Entering a Chronic Illness: The Numerous Cancer Diagnosis Announcements, Identity, Upheavals and the CAM Perspectives'

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Abstract: *The announcement of the cancer diagnosis marks the entrance into a new field, with a new identity, a destiny to rethink and reorganize, a time-frame, interlocutors, and new activities. The moment of the announcement, a major biographical rupture, must be analysed in all its complexity. The announcement marks not only the entrance into disease and the opening of a new era in the patient's life in which the biomedical field dominates and decides widely. It is preceded by a particular personal and family history, a period of suspicion, tests and fears. Moreover, it generates an avalanche of consequences: further announcements – in fact, we are not dealing with one announcement but many – to the family, relatives, colleagues and so on, by strategic circles; an irreversible identity change – today cancer is considered by biomedicine, the sole authority in this area, to be a chronic disease; an upheaval of one's personal agenda in the short and long term, and a partial or total loss of control over one's life to biomedical professionals…*

The purpose of this paper is to highlight the issues and consequences of the cancer diagnosis announcements, to reveal the multiplicity and complexity of this announcement and the outcome of this event on the patients' identity. We shall also address the subject of CAM (complementary and alternative medicines) to see how their perspectives and offers impact on the process of entering into and living with cancer. This reflection is based on a two years of fieldwork among the various actors related to the cancer event, namely biomedical professionals, patients and CAM therapists in Switzerland.

Paper: The announcement of cancer is a key moment, marking the entrance into chronic illness and leading to major changes in an individual's identity and perspective. This article intends to show how the announcement is not only central but also multiple. We would like to highlight some of the consequences that might result from this announcement for the newly 'coined' patient's life. We will pay special attention to the way information and emotions are spread through the social network surrounding an individual struck by the announcement's earthquake. Finally, we would like to investigate this announcement in light of the potential contributions of complementary and alternative medicines (CAM).

Our present reflections are based on a two years worth of research on the therapeutic path of patients with cancer, their options and subsequent choices. We focused specifically on the issues surrounding unconventional therapies in oncology. Our goal was to define the different elements, representations, protagonists and structures that influence the experience of cancer in Switzerland. Through our presence on the field and mainly qualitative interviews, we encountered three perspectives of cancer reality: patients who are affected by or in remission of a cancer, non-conventional therapists, and professionals in the biomedical and cancer field.[1]

1. Before the announcement: Cancer illness

Since our aim is to illustrate how the announcement of cancer is a multifaceted experience, it is useful to contextualize the disease and recall its specificities and representations in contemporary society. We are seeing a huge increase of the global cancer incidence[2]: but what does it actually mean to have cancer today? How do society and the biomedical enterprise deal with it? What is the place of chronic illness in our society? What is the status of someone who is ill?

In her essay *Illness as a Metaphor* (1983), Susan Sontag analyses the place cancer occupies in our culture, its formidable metaphorical power and the public phobia it represents. Cancer is seen as the disease of modern civilisation, used as a metaphor for all kind of problems or plagues. It is linked with the repression of feelings and – unlike tuberculosis which used to be represented as 'dry' and 'clean' – cancer is perceived as a source of decay and hideous death. Furthermore, it is associated with multiple images, such as mutilation, putrefaction, excruciating pain, alopecia, etc. It must be emphasized that the disease does indeed vary enormously in form, in severity and prognosis. However, the fact that the public generally does not distinguish between cancer's different realities only contributes to strengthening the terror raised by its representation.

Whereas cancer is widely present in people's minds, its effects on the body are felt only much later by the tumour holder. Cancer can remain virtually asymptomatic for a prolonged period, it is a 'silent disease'. ' But one says it is not possible, I am in good shape, I feel nothing. I am in good shape and I have a cancer? But really it is, yeah, it seems not possible '[3], said a woman with breast cancer. Often, cancer is discovered during a routine check-up or a consultation for minor symptoms. The disease's elusive aspect reinforces the uncertainties surrounding cancer and its subsequent fears and phobias.

The flesh can remain silent about the development of the tumour for a long time. It can manifest itself only later and, paradoxically, as a result of biomedical treatments. Despite major advances in biomedicine, oncology's therapeutic arsenal is still very heavy: it mutilates, distorts, weakens, burns, and causes illnesses. Thus, based on the decision of a biomedical professional, someone who did not necessarily feel ill before is suddenly be required to undergo unpleasant, painful or even disabling treatments. The violence of the therapeutic enterprise may raise the question of the purpose of biomedicine and the limitations of a patient, who is handling his or her disease on an everyday basis (Baszanger 1986: 19).

Biomedicine's authority and legitimacy within the scope of disease (Good 1996) is all the more true for cancer. Biomedicine enjoys a monopoly in defining the disease; it has the

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[1] In this context, several teams – coordinated by Patrice Cohen from the University of Rouen – have been leading researches on the same issue in a comparative setting at sites in France, Belgium and Switzerland. The research – "Des systèmes médicaux pluriels de recours de non conventionnels pour les personnes atteintes de cancer : une approche anthropologique comparative (France, Belgique, Suisse)" – was funded by INCa (French National Institute of Cancer).

[2] 'Cancer is becoming an increasingly important factor in the global burden of disease. There are 24,6 million people living with cancer at the moment; by 2020 there will be an estimated 30 million. (…) The estimated number of new cases annually is expected to rise from 10,9 million in 2002 to 16 million by 2020 if this trend continues.', http://www.who.int/dietphysicalactivity/publications/facts/cancer/en/ (Accessed 29 September 2008).

[3] The quotations of patients and therapists not followed by a reference come from our interviews and were translated by us for the purposes of this article.

exclusive right to declare a person sick based on medical and biological analyses. In recent years, the biomedical approach has begun to consider cancer as a chronic illness. Hence the objective of the therapeutic enterprise is no longer to cure but – at best – to achieve total remission: 'Contrary to complementary medicines, scientific medicine has given up healing as a goal of its action. […] A cancer will resolve itself only in the form of remission. Indeed, more and more diseases are now treatable but in the sense of control rather than disappearance.' (Kiefer 2007: 33, our translation) This change in cancer's status is progressively but slowly making its way into the disease's collective and social representations. As we were told, the patients emerging from cancer do not always understand this identity; they thought they were finally cured but instead are told that they are in 'total remission'. The announcement of cancer thereby takes on an irreversible aspect, in which the earlier identity is never recovered.

Finally, despite scientific progress, many aspects of cancer remain unknown or elusive. The aetiology of cancer is not clearly defined, the functioning of cancer is not fully understood and the success of treatment is limited. These many unknowns leave a broad margin for interpretation, assumptions and all kind of theories, a margin which CAM dexterously exploit. The individual finds himself in a paradoxical position whereby the authoritarian and determinant biomedical institution is also ignorant and powerless in some circumstances (Ménoret 2007). Therefore, the patient – already in great danger and uncertainty – is confronted with the limitations of medicine and science and the lack of the wherewithal to make sense of his misfortune.

2. The announcement: An earthquake

Now that some important aspects of cancer have been introduced, we shall turn to the initial announcement, its impact and outcome.

One officially enters cancer with the announcement. The announcement of the cancer diagnosis, or 'mother announcement' as we may call it, can be defined as the moment when an individual learns from a biomedical, therefore approved, legitimate and trustworthy source, that he or she has cancerous cells in their body. This announcement provides information but is also a forecast, a prognosis (Fainzang 2006: 48). It can be made by the general practitioner, the oncologist or a biomedical professional such as a nurse or a technician.

Biomedicine has been aware for some decades now of the importance and stakes of the announcement of a serious illness and has realised that it must also respond to demands – social, emotional and psychological – that exceed the strictly biological dimension. Psycho-oncology has been particularly sensitive to the emotional shock experienced by patients at the moment of the announcement, as well as to the psychological, social, cognitive and functional problems that often ensue. Those reflections led to the elaboration of an announcement protocol (Buckman 1992, Héron 2006, Vannotti 2006, Julian-Reynier 2007). They include elements such as:

- time and space (be in a quiet, intimate place; schedule enough time, etc.);
- background of the patient (what does she/he already know and what does she/he want to know);
- always linking the announcement to a therapeutic proposition; etc.

The issues surrounding the announcement were a source of major concern for the medical institution we visited. Their supportive care team are working together with patients who experienced the announcement to find an appropriate way to pass this information on.

Beyond the ideal scenario that health professionals are working on lies reality and its constraints, as the accounts of our interlocutors illustrate. The person comes to this consultation with a certain background. Family history has a decisive influence: the presence of cancer in a family will make its members aware of this reality since they have lived with or encountered it and they might greatly feared it[4]. This may have led to the establishment of a preventive and control strategy. Everyone approaches the announcement with variable sensitivity, knowledge and perception of cancer. The period preceding the announcement – a period of suspicion whose length can vary from a few hours to some months – is also decisive. Before being announced or confirmed by a physician, the idea of cancer as a possibility for oneself may or may not have been present. Thus a doctor explained that during the period of analysis he was trying to make the patient aware of that possibility as a strategy to lessen the impact of the news.

Furthermore, this ideal scenario is also difficult to implement because of the institutional or professional constraints and the fact that the distinct realities of the patient and the physician are not meant to meet and adjust. Indeed, the patient is living a unique, terrible and traumatic moment, where the information received destroys all certainties and raises numerous and crucial questions relating primarily to survival. On the other hand, even if it is a difficult and emotional moment (Voelter et al. 2005: 1351), the doctor is operating in known territory – geographically, intellectually and organisationally – in a role he or she has already played many times before with considerably less dramatic consequences. The doctor is part of a system (Freidson 1970) that imposes restraints beyond the purely medical, for example economic and managerial. He also has a schedule to keep to and priorities to maintain.

Therefore, we were often told of more accidental or unexpected events. Some announcements were made on the phone, either at the insistence of the patient or despite his disagreement. In this context of multiple constraints, the physician has to evaluate the patient's profile to choose how to talk to them and what to tell them (Fainzang 2007: 241). The doctor may not be in possession of the necessary elements (or the proper training) to carry out this task, and sometimes the message is not received as expected.

As examples of more accidental announcements, we interviewed a woman who was sent to a room and arrived in the oncology department without having been alerted in advance about the nature of the medical investigations. In another situation, cancer had been announced to a woman patient, but its gravity and nature were not known. It was during the surgical operation that tissues were to be collected and tested while she was still unconscious: 'When I fell asleep, I didn't know. And when I woke up, in a flash of lucidity, I touched the dressing, felt it was all flattened out and thought to myself "Lady, you've had it!"'

The comments made during interviews conducted so far suggest that it is not so much the mechanism put in place that makes the difference as the meeting between two compatible personalities. Thus a state-of-the-art announcement was nicknamed 'court' and described as a traumatic experience[5]. A woman insisted that her doctor, calling to make an appointment,

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[4] A woman began an interview by saying : 'I have to tell you first of all that I'm a cancerophobic. Because my mother died at age 54, of a breast cancer. I was 18 at the time, and it was horrible, really heavy treatments, it was very traumatising. Now every mammo is a huge stress to me. "Will this time everything be ok again?" And once it was not ok.'

[5] 'That was Friday and on the following Wednesday, I think, I came before the "court". That is a dreadful moment. I was called in with my husband in oncology, in a room that was not even this big [8m2], at least not as wide. There was, besides my husband and I, in front of us, the oncologist, the radio oncologist, the assistant who was meant to follow me and two nurses. And all those white uniforms, all of which took the floor. Not the two nurses. One had the impression that it was a

transmit her the announcement immediately, and went on with her evening. It was only two weeks later that she gave the news to her children and to her husband. In addition to the multiple variables influencing the announcement, we face a plurality of receptions of the message and its consecutive influence on elements such as therapeutic alliance and compliance with the therapeutic plan.

2.1 Consequences of the announcement

The announcement of a cancer diagnosis is a shock whose impact is felt on many levels and on all terms. Few events in a lifetime have an impact as brutal and absolute. The announcement of cancer marks a major biographical disruption (Bury 1982, Williams 2000), both highly stressful and traumatic, that takes precedence over everything. The person quits her previous social group to integrate a new one, a group of ill people. She may be relieved of all her duties and removed from the professional circuit, with the powerful biomedical seal legitimising such reactions. Biological cancer develops in the body for months, but once discovered and managed by biomedicine, it becomes an emergency surpassing all others.

The first visible effect of the announcement is perhaps the emotional commotion it triggers, something that patients, CAM practitioners and biomedical professionals all insisted on during interviews. A woman explained her reaction while she was announced a breast cancer: ‘Then really, I felt very very bad. I was with my husband, my husband thought he was going to fall on the ground, and suddenly I was frightened, afraid for my life.’ A biomedical professional pronounces a single sentence and suddenly the future as previously projected is overturned or destroyed and survival is no longer guaranteed. ‘Illness, particularly chronic illness, is an experience in which […] the structure of everyday life, its taken-for-granted features and the tacit stocks of knowledge upon which they rest are profoundly disrupted.’ (Williams 2000: 43) According to patients, the shock takes weeks to be digested. The stupor may be psychological as well as intellectual[6].

In the short term, the announcement may be experienced as a relief, when it ends a diagnostic meandering. Symptoms finally receive an explanation and a name; it may be harder to face an unknown state than a grave disease.

The impact on a patient’s identity can be significant and endangers its very foundations. The announcement is performative because it makes a healthy person ‘sick’. Cancer is a personal tragedy, but it is also a social event and the patient’s identity is a result of the place society gives serious illness and patients. This new status gives him certain rights and certain duties, which though not clearly defined in detail are broadly agreed in outline. For example, a person with cancer has greater flexibility expressing her emotions and dealing with her social relations. A woman with breast cancer stated it lucidly: ‘Cancer is a good excuse to define ones’ limits, I intend to use it. Not to take advantage of it, but to gauge the drama barometer. It’s a life experience that one can use to learn to listen to oneself and say no.’ One can also – or perhaps even should – be inactive professionally. As for duties, we witnessed considerable social pressure to follow biomedical protocols and obey biomedical authority. ‘Putting up a good fight is socially endorsed. […] social constraints may demand a prescribed course.’ (Little et al. 1998: 1491)

With this threat weighing very directly on survival, the patient’s plans are suspended. The fight against cancer – according to the military jargon often used in this context (Pinell 1992)

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court. It was horrible! I didn't understand anything, well I caught a thing or two.’ (Woman with a breast cancer, our translation)

[6] For more information on the psychological implications of the announcement of a serious illness, please refer to Misery & Chastaing (2005).

– takes precedence over everything else. The ‘else’ will adapt to treatment’s constraints, life as known and lived before is shattered, the magnitude of this depending on the severity of the cancer and the constraints and damages of the treatment. From the point of announcement, the patient will go through learning about and handling the disease (Baszanger 1986: 3) with a new vocabulary, new hierarchy, new temporality, etc. The broken biographical line is recomposed on a daily basis. As Baszanger has shown, chronic illness constitutes a social world in itself.

Disease belongs to biomedicine and therefore, the patient belongs to it too. ‘[Serious illness] takes the ill person away from their “proper” sphere, and passes responsibility for his or her continued existence and for the shape of their life trajectory to another agency.’ (Little et al. 1998: 1492) The biomedical enterprise – recognized and supported by a society that places a high value on this survival of its members – takes control over much of the patient’s existence. It is unusual for people with cancer to rebel against this situation. We met no one who refused the biomedical agenda and a few who negotiated it. A man with a sarcoma postponed one chemotherapy to make time for a non-conventional treatment. A woman with breast cancer who used to work as a nurse explained: ‘They offered me a preventive chemotherapy. I refused. I had seen too many bad experiences at work. I didn’t tell my family. […] But I could say no because I was a nurse, and I knew the milieu.’ Once made patient, one is no longer free to set his or her own agenda and priorities according to their own criteria; one must obey the medical and care personnel who take into account numerous physical variables (exhaustion, rate of leukocytes, healing) and personal and social variables to a certain extent (emotional state, important personal events).

3. Replicas: Multiple announcements, good news and bad news

The theme of the multiplicity of announcements strongly emerged from our fieldwork. It was during interviews with patients, when we asked them to relate the event of the announcement in their history of cancer, that we realised that there was in fact not one announcement but several. From the mother announcement, which we described in general terms, a spate of secondary announcements deploy throughout the individual’s therapeutic path.

3.1 Recasting of the announcement

‘Even in situations where non-fatal illness is being discussed, there is a limit to the amount of information that patients can incorporate at any given time. […] It is a common experience for physicians that having informed a patient of the possibility of malignant lesion, and having then fully explained the implications of the illness and a recommended course of action, to discover the next day that the patient is asking the same questions, often giving the impression that the matter has not been discussed at all.’ (Premi 1981: 840) Since the emotional shock, the complexity and issues surrounding the news are great, the announcement needs to be redone, as replayed by the same actors (Reich 2001). There will be a reproduction of this first announcement by different members of the biomedical team until the patient understands his misfortune and remembers its significant details.

3.2 Announcements: Breaking the news to

The social person exists at the centre of various circles of individuals who make up her social network: her family, friends, colleagues, neighbours etc. The biomedical sphere has transmitted the news of cancer to the patient. The patient turns to his network and chooses to inform some members and some circles, following his own logic. Some people spread the information widely. Sometimes biomedicine removes the patient from society for surgery. The patient can only inform those closest to him, relatives or friends who must then take up the heavy task of passing on and dealing with the news. Other patients limit the information to those they are closest to in order to control the information: 'So when the diagnosis came out and I had to have surgery, of course, I warned the management, the dean and the secretariat. And I demanded, and it has been observed, that the news wouldn't leak out. So my husband knew it, a week later my mother, a common friend, and the daughter of my husband.'

The experience of this round of announcements – with the transmission and sharing of information and emotions – is essential. Indeed, the patient finds himself in the place of the doctor, but without possessing his knowledge, skills or awareness. Because he may have had time to digest the announcement and its implications, he sometimes finds himself consoling a shocked audience, adopting an optimistic tone and putting into perspective his misfortune, as we see in the following example: 'Right then it was a bit of a shock. But I am optimistic. And I informed my wife and she was more upset than I was. I remember, we went out for dinner in a good restaurant and she was in a state. And it was I who comforted her and cheered her up: "It will heal, it is the beginning [of the tumor], blah-blah."' During these announcements, the individual adopts the medical vocabulary, popularised and revisited. He acts as a bridge between the biomedical and the lay spheres.

As we have seen, there is often a gap between how the patient feels and what he is told. These rehearsals lead the individual to gradually incorporate the cancerous identity. This process takes place through successive announcements and the reactions encountered. These reactions have often been described as difficult times, moments of great clumsiness, shock, faces of people on which one reads the seriousness of one's fate. It is through this mirror that the magnitude and the reality of the announcement can be progressively understood and assimilated.

3.3 Announcement to oneself: Side effects and the clash with reality

That reality, however, remains difficult to fully absorb. The body fails to confirm the diagnosis except perhaps through minor signs and the rare and brief encounters with the biomedical institution hardly facilitate the identification with the idea of being ill. It is sometimes through side effects that the announcement is finally confirmed to the patient. Patients described hair loss at length during interviews. Suddenly the image one sees in the mirror matches the image of someone with cancer: a bare skull with a pale complexion and the peculiar expression brought on by the absence of eyebrows and eyelashes. Through the dual impact of the eyes of others and the physical stereotype of cancer, cancer's presence is finally acknowledged.

3.4 Announcements throughout the cancer experience

General attention and reflection are concentrated on the initial announcement. Yet the experience of cancer is marked by numerous announcements, each spread further into the social network of which the patient is a part. The daily life of an ill person is defined by biomedical announcements regarding the state of health. Patterns of hope and disappointment punctuate the cancer experience. During this period, the patient is often much more vulnerable than at the mother announcement, because he has already been through numerous difficulties.

After each visit or examination the doctor or health care worker will have an announcement to make: the fragility of a vein, the number of infected sentinel lymph nodes, the presence or absence of metastasis, the extension or potential modifications to chemotherapy… With some physicians disclosing the announcement step by step, and with differing personal representations, the shock may occur later for certain patients. In one case, a woman with breast cancer considered her cancer to be ‘light’ and ‘small’, and her shock and real concern came with the announcement that she would have to have a surgical operation after all. And at the end of her biomedical protocol, she was very relieved to learn that she would not have to take a preventive and menopause-inducing drug for five years.

All these process of communication bring to light the importance of the patient’s relatives and social network. Mobilised friends and family follow those good news/bad news from the ‘front line’, they will be sad and frightened, feel relief or frustration together with the patient. While they cannot actually feel the pain, their position is highly exposed and their participation in the daily handling of the disease may be important, as a woman with intestinal cancer stated: ‘I think it’s a lot. [My husband] was afraid that I might…, he told me later. He was doing everything, two big meals a day, housework, everything. One has cancer, but for the spouse, and the family as well, it’s very hard, they suffer a lot.’

4. Announcements and CAM

We need to shed additional light on what has already been said about the process and experience of entering cancer disease. Indeed, in a context of medical pluralism and of patients’ empowerment, CAM[7] may have an impact on the way persons live their entrance into cancer, their cancerous identity and their experience of the illness.[8]

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[7] CAM is a general term that covers a very heterogeneous offer, with different techniques, theories and vision of the world and of the body. The NCCAM (National Center for Complementary and Alternative Medicine) defines them as follows: ‘CAM is a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine. Conventional medicine is medicine as practiced by holders of M.D. (medical doctor) or D.O. (doctor of osteopathy) degrees and by their allied health professionals, such as physical therapists, psychologists, and registered nurses. Some health care providers practice both CAM and conventional medicine.’ (http://nccam.nih.gov/health/whatiscam/, accessed 29 September 2008). For more information on CAM, please refer to Benoist 1996, Dilhuydy 2003, Cassileth & Deng 2004, Schmitz, 2006.

[8] In the Swiss context of our ethnographic field, the legal status of complementary medicine remains unclear, but it is generally tolerant. Depending on the canton in which they practice, CAM therapists are subject to 26 different legislations, ranging from severe to benevolent.
Health insurance is compulsory and the reimbursement of therapy is therefore an important issue. Those therapies must be “efficient, appropriate and economic”. Between 1999 and 2005 the government decided to reimburse six CAM – acupuncture, Chinese medicine, anthroposophic medicine, homeopathy, neural therapy and herbal medicine – as a test. The Swiss authorities then suddenly decided to revoke the experience in a very unclear context. There is a gap between this political decision and popular will and practices. The use of CAM by Swiss people is widespread (Molassiotis 2005).

4.1 Caution, relativization and criticisms

Biomedicine has been contested on its own territory – health, disease and their care – for several decades now (Illitch 1981), and has consequently lost some of its authority and exclusivity. CAM grow and flourish in its gaps, flaws and failures. But making a cancer diagnosis remains an absolute monopoly of biomedicine. Moreover, this diagnosis is accepted and used transversally by all actors in the therapeutic field. The CAM act only downstream, after the person has been 'cancer labelled' by biomedicine.

The proponents of CAM handle cancer with the utmost caution. During interviews, they always insist that cancer has to be treated by biomedicine and that they never advise patients to quit biomedical protocols. Then they would explain what they could do for patients with cancer, usually against the side effects of biomedical protocols, for wellbeing or existential issues. They often present themselves as a 'support' to biomedical protocol.

CAM practitioners seldom if ever call into question the reality of cancer or the accuracy of the diagnosis. However, some CAM currents do try to put cancer into perspective. They try for instance to temper cancer's terrible reputation and the consequent trauma of an announcement, as this naturopath who says : 'If it is a cancer or if it is haemorrhoids, I will deal with it the same way. At least I'll try, I don't want to let me scared : "Aaah, it's a cancer !" '

The biomedical announcement of cancer is often seen as pathogenic. For instance, Dr Hamer[9], whose theories are widespread in CAM circles, explains how every cancer starts with a brutal emotional shock lived in solitude. He envisages a system of correspondences between the nature of the shocks and the affected organs. In this paradigm – as a naturopath stated – '[f]rom the moment the announcement of cancer is made, it will make a second aggression on the brain and it is what will do what docs call metastasis.'

Other criticisms concern the alleged harmfulness of the convictions of the physician, reflected or contained: 'And we clearly see that, when patients receive their diagnosis, its impact greatly depends on how they received the message, how the person told them. And it depends on the convictions of this person.' (naturopath and Simonton therapist) They are meant to be a death sentence for a trusting and vulnerable patient (Fainzang 2007: 238). The clumsy handling and abuse of statistics would also be highly detrimental to the health of patients. The latter would 'conform to' the predictions of the biomedical authority, as this physician and homeopath explained: 'Doing positive predictions for oneself, this axiom, which is recognized in medicine, holds that self-made predictions automatically happens. If someone tells you "My poor Madam with your cancer you have 6 months, you'd better arrange your things". You can say it nicely, take an hour to say it, but that's the message at the end. If the person thinks "Well this doctor is a good doctor, he must be right", then in six months she'd be dead.' In such a situation, the symbolic strength of the statistical tool would be retained, and not its interpretable nature and cryptic predictions.

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[9] Dr Ryke Geerd Hamer, inventor of the New Medicine, is a very controversial character notably because he advises his patients to quit biomedical protocols. He was arrested in Spain and extradited to France where he spent 3 years in jail for fraud and complicity in illegal practice of medicine. For an introduction to his theories see http://medecinenouvelle.com or http://www.hbci.com/~wenonah/new/hamer.htm (accessed 29 September 2008).

4.2 CAM offer and perspectives

CAM are usually used in a cumulative way with biomedicine. As the complementary and alternative label in fact regroups a very heterogeneous offer, the tools and theories proposed to heal and help the patient are multiple.

CAM propose to heal the physical, existential and psychological consequences of cancer and biomedicine. For instance, '[t]he indications of acupuncture in diseases like cancer is dealing with side effects, namely nausea, vomiting, pain, related to treatments or to the basic disease.' (physician and acupuncturist) The Simonton method[10] helps to answer existential questions as: Why do I have a cancer? What can I change? What do I want to live for? Patients quite regularly reported using the 'secret'[11] to deal with the burns caused by radiotherapy.

CAM propose to care if not cure. We often encountered the idea that the person was not taking care of herself until the announcement and that this may be linked to the causes of the cancer. Pay attention to oneself and care for oneself – by doing different sorts of massages or energy manipulations for instance – may be a strategy to survive. Some CAM practitioners do consider cancer to be an urgent message from the body to slow down and take care of oneself, an opportunity to think about one's life and change it. A Simonton therapist said: 'When he [the body] is making me a cancer, he's shouting "Stop, I can't anymore! I adapted, adapted, but it's over now". Then he's telling me very clearly "You have to take care of yourself, of me." That's the first message of the disease.'

CAM allow individuals to play an active and responsible role in the management of their illness. The patient will not simply wait for the next biomedical appointment or obey the biomedical professional, but try to be active in changing their nutrition or understanding the meaning of the disease. CAM also aim to regain a lost balance and 'clean up' the body (from chemotherapy in particular).

But above all, CAM propose other perspectives. The announcement is a key moment in which doors open to certain worlds. The biomedical world is largely dominant in our society, but it is not unique (Rossi 1996), and it is challenged by this wide range of paradigms that propose other paths and open alternative space. Very few people evade biomedicine; rather, they constitute a keychain which allows them, in a cumulative and differentiated way, to open perspectives that have been closed by the biomedical announcement. The CAM aetiologies of cancer are multiple and refer to different level. For instance, anthroposophy[12] proposes another scenario, as they believe in reincarnation: cancer may be explained by events of a previous life and have consequences in the next one. Moreover, anamnesis and undertaken therapies do not take into account only the physical level but three others as well. A common popular aetiology sees mismanaged emotions or emotional shocks as a cause of cancer. Those aetiologies have a strong influence on the management of their illness by individuals and the therapeutic path they choose.

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[10] Method designed in the 70s by Dr Carl Simonton in USA. It seeks to provide support for cancer patients through certain techniques such as visual imagery, relaxation and emotional intervention. It also works on life events and on a contextualisation and explanation of the emergence of cancer. (Simonton et al. 1978)

[11] The 'secret' is a popular and commonly used practice in Switzerland. It is a religious incantation a healer mumbles while thinking of the patient. The patient or a concerned third party contact the healer, there is no physical encounter. The consultation must be free of charge. Most common indications of secret are warts, bleeding and burns.

[12] Anthroposophical medicine is a complementary medicine founded in the 1920s by Rudolf Steiner. It is a holistic approach used as an extension to conventional medicine. Anthroposophy considers the four levels of the patients, namely physical constitution, etheric body, astral body, and ego, and proposes among other thing mistletoe and eurhythmy to handle cancer.

By consulting CAM therapists, patients aim to reduce the uncertainty resulting from the occurrence of the disease in their lives and to reconfigure the impact of diagnosis. They also seek to deal with levels – emotional, spiritual, ethereal, energetic, biographical, transgenerational – that biomedicine does not deal with and that may help them better live the cancer experience and leave its acute phase more quickly.

The announcement, while marking the entrance in a new area and shattering the life of the tumour holder, creates the fertile terrain for a profound questioning and a quest for sense (Durisch et al. 2007): Why me? Why now? Why this organ? The attempt to achieve understanding and order from chaos and the whole path through disease will be conducted by a patient picking help into the plural therapeutical culture of our societies.

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