic saga of their predecessors fighting for science and against obscurantism" (p.7). Within

my fieldwork, this "progressive vision" of French medical history was given to me in exact terms within the discourse of Doctor T:

> "What revolutionized medicine in France was the Enlightenment […] in the Enlightenment […] all the great French doctors that were in the 17th and the 18th centuries enthroned a method to care for people rather than the dogmatic position of our ancestral doctors, of Hippocratic medicine, in which doctors transported dogmas from generation to generation- bloodletting is a typical example, *hein-* and all of the methods that we used before to treat illnesses from a dogmatic position, saying that, 'It's like this and cannot be otherwise.' What revolutionized the Enlightenment thinkers was to say, '*Bah* we're going to see if practicing bloodletting on patients truly gives us an amelioration or not, we're going to do comparisons.' For me, what is guilty of completely separating the world of conventional medicine from the worlds of nonconventional medicines is the opposition of a method in conventional medicine- that is the scientific method […] in the large sense- meaning we ask a question and try to respond by applying a protocol and a method, and we can reply with yes or no, true or false, whereas nonconventional medicine is based on dogmas and dogmatic positions" (2017).

While there is much in this citation that can be unpacked, I felt it of incredible significance that Doctor T spontaneously used the same verb "enthroned" as Hahn used in his 1971 study of the Paris Academy of Sciences; especially since both were using it to reference the Enlightenment era authority that science took on as a result of its professionalization and the codification of its methods. Thus, we can see that the scientific authority that directly resulted from the developments with the Academy of Sciences in the 17th and 18th centuries remains firmly in place within the contemporary French social memory; even if it has been re-imagined as what we now call the "scientific method in the large sense." I also found it somewhat ironic that while Doctor T perceives conventional medicine to be in direct opposition to complementary medicine due to its basis on "a method," rather than, "on dogmas and dogmatic positions;" his own description of a "dogmatic position" can be interpreted as a reverence to the authority of the scientific method that is suspiciously close "to saying that it's like this and cannot be otherwise." According to Friedman (1992), this paradoxical vision within Doctor T's rhetoric is a clear example of, "the construction of histories as products of particular social positions. These social positions constitute the conditions of existence and formants of identity spaces or habitus, which in their turn select and organize specific discourses and organization of selfhood, including histories of the self "(p. 194).

In this sense and in following with Hanegraaff's (2015) analysis of Jung, Doctor T's view of the triumph of the scientific method places complementary medicine within the realm of "various traditions of 'rejected knowledge' that can be studied historically" (p.75). Indeed, according to both Kuhn (1970) and Hahn (1971), the banishment of dogmatism that Doctor T discusses in terms of the "enthronement" of the scientific method equates to the developments made by the Academy of Sciences and its definition of accepted knowledge that was "predicated on the assumption that the scientific community knows what the world is like" (Kuhn, 1970, p. 5). As such, it is possible to interpret this discourse as an example, within the French social memory, of a particular view of medicine as exclusively based on the scientific method that has been "transported […] from generation to generation," spanning from the present to late 17th century France. We can also see how this specific social memory is currently being used instrumentally as a form of resistance against the "acceptance" of complementary medicine and the growing research that surrounds it.

While the post-revolutionary period and the repositioning of French medicine along with the emergence of the Third Republic will be explored in the next section, for now it is important to analyze some of the comments that were made to me by various practitioners in order to see if this notion of scientific authority as the cure of obscurantism really remains rooted in the minds of contemporary conventional and complementary practitioners. According to my fieldwork, this discussion is worth having since the preeminence of science was mentioned in relation to the specificity of France repeatedly and by a wide variety of practitioners on both sides of the conventional-complementary relationship. For example, Kinesiologist R noted that:

> "First, France has a past of rationalism that is rather pronounced. Everything had to pass through scientific studies to be approved of, or to have a certain kind of recognition, because it followed from this sort of study. France is a very Cartesian country, *hein* and it has a past" (2015).

This remark is particularly relevant here because it implicitly describes the function of the Royal Academy of Sciences, indicating that this structure and its legacy does indeed remain embedded in the French social memory. During our interview, in response to this remark, I asked Kinesiologist R the following questions: "Yes, but where did that come from? Why is France like that? Is it cultural, political, religious…?" To which he replied:

> "I'm already thinking of the language […] it's a very Cartesian language, very precise in fact. The French language is very precise and it was the first scientific language in the beginning- actually before English took its place, it was one of the languages that was accepted, well, that was scientific, I mean to say admitted in publications of scientific writing […] I suppose there is a side of everyone, in whom recognition comes from the recognition of scientific validity, the scientific proof of a procedure" (2015).

This quote can be interpreted as interesting evidence of the nature of the long-standing supremacy of scientific authority in the French mindset. Furthermore, it indicates that within the French social memory, there is a direct association between the history of French culture, specifically its language, with scientific authority. For example, notice how Kinesiologist R refers to French as "the first scientific language," which is a gross reduction in terms of the history of science. As concrete evidence to this point in the context of this discussion, we can underscore the fact that the French Royal Academy of Sciences was far from being the first or the only European scientific institution publishing its findings in the 18$^{th}$ century. In fact, the creation of the French Royal Academy of Sciences occurred after, and was directly modeled on, the successes of the *Accademia del Cimento* in Florence and the Royal Society in London (Hahn, 1971, p.6). Nevertheless, throughout my fieldwork I heard multiple comments characterizing France and the French language as the avant-garde of Enlightenment era scientific authority. As such, it corresponds to the notion of a "language ideology;" in this case, this social memory of scientific authority constitutes a shared notion about the "scientific" nature of the French language (Woolard, 1992).

In this sense, I feel as though another example of this particular social memory is encapsulated in the multiple references that were made within my fieldwork to being "Cartesian." Indeed, a significant number of these comments have been cited throughout this thesis. In all of those examples, the usage of the term implied that the current French conceptualization of being "Cartesian" equates to associating oneself with reverence to the scientific authority of the "phenomenological positivism" that characterized the Royal Academy of Sciences rather than specifically ascribing to the totality of Descartes'

cosmological views. What I find particularly curious about this equation is that it can be interpreted as a contemporary re-imagining that has become inverted in much the same way as we saw with Doctor T's anti-dogmatist stance. In this case, characterizing oneself as "Cartesian" without fully subscribing to Descartes' worldview appears to be a contemporary inversion of the use of the term "Cartesian." This is because the first French professional scientists were actively against "doctrinal dogmatism" which they considered to be, "contrary to the progress of science" and thus, the Royal Academy also did not officially follow or support an "Aristotelian, Cartesian, or Leibnizian worldview" (Hahn, 1971, p.31).

As such, the repeated declarations of being "Cartesian" that we have seen throughout this thesis can be interpreted as a contemporary re-interpretation of a long-standing French social memory. This was evidenced in my fieldwork through repeated contemporary references linking being "Cartesian" with the perceived gold standard of evidence-based medicine that currently dominates conventional medical research and practice. For example, recall Doctor O's remarks from Chapter 2 in which she said, "I am very Cartesian, very evidence-based medicine. That's things that are proven- we have studies and clinical trials and after results, and these results show that it is significant" (2015). Going further, we can also evoke Doctor M's admittance from Chapter 2 that:

> "My feeling is that French conventional medicine is profoundly Cartesian and that once Sackett in the United States created the concept of evidence-based medicine […] he adhered completely to the French Cartesian concept- the discourse and the method […] the concept of evidence-based medicine reapplied Descartes' discourse to science as one and the same […] and we adhered completely, French medicine completely adhered to this concept of evidence-based medicine and it considers medicine only as the application of scientific proofs" (2015).

Reconsidering these citations here, we can see that they take on much deeper levels of significance; namely, because they both strongly suggest the presence of an enduring historical vestige that developed out of the professionalization of scientists in the Royal Academy of Sciences and the subsequent reorganization of both scientific authority and its social placement that it engendered. As Doctor M's quote indicates, this vestige has been re-imagined in the contemporary context using the tenets of evidence-based medicine as a basis. Thus, it is arguable that one of the reasons the French "adhered completely" to the principles of evidence-based medicine is because they are a direct echo of the "phenomenological positivism" (now called "Cartesianism") that has long shaped French science and its social conception. This is because, Descartes' method was based on rationalism, which is a near-perfect opposite of the empiricism inherent in evidence-based medicine. As such, we can see that the contemporary association of being "Cartesian" with fully-adhering to evidence-based medicine is a social memory that constitutes a contemporary inversion or re-imagined form of the "phenomenological positivism" that characterized the Royal Academy of Sciences. While the repositioning of French medicine in relation to science will be discussed in the next section; for now I feel it is important to state that based on the data I gathered through my fieldwork, this historically-based re-interpretation appears to be one of the keys to explaining the continued resistance to the acceptance of complementary medicine in France, despite its currently expanding presence and phenomenal market-potential. This argument will be further developed within the subsequent section's discussion of the specific case of homeopathy.

Before moving on to the current polemics surrounding French homeopathy, it is worth returning to what many of my fieldwork participants and experiences identified as a specificity of the French language; namely, references, such as those given above by

Kinesiologist R, characterizing the French language itself as "Cartesian" and/or "scientific." This is important to consider, because not only were Kinesiologist R's remarks far from an isolated incident; the perceived "scientific" nature of the French language was clearly identified as one of the major stumbling-blocks preventing the universitization and regulation of complementary practices in several instances of my fieldwork. One example of such references is encompassed within the following quotation from Shiatsu Practitioner C. His remark was given in the beginning of our initial interview as a result of my use of the term, "alternative medicine" in relation to Shiatsu. This was a clearly a faux pas on my part that Shiatsu Practitioner C did not hesitate to emphatically correct by saying:

> "Attention madam, the French language is very scientific, so you have to be careful of the language that you use, meaning the definitions of the words. You have to be careful because you are in a formidable country, which is France- France is, how can I say- very organized in this area, it's historical. So for example we don't say we're a parallel medicine, because by definition parallels don't meet […] we prefer to use complementary, because it doesn't make competition with allopathic medicine […] and we say therapy, because medicine and its doctors- doctors in France- it's better not to touch them because they are very concerned with their prerogatives, ok?" (2015).

Indeed, just as Shiatsu Practitioner C indicated, this issue of scientific precision and semantics in the French language was a reoccurring theme throughout my fieldwork. One of the most concentrated examples of this occurred during my participant observation at a closed meeting of the OMNC in Nice in 2017. During this meeting on complementary medicine and its place in French society, a remarkable amount of time was spent discussing the definitional difficulty surrounding complementary practices. Doctor T characterized these "questions on terminology" for complementary practices as a major blockage preventing their integration into medical school curriculum. He explained that in order to be taught in universities, the scientific evaluation of complementary practices was necessary; however, as was indicated in Chapter 1, it becomes incredibly difficult to rigorously evaluate something that proves troublesome to clearly define. This was brought to light through Doctor R's reflections concerning the confusion surrounding users' understandings of relaxation and sophrology in Chapter 1; the blurred lines demarcating the boundaries of many complementary therapies makes developing evaluative methodologies for them a formidable task.

Approximately 15 minutes later into this OMNC meeting, Professor E put forward the same argument as Doctor T saying that in order to advance the integration of complementary medicine in university teaching, "It all starts with semantics […] the problem is that we need to create common terminologies" (2017). This comment was then directly supported by Neuroscientist R in his discussion of hypnosis and his call for, "precision of language because there's a lot of confusion surrounding hypnosis" (2017). Following Neuroscientist R's discussion, Chinese Medical Doctor S also emphasized the importance of structuring reflection on the definition of a "common language" that would allow for "communication between specialties" (2017). Listening to this discussion made me think of an explanation that Shiatsu Practitioner C had given me during our interview, but that I failed to see the significance of at the time:

> "The French are scientific to the extreme and anything that is not scientifically proven doesn't exist. If we don't have definitions we don't believe, France is a difficult country […] it's very scientific the French milieu- it's science first" (2015).

In particular, Neuroscientist R's remarks during the OMNC meeting helped to shed light on exactly what Shiatsu Practitioner C meant when he said, "If we don't have definitions we don't believe." This is because even though Neuroscientist R reiterated the perceived primacy of "semantics" and seconded calls for the creation of a "common terminology," he also explained his active work with a team conducting "medical evaluations of hypnosis […] and studying hypnosis, the brain, and consciousness" via use of the brain scanners at his facility. During the coffee break following this meeting, I asked Neuroscientist R about his work and he happily explained the exciting results that his brain scans of people in hypnotic and meditative states are producing. Thus, we can see a contradiction in his public remarks emphasizing the primacy of semantics; clearly despite the "confusion surrounding hypnosis," Neuroscientist R is actively conducting clinical research on it. Yet, his remarks during and after the meeting indicate that the lack of "definitions" and "common terminology" prevent his research from being accepted as serious scientific work. In fact, within our follow-up interview it seemed as though even Neuroscientist R himself struggled to fully accept or "believe" his own scientific results. This emerged through his rather entertaining self-characterization as a sort of rogue scientific cowboy, bravely exploring the wild frontiers of meditation, hypnosis, and consciousness. He confided that he conducted much of his research "in the shadows" by using the scanners on the weekends and without any form of approval. This "obscurantism" made me think of Hospital Administrator A's admission of hiding metaphysical books in public as if they were "pornographic." Here, we see Neuroscientist R hiding his passion for the metaphysics of hypnosis, meditation, and consciousness in much the same manner; in part because these terms have not yet been "scientifically" defined in French semantics.

Thus, here we again see the interplay between the re-imagined form of "phenomenological positivism" in the contemporary French social memory and French language ideology. Indeed, according to the principle of the underdetermination of scientific theory by evidence, science and the scientific method disprove rather than prove any given hypothesis[83]. Nevertheless, throughout my fieldwork there was a common and repeated emphasis on this re-imagined, "scientific" nature of the French language as a form of ideological resistance against complementary medicine. For example, in my follow-up interview to the OMNC meeting with Doctor T, who also emphasized the strong link between terminological precision and scientific evidence by stating:

> "What I try to do is to differentiate between treatment and- words have a considerable importance, semantics have a considerable importance. I think that we should use 'treatment' for all care processes which have results that have been scientifically proven, that's a treatment, for example […] the treatment for a bacterial infection of the lung is antibiotics, the treatment of syphilis is penicillin- so those are what we can call treatments" (2017).

Here we see language being actively used to clearly demarcate the domain of conventional medicine. Doctor T's definition of the term "treatment" is remarkably precise, leaving no room for doubt at first glance. It acts as a perfect counter-point to the definitional confusion surrounding the prodigious diversity of possible definitions of hypnosis, meditation, and consciousness. By doing so, it further grounds Neuroscientist R's perception that his research positions him at unexplored, metaphysical frontiers that appear to be well-outside of the precise definitions of the French conventional medical

[83] It is of note that even Descartes appealed to a form of underdetermination in his *First Meditations* when he used the 'evil demon' argument to explain knowledge of one's own existence.

domain. This can also be interpreted as adding additional nuance and historicity to this thesis' emphasis on the difficulty the French healthcare system is having bridging the "medical" and the "medico-social" divide. In fact, another semantic issue that further emphasizes this point was the commonly cited importance of semantically distinguishing between "patients" and "clients." I was repeatedly told that "patients" belong uniquely to the medical domain whereas "clients" populate the psychotherapeutic and complementary realms. What is interesting is that this again justifies Shiatsu Practitioner C's warning about using linguistic caution in order to avoid encroaching upon the "prerogative of doctors."

Thus, in all of the examples discussed here, we see that "science" and its authority has been repeatedly evoked and, in many cases, directly linked to the French language and mindset. As such, I interpret these comments and related issues as evidence of the contemporary French re-imagination of a social memory of the scientific authority that was "enthroned" by the Royal Academy of Sciences. This is because while science is repeatedly evoked as a supreme authority governing the semantic specificities mentioned here, in reality they are all rather arbitrarily defined or accepted. For example, consider Hypnotherapist A's reflection on the French distinction between "patient" and "client":

> "It's a big debate, we use the two. Some of my colleagues use the word 'patient' and others say, '*Ah*, when it's linked to an act that is being followed by a doctor we can talk about a patient, but when someone comes […] with a stress-related problem, *bah*, it's a client.' It's in the language, if we consider the professional as being within the health domain we talk about patients, but when I do a pure [psycho]analysis I never talk about patients, I talk about clients […] you see some talk about patients, others talk about clients, some use the two in permanence, but at what point do we talk about clients and at what point do we talk about patients?" (2015).

Indeed, many of the complementary practitioners I spoke with privately referred to their clients as "patients," only ensuring their use of the term "client" when in public. When I asked them why making this distinction in public was so important, they typically evoked a fear of being labeled as a "charlatan" and then becoming the object of persecution. Doctor J explained this in the following terms:

> "You have to be careful, those who have the power and who make decisions have enormous influence […] they have a kind of science- scientism rather- that has a regard that is often suspicious, ironic, and scornful towards all that is 'other' and that can easily trigger attacks that are incredibly radical, we put the emphasis on sects and then there are judicial measures and intimidation- it's a kind of witch hunt that's fairly typical of France" (2014).

Thus, we have come full-circle in our discussion of what my participants claimed to be the particularly "scientific" nature of the French language, and we see the contemporary use of the language related to complementary medicine that does not appear to be particularly precise or scientific. The most striking examples of this are in the arbitrary dichotomies that are being used to separate conventional and complementary practices, such as "treatment" vs. "therapy" and "patient" vs. "client." While Doctor T did try to frame this using a scientific approach by saying that "treatments" could only be used to refer to that which is scientifically proven, this is a personal and arbitrary distinction since chemotherapy, pharmacotherapy, and physiotherapy are all examples of scientifically proven conventional medical "therapies" that regularly feature in mainstream conventional medical publications. Furthermore, Shiatsu

Practitioner C's remarks on not touching medical "prerogatives" implies that the "treatment"/ "therapy" distinction is being used instrumentally as a means of resisting the full-integration of complementary therapies in the conventional medical domain. Likewise, Hypnotherapist A's very poignant question about where exactly the boundary between a "patient" and a "client" can be drawn coupled with his admittance that there is a significant mixed use of these two terms among mental health professionals also shows the very un-precise and non-scientific nature of the "patient"/ "client" distinction.

Yet, the rhetoric of Kinesiologist R, Shiatsu Practitioner C, and Doctor T all emphasized the importance of semantics in the French language, directly linking them to science and precision. Two of these dialogues go even further by referring to the long history linking science and the French language. As such, it is possible to interpret this sentiment as another contemporary re-imagination of a French social memory; namely, the emergence of the first "official" French scientific publications that were produced by the Royal Academy of Sciences. It appears as though this contemporary version of the memory is being used as a form of resistance to complementary medicine: both through an emphasis on the perceived necessity of creating semantic precision that is presented as a precursor for generating the scientific evidence considered essential for the acceptance of complementary practices in scientific and academic knowledge; and as a means of keeping them separate from the medical domain through the creation and maintenance of clear, linguistic boundaries. While the need to define an object does seem necessary for its scientific study, my research indicates that this is being over-emphasized as a stumbling block. As evidence to this point, I'd like to recall the discussion in Chapter 1 presenting the difficulty of defining "conventional medicine." Doctor M summarized this point nicely by saying:

> "We don't know how to name [conventional medicine] because by definition we consider it as our own and as the only one. And that is terrible, because it translates into the fact that our students consider- and since we don't teach them any other kind of medicine- our students think that there is only one and when we look at the denomination, we are incapable of defining this medicine. You have conventional medicine, Occidental medicine, biomedicine, mainstream medicine- biomedicine is the most common, but biomedicine doesn't mean anything because obviously medicine is biological […] It's amusing because we don't know how to name it […] you have to see that medicine is very cultural […] Chinese medicine is also- it's much more than just a medicine, it's a health system. I think it's better to use the term 'health system,' it clearly shows that medicine is also integrated into […] a cultural space" (2017)

Indeed, despite these definitional complexities surrounding the "common terminology" for the "object" that is conventional medicine, there is no shortage of available scientific research on the efficacy of its various forms of treatment. Furthermore, despite the difficulty defining the "health system" that constitutes Chinese medicine, there is a growing body of evidence-based research on the efficacy of many of its "treatments" or "therapies." Thus, we can see that the emphasis on the semantic aspects hindering the ability to effectively study complementary medicine can be interpreted as a resistance in the form of a belief related to the social memory associated with the "scientific" nature of the French language that is hindering complementary medical research. However, my fieldwork indicates that this does not appear to be a deliberate conspiracy; rather, it can be seen as an example of belief with deep-seated historical roots. It also corresponds to an example of the sub-optimal performance that characterizes a complex adaptive system. During the OMNC meeting I attended in Nice, all of those present seemed to be seriously interested in developing research

for complementary medicine. Yet, since they were all operating according to their individual dynamics and interacting in unpredictable ways, the definitional difficulty they each face in their incredibly varied, individual conceptions of complementary medicine emerged as the only common ground between them. So, rather than focusing on coordinating among themselves to develop concrete and costly research protocols, the path of least resistance was to focus on the need to create common definitions for this kind of research.

While the historical antecedents that have been explored within this section are far from exhaustive, by coupling them with many of the different remarks and experiences that emerged throughout my fieldwork we begin to have a more nuanced understanding of the "cultural space" that gave form to the roots of several of the ideological aspects that are currently shaping the conventional-complementary relationship in France. Namely, we examined two cases that reflect the emergence of the specific authorities that were frequently mentioned as being related to conventional medicine within my fieldwork. The first medieval case, reflected the rise of French university authority and shed light on how that academic authority instrumentalized church authority in its attempts to combat charlatanism in 14$^{th}$ century Paris. While we saw that this fight was framed within a discourse pertaining to the overall public good, the particular case of Jacqueline Félicie indicated that the medieval fight against charlatanism was also related to the faculty of medicine's attempt to standardize and supervise medical practice. We then examined the case of the establishment of the Royal Academy of Sciences in the 17$^{Th}$ century in order to explore the emergence of scientific authority in French society. In this case, we saw that scientific authority was "enthroned" both through its royal patronage and protection as well as through the standardization of the scientific procedure that the Academy created. Thus, we saw that when this standardization and professionalization was coupled with the dominant governmental authority of the time, it became a powerful agent in society.

Within this analysis, these historical antecedents were presented along with contemporary remarks and examples that I collected throughout my fieldwork as a means of understanding the deeper roots that informed my participants' rhetoric. Thus, this analysis attempted to uncover some of the sources of the social memories that my fieldwork participants evoked. These vestiges were considered to be re-imagined in the contemporary French mindset and, in many cases, were identified as informing the specificities of France. Furthermore, it is of note that my fieldwork participants either felt that these historical vestiges are feeding resistance against accepting complementary medicine or are being instrumentalized as a means of resisting its acceptance. As such, the next section will move this analysis further by exploring the emergence of medical authority and its repositioning within the contemporary French state that developed in the wake of the Revolution.

## *4.4: Contemporary French Medical Authority and Resistance*

In the previous section, we focused on some of the deeper roots of the ideological considerations that seem to be shaping the contemporary French discourse surrounding complementary medicine. Specifically, we looked at the rise of university authority and the emergence of scientific authority in historical French society. When these components of the French social memory are taken into consideration along with the stigmas, stereotypes, and fears that were presented in Chapter 2, we begin to have a much more nuanced picture of the

elements that are shaping the contours of the conventional-complementary relationship in contemporary France. As such, it is now time to complement the analysis from Chapter 3 of what we identified as some of the ideological aspects of the French healthcare system that seem to be acting as blockages preventing the extension of the scope of the medical gaze to include the notions of health and well-being. To these ends, Chapter 3 considered some of the global public health trends that are contributing to a shift towards an interest in health and well-being in addition to the rise of socialized notions of global public health and preventative medicine. These were related to the growing palette of chronic and noncommunicable health conditions that characterize our globalized world. In the previous sections, we related the ideological basis of French medicine and its curative-based approach to illness with the structural organization of the overall healthcare system. We then argued that this created a rapidly expanding "space" within which complementary practices are flourishing. This section will now take this analysis further by exploring the historical antecedents to the curative-based approach and the emergence of French medicine in relation to the State and public health. As we shall see, not only will this analysis continue shedding light on contemporary sources of conventional resistance, it will also allow us to consider the roots of the types of complementary medical resistance to medical mainstreaming that we saw in Chapter 2.

To begin, it is worthwhile to consider a concrete contemporary case of resistance to a specific complementary practice; namely, the polemics that are currently unfolding around homeopathy in France. As we shall see, this case is particularly well-suited to this and the previous section's analysis; namely because, as was stated in Chapter 2, homeopathy can be considered as one of the most "accepted" complementary practices in France. Not only has it been practiced in France for nearly 200 years, homeopathy meets a variety of the criteria that this thesis has related to the notion of the "acceptance" of a complementary practice. Indeed as it currently stands, "homeopathic medicines are reimbursed in France" (Representative of the *Ordre des médecins*, 2015). Since 1965, homeopathic preparations have been "included in the Pharmacopoeia," which Homeopathic Doctor Q told us means, "It's official […] there are instructions for its use and preparation that are official" (2015). According to the Representative of the *Ordre des pharmaciens*, homeopathy is legally codified as, "a medicine […] it is registered as being able to modify or correct illnesses" (2015).

In addition to being reimbursed by the French Social Security, legally codified as a medicine, and sold with regularity in French pharmacies, DUs and DIUs in homeopathy have been offered in French pharmacy schools for the past thirty years (Peron, 2018). In 2014, the University of Brest became the first French medical school to offer a DU in homeopathy (Le Télégramme, 2014). Over time, approximately 20 other medical schools followed suit, such as the medical school at Paris University 13. Homeopathy is officially accepted by the *Ordre des médecins* and constitutes a title that can be legally displayed on a doctor's name-plate and prescriptions. Furthermore, according to the criteria put forth in Chapter 3, homeopathy has both a critical mass of visibility and use; attested to by France's position as a world leader in homeopathic production and consumption, resulting in sales totaling more than 300 million euro for Boiron laboratory in France alone in 2014 (see footnote 81).

Thus, we can see that homeopathy can easily be considered as an "officially" accepted complementary practice in France. Nevertheless, over the course of writing this thesis, not only has homeopathy turned into a controversy receiving wide-spread media attention, its reimbursement by the Social Security system has been put under question by the current Minister of Health, Agnes Buzyn. Curiously, the entire highly-charged debate that is currently surrounding homeopathy was instigated by an opinions piece that was published in *Le Figaro*

on March 18, 2018 and signed by 124 doctors. This piece attacked "alternative medicines" in general and homeopathy specifically, calling on both the *Ordre des médecins* and the "public powers" to immediately: remove the authorization allowing doctors to display their homeopathic titles; suspend the recognition of homeopathic diplomas; prevent the creation of homeopathic trainings in universities; discontinue reimbursements for homeopathic medications; initiate public awareness-raising campaigns on "alternative therapies;" and ensure that all healthcare professionals refuse to give "useless and ineffective treatments" (Le Figaro, 18 March 2018).

Furthermore, the authors of this opinions piece created an association called "Collectif Fakemed," with a website championing their cause and recruiting additional signatories[84]. As it currently stands, there are now 3,337 signatories listed on the association's website. In direct response to the March publication, the National Syndicate of French Homeopathic Doctors (SNMHF) sent an official letter to the *Ordre des médecins* on April 13, 2018, filing a complaint against the 124 original signatories for "non-confraternity and disrespect of the deontological code" (Franc & Vanlerberghe, 2018). Additional official complaints against the signatories were sent to the *Ordre des médecins* by the syndicate, The Collegiate Union (Le Figaro 27 July, 2018). While the *Ordre* refused to accept the SNMHF complaint on the grounds that "collective complaints" are considered to be invalid, more than 10 of the original signatories have been served with individual suits and proceedings are currently underway (Le Figaro, 11 September, 2018). In light of the media attention, the *Ordre des médecins* first published a statement on March 22, 2018, calling on the Academy of Medicine to conduct a study on homeopathy and recommending that the Minister of Health ask the HAS to do the same (Ordre des médecins, 22 March 2018).

Indeed, in the case of homeopathy there is a reason justifying the Minister's call for an HAS study. This is because, as confirmed in my interview with a Representative of the *Ordre des pharmaciens*, "Homeopathic medicines are treated separately, because obviously there is no randomization that functions" (2015). The difficulty surrounding the creation of randomized trials for homeopathy is at the heart of the current controversy and claims that it is "unscientific." This is because homeopathic medications have never been required to pass through the same rigorous process that is used to evaluate pharmaceutical products in France. The Representative of the *Ordre des pharmaciens* explained this process in the following terms:

> "So, we have to verify [a medicine's] therapeutic efficacy, meaning that we have to have randomized trials along with a placebo to prove that the effect of the medication is clearly superior to the placebo effect. Then there is a commission at the drug agency [ANSM],called a transparency commission, who gives an opinion comparing not only the medication's trials against the placebo, but also comparing it to other medications of the same class, where the same therapeutic effects have defined the notion of medical service rendered [SMR] and the amelioration of medical service […] The [pharmaceutical] laboratory can- how to say- use this opinion to ask the pricing commission, it's what we call the Executive Committee of Health Prices [CESP], which is the Ministry of Finance […] This commission defines the price for the product's reimbursement- if it is accepted for reimbursement, which is determined by the amelioration of medical service given. Obviously, if there is no reimbursement given by the Social Security, it become difficult to put the product on the market, because there is no interest"

[84] https://fakemedecine.blogspot.com/

This discourse clearly outlines the key problem of homeopathy in France: it is incredibly difficult to evaluate using the randomized controlled trials that work so well for most pharmaceutical products, resulting in little compelling evidence that it significantly improves medical service rendered in comparison to pharmaceutical products[85]. Considering the evaluations process outlined here, we can see that the discussion in Chapter 2 concerning the individualized treatment approach that characterizes homeopathy makes it politically problematic. As such, on May 24, 2018, the Minister of Health officially requested that the HAS conduct a scientific investigation on the efficacy of homeopathic medications with a final decision due at the end of February, 2019. Buzyn declared that a decision concerning the continued reimbursement of homeopathic medications would be made following the HAS conclusions.

On June 14, 2018, the *Ordre des médecins* published a somewhat ambiguous statement on its website that both condoned and contradicted the Health Ministry's position. Framing its statement as a reminder of the medical deontology code, the *Ordre* "firmly recalled" that the use of the term "medicine" was limited to the conventional medical domain and that all French doctors have a deontological responsibility to practice according to "data acquired by science." Nevertheless, the *Ordre*'s same statement concluded by recalling that all doctors can employ "additional or complementary prescriptions, pharmaceutical or other, which the doctor values in light of their consciousness of each situation and once they have given the patient honest, clear and appropriate information" (Ordre des médecins, 19 June, 2018). It is of note that this communication also condemned the use of the term "complementary and alternative medicine" in reference to homeopathy.

While on the surface, when the *Ordre*'s March and June public communications are taken together they seem incongruous, a statement given to me by Doctor J in our initial interview appears to shed light on what can be interpreted as the *Ordre*'s somewhat muted response to the homeopathy controversy:

> "In France, we can say that there is a sensibility that is fairly widespread among the population and that the authorities are trying to dominate […] there is a faction that is interested and open, another that is a bit distant, but not in an ideologically aggressive way, and then there is a core that is ultra-rigid that excludes, combats, and condemns. In general the *Ordre des médecins*, which is not at all homogenous- there are acupuncturists and homeopaths in the *Ordre* as well, so the *Ordre* is not homogenous" (2014).

Here, Doctor J gives us what appears to be a rationale for the ambiguous position that the *Ordre des médecins* is taking in the current homeopathy debate: the *Ordre* is composed of a variety of doctors with different specialties, some of whom are doctors using complementary

[85] While the rationale for this statement was given in Chapter 2, it is worth recalling that homeopathic practitioners repeatedly emphasize the individualized nature of homeopathy in which multiple patients suffering from the same complaint will be given different remedies (or combinations of remedies) depending on their specificity and their individualized symptoms, rather than on the patient's disease. This makes it difficult to evaluate homeopathy using randomized controlled trials that are based on the efficacy evidence of a single molecule for multiple cases of a single disease. Furthermore, as was indicated in Chapter 2, there are both publishing and funding biases against homeopathic research that prevent homeopathic trials from being scientifically evaluated and published with the same scale and rigor as for pharmaceutical products. For example, many homeopathy studies with negative results are not replicated and many positive results are quickly dismissed as invalid (For example see: J. Jacobs, W.B. Jonas, M. Jimenez-Perez, D. Crothers, "Homeopathy for Childhood Diarrhea: Combined Results and Metaanalysis from Three Randomized, Controlled Clinical Trials", in Pediatric Infectious Disease Journal, 2003; 22: pp. 229-234.; and Canadian Paediatric Society, "Homeopathy in the peadiatric population," in Paediatric Child Health, 2005; 10(3): pp.173-177).

practices. This fact was confirmed to me by the Representative of the *Ordre* during our interview. When I asked him, "What do you think of homeopathy?" he replied:

> "I practice homeopathy in action. What I think is that we shouldn't be- like all things in life- we shouldn't be fundamentalist, meaning that we should use all the means that exist- as long as they are not harmful or contraindicated and they can bring someone- for example, rather than taking anxiolytics if someone takes homeopathy and that helps them, *bah*, all the better. Anxiolytics are linked to dependency, they're not harmless, they can have side-effects, so if there's no side-effects, all the better, we've won. In particular with children- stressed parents come to us in a panic saying, 'My son isn't sleeping and has a stomachache, what can I do?' Well, you're not going to bombard them with medications if you see that it's mundane nervousness- giving them homeopathy allows the parents to take care of their child so they're happy and thus, all of them are better" (2015).

According to a 2012 study of the prevalence of homeopathy in France that was based on an analysis of homeopathic reimbursements in the national French health insurance database, this particular approach to homeopathic use is fairly widespread. This study found that in the 12-month period under examination, a total of 120,110 different healthcare providers prescribed a reimbursed homeopathic preparation to their patients at least once; corresponding to approximately 43% of the total number of potential prescribers in France in 2012 (Piolot et al., 2015). Furthermore, the results of this study confirmed the accuracy of the Representative of the *Ordre*'s aforementioned clinical vignette. Indeed of the almost 118,303,100 homeopathy units that were reimbursed by French national health insurance during the study period, the highest proportion of the beneficiaries receiving these treatments were children aged 0-4 years (18.1%) (Ibidem). In light of this thesis' discussion of examples related to the ageing population and palliative care, it is of note that this study also found a significant number of beneficiaries for homeopathic prescriptions among the population aged 65 years or older (Ibidem). In other words, the results of this study also support this thesis' claim that complementary medicine is flourishing in the "space" that is beyond the scope of the conventional medical gaze and/or efficacy[86].

[86] While the subject falls well outside of the scope of this thesis, it is worth highlighting that this same study also found that the population receiving the homeopathic prescriptions reimbursed in the study period was predominately female (68.2%) with a higher median age than that of the male population (45 vs. 29 years) (Piolot et al., 2015). This is significant in light of recent research on gender disparities in healthcare, in which it is indicated that women are discriminated against by healthcare providers due to gendered norms. For example, studies of women with chronic pain conditions, such as fibromyalgia, indicate that they risk being perceived of by their doctors as hypochondriacs, hysterical, emotional, or suffering from psychosomatic pain (Samuelowitz et al. 2018. Available at: https://doi.org/10.1155/2018/6358624). Likewise, Hoffmann & Tarzain (2001) show that women are more likely to be undertreated, misdiagnosed, or treated less aggressively than men for pain (Available at: http://dx.doi.org/10.2139/ssrn.383803). Going further, an online study of 2,400 women with chronic pain in the United States found that some of these women try complementary therapy as a result of perceived healthcare discrimination (nationalpainreport.com, 12 September, 2014. Available at: http://nationalpainreport.com/women-in-pain-report-significant-gender-bias-8824696.html). Thus, this study's results indicating a gender disparity in homeopathic prescriptions suggests that in the case of French homeopathy, gender norm-based discrimination may be a contributing factor to the higher homeopathic prescription rates for women. For example, reconsider the Representative of the *Ordre*'s clinical vignette concerning "mundane nervousness" in the context of gendered norms concerning pain and hysteria. Then couple it with his remark about prescribing homeopathy in lieu of "bombarding" nervous children with anxiolytics, keeping in mind the studies mentioned here. In other words, it seems as though it would be worth investigating whether the logic behind this vignette also holds true for women.

It is of further note that the reimbursement expenditure for homeopathic prescriptions in the period of this study equated to approximately 98 million euro for the French national health insurance (Piolot et al., 2015, p.444). This is significant because, according to a statement given to me by the Representative of the *Ordre des pharmaciens*, "Homeopathic reimbursement is the weakest and most of the time its products are not reimbursed" (2015). Indeed homeopathic reimbursement currently stands at approximately 30%. As a result, considering the 34.4 billion euro total Social Security expenditure on medicines in 2010, homeopathy reimbursements only represented roughly 0.3% of the health insurance's medication costs for the study period (Piolot et al., 2015, p. 447). In fact, this study indicated that homeopathy reimbursement costs for the period represented less than one-third of the total reimbursement costs for Doliprane alone (Ibid, p. 447). More recently, the Social Security's reimbursement costs for homeopathic preparations remained steady constituting approximately 0.29% of the 25 billion euro of total Social Security spending for medications' reimbursements in 2016 (Méréo, 2018).

According to the 2011-2012 study presented here, only 6.3% of the homeopathic prescribers were registered as "special practitioners," including homeopathic doctors, acupuncturists, and specialists in vascular medicine (Piolot et al., 2015, p.444). Otherwise, the vast majority of homeopathic prescribers included general practitioners (accounting for 58% of the active healthcare practitioners who prescribed homeopathy in the study period), followed by dentists (10.7%), ophthalmologists (3.4%), dermatologists (3%), midwives (2.8%), gynecologists-obstetricians (2.7%) and pediatricians (2.5%) (Ibidem). This practitioner breakdown remained consistent in 2016, during which 25% of all French general medicine practitioners and 72% of all midwives prescribed homeopathy on a "very regular" basis (Méréo, 2018). Despite the popularity of homeopathy, almost 55% of the homeopathic prescriptions reimbursed between 2011 and 2012 were given in combination with allopathic medicine. In other words, rather than using homeopathy as an alternative, the majority of French prescribers are using it as a compliment to their conventional medical practice. This with evidenced by the especially high rates of homeopathic prescriptions given in the period from October to January, during the peak of cold and flu season (Piolot et al., 2015, p.445) [87]. It was also confirmed within various discourses collected during my fieldwork, such as the one given by the Representative of the *Ordre des médecins* above.

During my interview with the Representative of the *Ordre des pharmaciens*, he made an observation about homeopathy that provides insight into why its granules are so widely prescribed in spite of the general lack of rigorous randomized evidence proving their efficacy. His remark gains significance considering that it concerns homeopathy use among dentists, the second-highest prescribers listed in the 2011-2012 reimbursement study. Specifically, the Representative remarked that:

> "There are dentists all around my pharmacy and they tell me that when they prescribe arnica and they manually remove wisdom teeth- they tell me, 'Well, we have less bruising and they bleed less.' They're official, I know them, they're honest practitioners who are not particularly convinced by homeopathy. So we're incapable of saying how it works, but they tell me, 'We assure you, it works, we have them take it the night before and in the morning, before we do the anesthesia, and after the extraction it's better than without it.' And we don't know

[87] It is of note that this study focused exclusively on doctor-prescribed homeopathic preparations, rather than including self-medication. This is a significant omission, because Boiron reported that 48% of its total French sales in 2012 were from over-the-counter products bought for self-medication, especially for colds, flu, and anxiety (Piolet et al, 2015, pp. 445-6).

why, well, we don't have the proof, the notion of proof for the efficacy of homeopathy- well, but anyway we don't know how it functions or why it functions. If we were to give them sugar would it work the same? I don't know" (2015).

Of the homeopathic products for which more than one million units were reimbursed by the Social Security in 2012, arnica montana constituted the preparation with the most units sold (Piolot et al., 2015, p.444). Additionally, within the Representative's rhetoric, notice how he emphasizes that the dentists prescribing homeopathy in the area around his suburban pharmacy are "official" and "honest" practitioners. This echoes the argument put forward in the previous section concerning the difficulty that French practitioners have in accepting that which is not "scientifically proven". For example, consider the Representative's discourse circling around the notion of homeopathic efficacy. In the span of a few seconds he goes from saying that "we don't know why" it works to, "we don't have proof" of why it works, to saying that what we don't have is "the notion of proof" for homeopathic "efficacy;" at which point he changes course to say that "we don't know how it functions of why it functions," and then finally back to the notion of proof coming from a randomized trial. In other words, it appears that the Representative is trapped in a logical loop of doubts and questions in his attempt to make sense of the qualitative evidence that the dental prescribers in his area give him concerning their experience in practice. Nevertheless, just as we saw in the previous section concerning the difficulty accepting that which has not been scientifically defined in terms of semantics and terminology, here we see that the same is true for practices. This Representative of the *Ordre des pharmaciens* has enough personal experience with practitioners who actively prescribe arnica because they have consistently seen its efficacy in their clinical observations; yet, because this is not backed by a critical mass of evidence-based medicine's gold standard of "proof," his rhetoric clearly indicates that he is having a difficult time accepting his colleague's qualitative results, despite their prescription habits.

Considering recent developments in the current homeopathy controversy, it appears as though some of the heads of French medical schools share the Representative of the *Ordre des pharmaciens'* doubts in terms of randomized data demonstrating the efficacy of homeopathic preparations. This was evidenced on August 31, 2018, when the University of Lille medical school announced the suspension of its homeopathy DU pending the conclusions of the HAS report and "national exchanges on a framework for this practice and its teaching" (Le Figaro, 11 September 2018). In response, the *doyens* of the medical and pharmacy schools published a communication promoting the continuation of the university teaching of homeopathy as a means of ensuring that both its interest and its limits would be presented to future healthcare professionals (Europe 1, 6 September, 2018). In light of the pending results of the HAS evaluation, the *doyens* envisioned the creation of a "university observatory" that would conduct "a precise inventory" of the university diplomas as well as the reevaluation of the DUs following the results of the HAS evaluation (Ibidem). Nevertheless, following the Lille example, the medical school of Angers definitively suspended its homeopathy DU on 9 September, 2018. In his explanation for the decision, Nicolas Lerolle, the *Doyen* of the Angers medical school announced, "In the absence of scientific proof we would not like to take on the responsibility of training allowing for the display of a university diploma for a practice that is not validated" (20 Minutes, 9 September, 2018). This statement is significant considering that at the time it was made, neither the HAS nor the Academy of Medicine had published reports on their findings concerning the scientific evidence for or against homeopathy. In response to the Lille suspension, Didier Deswarte, the vice-president of the SNMHF denounced the cessation of the university teaching of homeopathy, which he felt could result in homeopathy "arriving in the hands of people who

do not have a health diploma" (Peron, 3 September 2018). In this same statement and in direct echo of a comment made by Christian Boiron, the current head of Boiron laboratories, Deswarte went on to say that the current actions against homeopathy constituted a "witch hunt" that discredited both homeopathy DU holders and doctors prescribing homeopathic preparations (Ibidem).

When the imbalances in the ratios related to both sides of the current homeopathy controversy are taken into account, its comparison to a "witch hunt" becomes more grounded. For example, consider the fact that the entire controversy began because of an opinions piece that was published and signed by 124 practitioners. This number is significant when it is considered against the 5,000 French doctors that are officially registered as "homeopathic specialists." Furthermore, the original opinions piece, or "tribune" in the French presses, was then reproduced on the "Collectif Fakemed" website with an open invitation to become a "signatory." As it now stands, this website lists 3,337 signatories. In response, a petition was published on the website "change.org" in order to collect the signatures of those opposed to removing homeopathy's reimbursement by the Social Security[88]. This petition managed to collect 36,544 signatures, which is considerably more than the original "tribune."In other words, we see that a small number of healthcare practitioners who are opposed to homeopathy on the grounds that it is a practice that is "unscientific, unethical, irrational, and dangerous" have managed to create a national controversy surrounding its reimbursement, its place in French university teachings, and its overall legitimacy.

In practice, this means that the opinion of 124 doctors may eventually prove to be powerful enough to dramatically change the medical behaviors of 5,000 doctors; and may moderately limit the prescription practices of thousands more. Homeopathy is a multi-million euro industry in France that has been consumed at least once by more than 50% of the French population. Furthermore, since a significant proportion of the total French homeopathic sales result from self-medication, there is clearly a strong consumer interest in this treatment despite the debate surrounding its "unscientific" nature. Much of the argument against homeopathy is that it is an unnecessary burden on the Social Security at a time when the system is in a deficit. Yet, homeopathic reimbursements account for well under 1% of the total Social Security costs, despite it being regularly prescribed by a considerable percentage of French healthcare practitioners. Going further, considering the approximately 100 million euro the Social Security spent on total medication costs in 2016, removing homeopathy from the reimbursement list seems counterintuitive considering its generally low costs in comparison to some of the most prescribed medicines in France. Doctor R supported this claim by saying:

> "It is out of the question to adhere to or reject therapeutic procedures that are widely used and that produce effects. Why did the Social Security partially reimburse homeopathic medications? Because the Social Security said to themselves, 'If people use homeopathic treatments, which are not expensive, maybe they will use less medications that are very expensive, so we should reimburse it.' So it's an economic interest" (2017).

Upon reflection, the numbers do not seem to add up in this controversy. A small number of practitioners with a very strong opinion has sparked a debate concerning a practice that has been used for more than a century; that is consumed by the majority of the overall population; that is commonly used as merely a compliment to conventional medicine; that is

[88] Available at : https://www.change.org/p/madame-la-ministre-de-la-santé-agnès-buzyn-non-au-déremboursement-de-l-homéopathie

inexpensive to the Social Security regime; that is economically advantageous to the country's economy; and that a significant number of healthcare practitioners consider brings added value to their clinical practices. This begs the question as to how it is possible for the lack of one kind of quantitative result to so quickly outweigh such widespread qualitative evidence of efficacy. Indeed, it is incredibly difficult to imagine that more than 43% of the total medical prescribers in France are "charlatans" using the "medical title to promote false therapies with illusory effects" (Collectif Fakemed, 2018). Nevertheless, some healthcare practitioners, such as the *Doyen* of the medical faculty of Angers, are unwilling to accept any proof that does not fall into what the last section identified as the accepted scientific knowledge that continues to bolster medical authority. Clearly, this notion of "accepted knowledge" is so powerful that falling outside of its scope is able to effectively classify thousands of healthcare practitioners as "charlatans;" even though many of these "official" and "honest" practitioners prescribe homeopathy because they have seen evidence of its efficacy. For example, even the Representative of the *Ordre des médecins* stated that, "There is a small placebo effect in it, that's true, but I can assure you that there are certain homeopathic products that I can give you and the effects will be completely visible" (2015).

With all of this in mind, it is worth examining the deeper roots underlying the debate about removing homeopathy from the accepted reimbursement medications list, which we were told makes it "difficult to put the product on the market, because there is no interest." Even though the self-medication sales of homeopathic preparations for colds, flu, and anxiety indicate that homeopathy would continue to be consumed in France even if it were no longer reimbursed; de-reimbursement would most likely significantly reduce the overall volume of its sales. As such, since economic, prescription, and consumption trends do not logically seem to support the argument that homeopathy constitutes nothing but a "belief promising miraculous healing without risk," there must be a deeper ideological issue at play; even if it is tempting to imagine that the French Social Security reimbursed more than 129 million tubes full of nothing but placebo-induced, "illusory" "miracle treatments" in 2016. In light of the previous section's analysis, this controversy can be interpreted as related to a contemporary re-imagining of the "phenomenological positivism" that was enthroned by the Royal Academy of Sciences in the 17$^{th}$ century. In other words, it appears as though the homeopathy controversy is linked to this historical vestige re-imagined in the form of evidence-based medicine. As such, it is now time to examine a concrete case of a particular transition in French society that was a precursor to the contemporary form of this re-imagined scientific authority and its basis as the epistemology of evidence-based medicine.

This thesis began with a consideration of the 19$^{th}$ century professionalization of French medicine that occurred following the first Medical Congress; however, as we saw in the previous section, attempts to professionalize French medicine began long before the modern era. Thus, it is worth briefly examining a historical antecedent to this event that significantly reorganized medical authority in French society; namely the shift that occurred between the 1778 creation of the Royal Society of Medicine and the 1820 founding of the Academy of Medicine. These instances were incredibly significant in the social organization of French medicine because they marked the creation of an enduring link between the "profession" of medicine, State administration, and their joint surveillance of the health of the French population. Much as was the case for the Royal Academy of Sciences, the 1778 creation of the Royal Society of Medicine also served as an interesting example of the trade-off of political service in exchange for royal patronage and authority. Indeed, before the creation of the Royal Society of Medicine there were already groups of doctors organized to varying degrees throughout the French Provinces; however, it was not until its creation that State administration over public health was transformed beyond a rudimentary form (Grmek, 1990).

Thus, the regrouping of the medical profession under the authority of the crown acted as a means of officially expanding royal power over the population and its health concerns (Tournay, 2007). In doing so, the establishment of the Royal Society of Medicine marked the true beginning of the medical surveillance over the population, driven by the standardization and coordination of techniques for gathering information about the population's health that went beyond the simple collection of birth and death rates. According to Foucault (1974), this corresponded to a moment when the state emerged as an "instrument and place of the acquisition of specific knowledge," and as we saw in the previous section, that specific knowledge was scientific (p.16). Thus, the standardization of the collection of national medical data demonstrates the influence of the scientific methodology that the previous section indicated was "enthroned" at the time. Also, just as was the case for the scientists of the Royal Academy, this reorganization of French doctors transformed them into professionals at the service of the State; thus, solidifying medicine's double loyalty to both scientific and royal authority.

As Foucault (1974) indicated, this can be considered as the emergence of French "State medicine," which corresponded to the implantation of the notion of the "medical police." This concept was originally created in 1764 by the Austrian Wolfang Thomas Rau and popularized by Johann Peter Franck in 1779. The "medical police" can be understood as a combination of medical expertise and public action, a conception that places the health of the population under the responsibility of the state through their medical surveillance (Tournay, 2007). It must be emphasized that this notion of health did not include the contemporary reference to "health in terms of happiness" or even "well-being;" rather early State medicine was utilitarian in nature and based on the maintenance of bodies that were healthy enough to be active components in the work force. Within my interview with Politician C from the Ministry of Health, this concept was clearly elicited:

> "Everything is a political decision, what is reimbursed is a political decision based on science- the science of morbidity and medico-economics […] We have data which permits us to make decisions […] when you decide to focus on cancer you put lots of money into it and that's a political decision, the reasoning is the same as if we were deciding where to put money in the army" (2015).

Thus, we can see that the historical emergence of State medicine and the medical police remains firmly entrenched in the French social memory and remains as an active mechanism in the political decision-making process for health issues. We also see that the same relationship between the science of medical surveillance and "medico-economics" remains as a key component in the administration of French healthcare. It is also particularly interesting that Politician C equates the evidence-based health decision-making to decisions on defense spending, since in his discussion of the emergence of the medical police in France Foucault (1974) indicates that the normalization of medical education occurred after the normalization of State activities in the military industry (p.18). This only further underscores evidence of the depth of this historical antecedent in the French social memory.

According to Foucault (1974), the medical police consisted of the creation of a State-level observation and recording system monitoring population morbidity in detail, including both epidemic and endemic phenomena. It also entailed a normalization of medical practice and knowledge. This normalization brought university authority back to the forefront as a result of the need to control medical formation and exercise; though the administration of this medical monopoly now occurred in tandem with State authority. This double authority was further developed through the creation of State functionaries and organizations for the

surveillance of medical activity (Foucault, 1974). While historians diverge over their fixation of the exact moment in which the notion of the medical police became embedded in French society, there is general agreement that it occurred somewhere between 1789 and 1820 (Grmek, 1990).

While the French Revolution resulted in the disintegration of the royal societies, their organization re-emerged under a republican mantle. This occurred because Napoleonic legislatures and their successors actively contributed to the creation of medical elite responsible for supervising the administration of public health and hygiene (Nye, 2006). This led to the 1820 establishment of the Academy of Medicine, which was given the responsibility to collect information and provide useful counsel to the government. Thus, we see that while the "royal" was dropped from the professional conception of French medicine, it was still bound to the same double loyalty to both science and the State. In addition, the medical surveillance over public hygiene brought medicine into closer contact with other scientific disciplines in the attempts to carry out medico-political activities to prevent epidemics; such as moving cemeteries, ensuring the circulation of air and water in urban centers, and monitoring the overall state of health of the lower classes. In this sense, knowledge was an object of the State and a means of monitoring both its natural resources and the condition of its population, which would better ensure its functioning. Thus, the body was transformed into a productive force in society and a "bio-political reality" (Foucault 1974, p.15). The 19th century medicine that this was based on drew from the scientific discoveries of figures like Bichat and Morgagni, which rendered us all alike, incarnated in socialized bodies that function according to a common set of anatomical mechanisms. Thus, the great scientific discoveries of the 19th century and their integration into the normalization of university medicine, coupled with the transformation of medicine into an extension of State authority can be seen as politicizing modern, scientific medicine and its authority over our bodies. This vision was squarely based on both a curative and a collective approach to the body and public health that Politician C reminds us, remains intact in the medico-political sphere.

In light of the ideological tenets underlying the dawn of the Third Republic, the re-emergence of the medical profession was coupled with a strong preference for a model of liberal medical practice based on the independence of individual practitioners (Nye, 2006). As such, the early relationship between the modern French State and the newly professionalized medical practitioners was marked by tensions; doctors both had obligations to the State to collect data on and to ensure the population's health, yet the medical profession was strongly inclined to maintain their individualism and professional autonomy (Ibidem). Nevertheless, medicine was also reliant on State power as a means of supporting the fight to ensure adequate revenues for medical professionals. While medicine had become professionalized, its newly organized reputation and revenues were threatened by the considerable presence of traditional and folk healers throughout the French countryside acting as direct competitors to the medical monopoly. As such, just as we saw in the previous section's discussion of the anti-charlatan efforts that occurred in the wake of the medieval professionalization of French medicine, the same battle was again waged in the 19th century. Furthermore, while medieval medical professionals sought church authority in order to bolster themselves in this effort, modern medical professionals looked to the State for assistance (Nye, 2006).

Thus, we have arrived at the 1845 Medical Congress from Chapter 1 that we characterized as a response to a French "medical identity crisis." Taking into consideration the discussion here, we now have a better picture of the professional, social, and political factors that led to this medical identity crisis; as well as its implications. The tensions between

medical independence and State service in the face of an ongoing fight to stamp out the competition presented by unlicensed healers and charlatans necessitated State assistance and contributed to the need to define the identity of the French medical profession as a means of creating professional unity. As Nye (2006) explains, at the time there was a common conception of the medical profession as a "noble profession…with an honorable mission," this led to the internal formalization of professional medical ethics as a means of defending the rights of medical practitioners and "distinguishing themselves from their illegal competitors and reinforcing their demands for State protection" (p.22). In other words, we see that just as in the Middle Ages, the modern French medical fight against charlatanism was interwoven with attempts to ensure the identity, revenue, and protection of the medical profession following its professionalization, normalization, and codification.

This is incredibly significant when we take into consideration the language being used in the contemporary controversy over homeopathy. On the Collectif Fakemed website in the section introducing the "tribune" published against complementary medicines, the authors explain that, "In the face of the increasingly numerous esoteric practices and the growing defiance of the public vis-à-vis scientific medicine, we must react with force and vigor" (fakemedecine.blogspot.com, March 2018). In other words, just as we saw in response to the 1845 French medical "identity crisis," the current fight against homeopathy is also deeply related to conventional medical protectionism of its professional identity and domain. Considering the relatively low-cost, widespread usage, long-term presence, and market potential of homeopathy in France; a protectionist response to the perceived threat of doubts concerning medical identity and authority appears to be the most logical explanation for the current polemics. Furthermore, the presence of rhetoric calling the fight against contemporary "charlatanism" a modern-day "witch hunt" or "Ku Klux Klan" mounted against homeopathy in particular and complementary medicine in general begins to take on additional nuance. Namely, it appears to be evidence of the historical vestiges of previous "official" campaigns against complementary medicine that remain in the French social memory. Shiatsu Practitioner C explained this in relation to Shiatsu by saying:

> "It's a fight. We create competition with physical therapists and doctors […] competition with pharmacists and with all medical professionals. We don't play the game of consumption- it's political. And it's an old story, ever since there was scientific medicine we have a tendency to exaggerate the 'scientific' side, that's why we're not recognized as being among the French scientific milieu" (2015).

Before moving our analysis further through a brief consideration of the complementary side of the equation, it is worth indicating that the modern medical identity in the politics of the French State was solidified into a distinct medico-political behavior and ideology from the late 19th century up until the outbreak of World War I. In fact, some historians refer to this as the emergence of the priesthood of medicine[89] (Ellis, 1990, p.10). This medical "priesthood" consisted of waves of physician-legislators that flocked to Paris and dominated the legislative bodies. Indeed, between 1871 and 1914, a total of 358 doctors won elections as deputies or senators, giving them a disproportionate amount of control over French laws and society in terms of their overall numbers (Ellis, 1990). This dramatically expanded the range of the medico-political activities across all governance levels, resulting in the completion of the medicalization of French society and the transformation of medicine into a political activity based on a long lineage of scientific and state authority.

[89] *la médecine sacerdoce* in French

In his explanation of the rationale behind this development, Ellis (1990) quotes one such doctor in 1897 saying that, "Through hygiene, it [medicine] touches on politics; through the latest physiological research, it borders on philosophy; through the pity it exhibits in regard to all human miseries, it becomes a religion" (p.2). I feel this quote is particularly significant in this context, because it acts as the closing of what appears to be a full circle. While it is by no means exhaustive, this brief historical overview focusing on the specific instances in which medical authority was redefined and repositioned in the wider context of French social organization indicates that medicine has long enjoyed a privileged place of power at the top of the hierarchy of French society. This indicates that French medicine cannot be separated from power, social organization, and the controlling social authority at any given time. Whether it be along with the church, the crown, science, or the State, medicine has long maintained an enduring position of power in French society. The Representative of the *Ordre des médecins* clearly evidenced this in his explanation of the *Ordre*'s activities:

> "We are related to politicians. At our last congress, the President of the Republic came. Also there was a new health law that just got passed- well, for that we had many discussions with the Minister of Health. So we deal with national-level reflections on the large problems of society in relation to medicine […] we also have relations, on the departmental level, with the ARS, which is also on the regional level- it's a little like being the prefect of health" (2015).

Thus, we can see that the medico-political activities of the medical profession remain alive and well on all governance levels of contemporary French society. Perhaps this is how a group of only 124 doctors may be able to change the relationship that the entire French populace has with homeopathy. What is particularly interesting about the analysis presented here is that it frames the current tensions in the conventional-complementary relationship in terms of historical vestiges in the contemporary French social memory. As such, it is now time to consider the historical roots of complementary medicine in order to shed light on some of the considerations that are informing the stigmas, stereotypes and fears presented in Chapter 2. This is because, as we explored in previous chapters, complementary practitioners are themselves resistant to becoming fully mainstreamed into medical practice. We saw this particularly clearly in the case of osteopathy and the osteopathic lobbies' fight against the medical appropriation of osteopathic practice. As a result, we saw that tensions were created between the three statutes of osteopathic practitioners: doctors, physical therapists, and the "*nie-nies*" who are non-medical practitioners with a diploma from a private osteopathy school. Considering the rhetoric we saw from various practitioners discussing the difficulties of being "invisible" and working "in the shadows," or without any form of official recognition, a brief consideration of the deeper historical roots of the separatism that many complementary practitioners are emphasizing will add nuances to the contemporary conventional-complementary relationship. It will also better explain why many complementary practitioners spoke about concepts such as "heretics," "witch hunts," and "competition" that goes beyond economic and scientific concerns.

A study of the history of medicine shows that for as long as there have been humans, we have been fascinated with our bodies and the world around us. Furthermore, the archeological record indicates that throughout human history, when our interactions with our bodies and the world around us caused injury, we attempted healing practices of varying sophistication and efficacy. Also, since the beginnings of prehistoric trepanations and ancient medical texts from places such as India, China, Egypt, and Greece; magic, spirituality, and superstitions have been so closely related as to be interwoven with medicine and the art of

healing. There have also been periodic moments in which societies tried to separate the material and the metaphysical aspects of nature, the body, and the healing arts. Perhaps the earliest of these moments occurred in ancient Greece when the likes of Hippocrates and his expulsion "of the gods from medicine" (Robinson, 1943, p.51). Indeed, the Hippocratic corpus including detailed case histories describing signs, symptoms, and the development of illnesses in a secular fashion is considered by many medical historians as the ancient beginnings of what we call clinical medicine. Nevertheless, as Kuhn (1970) and Koyré (1957) have both shown, facts and observations are shaped by the beliefs of the social context of the time; and every social context comes with various beliefs. In ancient Greece, despite the Hippocratic method, appeals to the supernatural remained (Rhodes, 1985). From making pilgrimages and offerings to temples and shrines, from holy men throughout the ages praying for healing, and from any number of herbs, plants and compounds, the "official" history of Western conventional medicine has always been accompanied by various undercurrents of alternative visions of the body, illness, and healing. While the richness and diversity of these undercurrents and their relationship to the histories of the myriad complementary practices that are present in contemporary France is impossible to discuss in any one work; it is possible to make some small observations and commentaries.

For example, in his study of the history of what he identifies as "esotericism," Antoine Faivre defines it as "a diverse group of works, authors, trends, which possess an *aire de famille* and which must be studied as part of the history of religions because of the specific form it has acquired in the West from the Renaissance on" (Faivre & Voss, 1995, p.49). What is incredibly interesting and useful about Faivre's concept is that it allows for a diverse set of traditions and practices to be considered together, without debasing the value of their individual specificities. This allows him to provide a fascinating historical outline of traditions ranging from hermeticism to Kabbalah to mesmerism all the way into new ageism. To do so, Faivre considers "esotericism" as a "form of thought," which can be identified in terms of his four intrinsic and two relative components.

Specifically, he defines esotericism as a form of thought involving: 1) Correspondences- the principle of universal interdependence in which both symbolic and real correspondences are said to exist among all parts of the universe, both seen and unseen. 2) Living Nature- nature is seen as multi-leveled and full of potential meanings linked in a dynamic network of sympathies and antipathies; thus, the universe and nature are essentially alive and full of forces circulating through it. 3) Imagination and Mediations- these are linked and valorized. The imagination is seen to be an "organ of the soul" that allows access to different levels of reality through intermediaries, symbols, and images that creates a gnosis necessary to decipher nature, put the theory of correspondences into practice, and to experience the mediating entities operating between the spheres of Nature and the Divine. 4) The Experience of Transmutation- in which "transmutation" is considered to be a sort of alchemical metamorphosis resulting from a cooperation between gnosis and active imagination that allows for an illuminated knowledge conducive to a "second birth" of some kind (Faivre & Voss, 1995 p. 60-1). The two relative components include 5) The Praxis of Concordance- involving consistent attempts to establish a common denominator between several or all esoteric traditions in the hopes of gaining superior gnosis. 6) Transmission- there is an emphasis on the transmission of an esoteric teacher from master to disciple and initiation following a pre-established channel; authenticity is based on filiation to an established line of transmission.

It is of note that Faivre considers "esotericism" to be incarnated in time and space; meaning that it is a "form of thought" that exists as a product of specific historical and

cultural conditions. Thus, it allows for an examination of both the transformations of any given esoteric example in relation to society as well as the examination of the collection of the different forms of thought that make up the esoterics of society at a given time. Going further, in his examination of globalization and esotericism Hanegraaff (2015) considers the "Western esotericism" present during the Enlightenment as the "logical counterpart" or "Other" to the Enlightenment form of thought (p. 79). Indeed, by taking Faivre's characteristics into consideration the esoteric traditions in the Enlightenment era can be considered as the antithesis of the mechanical clock of nature and the materialist, positivist empiricism that dismissed the imagination. Hanegraaff thus characterizes esoterics at the time as a "second way of thinking" that involved "confrontation between new ideologies of rational, scientific modernity and everything else" (p. 84). He then goes on to discuss the place of ideological dominance that science developed throughout the Enlightenment concluding, in much the same fashion as we saw in the previous section, that the ideological "bias is seen in historical narratives that are rooted in the idea of a natural organic and teleological development of reason from the birth of philosophy in Ancient Greece to the triumph of modern science" (p. 84).

When the triumph of the Western scientific dominance of nature in the 17th and 18th centuries that led to the scientific dominance of medicine and the body in the 18th and 19th centuries is taken into account using Hanegraaff's characterizations, the 19th century explosion of complementary medical practices begins to take on additional nuances. Indeed, homeopathy, naturopathy, osteopathy, chiropractics, and mesmerism all developed out of this period- and all of them shared a similar conception of the body that was based on holism and the correspondence between the body as microcosm and nature as macrocosm; the notion of a vital force that both animates nature and the body; the notion that the human imagination can decipher the multiple levels of the body's and nature's realities in order to find the true source of illnesses and remedies; and the belief that the body can transmute illness or imbalances and restore its own balance and equilibrium. Recalling that Faivre (1995) highlights the "increased knowledge about the East" that intensified in the 19th century, resulting in the emergence of a more mixed concordance within Western esoteric traditions; I find it incredibly significant that my fieldwork identifies a similar concordance that developed out of globalization influences in the 20th century. Indeed, my research indicates that many of the "non-Western" healing practices that all also display evidence of Faivre's characteristics- such as Tibetan medicine, Chinese medicine, tai chi, qi gong, shiatsu, reiki, yoga, and neoshamanism- expanded in France during the 20th century and are now practiced in the form of Western hybrids, or re-imagined versions of these practices colored by Western (mis)interpretations of "authentic" non-Western healing arts.

For example, as evidenced in Chapter 2, Shaman C regularly made references to a wide mix of traditions as a means of helping his clients understand the more gnostic aspects of his practices. To these ends he would discuss the force he worked with in terms of "Qi," "Chakras," and the "Spirit" with remarkable consistency in his discourse. In a study of French and Italian acupuncture, Candelise (2011) confirms a similar concordance of traditions by characterizing the acupuncture practiced by French practitioners as "traditionalist French acupuncture" due to the French redefinition of their approach to Chinese acupuncture (p.45). In my previous work, I referred to this form of re-imagination using the term "ontological hybridization," underscoring that it is facilitated by globalization mechanisms (McEwen & Midol, 2017). Within my fieldwork, this was confirmed by Doctor J's and Shiatsu Practitioner C's discourses concerning the transmission of acupuncture and shiatsu practices by French teachers who had either been trained abroad or had been trained in France by Chinese and Japanese teachers; this was discussed in Chapter 3.

Thus, the value of Faivre's conception of esoterics in this thesis is that it allows us to examine what I consider to be similarities in the ontological basis underlying many of the complementary practices I encountered in my fieldwork. This is because rather than considering them individually as distinct practices, we can explore them as a group of practices that have an "*aire de famille*" and striking similarities in their underlying "forms of thought" about both Nature and the nature of the body. Doing so allows us to view the current backlash against homeopathy in terms of a contemporary expression of a long-standing conflict between the scientific form of knowledge that has been dominant since the 17th century and the various forms of hidden knowledge, mysticism, gnosis, and ecstatic and altered states of consciousness that have been continuously present throughout human society. Thus, as this and the previous section indicate, the history of medicine has been long punctuated by various movements to reject, deny, or to suppress their presence depending on the dominant ideological trends at the time. Some of these "forms of thought" entail healing practices ranging from the kinds of folk medicine, herbal remedies, bone-setting, faith-healing, laying of the hands, and exorcism that have been in France throughout its history and that remain, in re-imagined forms, in contemporary complementary medicine. Other practices sharing these "forms of thought" have been developing since the 19th century onward, such as homeopathy, and are flourishing in contemporary French society. Still others have become integrated into contemporary complementary practice as a result of globalization mechanisms, such as some of the hybridized forms of practice we have seen throughout this thesis. Nevertheless, as indicated in Chapter 2, all of these practices are based on a surprisingly similar "form of thought" about the body that is antithetical to the current conventional paradigm. In this and the previous section, we saw evidence of their attempted suppression following precise moments in which university, then scientific, and then medical authority became normalized, professionalized, and authenticated powers in French society. More recently, it appears as though globalization mechanisms and the reaction to the over-technoscientification of conventional medicine have both dramatically increased the presence of these "esoteric" healing practices and resulted in their perception as a threat to conventional medical dominance. This is evidenced in the current homeopathy controversy through repeated characterizations of complementary practices as "esoteric practices."

Indeed, the current debate surrounding homeopathy and complementary medicine in France clearly places them into the category of "rejected knowledge" that Hanegraaff associates with esoteric forms of thought. In many respects, based on my fieldwork experiences, I feel as though considering the plethora of complementary practices present in contemporary France as a "secondary way of thinking" that is a rejected form of knowledge provides significant insight into the paradoxical relationship between French conventional and complementary medicine. It also helps explain the currently unfolding conflict between homeopathy and the dominance of the "evidence-based" ideology of conventional medicine. Indeed, most of the practices that I encountered during my fieldwork directly correspond to Faivre's characteristics;[90] and considering them as a relatively unified "second way of

[90] The one notable exception to this statement that I encountered within my fieldwork is neurolinguistic programming (PNL in French) which is a form of psychotherapy that was developed in the 1970s in the United States and is currently popular in France. For example, several of the hypnotherapists I spoke with also practiced this form of psychotherapy and it was regularly featured among the complementary therapies present in the trade events I attended (discussed in Chapter 2). Nevertheless, since neurolinguistic programming clearly falls under the psychotherapy umbrella, it does not constitute a complementary practice; even though psychotherapy is considered to be a non-pharmaceutical intervention, which is sometimes used as a synonym for complementary practices in France. This further underscores my dismissal of the "non-pharmaceutical intervention" term in reference to complementary practices in Chapter 1.

thinking" explains their regrouping via a negative definition and adds nuance to the semantics discussion from the previous section.

Going further, this vision of complementary practices helps to explain why even non-esoteric complementary practices- such as the biofeedback and Doctor Z's myotenofasciotomy technique that were considered in Chapter 3- get grouped into the sprawling category of complementary medicine; and are thus, dismissed or rejected from the accepted body of scientific knowledge. In the case of biofeedback, this is because it is based on a mechanism of mind-body interaction that medical science has not yet mastered. In the case of Doctor Z's surgical technique, it is because it is practiced on too small of a scale for it to obtain the considerable resources necessary to meet the methodological standards that evidence-based research requires in order to be accepted. This was alluded to in Chapter 3's discussion of Doctor Z's rhetoric concerning his attempts to secure funding for research. As such, in both cases, these practices are dismissed as "unscientific" and grouped in with the general category of complementary medicine, which results in their dismissal from the "accepted forms of knowledge;" even though they are both based on the same scientific knowledge of the body as conventional medicine.

Furthermore, by considering complementary practices in terms of this particular notion of "esoterics," I feel as though it becomes easier to understand the staunch resistance of various complementary practitioners to the medicalization of their practices. For instance, in Chapter 2 we examined the rhetoric of President D of an osteopathic association and his fight for osteopathy to be recognized as a "separate but equal" form of practice. In other words, while President D's association is lobbying for the official recognition of osteopathy, it is also fighting against its medicalization. This was also true in the case of Kinesiologist R's lobby group which is fighting for the same separate status of kinesiology and against its medical appropriation. In Chapter 2, I suggested that one of the reasons for this was a strategy that would allow these complementary practitioners to establish their professional identity and to maintain their share of the market demand for such practices. Now, however, within the context of this and the previous section's discussion, we can go one step further and suggest that part of the reason that these complementary practitioners refuse medicalization is to protect the "form of thought" that underlies their practices' conception of and approach to the body, health, and illness. For example, within our interview, Osteopathic President D directly related the financial concerns of osteopathic practitioners' revenues with his association's work to promote the "official" recognition of the osteopathic profession. He then went on to discuss his association's lobbying efforts on the European level in similar terms. Nevertheless, at the end of our interview he went a step further concluding that,

> "Osteopathy can really bring benefits to humanity […] and we are working to help the world […] because it is essential for people to feel good and to experience harmony in their bodies and minds. In some senses we are brothers to Indian medicine […] I believe in integrative medicine, each brings its own specialty- and I'll tell you a secret- osteopathy is really energetic" (2015).

As we can see within this rhetoric, President D's lobbying against osteopathic medicalization clearly goes beyond simple professional protectionism. His belief that osteopathy can "bring benefits to humanity" and "help the world" reveals a much deeper ideological consideration. This is further underscored by his characterization of osteopathy as a "brother to Indian medicine," or Ayurveda, and his revelation that "osteopathy is really energetic." In other words, President D is saying that at its heart, osteopathy is a form of "energetic medicine" that is based on the notion of the interplay between natural vital forces

and the body's functioning. Taking this into account, we can interpret the "harmony in their bodies and minds" that he refers to in terms of the harmonization of the body's vital forces. Thus, this discourse provides very concrete evidence of President D's conception of osteopathy that corresponds directly to Faivre's notion of an "esoteric form of thought." Of significant note within this discourse is President D's notion of "integrative medicine" to mean an attempt to establish a common denominator between different esoteric traditions; in this case Ayurveda. Not only does this appear to be an attempt to give the osteopathic "energetic" conception more authenticity by linking it to a much older lineage of what President D perceives to be an "energetic practice," it also emphasizes the separateness of osteopathy. To these ends, President D also told me that

> "One of the reasons there is sometimes antimony with medicine is because of its scientific vision of health. We treat humans and humans are complex and global- so doctors can go into osteopathy, but they lose the height of the vision of a human in their totality" (2015).

Thus, here we see that President D perceives of osteopathy as having a distinct "vision of a human it their totality" that he feels is antithetical to the compartmentalization characterizing the specialty-based "scientific vision" of medicine. As such, if osteopathy were to become medicalized, he feels as though it would lose the specificity of its way of thinking about the body and its treatment. This indicates that going beyond the professional and economic concerns related to maintaining a "separate but equal" approach to complementary regulation, there is a deeper ideological source of resistance that appears to stem from the "way of thinking" about the body, health, illness, treatment, and the universe. We saw this earlier in this section in Shiatsu Practitioner C's insistence that Shiatsu practitioners are perceived of as competition by medical practitioners because they "don't play the game of consumption." This implies that Shiatsu has a different way of thinking about health and the body that is not based on the same logic informing the highly pharmaceutical approach of conventional medicine. Doctor M described this conventional pharmaceutical logic in the following terms:

> "The relation between patients and their medications in our Occidental health system is of a shamanic order- that is to say that in the behavior of the doctor and the patient […] they consider that it is the only path, the royal path" (2017).

This statement further emphasizes the perceived differences in the conventional and complementary "forms of thought." Five minutes earlier within this same interview with Doctor M, he made another statement underscoring the different ways of thinking that characterize conventional medicine and Chinese medicine that directly informed my interpretation of his statement concerning pharmaceuticals. Namely he said:

> "I think to be a good Chinese doctor […] you have to have suckled at the breast of a Chinese mother. So I am a bad Chinese doctor, meaning- and I think, by the way, that it's the case for many among us- we don't know how to really do integrative medicine […] Real integrative medicine in a hospital like this one is to have a […] medical care center with an initial consultation in which you have a double reflection- meaning you have [Doctor M] who thinks in Occidental medicine and [Chinese Medical Doctor S] who thinks in Chinese medicine and we put these two reflections together in our consultation with the patient, because in the actual state of things, I don't think that there is a type of schizophrenic brain that can think in Chinese and in Occidental at the same time" (2017).

Thus, we are beginning to see an underlying nuance informing Chapter 2's discussion of the preference among complementary practitioners to remain clearly separated from conventional practitioners that goes beyond capitalizing on the market potential. Indeed, throughout my fieldwork one of the things that surprised me the most was that the vast majority of the complementary practitioners I spoke with all seemed to identify a "common denominator" in the thinking that formed the basis of their practice. Furthermore, they all seemed to feel as though this way of thinking was incompatible with the standard paradigm encompassed in contemporary French conventional medicine. This is particularly clear in Doctor M's above rhetoric in which he suggests that only a "schizophrenic brain" would be capable of thinking "in Chinese and in Occidental at the same time." As such, Doctor M, President D, Kinesiologist R, and a variety of other practitioners all identified integrative medicine as the preferred path forward. Doing so would allow each practice to maintain its ideological specificity, and to work in compliment with other approaches to the body and healing. For example, as Shaman C explained it:

> "Medicine is not a pure science […] and what I feel is that doctors do have alternatives. One day the biochemical machine that shapes doctors' understandings will no longer be useful- this is obvious because medicine seems to be getting weaker as people heal themselves with energy and spiritual alternatives- but what I'm referring to isn't energetic, or spirituality, or an alternative. What doctors don't know is that there is a human heritage of natural healing that is far more advanced than science. For example, the plants in the field are full of wisdom and there's an ancestral knowledge of how to use them to heal. What we need is for this knowledge to be seen as equal in the current era- integrating this knowledge would be a success- but first we have to allow for there to be liberty to do this [laughs]" (2014).

Taken together, it appears as though underneath the scientific, economic, and political concerns that have been repeatedly cited throughout this thesis, the key factor that shapes the current conventional-complementary relationship into a paradox is a power struggle over the control of "accepted knowledge." Despite their overwhelming diversity, I was repeatedly impressed by the common denominators underlying the myriad of complementary practices that are currently present in France. Whether they were ancient or modern, well-established or on the fringes, they all seemed to share a surprisingly similar view of the body and its relationship to illness, healing, and the world around it. When I found Faivre's discussion of the four characteristics of what he refers to as "Western esoterics," I realized that it was a useful way of taking these similarities into account without debasing the individual specificities of each complementary practice. Going further, I realized that Hanegraaff's characterization of these esoterics as the "Other" form of knowledge that is antithetical to the dominant paradigm at any given moment in an individual society seemed to encapsulate the underlying resistance that French complementary practitioners have to becoming fully mainstreamed and medicialized; despite their lobbying and struggles to become "officially" recognized and professionalized. It also seemed to explain why there is such deep-seated resistance to complementary medicine in France, despite its wide-spread use, market-potential, and cost-saving implications.

Additionally, Hanegraaff's assertion that "esotericism is incarnated in time and space" fits in beautifully with this thesis' consideration of the wider environment of globalization (Hanegraaff, 2015, p. 78). This is because it allows us to account for current geographical variations in form and practice; such as the differences between American osteopathy, which is fully medicalized and supportive of pharmaceuticals, and French osteopathy, which is

actively resisting medicalization and in which there is a strong emphasis on non-pharmaceutical interventions. This perspective also takes into account the "ontological hybridizations" of practices, such as neoshamanism and yoga, and their disembedded forms that mutate as they travel laterally throughout global time and space. It also leaves much room for additional research into the transformation of any given complementary practice over time.

Another particularly useful aspect of the consideration of the "common denominator" of the complementary "way of thinking" that appears to be surprisingly shared among different complementary practices is that it can be interpreted as an emergent pattern that comes out of the interactions within a complex adaptive system. While the multitude of complementary practices currently present in contemporary France are interacting in unpredictable and random ways, this thesis has identified a variety of different ways in which those interactions are producing patterns and synchronicities. For example, we have seen how they are consistently regrouped through trade events, how a sense of shared community is being produced through the use of polyvalent spaces for rent, the cross-pollination that develops out of individual practitioners' interactions with both clients and each other, and shared lobbying or regrouping attempts to raise visibility in the fight for recognition. Now, we can add to this list a shared sense of vision about the body and its interactions with the world around it that is both perceived and instrumentalized as a means of maintaining a certain separation from conventional medicine. Following along with the tenets of complex adaptive systems theory, we can see that this seems to be directly influencing the behavior of the other agents in the overall French healthcare system. In fact, this change can be interpreted as a double-edged sword that is both raising the visibility of complementary practices and their perceived legitimacy, while also feeding into and inflaming the current conventional backlash against complementary medicine as a whole, and homeopathy in particular.

Taken together, this indicates that the relationship between conventional and complementary medicine in France can be seen as an example of what Bourdieu (1979) refers to as a hegemonic struggle over distinction and its transformation of small differences into a hierarchy using cultural and economic capital. We see that conventional medical practitioners are using semantics and science as means of keeping complementary medicine separate from conventional medicine. This is justified with emphasis on the "unscientific" nature of complementary medicine which places it lower in the cultural hierarchy by limiting both its access to cultural capital (language and terminology) and economic capital (clients, research funds, investment). On the complementary side, we see that complementary practitioners are emphasizing the individualized, holistic, and esoteric natures of their practices as a means of securing a growing share of cultural capital (perceived legitimacy and acceptance as a "second" way of thinking) and economic capital (clients, profitability, funding). The analysis in this thesis suggests that as complementary practices continue to gain ground and shares of capital in "mainstream" French society, they are perceived as a threat to the hegemony of conventional medicine; resulting in a backlash against them. This notion provides considerable insight into what can be qualified as the illogical aspects of the current homeopathy controversy. By considering the conventional-complementary relationship in terms of "two ways of thinking" about health and the body, we are able to identify the role that is played by the historical vestiges of French academic, scientific, medical, and State authority that remain an active part of the social memory; it also allows us to consider the deeper underlying concerns that are shaping the conventional-complementary relationship.

At a time when complementary medicine is rapidly expanding and conventional medicine is struggling to respond to a shift in public health concerns, a budgetary deficit, and a variety of medical scandals involving everything from pharmaceuticals to inefficient hospital administration; it is understandable that tensions between the two "ways of thinking" and practicing would be high, and that complementary medicine would be perceived as a threat to the conventional medical dominance over significant aspects of French cultural and economic capital. Furthermore, as indicated throughout my fieldwork, doctor preferences for a work-life balance are changing, hospitals have new financial concerns, and patients are able to shape their own "medical" knowledge and preferences through the internet and new communications technology.

As the speed of life continues to increase and the rate of movement and exchanges along with it, conventional medicine is faced with new challenges. According to the current French rhetoric, the overwhelming growth and popularity of complementary medicine can be seen as one of those challenges. This is because, as was discussed in Chapter 3, the "acceptance" of complementary medicine really comes down to the obtainment of a critical mass of visibility and finance of some form. As complementary practices continue to expand in the fringes beyond the conventional medical gaze and in the shadows of conventional milieus, they are gaining in popular acceptance. Just as was the case for osteopathy, eventually the visibility gets so large that it must be acknowledged. Thus, we can see that the current backlash against complementary medicine constitutes a negative acknowledgement aimed at hindering the growth of complementary practice. Considering the ideological concerns brought to light throughout this thesis, this response appears to be logical. Only time will tell if it will be successful and what the consequences will be as a result.

# Conclusion

Throughout this thesis we have examined multiple facets of the conventional-complementary relationship in contemporary France. We have seen that both sides are complex, involving a diverse mix of priorities and practices with underlying beliefs that run deep. We have looked at the definitional difficulties surrounding both medicines and the epistemological concerns that they entail. We then saw how both sides of the conventional-complementary relationship in contemporary France maintain rhetoric that characterizes "the other" in terms of stigmas, stereotypes and fears. Various forms of evidence drawn from my fieldwork indicate that many of the fears of both sides are grounded, which creates tensions in the relationship as well as unwillingness on both sides to fully integrate the two into a comprehensive practice. Nevertheless, we also saw multiple cases in which this integration is occurring on a de facto basis as healthcare practitioners seek to take advantage of what they perceive as the added benefits of complementary practices and as complementary practitioners lobby for professional recognition and regulation. Despite these attempts, the current homeopathy controversy indicates that the French conventional-complementary relationship remains fraught with tensions and that the "acceptance" of any given complementary practice or practitioner can be easily abolished. Indeed, at the time of writing this conclusion not only is homeopathy currently under governmental scrutiny, two of the associations I worked with during my participant-observation are also facing legal difficulties as a result of their complementary activities. This indicates that rather than following a linear progression, the development of complementary medicine in France is co-evolving along with conventional medical and national political developments. As such, we concluded our analysis with an exploration of the historical vestiges that appear to feed into the ideological underpinnings shaping both the current conventional-complementary relationship and the challenges and polemics that surround complementary medical practices in contemporary France.

Taken together, all of the evidence and the analysis in this thesis lead to the conclusion that the conventional-complementary relationship in contemporary France can be interpreted in terms of Bourdieu's (1979) notion of a hegemonic struggle over cultural and economic capital. Conventional medical authority- which is irrevocably intertwined with State authority and backed by the current scientific paradigm, technology, and epistemology- is struggling against the growing interest in and use of complementary practices. While throughout this thesis we have seen that this struggle is far from new, the case studies and trends identified in Chapters 3 and 4 suggest that what is new is the increased speed and scope in the extension of contemporary complementary practices and their respective networks. As a result, complementary practices are rapidly increasing their share in the health and well-being market and are becoming increasingly integrated into various French conventional medical milieus through myriad individual efforts to self-organize, raise visibility, and position complementary practices in the mainstream. This, in turn, accentuates hegemonic resistance to complementary medicine as a cultural "other" that is perceived as a "new" and growing threat to the monopoly of conventional medical authority. As we saw in the discourse surrounding the current homeopathy polemic, the "threat" of complementary medicine is further underscored by what was identified as a sense of doubt or mistrust in conventional medicine among the general public. As such, in Chapter 4, this thesis attempted to ground these claims within a discussion of the globalization-influenced public health trends that appear to be shedding light on the limits of the conventional medical gaze and the French healthcare system's inability to expand beyond its strictly curative orientation. Despite these

trends, in Chapters 2 and 3 we saw that the contemporary battle against complementary medicine is being justified by what my fieldwork participants clustered around the "unscientific" nature of complementary practices and their potential threat to the health of the population. Nevertheless, throughout this thesis, we have seen ample evidence suggesting that complementary practices can be used as rational extensions of the conventional medical gaze with the potential to be studied scientifically. Furthermore, it is arguable that if complementary medicine were integrated into conventional medical pathways and thus, ceased to be perceived as an "other;" then people would not seek complementary care instead of conventional care, but rather as an integrated part of a more holistic type of care.

With this in mind, there remain a few considerations that are worth highlighting as a means of responding to the questions of "Why now?" Why is complementary medicine growing so quickly now, when it has been present for many centuries? Despite the phenomenal growth in complementary interest and practice, why is there currently a significant backlash against complementary practices, such as homeopathy, which have been present and relatively accepted in French society for a considerable length of time?

One major element that responds to these questions and that directly shaped the analysis within this thesis involves globalization and its mechanisms. In Chapter 3, we saw that globalization mechanisms are disembedding various complementary practices from their local contexts and allowing them to circulate with increasing speed and scope around the globe due to the effects of time-space compression and communications technology. We also saw how these disembedded complementary practices are being actively integrated into the socio-economic tissue of globalized capitalism; as exemplified in complementary trade events and marketing strategies. In Chapter 4, we saw how these movements facilitate the hybridization of practices and their underlying ideologies, which is increasing their presence in multiple settings as a result of the fracturing of complementary practices into their composite parts and their subsequent reconstitution into re-imagined forms. In Chapter 4 we also saw how globalization patterns are changing our lifestyles and, by extension, our illness profiles. In light of the structural, ideological, and political orientations of conventional French medicine, we saw that adapting the healthcare system as a means of responding to these changes is proving difficult. This was defined in terms of limitations in the scope of the medical gaze that are creating a "space" in which complementary medicine is rapidly expanding. We then saw that this expansion both creates opportunities and political difficulties within the conventional-complementary relationship. For example, in the rhetoric of the current homeopathy polemic, the growing public mistrust in conventional medicine was explicitly cited as the key component of the medical call to action against complementary practices. According to multiple practitioners I interviewed during the course of my fieldwork, this trend is further exacerbated by highly publicized pharmaceutical drug scandals such as Mediator and Vioxx. Taken together, this indicates that in light of contemporary public health trends, patients' illness experiences are bringing the limitations in the conventional medical gaze to the forefront of the public's awareness. When this is coupled with the networks and information that globalized communications technology is generating, the public is no longer beholden to the conventional medical monopoly over health-related knowledge and practices. In other words, just as we saw in the cases of USPE and Eurordis in Chapter 3, the public is now able to inform themselves and connect with others using the internet and social media as a means of taking their health into their own hands.

Furthermore, we also see how globalization mechanisms are allowing complementary practitioners to go beyond the national level and to use international structures and forums as a means of raising their visibility, gaining funding, and increasing their perceived legitimacy.

As such, in Chapter 3 we also so several examples indicating that even in the absence of national regulation for complementary medicine, its practitioners are building networks on the international level as a means of influencing much larger trends in the propagation of complementary medicine. We also saw that many practitioners and patients are willing to cross international borders as a means of providing or obtaining complementary care. All of this indicates that despite national-level resistance to complementary practices in any given society, such as France, national governments will not be able to effectively hinder the growth and integration of complementary practices despite their political and social specificities.

This is why the complex adaptive systems approach has been a useful tool for this thesis' overall analysis. It has allowed us to consider the individual beliefs, practices, and movements of various agents as a means of understanding how they interact with and change not only the French healthcare system and its practices, but also a larger international movement of complementary medical growth and transmission. Within this thesis, we saw that this included successful lobbying attempts for complementary regulation; the securing of funding from foreign governments for the development of specific complementary practices, such as Traditional Chinese Medicine, in France; and the integration of complementary practices in individual French hospital services. Not only have all of these developments been largely instigated and managed by individual agents, they have led to the expansion of various complementary practices- such as aromatherapy, hypnosis, and sophrology- creating networks of interest and practitioners stretching throughout entire hospitals, departments, regions, and even up to the international level. We also saw various patterns emerging from the near-chaos and complexity that is generated by allowing complementary practices to develop largely "in the shadows" and through the initiatives of individuals, groups, institutions, and networks. We saw that these initiatives are as dynamic as they are fragile; as well as how the strong opinions of a small group representing a form of "authority," can easily and quickly set back hard-earned political progress. Throughout this thesis, evidence of these developments repeatedly emphasized the depth and power that beliefs about the body, illness, health, and healing have over all forms of medical practice and the overall organization of a national healthcare system. Indeed, we saw evidence suggesting that ideological considerations constitute the primary units giving shape to the contemporary French conventional-complementary relationship. As a means of making sense of this consideration, in Chapter 4 we examined how different forms of medically-related authority have emerged or been re-organized in French society. We saw that this created a cultural hegemony in which conventional medical authority is positioned at the top of the hierarchy of accepted knowledge and bolstered by the authority of both contemporary science and the State administration over public health. We also saw that these power arrangements have deep historical roots in French society that remain active components in the French social memory. This was evidenced through rhetoric concerning complementary medicine characterizing it as a cultural "other" that is "esoteric" and pursued in through a modern "witch hunt." In other words, this rhetoric sheds light on an underlying, historically-based, and deep-seated power struggle over what constitutes "accepted knowledge" for thinking about the body, illness, and health in French society.

Thus, the complex adaptive systems perspective that was maintained throughout this thesis was instrumental in helping to consider the contemporary French healthcare system in all of its complexity. Rather than limiting analysis to the role and definition of any individual agent, structure, or trend, a complex adaptive systems approach allowed us to consider the French system as a sort of living ecosystem. Just as any ecosystem in nature is the product of its own unique historical ecology, the analysis within this thesis brought to light the importance of the French healthcare system's historical ecology (Crumley, 1994). This emphasized the contingent interaction between science, socio-political trends, and medical

authority. It also allowed us to better see the complex interactions between individual agents and the system as a whole that results in its cohesive operation on what my interlocutors identified as a system involving so many actors, institutions, and structures that it can be characterized as on the border of chaos. Furthermore, it also allowed us to see the co-evolution that is occurring between the French healthcare system and the globalization mechanisms that are shaping contemporary human society on the international level. This included the new health challenges of chronic diseases and mental health related stresses as well as the new forms of networked interactions that communications technology has made available.

What is interesting is that considering the current reality of our hyperconnected lives in a globalized world, it appears as though the growth of complementary medicine will continue; even in light of its non-regulation and "official" consideration as a "cultural other" that does not have a legitimate place in the conventional medical world. The evidence that came to light during my fieldwork indicating that complementary medicine is being easily adapted to and profitably participating in the contemporary market economy; is being integrated nation-wide through different university diplomas, hospital services, and hospitals; is being followed by largely self-organizing communities; and is being recommended and consumed by significant portions of both the French population and its healthcare practitioners all support this claim. Going further, the globalization mechanisms identified here can be seen as facilitating the internalization of complementary practices via ontological hybridization. Finally, the internet and its communication potentials is also working against the monopoly over information about illness, health, and wellness; which only further weakens the contemporary medical authority over our bodies and our health. This all suggests that complementary practices will continue to remain present and most likely to expand in France as it is part of a larger trend within the globalized environment that we are all embedded in.

Beyond globalization mechanisms, there is another factor that I feel is currently shaping the conventional-complementary relationship and feeding into the interest in integrative medicine that my fieldwork identified. As was introduced in Chapter 1, we saw that complex adaptive systems theory emerged out of the increased complexity that quantum physics brought to our worldview. Specifically, during the early 20$^{th}$ century, various scientific discoveries, such as Max Planck's work on quantization, showed us that the laws of classical physics did not accurately describe the phenomena in our world. This instigated a scientific paradigm shift that is redefining the scale and scope of our understanding of ourselves and the universe around us. In other words, quantum physics demonstrated that phenomena that were very small and/or very fast could not be explained using the rules of classical physics that had long defined our understanding of the universe and all it contains. In Chapter 1, we saw that this had direct philosophical and ontological ramifications, resulting in the development of complexity theory as a new way of looking at the entities that make up our world. Nevertheless, the new quantum vision of the world remained largely constrained to the realm of the sub-atomic and speeds in the vicinity of the speed of light until relatively recently. Indeed, it is only in the past few decades that technological developments have allowed us to begin exploring the interaction between the level of the sub-atomic and the entities that make up the macro level of phenomena such as the human body. One of the areas in which this is bringing forth new and interesting research that my fieldwork experiences indicate is directly related to developments in complementary medicine is the neuroscience of the brain and consciousness.

In his discussion of consciousness, Hameroff (1998) begins with the observation that, "The workings of the human mind have been historically described in metaphors of contemporary information technology" (p. 1870). Thus, in ancient Greece, the memory was discussed as a "seal-ring in wax;" in the 19th century it was "seen as a telegraph switching circuit;" and in this century "the classical computer has been the dominant metaphor for the brain's activities" (Ibidem). As such, what the quantum revolution has resulted in is a new metaphor for understanding consciousness- that of quantum computation. This shift has opened neuroscience up to an entirely new level of complexity in terms of the mind-brain problem and is allowing us to go beyond the molecular understanding of neurons to explore things such as the oscillatory effects of neural networks and the quantum potentials of neuronal microtubules (Llinas, 2002; Hameroff, 1998). This is evolving our conception of consciousness, which can now be considered as a non-material object that is able to influence the physical motion of our material brains (Eccles, 1994, pp. 28-9). A fascinating body of neuroscientific research on the quantum computations and functioning of the brain and consciousness has resulted, indicating that the strange laws governing sub-atomic behavior do indeed directly influence our body's physical functioning[91]. This, when coupled with innovative research such as Andrieu's (2016) considerations of the supra-conscious activity of what he terms the "living body" are significantly expanding the possibility for research on different mechanisms purported to underlie different forms of complementary medicine. For example, perhaps our growing understanding of the brain and its functioning will allow us to one day see the body's electro-chemical functioning on a new level of detail.

Indeed, recent medical discoveries such as the presence of the "interstitium"- a series of fluid-filled compartments that are joined together throughout our bodies in the form of a network supported by strong, flexible proteins- may not only help us to get a new perspective on medical questions such as the spread of cancer; but also a more complex understanding of the body as a networked organism. In other words, new scientific discoveries and the vision of the world that is now opening to us seem to hold the potential to help explain complementary practices. In my fieldwork, I found that many complementary practitioners have this same sense and are using it as a means of providing their practices with a strong perceived legitimacy. For example, in Chapter 2 Homeopathic Doctor Q referred to the neuroscientific advances discussed here as a means of explaining why our scientific data has not yet identified the sub-molecular mechanisms of homeopathic preparations. It is of note that Christian Boiron also made this same reference about homeopathy. Specifically, he said that homeopathy's "original sin" is that its workings are "beyond the current understanding of physics" (See footnote 81). Another example of this trend can be found within the discourse of "quantum medicine" practitioners and their theories on the use of electromagnetic fields for healing. This is far from a new notion, attested to by Galvani's 18th century experiments in electrophysiology; however, what is new, is one of the key implications of quantum physics. Namely that we have gone from the closed universe defined by the laws of thermodynamics, to an open universe in which we have theories about multiple dimensions and entanglement. As the Penrose-Hameroff model suggests, these questions carry significant implications for our understanding of mind-brain-body interaction.

In other words, recent advances in neuroscientific research and consciousness can be seen as expanding the scientific potential to study some of the underlying "beliefs" associated with the mechanisms purportedly underlying various complementary practices, such as: the *qi*

[91] For those interested, a very clear example of this that is worth exploring is the "London Force" and its regulation of the shape of protein chains. According to the Penrose-Hameroff model of consciousness, this "quantum effect" is a key to structures called microtubules and their activity in neurons (Hameroff, 1998).

of Traditional Chinese Medicine; the *prana* in Ayurveda; the body's intelligence in homeopathy and yoga; the mind-body interaction in hypnosis and kinesiology; even the cosmic consciousness of Shaman C. Throughout this thesis, one of the points that was repeatedly highlighted throughout my experiences in the complementary medical realms was the surprisingly common perception of the mechanisms at the root of complementary practices. Namely, that they all involved balancing an individual's body and mind with their wider environment and activating what is perceived as the body's inherent healing capabilities and intelligence. Throughout this thesis, this was discussed in terms of Andrieu's notion of the "living body," which neuroscientific research has proven to act 450ms before we are consciously aware of it via our "lived body" (Andrieu & Burel, 2014). This coupled with new research on the brain's quantum capacities and functioning carries within it the potential to open up the scientific gaze to the non-material aspects of our bodies and their functioning.

What would be incredibly interesting for further research would be to analyze how the conventional-complementary relationship continues to develop in France. What will become of homeopathy's reimbursement and how will the different segments of the population react? How will the French government continue to adapt its healthcare system in light of its financial precariousness and the changing needs of the population's health? What will happen as different complementary practices such as osteopathy, anthroposophy, reflexology, shiatsu, naturopathy, and sophrology continue self-organizing and gaining visibility? Indeed, at the time of writing this paragraph I am also consulting with a reflexology syndicate on their effort to develop a nation-wide survey on the number of actively-practicing reflexologists in France. Over the course of the next years, these questions will continue to play out, providing us additional insight on the potential of complementary medicine and its integration as an accepted part of France's cultural and economic fabric. As such, comparative research is greatly needed in order to shed light on the conventional-complementary relationships in different countries and their social, political, and economic responses to the globalization-driven explosion of complementary practices worldwide. An analysis of these trends and their ramifications carries with it the potential to provide valuable insight into the identification of methods for transforming complementary medicine into a cost-effective, complement to national healthcare systems with potential long -term benefits for the health of the population.

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