



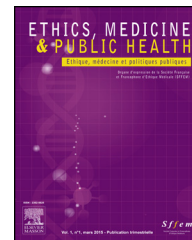
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## SHORT REPORT

## Treating strangeness: Medicine and human dignity at the time of COVID-19



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**Summary** The concomitance of a migratory wave and the hospital crisis once again raises the question of the care that the French healthcare system is able to provide to migrants. On the occasion of SFFEM's 19th annual day, we present a synthesis of the research work that has been communicated at that time. Firstly, we will discuss how doctors have been able to overcome strangeness to revive the notion of hospitality according to Levinas; secondly, we will discuss how the hospital is departing from its mission of institutional hospitality because of administrative injunctions; thirdly, we will discuss how ethnomedicine gives us keys to open up to other cultural norms; fourthly, we will see the inadequacy that exists between rights of access to medical care and their effectiveness; finally, the conclusion of Xavier Emmanuelli, founder of the social ambulance service, will remind us how much the values of the French Republic call us to the notion of care and openness to otherness.

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## Introduction

The concept of dignity is a fundamental principle linked to the human person and to life. Mentioned in the United Nations Charter (1945) and then the Universal Declaration of Human Rights (1948), it was recognised in France as a constitutional principle in 1994 [1,2].

In medical ethics, respect for the dignity of the person is a fundamental duty, in the same way as human life: dignity is considered inherent to every human being and justifies equal care regardless of the patient's social background or origin [3].

The concomitance of a migratory wave and the hospital crisis once again raises the question of the care that the French health system is able to provide to migrants. On the occasion of SFFEM's 19th annual day, we present a synthesis of the research work that has been communicated at that time. Firstly, we will discuss how doctors have been able to overcome strangeness to revive the notion of hospitality according to Levinas [4]; secondly, we will look at how the hospital is moving away from its mission of institutional hospitality because of administrative injunctions; then we

will discuss how ethnomedicine gives us the keys to open up to other cultural norms; fourthly, we will see the inadequacy that exists between rights of access to care and their effectiveness; finally, the conclusion of Xavier Emmanuelli, founder of the social ambulance service, will remind us how much the values of the French Republic call us to the notion of care and openness to otherness.

## The foreigner in the history of medical discourse

Ancient societies did not really experience waves of migration as we see it today. Rather, they were used to the existence of mobile populations such as merchants, craftsmen, pilgrims, dykes or artists. Prof. Stanis Perez (historian) maintains that Hippocratic medical art has long avoided medicine to embrace racist theories: on the one hand, the Hippocratic oath obliges doctors to treat all people equally, on the other hand, his theory of climates immediately suggested the importance of the environment in the transmission of diseases, thus ruling out the hypothesis linking a disease to an ethnic group. Even when he speaks of

the “moral slackening” of Asian populations, Hippocrates draws only an epidemiological interpretation from this [5].

Until the 17th century, it was believed that a white woman could give birth to a coloured child and this was attributed to the power of a woman’s imagination: this shows that there was no difference in nature attributed to the colours of beings. At the end of the 17th century, Buffon recognised that if people of different skin colours could procreate together, it meant that they belonged to the same family [6]. This universalist medical view was not always shared by the rest of society, which was looking for scapegoats in times of epidemics. However, if foreigners polarise suspicion, it only applies to recently arrived people, which supports an epidemiological and non-racist thesis. It should be remembered that the movement of military troops and galley slaves is not in vain in the spread of epidemics, and that syphilis was called the Italian disease in France, and the French disease in Italy [7].

The industrial era of the 19th century saw the emergence of infectiology and new explanations for the spread of epidemics. At the same time, these positivist theories are the breeding ground for racist clichés, since it is by touching a foreigner that one is affected by a disease. In the West, the foreigner is then associated – in racist theories – with defilement, a health scourge, degeneration, etc. Conversely, in colonised countries, Senegalese people fear that France may want to transmit disease to them by vaccinating them. Gradually, fear of the other is taking hold in all societies, but one has to say that historically, medical theories have always been based on epidemiological analysis and have never stigmatised the ethnic nature of populations, this being the prerogative of ideologists rather than scientists [8].

### The experience of strangeness handled by today’s physicians

Confrontation with the stranger exists in the simplest doctor-patient relationship: because the Other is not Me, I enter into a process of recognition and consideration, which leads to the caring relationship [9]. However, certain “abnormalities” are such that the carer finds it difficult to consider the Other in his or her world, sharing the same cultural framework: there is then a clash of cultures.

### Mental illness

Freud considered psychoanalysis to be the third narcissistic wound of the human race: after learning that the Earth was not the centre of the world and that *Homo sapiens* was only one link in the History of species, the recognition of the unconscious teaches men that the conscious Ego “is not the master in the house” [10]. For a long time, the mentally ill were considered to be humans apart, so different that they had to be locked up in asylums. Part of their difference lies in the fact that they do not have the same behavioural limits as people who do not suffer from pathologies such as psychoses. Prof. Bernard Golse (psychiatrist) even goes further when saying that madness is a cultural world in itself. In psychiatric care there is therefore also a clash of cultures, and it is essential for the psychiatrist to be part of the path to this world where his patient is

locked up. The fear of this strangeness can be interpreted as the fear of oneself projected onto the Other, leading to the idea that the first stranger would be the unconscious. According to Bernard Golse, the international classifications of psychiatric pathologies, only interested in “superficial” external symptoms, refuse this plunge into the unconscious which would help us so much to apprehend the strangeness of mental illness.

### Morbid obesity

Obesity is a pandemic (13% of the world’s population is affected) and is associated with stigma at work, in schools and in the health care system. According to Dr Alban Zarzavadjian-Le Bian (digestive surgeon), this malaise is rooted in childhood and is a source of vulnerability. For him, while bariatric surgery promotes weight loss and increased life expectancy, it will never cure self-image disorders or psychological comorbidities: the expectations of doctor and patient can then be very different. This shows that, far from psychiatry, there is also a relationship with strangeness in a surgery that responds to a quest for normality, a demand that combines physical and psychological disorders.

### Gender dysphoria

The question of normality can also be addressed with the question of gender: what is a normal woman or a normal man? As soon as the 2nd trimester ultrasound scan and the description of a child’s sex, his parents will assign him his gender, reports psychiatrist Dr Bernard Cordier. During childhood and adolescence, some children will feel a discrepancy between their sex and their gender: this is gender dysphoria [11]. If this situation was already observed in Antiquity, gender incongruity was only recently recognised in France as a “long-term affection” and its treatment is now 100% funded. In order to begin a process of gender reassignment, the patient must demonstrate early and lastingly the desire to live and be accepted as a person of the opposite sex. And since this involves risky surgery and sterilisation, a psychiatric opinion is necessary to ensure that there is no psychiatric disorder motivating the request. Although this is not pathological, the care of gender dysphoria is still the care of a pathological image of the body, this strangeness.

### The management of strangeness by the health system

#### Emergency department and the mission of hospitality

Dr Bertrand Galichon (emergency doctor) evokes the strangeness of poverty and living in the street. He considers that since we do not share the lonely nights that homeless people spend on pavements or in railway stations, we cannot fully understand what misery is. For him, the death of dignity takes place in four stages when a person is on the street: silent shame, revolt, self-containment (aggravated by addictions) gradually reducing living space, and finally the loss of the gaze of others motivating the greatest carelessness. COVID has encouraged hospitals to expel all those who did

not receive specific care. The tradition of night hosting of people in precarious situations in the emergency room has therefore come to an end. By considering its hospice mission as non-essential, public assistance has also wounded the dignity of the carers. If the homeless no longer have the freedom to spend a winter night in hospital and the carers no longer have the freedom to fulfill their vocation, all lose their dignity, having already lost their freedom.

### Dealing with complex social situations within the PASS programme

Healthcare Access Points (PASS: French acronym) are hospital structures with the specificity of welcoming and caring for the most precarious patients, whatever their illness. In a highly compartmentalised hospital where therapies are increasingly innovative and costly, the reception of foreign patients can become a real headache for both professionals and patients themselves. Sometimes, the waiting time for patients who have crossed borders to receive treatment is based on false hopes which it is important to treat quickly. It is in this context that the PASS at St Louis Hospital, led by Dr Claire Georges, has set up multidisciplinary medical-social and ethical meetings with the aim of rapidly proposing pragmatic and realistic solutions for each patient. In these structures, the clash of cultures is omnipresent, be it on the metaphysical as well as the linguistic, social and economic dimensions. Strangeness must be considered in its entirety in order to provide the most appropriate answers in a limited time, with the help of translators, psychologists and social workers. This entirely human and, paradoxically, specialised care is an important means of preserving the dignity of patients, before they sink into poverty waiting for treatment they could not receive or endure [12]. During the first lockdown related to COVID, these people had to face new difficulties according to Dr Sophie Emery (general practitioner in PASS): barrier at the entrance of the hospital and police control. In addition to the language barrier, the mask and the Plexiglas windows limiting communication, the PASS consultation was momentarily considered "non-essential" although it takes care of the most precarious people. For those who were contaminated, it was necessary to confine people who had no roof over their heads and to carry out an out-of-hospital follow-up with patients who had no telephone. All these obstacles are very specific to migrant populations and it is clear that the systems set up by the Ministry of Health were not adapted to them.

### The role of ethnomedicine in the care of migrants

#### Culture shock and understanding of the Other

Based on the results of a qualitative study conducted in France and in Tunisia, Anne-Marie Duguet (forensic medicine) describes how care must take into account cultural particularities regarding the management of modesty, nudity, intimate care or death rituals. She invites us not to transpose our values and cultural models when these have other origins than our own and to respect the spiritual need at the end of life [13].

For Chantal Bouffard (Canadian ethnologist), the medical systems are not adapted to the different cultures they deal with. This should encourage the integration of traditional medicine into biomedical care in both the North and the South. For her, medical anthropology has not succeeded in making cultural diversity a constituent element of bioethical principles. On the contrary, ethics has perhaps become locked into its ethno-geographical context. Henceforth, it would be advisable to develop data collection tools and analyses capable of understanding disease and medicine in its cultural vision. This diversity, far from calling into questioning evidence-based medicine, should be seen as a pragmatic force, a panoply of tools for carers, rather than as a conflict [14].

### Encounter with patients' beliefs

This cultural openness is also developed by Charles Di (philosopher). For him, among the great ontological philosophies (monism, dualism, pluralism), pluralism is the one which explains the sub-Saharan metaphysical system with the visible world and the invisible world: the invisible world is that of the geniuses and the dead [15]. As the vision of a disease depends on our ontological vision of the world, it becomes essential to take into account this gap in vision between patient and carer. If there are invariants across borders, there are other elements that make the cultural particularity. To treat without taking this particularity into account would be practicing veterinary medicine and denying the dignity of the other. Emmanuel Lévinas says that vulnerability is at the heart of care, and therefore also is the specific vulnerability of migrants. Paul Ricœur evokes the "just institutions": being the emanations of our community way of life, can they welcome otherness and the stranger? They can be just for us without being just for those who arrive from elsewhere. Perhaps the beginning of the answer lies in the transcultural approach. Charles Di reminds us that remaining in the biomedical field will only allow us to treat biomedical symptoms. He urges us to "come out of our metaphysical clandestinity"!

The examples quoted previously by Sophie Emery and Bertrand Galichon showed us that the pandemic situation had highlighted the rejection of the most precarious people in the hospital. They warn of the need to regain awareness of the hospitality mission of public assistance.

### Access to healthcare for migrants

#### Vision of the Defender of Rights

In 2016, the Defender of Rights published a report on the rights of foreigners [16]: specific difficulties in accessing employment, accommodation, health protection, health-care access. Three years later, he decided to publish a new report specifically devoted to the rights of ill foreigners [17], taking note that many of the issues pointed in 2016 were still carried on whereas new laws have created new difficulties in rights access. If in the name of the right to health and protection of life, France does not expel seriously ill foreigners for whom there is no adapted and accessible treatment in their country of origin, it does not give the right to come to the national territory to be treated. Today, residence permits granted for medical reasons only concern <2% of

all residence permits. According to Elsa Alasseur (co-author of the two reports), foreigners are currently subject to a tightening of the rules even though many of their rights are not effective.

### Legal vision of asylum applications

Asylum-seekers do not have a special status, unlike refugees. In 2020, there has been a small decrease in the number of asylum seekers, this being linked to the pandemic and also to the complexity of the application process. At the same time, Hungary has been condemned by the EU for not respecting the rights of asylum seekers. In France, we are only interested in a candidate from the moment he enters the national territory, insists Fabienne Jault-Seseke (professor of private law). A more efficient system would allow these applications to be processed while the person is still in his or her country of origin [18]. In any case, the ineffectiveness of the rule of law undermines the dignity of the asylum seeker, which is the case at the borders when migrants are kept in camps for several years. According to her, there are several sources of attacks on dignity of asylum seekers: the saturation of reception structures, the lengthy processing of files and the inability to provide material conditions for a dignified life (people ending up on the streets very quickly).

### A need to care for institutions and French republican values

Xavier Emmanuelli (Social ambulance service) invites us to reintroduce the human element into the care relationship, even when this is made difficult by the patient's social context. The carers are entrusted with a mission of welcoming, they must offer a soothing welcome, an attentive listening to the suffering. This attention in no way detracts from the pragmatism imposed by the medical situation. As Emmanuel Levinas vowed, it is a matter of grasping the presence of God in the face of the Other, the presence of immanent dignity, love, transcendence<sup>4</sup>. For this and beyond the incantations, politicians have the duty to put in place the means that will allow for the respect of human rights and the most equitable care.

In conclusion, let us remember that the foreigner does not only come from elsewhere, that he is at the same time the most autochthonous patient there is and even our own unconscious. The ancient "Know thyself" is therefore paradoxically very necessary for understanding the Other, his fears and hopes. Equally astonishingly, respect for human dignity at the individual level can only be achieved within fair and equitable institutions, which must be an object of reflection for each practitioner within it. Medicine could not fulfil its vocation if it did not fulfil its mission to welcome, to offer hospitality and to take care of human distress.

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### References

- [1] Cossalter P. La dignité humaine en droit public français : l'ultime recours. Intervention à la 7<sup>e</sup> conférence-débat du Centre de droit public comparé. Université Panthéon-Assas Paris II. *Revue générale du droit*; 2014. p. 18309.
- [2] Assemblée générale des Nations unies. Déclaration universelle des droits de l'Homme (217 [III] A). UN General Assembly; 1948 <http://www.un.org/en/universal-declaration-human-rights/>.
- [3] Bommier C. La notion de personne humaine dans le débat public. *Ethics Med Public Health* 2019;9:12–8, <http://dx.doi.org/10.1016/j.jemep.2019.04.005>.
- [4] Lévinas E. *Totalité et Infini. Essai Sur l'extériorité*. Martinus Nijhoff; 1961.
- [5] Littré E. *Œuvres Complètes d'Hippocrate*. Baillière; 1840.
- [6] Leclerc G-L. *Comte de Buffon. Histoire Naturelle, Générale et Particulière*. Imprimerie royale; 1749.
- [7] Bayle A, Pennuto C. La syphilis au XVI<sup>e</sup> siècle : maladie nouvelle, discours nouveaux. *Histoire Med Sante* 2016;9:9–17.
- [8] Perez S. *Histoire Des Médecins*. Perrin; 2015.
- [9] Ricoeur P. *Soi-même comme un autre*. Seuil; 1990.
- [10] Golse B. L'autisme et les trois blessures narcissiques de l'humanité. *Le Carnet PSY* 2014;178:1, <http://dx.doi.org/10.3917/lcp.178.0001>.
- [11] Davy Z, Toze M. What is gender dysphoria? a critical systematic narrative review. *Transgend Health* 2018;3:159–69, <http://dx.doi.org/10.1089/trgh.2018.0014>.
- [12] Georges-Tarragano C. *Soigner (l')Humain – Manifeste pour un soin au juste coût*. Presses de l'EHESP; 2015.
- [13] Duguet A-M, Duchier J. *Respect du corps et des souhaits de sépulture des Maghrébins âgés*. *Hommes et Migrations* 2015;(1309):147–54.
- [14] Bouffard C, Marin A. Juste un mot : premiers jalons pour une éthique ethnomédicale. *J Int Bioéthique Ethique Sci* 2015;26:11, <http://dx.doi.org/10.3917/jib.263.0011>.
- [15] Di C, Moro MR. Les enfants dits « sorciers », analyse d'un contre-transfert culturel. *Soins Pédiatrie/Puériculture* 2019;40:30–2, <http://dx.doi.org/10.1016/j.spp.2019.03.006>.
- [16] Défenseur des droits. *Les droits fondamentaux des étrangers en France*; 2016 [https://www.defenseurdesdroits.fr/sites/default/files/atoms/files/736160170\\_ddd\\_rapport\\_droits\\_etrangers.pdf](https://www.defenseurdesdroits.fr/sites/default/files/atoms/files/736160170_ddd_rapport_droits_etrangers.pdf).
- [17] Défenseur des droits. *Personnes malades étrangères, des droits fragilisés, des protections à renforcer*; 2019 [https://www.defenseurdesdroits.fr/sites/default/files/atoms/files/rap-etrangmalad-num-07.05.19\\_0.pdf](https://www.defenseurdesdroits.fr/sites/default/files/atoms/files/rap-etrangmalad-num-07.05.19_0.pdf).
- [18] Jault-Seseke F. Évolution récente du droit des étrangers et du droit d'asile. *Rev Critique Droit Internat Prive* 2017;1:37–43.