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ANTHROPOLOGY, ETHICAL DISSONANCE AND THE CONSTRUCTION OF THE OBJECT

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Abstract
In this article, I discuss certain questions relating to the ethical difficulties faced by anthropologists when dealing with two different social groups and when one group holds a position of dominance over the other. In the first example, I draw on my work on doctor-patient relationships in France; in the second, on a study on reproduction in immigrant African families from Mali and Senegal, living in polygynous households in France. I use these examples to explore questions of positionality, beneficence and potential harm. I show the choices I made in order to construct an epistemologically ethical object.

The importance of ethical considerations in research is part of the contemporary anthropological landscape (Faubion, 2011; Fluehr-Lobban, 2013; Lambek, 2010; Caplan, 2003), particularly in medical anthropology (Anthropologies et sociétés, 2000; Scheper-Hughes, 2005; Singer and Bauer, 2007, who stressed the need for political engagement). For example, a special issue of *American Ethnologist* (2006) was devoted to the difficulties faced by researchers because of the bureaucratic ethics regulations managed by Institutional Review Boards (notably Katz, 2006; Shweder, 2006; Fassin, 2006; Lederman, 2006). The place of ethics in ethnographic research, and the epistemological principles and ethical concerns that are involved, have also been examined in medical anthropology, in a special issue of Ethnographiques.org (Desclaux and Sarradon-Eck, 2008). In this, the contributors addressed the problems posed by applying the ethical principles of medical research to the practice of ethnography in relation to issues such as informed consent and confidentiality, and examined the dilemmas researchers had to deal with on the ground (for instance, Beaudevin, 2008; Musso, 2008; Sarradon-Eck, 2008; Desclaux, 2008; Sakoyan, 2008).

To further explore the place of ethics in ethnographic research on health and suffering, in this article I focus on the difficulties posed when studying a question which involves two distinct but interrelated social groups, whether they are in an antagonistic relationship or an inclusive one. I use two examples from my field work to discuss this. The first concerns my research into doctor-patient relationships in urban hospitals in France (Fainzang, 2010), which led me to examine the practice of lying; below I explain my decision not to address this from an ethical perspective. I show that the ethical stance for anthropologists consists of analyzing lying as any other social practice, without making an *a priori* moral assessment of the practice. In the second example, I draw on a difficulty I encountered during a study of reproduction in

immigrant African families from Mali and Senegal (Fainzang and Journet, 1989). In these polygynous households in France, male domination is particularly pronounced and women are led to behave either submissively or rebelliously. I examine the difficult situation in which the defence of certain values to the benefit of one group may be simultaneously seen as detrimental to the population to which it belongs. In such circumstances, anthropologists find themselves having to make choices (Appell, 1978; Cassell and Wax, 1980). These choices depend on each anthropologist's sensibility and his/her ideological, philosophical, or political opinions. I describe this situation as 'ethical dissonance', in reference to the notion I coined to account for the difficulties doctors face, when confronted with differing or even opposing values through which they must navigate (Fainzang, 2006).

In this discussion, I refer to the primordial ethical principle specified in the AAA Statement of Ethics (2012) that one must 'do no harm'.[1] The common factor of these two situations is the focus on two groups of people linked by a relationship of power: one the doctor/patient relationship, the other relations between the sexes. In each I explain the nature of the ethical problem and how I managed it, since, as Fassin (2008) has highlighted, ethics should be perceived as a process of construction during which researchers make the problems they encounter explicit, explore the stakes involved, and negotiate the possible responses. In the two cases, the question I had to address concerned the construction of the object of research, in connection with the reactions that these types of research provoked in the medical environment for the first and in the academic world for the second. I explore methodological and ethnographic dimensions of these studies in order to allow the reader to better grasp the issues discussed here.

AN ETHNOGRAPHY OF LYING: BETWEEN ETHICS AND EPISTEMOLOGY

The first case I examine is a study on the provision of information and lying between doctors and patients in France. The study was mainly conducted in two departments (oncology and internal medicine) of two different urban hospitals, and aimed to reveal the logics and mechanisms underlying information exchange between doctors and patients. Despite the variability between departments and their different specialities, similar behavior in terms of patient information can be observed within the services studied. As Van der Geest and Kinkler (2004) argued, "Hospitals both reflect and reinforce dominant social and cultural processes of their societies" (1995). The study included 80 patients, 60 with cancer and 20 with chronic inflammatory or autoimmune diseases. I met the patients at different stages of illness, with some considered as virtually cured and only coming to hospital for check-ups, while others were receiving treatment (chemotherapy, radiotherapy or surgery) or were under palliative care. They were of different ages (from 30 to 80, with a majority between 55 and 70), of both sexes and from various socio-professional backgrounds.

The investigation consisted of observing medical consultations and then separately meeting the doctors and the patients to see how the verbal exchange was constructed and to decode the reasons for and mechanisms of their actions and words. I used open-ended interviews with patients, paying attention to the questions that they asked themselves, the questions they asked the medical personnel, the answers they were given, the information they were provided, and their reactions. I also conducted non-directive interviews with 12 doctors to learn how they

understood the issue of information and how they perceived patient expectations. No formal ethical clearance needed to be obtained to conduct this work, but in addition to getting the consent of the doctors and patients, I simply had to request authorization from heads of the medical departments.

The objective of this study was not only to gather data on how doctors give patients information, but also on how patients pass on information to doctors, and on the lies they sometimes tell each other. The research was thus based on two distinct orders of potentially antagonistic thought, produced by patients and doctors respectively. To achieve this objective, it was important not to favor one point of view over the other and not to take sides, but to have what I have described elsewhere as "dual empathy" (Fainzang, 2010: 102), that is to say, empathy for both sides. This dual empathy allowed me to highlight the social issues at stake. Indeed, in seeking knowledge,[2] anthropologists must strive to develop empathy with the Other, but also, in studying social relationships, with 'the Other of the Other' (doctors versus patients, the strong versus the weak), even if one may feel better able to identify with some groups than others. Thus it is appropriate to distinguish between what I call 'moral empathy' and 'methodological empathy', that is, between the predisposition to put oneself in the shoes of the group studied, and the need to deliberately try to do so. For Engelen and Röttger-Rössler (2012), empathy combines aspects of thinking and feeling. In distinguishing between understanding the other cognitively and understanding the other emotionally, they refer to the cognitive and affective dimensions at work within empathy (whether or not these can be separated). In this vein, my definition of moral empathy and methodological empathy aims, on one hand, to indicate the postures that allow one to arrive at these two forms of understanding, and on the other hand, to highlight what distinguishes them: moral empathy refers to the anthropologist's tendency to put him/herself in the place of those who s/he initially has a greater ability to understand emotionally, whereas methodological empathy refers to the willingness or attempt to understand, at least cognitively, the reasons for the actions of the people under study, without necessarily conforming with them. Understanding the emotional state of another person need not entail sharing it.

Most works carried out on the question of truth in medicine, mainly medical, philosophical or sociological works (Abiven, 1996; Barnes, 1994; Bok, 1979; Constant, 2003; Delaporte, 2001; Fletcher, 1979; Geets, 1993; Hoerni, 1985; Kuran, 1995; Shibles, 1985), either take the form of justifying what is referred to as 'therapeutic privilege' or else make pleas for patient participation. Because the question of truth and lies is often addressed in ethical terms, many authors choose it as their subject in order to defend a particular position, while underlining the ethical dilemma of whether to tell the truth or lie. Some follow the Hippocratic oath which states that one must do a patient no harm, and they interpret this as a reason to reveal to patients their true condition or prognosis; others take this as a reason to shield patients from such information that concerns them. As we can see, 'do no harm' is in itself a very subjective judgment. When the debate is framed in ethical terms, partisans and adversaries of truth construct their points of view and elaborate their justifications on the same grounds: the same arguments ('for the good of the patient' or 'to do no harm') are used to support radically opposing positions. Additionally, those who advocate patient information are also divided between those who support information *in itself* (the patient's right to know) and information *for a determined end,* as a means of convincing patients of the need to follow a certain treatment.

In the first case, it is a question of informing the patient as a person with the right to this information concerning his/her health; in the second, it is a question of giving information with the aim of obtaining better treatment compliance. The first position supports a moral position, a principle, while the second takes a utilitarian position, equivalent to a therapeutic strategy. The positions that actors develop combine ethical and therapeutic options in order to justify informing a patient or not (or even lying to them), but these are often relatively arbitrary. The arbitrary nature of these positions is reinforced by the fact that doctors often find themselves caught between opposing choices. I qualify this situation as 'ethical dissonance' to account for the contradictory principles and opposing values through which doctors must navigate, and to underline the disharmony between the different ethical principles to which they have to refer. They must on the one hand reassure the patient (a role that some attribute to the paternalistic model of the doctor-patient relationship), and on the other, empower the patient, allowing them their liberty to manage their own life and their body (a role which fits into a more egalitarian relationship). Taking sides in this debate would have meant opting for one principle over another, and risked obscuring the true stakes involved in the mechanisms underlying the practices of actors. But, while it was relevant to study the conditions and meanings of social practices developed in relation to ethical principles, my aim was not to take a stance in this ethical debate.

It was therefore necessary to tackle the issues in a different way from how they are generally approached. I had to look at the subject from an anthropological perspective, and to analyze the situation without inferring any normative position. This approach required a certain number of epistemological conditions. Firstly, it required that, from an emic point of view, I start not with *my* conception of what a lie is, but with that which the actor believes to be true or not. This then involved accepting the purposely iconoclastic nature of the term 'lie' as applied to the medical profession, with no judgment on the practice of lying from the onset. Though some doctors prefer to use the terms 'withholding information' or even 'lying by omission', others advocate using the term 'lie', whether in the medical literature on the subject (Hoerni, 2004 ; Abiven, 1996) or in the field. Thus, for example, a doctor had told his patient, who had just had a rectal operation, that he had a polyp rather than cancer. The patient said: "I must say you sent me for a big operation for just a polyp!" The doctor answered: "Well, to be honest, it wasn't a polyp." The patient said: "You mean it was cancer?" The doctor (embarrassed): "It was a pre-cancerous lesion which would have become a cancer in a few weeks." Later, he told me: "In fact, that was a lie too since the 'pre' in pre-cancerous was false. He really did have cancer". This echoes Dr Merran's words as quoted by Favereau (1994): "Honestly, we often end up telling patients barefaced lies" (24).

The negative connotation of the term 'lie', used to describe a practice carried out by doctors, is often lessened by the fact that the so-called 'medical' lie is justified by a discourse that rationalizes it and provides legitimacy, even morality. Plato wrote in *La République* (1966) that only doctors and chiefs of cities possessed the right to lie, the former in the interest of their patients and the latter in the interest of the city. The lie told by a doctor is thus rationalized, legitimized, and even ethically justified. On this subject, Barnes (1994) highlights the existence of 'permissible' lies and shows that the manuals on medical ethics often include a section on lies that can be told to patients if they are dying, if they are receiving placebos, or if they are taking part in clinical trials. However, using the term 'doctors' lies' during interviews upset

some of them, even those who admitted to lying themselves. They thought that the word damaged their image[3] and undermined their position of power over patients (their 'therapeutic privilege'). It is as if, given the negative moral burden of the word, only doctors possess the right to refer to their practice as lying, and as if their perception of the ethically legitimacy of doing so prevents non-doctors from qualifying the practice in these terms.

Furthermore, examining lying as a bilateral practice made it possible to shift focus and to look at the therapeutic relationship as a social relationship. I then had to try to 'understand' the doctors' *and* the patients' reasons for acting, their motivations, the mechanisms of this information, and the evolution of doctors' and patients' social roles. This was a prerequisite to avoiding the risk of either becoming a mere spokesperson for the patients (which is not the researcher's role) or subjecting the study to a biomedical problematic by reducing the debate to one of the ethical stances of the health care personnel.

The inquiry revealed that while doctors think they give information preferentially to those they deem psychologically capable of dealing with it, in fact information is largely given to people who appear to belong to more privileged social backgrounds, that is, to higher social categories. Doctors prejudge their patients' capacity to understand the information they are provided with and their ability to accept it (in an amalgam between these two types of ability) based on external signs (language, clothing, body posture), approximate clues to social or cultural capital. By selecting those who receive information, doctors help to reinforce social inequalities in access to information.

When anthropologists examine a social question embedded in the public arena, they have to do so using their own epistemological stance. I was able to demonstrate the discriminations that characterize the modalities of information provision to patients, only because my objective was not to provide a moral or ethical perspective of the practice, but to move away from the usual stance (whether psychological, therapeutic or ethical) in order to define the cultural and social mechanisms involved. This made it possible for me to produce new results likely to enrich understanding of the social issues related to lying. This relates to the connection between ethical posture and construction of the object. Ethics and epistemology are strongly connected. For Lederman (2012), the link between the two can be seen in the tactical use of deception concerning the aim of the research. For me, however, attempting to approach the subject with a perspective that was not focused on the ethical issue was the *sine qua non* condition to understand the context of these practices and the social issues at stake – although, of course, a complete withdrawal from ethical commitment is not possible since the anthropologist's own emotional positions remain part of the disciplinary approach, as Crapanzano (1994) and Luhrmann (2006) have shown.[4]

My point here is that one can choose not to address a question from an ethical perspective for ethical, methodological and epistemological reasons. This involves not setting a research question *a priori* according to the values to which the anthropologist adheres or to the judgments which s/he might be tempted to make. The ethical stance for anthropologists consists then of analyzing lying as any other social practice, without making any moral assessment of this practice, whatever their posture or personal opinions, even if, for example, their convictions lead them to deplore medical paternalism and the inadequacy of patient information. Lying can be studied as an aspect of social life, even if it involves revealing the role it plays in exercising or resisting power. Likewise, one can study the underlying reasons that doctors choose to lie to

their patients in a non-judgmental manner even if one hopes to work to promote better patient information. There are, of course, many shades of grey in between 'truth' and a 'lie', with half-truths, dissimulation, deliberate misunderstandings, and so on, as I have analyzed earlier (Fainzang 2006).

The ethical character of the research resides in approaching the question with a perspective which is *not* ethical, both to decipher the arbitrariness of ethical positions on the subject and to be able to understand the social and anthropological reasons for the practices under examination. Here, to be epistemologically ethical is to approach the construction of one's object in a markedly different way from an ethicist, that is, on one hand, to withhold judgment and, on the other hand, to look beyond the usual psychological explanations, based on ethical arguments, in order to try to understand the social mechanisms at the root of the provision (or not) of information to patients.

ETHNOGRAPHY OF POLYGYNY: AN ETHICAL SUBJECT?

My second example comes from research I carried out some 25 years ago among West-African immigrant families (in particular the Soninke and Toucouleur ethnic groups) living in polygynous marriages in France. The object of the study was to understand how this type of household is organized, how the women manage their bodies, their sexuality and their health, particularly in relation to reproduction, and the relationships formed between men and women in the household. The research, permitted by the husbands and warmly welcomed by the wives, aimed to observe the relationships between husbands and wives on one hand and between co-wives on the other, and to study their impact on how the families manage biological reproduction. Although the husbands immediately assigned me a physical place with the women in adherence to the sexual division of domestic space, even when a family lived in a single room, my investigations also included men and their perceptions of the social relationships within their household.

The polygynous institution represents a particular modality of socializing feminine sexuality.. It responds to imperatives and choices that are political, economic, and cultural (Fainzang and Journet, 1989). The marital sexuality of women is subject to a number of limitations and prohibitions that leave no doubt as to its primary vocation: procreation. However, procreation is heavily codified, and sexual relations within a polygynous household are subject to precise rules.

Although polygyny is authorized and ratified by Islam with a limit of four wives, and is legitimized by the state in some countries where Islam is the dominant religion, the institution of polygyny is pre-Islamic. The legitimacy of the institution goes hand in hand with the establishment of strict principles dictating that the husband should treat each co-wife equally. This principle is best expressed by the institutionalized practice of 'turns', which regulates domestic and sexual obligation – these two obligations are generally linked together. In reality, women are often subject to unequal treatment and there is often strong rivalry between co-wives, particularly in relation to sexuality and reproduction. They traditionally take the form of competing for reproductive work. As a vector of prestige and recognition, biological reproduction is a fundamental concern for women in polygynous societies, determining their social and marital status, since the more children a woman has, the more prestige she has, as a

wife, in the eyes of the husband and the whole community. Rivalries between women also result in accusations of *maraboutage*, persecutory magical practices destined to jeopardize the other's reproductive capacity, and usually used to explain the onset of sterility and other sexual and reproductive health problems.

However, with immigration to a society where polygyny is not the norm, polygynous families may face economic and cultural realities that induce some women to want to interrupt reproduction and access contraception. When their husband refuses, these women sometimes take birth control pills secretly or adopt the strategy of resisting sexual services – what women refer to as a 'sex strike' – at the risk of compromising, they think, the future of their children because of the belief that a disobedient wife puts the health and morality of their progeny in danger. This weapon may be more or less effective depending on the woman's position in the household, since the possibility of real resistance is limited to the women most sexually valued by their husbands. Women resist their husband's will by using their sex as a weapon. In doing so, they reproduce the role assigned to them but also the social definition by which they are defined as women, since this weapon constrains them in an image and a definition of feminity, which renders them sexual and reproductive objects.

Some of my male anthropologist colleagues were critical of my choice of research subject because they believed that it risked harming the 'African population in France'. In their eyes, studying questions such as 'African polygyny' posed an ethical problem, since highlighting a practice of discrimination or domination would contribute to stigmatizing those who sanction it. I would therefore be contributing to the marginalization of the community with which I wished to work. While their criticism did not deter me from the project, it certainly weighed on my conscience, for their position suggested I should have judged the subject to be taboo and not even contemplated it. Yet the contemporary anthropological view is that culture is not a homogenous whole, and that differences of power among individuals within the group should be examined and exposed (Massé, 2000; Gupta and Fergusson, 1997; Hours et Selim, 2000). Anthropologists therefore also have an ethical obligation to emphasize the different forms of power that exist within a social group, including showing how those who hold a role of dominance in one context may be dominated by others. Polygyny is one form of domination, and not writing about it, I felt, perpetuated this. I believed that it was important to attempt to understand the symbolic logics and social pressures that govern relationships between men and women in the context of polygyny, particularly so because numerous immigrant women I had met had complained to me about their lives and asked me to take an interest, as an anthropologist, in their fate, in order to make their situation known.

So I chose to undertake this research, fully aware that this choice was linked to ethical and political options. At the same time, consistent with the principle of methodological empathy discussed above, I also decided to consider the social constraints to which the men were subject. Men were under considerable pressure to become polygynous and experienced great difficulty in avoiding this, with compatriots repeatedly cite the Soninke adage, "having only one wife, is like having only one shirt."

As this case indicates, anthropologists face difficulty in deciding between the possible choices available to them when working on a subject may be beneficial but, at the same time, may risk doing harm. The issue here is not concerning cultural relativism, which made it

possible to formulate "a critical challenge specifically to Western values and beliefs" (Lederman, 2012: 4) – though, as a backlash to this, it is with increasing reference to Western values that ethical reflection is developing today in anthropology. Within such a framework, one of the ethical questions could have been: How much should we silently acknowledge situations that go against the values we hold (Cefai, 2010)? And how far may our ethnographic practice contribute to endorsing or showing indifference to these situations? As Fluehr-Lobban (2013) and Lambek (2010) have suggested, the ethical debate must extract itself from one on relativism, so that the question of ethics is not reduced to debates over cultural relativism versus ethical relativism. Well beyond the debate on cultural relativism, there lies another question, of the ethical conflicts that arise from respecting epistemological norms.

In the case examined here, the conflict arose between two possible research postures when faced with the object under study. These postures are difficult to reconcile when a collision or even a contradiction occurs between the different social and political implications of the study, that is, when working on one specific issue could be seen both as a heuristic necessity or as a means of improving the overall situation of the people being studied (namely, the women who are subject to polygynous marriage), and as a risk of doing harm to the image of the wider group to which the subjects belong ('African' families). Here, the anthropologist also finds him/herself in a situation of 'ethical dissonance' to the extent that, in attempting to meet one ethical principle (help the weak, do good), s/he may fail to meet another (do no harm). This notion seems to me also appropriate in characterizing the difficulties that anthropologists face when they agree with two conflicting value registers. Ethical dissonance forces anthropologists to make choices that are necessarily arbitrary, since they depend on their own ideological, philosophical or political options. The notion of 'ethical dissonance' here accounts for the contradictory ethical principles to which the anthropologist adheres, and which s/he has to arbitrate. While what is described as an ethical dilemma by Appel (1978) is intended to characterize the problems encountered by anthropologists in cross-cultural inquiry, with an emphasis on the mental conflict between ethical imperatives as experienced by the anthropologist, the concept of ethical dissonance aims to underline the very contradiction between the various principles to which s/he adheres.

DISCUSSION

I am not dealing here with a conflict between two heterogeneous cultural systems or value systems, or even with the problem posed by the fact that the inquiry can take place at the intersection between divergent interests, as discussed by Appel (1978). Appel underlined the irreconcilable character of the anthropologist's multiple roles and the various 'moral expectations' implied. In turn, Lederman (2012) has discussed the potential conflict between different 'reference frames', including professional expectations, personal choices and values, and the restrictions associated with the networks to which one belongs. In this context, she discussed the difficulty researchers face in reconciling their own point of view and that of their donors. This difficulty was referred to explicitly in the AAA Executive Board Statement on Ethics (2012) thus: "Anthropologists must weigh competing ethical obligations to research participants, students, professional colleagues, employers and funders, among others, while recognizing that obligations to research participants are usually primary" (9). There, the

‘competing’ ethical obligations are the different social obligations to which anthropologists are subject, towards their different social partners. Consequently, when the AAA discusses the risk of conflicting ethics, it is in reference to the ethical principles with which anthropologists are confronted as researchers, members of an association, or fathers, for example, that is, while they are wearing several hats.

The point I raise here is different; I am concerned with the choice that anthropologists need to make between two differing value registers, both of which they can agree with. An ethical posture and an engaged posture do not necessarily merge. Despite the obvious necessity of creating an ethical framework for all research, there are inherent difficulties within the ethical choices made during any given research project and the ethical and epistemological stakes they represent. Although an epistemological-ethical approach to a group first implies accounting for the social relationships that can be observed there, this is far from simple when doing no harm to one group might involve harming another.

The question, therefore, is whether defending certain values, as a foundation of the choice to carry out research on certain people or groups, could actually go against the good or the interest of others. Through the critical perspective they adopt, some anthropologists may aim to improve the lot of human beings – for Nancy Scheper-Hughes in reference to her fieldwork in South Africa, it is even a “tool for human liberation” (1995: 415). But anthropologists have to confront questions related to the plurality of the people they study. The position I advocate is that we must free ourselves from the view that ethical posture should only be imagined in a dualistic and Manichean way, opposing good and bad. Anthropologists working in the field of medical are not necessarily facing nasty people (who discriminate, dominate others or put others' rights to well-being in danger) on one side, and good people on the other side. Anthropologists find themselves dealing with individuals who occupy socially distinct positions and interact with one another (men versus women, doctors versus patients, and so on).

Choosing to conduct research on polygyny in order to bring to light a situation of domination does not necessarily involve taking the women’s side in terms of the analysis, no more than choosing to study patient information in order to highlight its inadequacy involves not trying to understand the feelings and motivations of doctors. In the case of polygynous households, researching the social practices at work also implied not taking the side of one spouse or another, although there were also relationships of domination between co-wives. Relations between the sexes are socially constructed, of course, and sexual roles are imposed as much on one sex as the other. Men are as socialized as the women, even if the schemas within which this socialization is constructed are radically different. The socialization of men also supposes forms of constraint. Proof of this can be found in the lack of regard accorded to monogamous men and the pressure placed on men to take on additional wives.

Developing a critical analysis of the processes that take place in the field of illness, rethinking the question of power, working to enable people to manage their bodies and their health in an autonomous manner, or studying situations of vulnerability, domination, and inequality (Fainzang et al., 2009) does not protect a researcher from having to make choices about how the object is constructed and to review his or her position in the field. The two situations I have described have their own specific stakes. But both raise in their own ways the issue of constructing the anthropological object when this object is perceived or understood by civil society in ethical terms. In the first example, some health professionals reproached me for

discussing doctors' lies because of the negative moral connotation of this practice; in the second example it was my colleagues who were worried about me discussing the functioning of polygamy in African immigrant families because of the negative judgment of this practice in Western societies. The two situations also illustrate that to be ethical, one's decisions should necessarily also be epistemological. To this aim, while the task of the anthropologist is to take interest in the Other, he/she must not neglect to examine the points of view of the 'Other of the Other'. Studying doctors and patients in the therapeutic relationship, or studying husbands and wives in polygynous households, can allow for greater complexity because the dominant parties have also been given a voice and have had their reasons heard. In this respect, the two issues raised here have in common an emphasis on the ethical difficulty faced by anthropologists when dealing with two different social groups in relationships of opposition or of inclusion. This leads us to examine formal ethics statements, such as those of the AAA, in a critical manner.

The *Ethical Principles and Guidelines for the Protection of Human Subjects of Research*, known as the Belmont Report (1979), requires researchers to conform to three ethical principles: of Respect, Beneficence, and Justice (cf. Beauchamp, 1982; Cefai, 2010). However, simply respecting these principles does not exhaust the ethical questions raised in anthropological research. In line with the Belmont Report's recommendations, the *Statement on Ethics* established by the AAA Executive Board (2012), a reference point in the French anthropological community, lays down the *Principles of Professional Responsibility*. This latter text states that the primary ethical obligation is to do no harm and that "determinations regarding what is in the best interests of others or what kinds of efforts are appropriate to increase well-being are value-laden" (2012: 4). Yet, this assumes we are able to determine with certainty the good and the harm that our work can do. Is studying doctor's lies likely to harm the doctors, or does it benefit the patients? Further, this instruction conveys a slightly Manichean vision of what 'doing good' or 'avoiding doing bad' is, because the individuals and groups at stake are diverse and occupy non-identical social positions: Husbands are in a position of dominance in relation to their wives by virtue of the social construction of gender relationships in this framework, for instance, but they are in a position of vulnerability in French society by virtue of their social, economic and ethnic status as African migrants.

CONCLUSION

We can find ourselves confronted with problems routinely because of our choice of objects and how they are constructed. The question here was not about knowing if one should judge what one sees or not – a question Scheper-Hughes (1995) answered by imagining what forms a politically committed and morally engaged anthropology might take – or even whether it is possible to do so, although we could consider that judgment made at the beginning of the research is epistemologically prejudiced, but judgment at the conclusion of the research is ethically desirable. Anthropologists are confronted with numerous ethical questions in their fieldwork (Cassell and Jacobs 1987), whether they work beyond or within their national borders. Among those questions, the main one is generally that of knowing how to behave to do good or do no harm. As I have stressed, we should avoid approaching the issue in a Manichean way, all the more so because we sometimes work with people who may be both in a position of vulnerability and a position of dominance. Reflecting on the ethical questions that

anthropologists face supposes highlighting the complexity of social postures occupied by the actors.

If the choices that anthropologists make are to satisfy both ethical and epistemological requirements, they need to be made at the intersections of these two types of requirement. This meeting point will be different for each researcher, and his or her responses to them will depend on their own sensibility to the phenomena of discrimination, injustice and power. Despite ethical codes such as the AAA Code of Ethics, 1998, anthropologists constantly find themselves having to manage new ethical questions in the course of their research. Discussing the problems they face and the choices they make are important to contribute to the collective thinking about ethical challenges in medical anthropology.

NOTES

1. These three principles (of respect, beneficence, and justice) are divided up differently in biomedical ethics, where there are four principles, as the principle of non-maleficence is added to the principle of beneficence (Beauchamp and Childress, 1989).
2. On the issue of empathy inherent in ethnographic practice, and on the distinctive character of anthropological empathy compared to medical empathy in relation to knowledge, see Fainzang (2007).
3. On how the doctor profession is represented and the harm that the social sciences are accused of causing to their image, see Sarradon-Eck (2008).
4. In this respect, it is difficult not to react to the sometimes brutal words of some doctors, who, under the pretext that they are obliged to do so by law, bluntly disclose to a patient their diagnosis, or verbally abuse them. Not all doctors spare their patients' feelings, and the message can sometimes be very harsh.

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