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Resuscitation Narration. Some Comments Written afterwards in the Margins of if "*If I Were Told the Experience of Medical and Surgical Resuscitation...*" The Resuscitation Notebooks of Benoît Misset. The Ethical Powers of Writing

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Abstract: *The experiment that we are going to report here on new terms and about which we are going to reflect from a different perspective was already discussed in 2022 in the LUMEN journal itself (Clero, 2022). However it is not at all a question of repeating what was already said nearly three years ago. A few words are necessary for the reader who is not already familiar with this article and even for a reader who may have read it some time ago. Let us reassure the reader from the outset, however: this knowledge is not essential to read this article. But we must provide some clarifications. The experiment we are interested in is not entirely new. It had already taken place in France in around twenty hospitals that have an intensive care unit and there are reports of it in the medical literature, which echo the words of patients who have come out of it rather well (Clero, 2022). Psychiatry had also already encouraged the patient to keep a logbook, of which only he-and perhaps his psychiatrist- was aware. But this is where we almost immediately encounter the difference between the structure of these notebooks initiated by B. Misset and the previous structure (essentially used in psychiatry or neuro-psychiatry): unlike what happens most of the time in psychiatry, the intensive care patient, often being artificially put to sleep to be able to tolerate the care, is not capable of keeping a logbook for himself.*

Keywords: *affect(ivity); consciousness / unconsciousness; device(s); dysorthography; family; language (vernacular and symbolic); laws; machine(s); passions; redactor and writer; religious; resuscitation; sacred.*

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> "I dare not deny that the human body, although blood goes on circulating and there are other signs of life in it, can nevertheless change its nature for an entirely different one. [...] Sometimes, indeed, a man undergoes such changes that it would be difficult to say that he is the same; I have heard in particular of a certain Spanish poet who was stricken with an illness and, although cured, remains in such forgetfulness of his past life that he did not believe the comedies and tragedies he had composed to be his own; he might have been considered a grown-up child if he had also forgotten his mother tongue. And if this seems incredible, what can we say about children? A man of more advanced years believes their nature to be so different from his own that he could persuade himself that he was never a child if he did not, according to others, make a conjecture about himself."
> (Spinoza, 1913, IVth Part., Prop. XXXIX, Scholium, vol. II, p. 83).
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> "Probably, sufficient attention has not been paid to the subjects that philosophers refuse to address due to lack of time."
> (Spinoza, 1913, Vth Part., Prop. X, vol. II, p. 193).

A few adjustments are necessary to begin

Everything happens as if various people, who use the words I, we, you, [vous, tu], they, she, he, were keeping the journal in the patient's place or in their own, addressing the same patient or making remarks that concern him. The medical staff gives some information about the state of health of the person entering the ward, begins by indicating her/his age and a few other elements to present the situation objectively and then continues sporadically to intervene at crucial moments of the illness and during the twists and turns of his treatment. Everything we learn about the patient is known, moreover, only through the interlacing of written texts, which gradually and as if in bits and pieces reveals to us who the patient was/is, who her/his family was/is, who her/his friends were/are, her/his colleagues and therefore the job she/he did, how she/he lived, and many elements of the state of health that led her/him to an intensive care unit.

B. Misset[1], like the researchers who conducted the logbook experiment, puts a notebook at the family's disposal with the initial and often repeated aim, both through didactic discourse and through the very diverse actions of the hospital staff -doctors, nurses, nursing assistants, physiotherapists, hoteliers, psychologists[2]- of telling the patient what happened while she/he was asleep; the patient's falling asleep allows for great frankness on the part of the redactors. If the person dies, he will never see a series of increasingly gloomy health bulletins to which his family members react; if he survives the adventure, he will know, if he wants, after the fact, in bits and pieces, by means of these little writings, what he went through at the time when, plunged into a coma, he could not have been aware of it. But most redactors[3] do not stick to these instructions. More ambitiously, both on the part of the medical staff and that of the other visitors authorized to enter the patient's room, it becomes a question of constituting, as much as possible, by writing in the notebook, the substitute for a continuity of the subject which will have been lost, either by a coma into which the illness has precipitated him, or by an artificial coma into which the patient is deliberately plunged to support the respiratory assistance which is given to him.

The following text is a study of fifty-two notebooks of varying length, some very full, others not so much. They were published in very small numbers in Rouen within the very restricted circle of the ERIAC (Équipe de Recherche Interdisciplinaire sur les Aires Culturelles <Interdisciplinary Research Team on Cultural Areas>).[4] Some are mainly written by the family, others not, and are left entirely to the medical staff, who write them alone as they would have written a medical record, perhaps

[1] Benoît Misset was Professor of Intensive Care Medicine and Resuscitation at the University of Paris Descartes, then at the University Hospital of Rouen Normandy, France, where he became Head of the Intensive Care Unit. Benoît Misset is now Professor of Intensive Care Medicine and Resuscitation in Liège, Belgium. It is thanks to him that we became aware of the work of Dr. Maïté Garrouste-Orgeas, physician, Cécile Flahaut, psychologist, and several other researchers, in particular Léonor Fasse and Stephane Ruckly, who have published texts.

[2] One of them confided to the Notebook that she felt as if she had worked under the gaze of a patient who could not speak but who seemed to gain some coherence by watching her work.

[3] We will often use the word "redactor" to distinguish what it designates from the function of "writer," who works on the act of writing for itself; which is not the case for the redactor of a logbook, whom we will loosely call "notebook."
In French, the word *redactor* could have been rendered as "écrivant," which we would borrow in the sense we have just defined from R. Barthes.

[4] We do not despair that their rich material will one day be published; this is why, although the proper names have been changed, we have nevertheless kept the numbers of the notebooks which will allow one day, which I hope will be soon, to verify or complete my statements. However, with or without numbers, our purpose does not change in substance.

using less technical language in the notebooks. These fifty-two notebooks are taken from some five hundred notebooks, of which I have no knowledge; any statistical argument is thus devalued from the outset: we therefore never use any, unlike the research text whose title we gave (The ICU-Diary Study). If our research gains some universality, it is almost by following a reverse path that it achieves it. Conventional expressions hardly seem interesting to us; on the other hand, the singular, unexpected, and absolutely original ways of speaking by which the notebook is punctuated seem to us to be what it is possible to attach a universal interest to. Singularity is not an obstacle in the way of universality; far from it! It is often what one had the least chance of finding under the pen of one of the redactors, consequently what strikes the most, even in a surprising way, which can -precisely because one does not expect it- create the broadest agreement among those who read it, because it gives the greatest chance to a proposition which nevertheless has the least probability in its favor. This Bayesian method[5] of gaining universality is ours here. Propositions which are too expected, with vague content and too general a scope, have almost every chance of being false; only those which have the least vague content and the most singular scope possible have the greatest chance of being true.

On several points, the analysis must be refined compared to that of our first study -starting with the question of personal pronouns, the delicate interplay of which must be reviewed. The vocative[6] had, during my first reading, particularly impressed me by the contradictions it entails. It is understood only by a duplication -or, more generally, a replication- previously carried out on the subject of the patient, by which a sleeping being, certainly, is doubled by an individual who could have understood the treatment to which he is subjected if he had enjoyed all the consciousness to which we substitute ourselves while attributing it to him. We were struck by the surprisingly aggressive turn that the "vous" took when, at close range,

[5] Popper is indeed a Bayesian on at least one point, which is that a hypothesis of low probability can be scientifically superior to a hypothesis of higher probability. He finds at least two good reasons for being so. The first is that: the greater the information content of a hypothesis, the lower its degree of *a priori* probability (the more there is to do to make it true). Thus, science always has to choose between a high content of information and a high degree of probability; the choice must be made, in Popper's eyes, in favor of the former. The second concerns the greater testability of hypotheses that contain the most information and have a lower degree of *a priori* probability. Harsanyi (2022) saw these Popperian reasons very clearly, although he be far from entirely sharing them. We believe, for our part, that these two reasons are well founded.

[6] I could have spoken of *interpellative* rather than of *vocative*; but the former term is less common.

one wrote to the other, if not to his face, at least in his physical presence since he is a few centimeters from the place where it can be written: "Your state of health is declining" or "you seem a little lost but coherent" (Notebook 30-392-TM), "your state of consciousness is stagnating" (Notebook 34-312-PP), "you deteriorated during the afternoon" (Notebook 27-484-WP); « to-day, you are less confused and we can finally discuss your anxieties and your brain" (Notebook 29-412-PS), "you are not in a good mood this morning" whose intonation is close to that of Father Ubu[7] in his reproaches to Mother Ubu, his wife, who returns them in kind. If there are « vous » <*you*> of great refinement and almost self-effacing, like those that detect a concern, explain it and seek a way out of it,[8] there are « vous » <*you*> of extraordinary violence, truly grotesque. By the doubling -or multiplication- that it achieves, writing allows for the reinforcement of a brusqueness, of shortcuts, that one would not allow oneself in speaking under normal conditions.[9] Nothing, in any case, of Butor's *You* which, in *La Métamorphose* (Butor, 1957), relies on one side of consciousness held as a subject in order to speak of the other side, held, itself, as an object; this split not being apparent to others and preserving a self-sufficient mask of the person with regard to others who are, like him, carried from Paris to Rome in a railway compartment. The only escape from self-sufficiency takes place in the direction towards the reader, made witness to this intimate, gently multiplying use of the formal "vous"; and not violently as is sometimes done in the Notebooks, when the authors do not correct a very sharp break brought about by the simple fact of their intrusive existence in the patient's life under the pretext of repairing a breach or making a connection between two phases of life. One could say the same of the "Tu" <the Thou> which, in the Notebooks, is not the "Tu" that G. Apollinaire addresses to himself in

[7] The famous character of Jarry. It would have been more neutral to write as in Notebook 24-714-BC: "The return seems complicated."

[8] In Notebook 20-734-BD, a medical staff member wrote: "You are a little worried because you feel like you had forgotten certain parts of your life. Everything will gradually return to normal. This is also the reason for this logbook."

[9] "You are still a little disoriented," writes a nurse (in Notebook 09-538-DM) to the patient, who would certainly not be made to make such an outing face to face, which is moreover dangerous for the recovery. While it would be possible to tell the patient what is written in notebook 11-441-RJ: "Last night, you were agitated. When we were with you, you were calmer, as if reassured to hear the sound of our voice and perhaps to feel less alone." Perhaps even more absurd is to write in front of someone: "you are perfectly wide awake" (Notebook 24-532-JJ).

the inaugural poem of *Alcools* entitled « Zone » (Apollinaire, 1921, 7-15).[10] The "*Tu*" addressed to oneself does not have the coarseness and barbarity that the "*Tu*" can have when it is not familiar, the substitute "*Tu*" which plays its role too violently and spontaneously turns to aggression, which can go as far as revenge.[11] Let us note that the "Tu" can, like the "*You*", introduce an element of affirmation or negation; both turn to stupidity when they become interrogative: "Are you in a coma today?" is an absurd question, since it is introduced into a dialogue that implies from the addressee a real answer which is not possible to be given by whom it is asked. The shift from *vous* to *il* and even to *ils*, that from *nous* to *vous* constitute the whole range that deserves to be reviewed and taken up again in the sense of a multiplication of persons, beyond the six official persons of the French conjugation, so to speak. Have we become accustomed to it since our first reading? In any case, the game now seems more delicate to us and the first version that we gave must be corrected. There are abrupt

[10] Apollinaire's "Tu...": « L'angoisse de l'amour te serre le gosier / Comme si tu ne devais jamais plus être aimé / Si tu vivais dans l'ancien temps tu entrerais dans un monastère / Vous avez honte quand vous vous surprenez à dire une prière / Tu te moques de toi ». ["The anguish of love tightens your throat / As if you were never to be loved again / If you lived in the old days you would enter a monastery / You are ashamed when you find yourself saying a prayer / You mock yourself."] And, a little further on: « Tu es dans le jardin d'une auberge aux environs de Prague / Tu te sens tout heureux une rose est sur la table / Et tu observes au lieu d'écrire ton conte en prose / La cétoine qui dort dans le cœur de la rose / Épouvanté tu te vois dessiné dans les agates de Saint-Vit / Tu étais triste à mourir le jour où tu t'y vis / Tu ressembles au Lazare affolé par le jour ». ["You are in the garden of an inn near Prague / You feel very happy, a rose is on the table / And you observe instead of writing your tale in prose / The cetonia that sleeps in the heart of the rose / Terrified you see yourself drawn in the agates of Saint-Vit / You were sad to death the day you saw yourself there / You resemble Lazarus, maddened by the day."] Further still: « Tu es à Paris chez le juge d'instruction / Comme un criminel on te met en état d'arrestation / Tu as fait de douloureux et de joyeux voyages / Avant de t'apercevoir du mensonge et de l'âge / Tu as souffert de l'amour à vingt et à trente ans / J'ai vécu comme un fou et j'ai perdu mon temps Tu n'oses plus regarder tes mains et à tous moments je voudrais sangloter / Sur toi sur celle que j'aime sur tout ce qui t'a épouvanté ».["You are in Paris at the examining magistrate's / Like a criminal you are placed under arrest / You have made painful and joyful journeys / Before you realized the lie and the age / You suffered from love at twenty and at thirty / I lived like a madman and I wasted my time You no longer dare to look at your hands and at every moment I would like to sob / Over you, over the one I love, over everything that terrified you. »]

[11] "You kicked us out today"; "You're in a terrible mood." Or, more subtly, but in a terrifying return to everyday life after having poured out loads of love: "We warned you when you were going to kick us out of your room."

vocatives, which most often tend towards the burlesque (Clero, 2022)[12], and dolce vocatives. By a strange inversion, the *You*, by means of the doubling that it implies, even allows us to approach with a certain gentleness the relative weighing of a cessation of care and a now vegetative life of a man who was active; the doctor dares write to him that «[continuing resuscitation] would be offering you [him] an unbearable life; a life that you [he] would surely judge unbearable if you [he] could be aware of it.» The daughter repeats, in roughly the same terms, with a kind of serenity, to her father, still alive but unable to hear her, the explanation that his death is better than his survival. Not from an external point of view, but from his own point of view of a patient. She puts herself in someone's place to bring forward, at least by a few hours, his death. The duplication allows, in this case of Notebook 10-549-CM, a strange freedom and an astonishing flexibility in the play of points of view which concludes with the decision, however final, of the death of the father. The calculation, in its precision, supplants the rigor of a *you* or of a *tu* which has become evanescent. It is, moreover, to designate the medical staff, extremely harsh *They* emanating from people who do not suffer what they apprehend as an unbearable harshness of care.[13] These "*They*" are no longer of any descriptive value, but are properly *appellative*, or as we say, *vocative*, rather in the same way Germans use the third person plural (*Sie*) as a form of politeness. Simply, here, the redactors in the Notebook who use "*They*" in the way we just described and who know that the caregivers will read the message know perfectly well that they are addressing them—or even apostrophizing them—under the guise of description.[14]

It should be noted in this regard that never, from one of the fifty-two notebooks, can one glean the elements of the slightest dispute, much less the beginnings of a trial, of the treatment as it was carried out on the

[12] This aspect particularly struck us in our first version for the LUMEN article - Clero, J.-P. (2022). "If I Were Told the Experience of Medical and Surgical Resuscitation." The Resuscitation Notebooks of Benoît Misset. The Ethical Powers of Writing. *Logos Universality Mentality Education Novelty: Philosophy & Humanistic Sciences*, *10*(2), 01-40. https://doi.org/10.18662/lumenphs/10.2/67.

[13] It is not without a hint of hostility that a visitor says to the medical staff to the close relative: « Ils t'ont retourné ... Ils vont donc peut-être recommencer » ["They turned you over... So they might do it again" (Notebook 24-714-BC)].

[14] We should also not forget the French *On*, which is a *vous-nous* or a *nous-vous* that serves as a pronoun of sympathy towards the patient and participation in his effort. We find a superb one in the formula of Notebook 30-337-VF, noted by a member of the medical staff to signify some center of gravity between the *nous*, the *vous* and the *il*: « On évolue bien, c'est très encourageant » [« We are progressing well, it is very encouraging. »].

patient by the intensive care teams, regardless of the hospital of which they constitute one of the departments; rarely does suspicion arise when the stay turns into a nightmare and when the person who dies does not appear, in the eyes of the family, who does not understand the treatment and its harshness, to have been treated with the appropriate care; perhaps worse: when the person who collapses does not seem to have been listened to in her/his desire to end it all and when the resuscitation treatment seems to have been inflicted on her/him in all its harshness, without her/him having given consent if she/he had been conscious. We will return to this particularly evolving point in the French jurisdiction of this year 2025 and in the very months in which I am writing these words.

Let us, however, return to the thread of our discourse for the moment to emphasize that it is the overall point of view that must be reasserted, like the Copernican reversal: the "data" we used remains broadly the same. We simply now consider two aspects that we had neglected.

The *first* concerns this flight towards readers, largely unnoticed by them, and yet structurally organized by each of the Notebooks; the readers being, to varying degrees, *us* who study them, no doubt, but also the members of the medical staff who can read, like anyone else, among the participants in the great and perilous adventure of a close relative in intensive care, what the other redactors have written. In our first version, we considered the notebooks too much as so many expressions of the redactor with regard to the patient; not enough, conversely, as an opening up of the possibility of collecting as much data what other redactor write there, members of the patient's family or the staff who care for him, and, consequently, as erecting the Notebooks as precious observation towers on the way in which others envisage the same situation. We definitely only count with difficulty the point of view from which we see the points of view of others, which differ from one participant to another: it is difficult, even for an adult, to take into account his own point of view as part of the flow of the play of perspectives shared by each, to which none of them can be an exception; and we remain for a long time this child who, counting the members of the group of which he is a part, forgets himself in the counting. Yet this is perhaps the essential operation carried out by the Notebooks: to allow a play of very differentiated perspectives on the ways in which others envisage what is happening. This perspective, therefore, rather unnoticed - and because it is unnoticed- is obviously important for care: to whom is each of the redactors addressing themselves? What does each of those who are not doctors or who have not studied medicine understand about the treatment? Do they consider the full gravity of the situation? Which hope

does each family member have for the success of resuscitation? How do those who knew the patient in a completely different context than the medical circumstances evaluate the situation? What image do they each have of the patient's future? What narrative is the patient's body part of, for each of them? Who is/are the opinion leader(s) in a given family? How would each of them take a proposal to stop the care previously used with a view to healing, if it turned out to be useless? To which family member(s) should the doctor speak? And to which one(s) would it be especially unavoidable doing so? What happens in the family when a breath can tip the scales one way or the other?

The *second* aspect is that the "data" no longer provide us with the astonishment that gripped us when we first read the fifty-two notebooks; they must be revisited from a higher perspective that we acquired by reflecting on the functioning of fictions when they link a supposedly real foundation—that of the medical devices that encircle the patient's body, which follows a logic of technicality and scientificity—to a play of affects that does not follow the same logic as this foundation, although the two logics necessarily intertwine. We will need to delve into the details of this functioning, which has consequences that we were unable to highlight in our initial approach to the fifty-two texts. The main one lies in the inflection - or even the correction - of a suggestion that could not fail to creep into the mind of the person reading our first article: that of a sort of power of someone who, as a doctor or any other caregiver, is the holder of knowledge and who would speak in this capacity to introduce, most of the time, each notebook and, in addition to this prologue, to add, sporadically, some information on the development of the disease and the treatments or corrections to the treatments that it implies. Not that this dimension does not exist at all, but it must be qualified by inverse considerations: we are making here, in this second version, the hypothesis of a doctor in very practical search for support from the patient's family[15] and, to a lesser degree, from the patient's friends and acquaintances. Misled by what we took to be a kind of politeness, we let this aspect slip by without taking it seriously enough. In reality, the science of the doctor is less peremptory than it is of the order of trial and expectation, which, taken in the mathematical sense of the term, was very early established in the 17th and 18th centuries,

[15] The nursing staff and sometimes the doctor himself constantly emphasize the quality of this support when it occurs; this does not always happen or it seems to be paid for in a more or less subtle way in sibylline sentences. This is how we read the expression as curious as it is disturbing or equivocal: "just a little word to prove to you that I care about you" (Notebook 29-412-PS).

with B. Pascal, J. Bernoulli, C. Huygens and T. Bayes. In this last case of so-called "subjective" probabilities, we ask ourselves with what chances of being right we propose such a hypothesis or such a trial (of care for example) rather than another. This expectation jointly and dialectically affects the perspectives that open or close according to the illness and the treatment, which is adjusted to its evolution and attempts to give it an outcome that were neither death nor a conclusion that be too "disabling." This *expectation*, taken in the technical sense of the term, to which the English give the name of *espérance*, echoes a more affective *hope* that the French renders as *espoir*, which is the belief in the cure that each member of the family joins with that of the other members to bring its component which, articulated with that of the other members -because it differs from one to the other- and with medical expectation, constitutes a singular force, on which care relies; which can also be deceived. It is this force that we want to question: what is it? How is it "triggered"? How is it constituted? How does it evolve? How does this degradation into disappointment occur when death becomes inescapable, even though a favorable outcome may have sometimes appeared, for a few brief moments, during resuscitation like so many decoys?

It is not impossible that this interest in the strength of beliefs to which everyone contributes what they can - and which is most often particularly expressed, but sometimes also surprisingly absent - in the notebooks - joins an observation that I certainly did not neglect in my first approach but which seems to me today, on rereading the Notebooks, an approach that must be enhanced -re-ordered, in any case- among the very first plans; one can, summarily, qualify it as "religious".[16] Certainly, it is quite rarely a question of official religion with priest,[17] pastor, rabbi or imam; but rather of a religion that one would have willingly qualified as "natural" until the 18th century, and which, to be more diffuse and less positively identifiable, is detectable in the oaths of love towards the patient (victim of some devastating stroke, of some very serious pulmonary infection), and of declarations of faith in a favorable outcome. I would like to question this "elevation" which, if it is not spontaneous, nevertheless seems so, and to point out the interest that the medical staff has in it, not only because its

[16] At least, it is so that this approach will be discussed at the end of our paper.
[17] This is only a one-time thing, and exclusively for the patient in Notebook 02-661-LR, to receive the sacrament of the sick.

members are humanly touched by this entourage,[18] but also because the envelopment by the device equipment would not be productive of the expected effects without the non-technical envelopment of the affects in their dimension of truth and reality which surrounds the first mechanical encapsulation which divides the patient into multiple functions (respirator, stomach tube, urinary tube, dialysis, blood pressure monitor, etc.) which must be brought together and balanced at every moment. The success of this first entourage seems to depend on an affective envelope that the medical staff does not only discover at the moment of offering their condolences when the illness has gone wrong and the treatments have failed, but which is valid and counts unceasingly, through its continuum, for a hoped-for, unfailing partner in care, without whom what is undertaken in an atmosphere of great improbability of success would achieve no result. The notebook therefore joins its effect in reality or on reality, both through devices and through affects.

All these aspects lead me to a consideration that had until then remained largely hidden from me, that I had noticed but to which I had not attributed the importance that I now consider to be of the utmost necessity: the narration of the illness or of the inaugural accident which involved, as a last resort, resuscitation care, that of the parallel evolution of each, are linked to a staging of a theatrical nature, particularly provoked by the intrusion of the notebooks which transform, in essence, into a spectacle everything that happens in the life of the patient, in that also of his family put in danger, sometimes almost in peril, and which gathers and tightens on itself most of the time,[19] silencing, at least for a time, its quarrels[20] and pouring out treasures of love on the sick or the injured. We know that Elizabethan theatre did not hesitate to bring a scene onto the stage, introducing the theatre - a second theatre - into the theatre, with considerable effects, of

[18] "How lucky you are," writes a nurse in Notebook 02-661-LR, "to be so well supported in these difficult times!" The family echoes that the patient is very lucky to have the caregivers who take care of him.

[19] "When anything affects the tribe, it quickly reforms" (Notebook 10-300-GL).

[20] Such a son finds words of reconciliation with his father and regrets, in the face of the imminence of his loss, "our stupid characters » [« nos caractères de cons »]: "despite everything that has happened between us", he proposes, having placed his hand on a heart that still beats and which reminds us of the fragility of life, peaceful relations. (Notebook 18-632-BE). Another person in Notebook 31-459-LL asks to be forgiven by the unconscious patient by addressing this kind of ideal second personality: "I ask your forgiveness if I hurt you without knowing it". A sister who reproaches herself for not having been kind enough to her brother assures him of her presence alongside those who can say: "We are all with you" (Notebook 29-412-PS).

identification, of location, of warning that we understood what was to remain hidden - with regard to the characters of the first theatre. We can still and always stage a production. It is with this very Shakespearean image, - do we not find in the tragedy of *Hamlet* this process perfectly implemented? -, that we would like to begin our discussion, because its scheme unifies all the aspects we have just spoken about and because it joins a conviction, or rather a philosophical skepticism which will serve as a guiding thread throughout our analyses: the mind is not a substance which would concentrate unity, continuity, identity; it is rather a theatre, as established by Hume, who criticized these notions (unity, continuity, identity) and, as the idea has often been taken up (in particular in the Freudian psychoanalytic enterprise), which does not hesitate, at the risk of materialism), to "spatialize" the mind, to explode, according to several points of view, its representations, its impressions of sensation, its impressions of reflection, to understand its functioning. Because we already suspect this: the theatre is less an image than a true scheme which associates the various heterogeneous aspects of a situation.

But however spatial the scene of the mind may be, it is also temporal. The play evolves. There is a constant redistribution of roles as this evolution progresses. We noted three years ago that "people we might have imagined to be eminent fade away; while others, initially more marginal, soon find themselves propelled to the forefront. The break reveals a cluster of changing roles or a tree structure of roles in constant modification." The problem for medical personnel is to monitor and record, like fine seismographs, these modifications -not to provoke them because that is not Machiavellian, but- to understand what use to make of them in order to improve the patient's state of health. The force -if one can put it that way, since the word has been ambiguous since the 17th century- deployed by the modifications and which also bends them is the very material used in intensive care. We must encompass the determining forces—those of the devices and treatments that modify the parameters of the patient's pathological state and directly perform results—with the reflexive forces of affect, which indirectly achieve some effect.

Those are, by way of preliminaries, the elements of the task we set ourselves to further the work we proposed at the end of 2022, when LUMEN published the first stage of some ethical reflections on resuscitation.

We must start with the notion of *theater*, which underpins all the others in the ethics of resuscitation as it is envisaged through the Notebooks.

On the ethical question, which is the only one that needs to be changed profoundly, I started from the idea that placing a notebook on the bedside table of a patient in intensive treatment, with the freedom given to those who care for him and to all those who have permission to approach the patient -mainly family members- to fill it out, created the conditions for a transcendental point of view on the situation. Indeed, the reflections, the feelings -themselves being impressions of reflection- thus emerged from autism or autarky and were offered to a point of view that was not only mine, but also the point of view of others, exactly as in a demonstration, an analysis, or in the affirmation of a taste by some aesthetic judgment. Struck by the prodigious effect of the simple gesture of placing a notebook on the bedside table of a patient in intensive care, which finds its equivalent in the famous gesture of Columbus,[21] we suggested the idea that notebooks, by their very existence and even before the slightest word is written in them, had two *a priori* forces: that of *intersubjectivity* and that, distinct, of *commensurability*. Without being false, this position -too Kantian, expressed in this form- must be corrected. If it can explain how it relieves the one who contemplates and considers the situation of a close relative or a friend, of a pain that he would have kept to himself, in a schizophrenic way, simply by representing it and sharing it, it is nevertheless too abstract. It forgets that the one who thus shares his misery and his pain, and who thereby manages to diminish it -"a pain shared is a pain halved" says a Jewish proverb- because it is now carried by several people by communalizing it, and by transforming it, not only into a derivation, but also into a force, does not thereby remove himself from the game: sharing only changes the game by *pluralizing* and *replicating* the participation that each takes in it. A spectator who contemplates a scene in the theater is undoubtedly not on the stage, as are the actors he is watching, but he is not located outside the conch or the ovoid of the theater, in which he finds himself embarked for a destiny which, even when it is written by the author of the play, even if it has been prepared by the actors, remains probable and relatively indeterminate. The theater is without a subject; at least the subject who installs himself on the stage or who believes he is watching it is nothing but one function among others; the mind of the spectator is itself a theatre. If discovering a close relative engulfed, caught up and as if swallowed by machines is a distressing

[21] Because of the great effects that can be drawn from small causes.

and upsetting spectacle, the act of writing a few words in a notebook is a derivative of this spectacle, their scriptural content bearing on this mechanical envelopment and consisting of the emitting of wishes to the one whose healing one wishes, modifies the spectacle to the point of introducing another into the spectacle itself; which amounts to embedding the scenes one within the other and creating another narrative about the first; a bit like one can, about a function, calculate its first derivative, second derivative, etc. And above all by engaging in a montage of fictions which builds on "real" entities a whole superstructure of other entities. The distressing nature of these devices which can only heal by substituting themselves for the life of the close relative must be turned to advantage: "we are always so much together because of [in spite of?] these devices which surround you" says one of the redactors to his patient relative (Notebook 22-345-CC). Medical staff need this subtle game to explain what is being done and which can vary from one moment to the next, given the peril of the situation, to make it understood, to obtain at least the tacit agreement of the family members to often take decisions that are terrifying for ordinary people, without having time to consult anyone: a tracheotomy, a deep sleep, medication to get out of it after having caused it, etc. Placing everyone in a common narrative certainly constitutes, behind the stated goal -in which no one can seriously believe- of the reconstitution of a lost continuity or identity, the true goal, tacit, un-avowed, perhaps unconscious, of the issuing of the notebooks. For why would it be important to ensure, even fictitiously, a continuity between the period preceding the coma (artificial[22] or "natural"[23]) and the one that follows it if one wakes up from it, to entrust this continuity to others who would guarantee a continuity to the patient that they could not ensure for themselves? What is the way to qualify oneself as a repairer of breaches,[24] a mender of cracks, a darner of holes when both are mental? Let us describe more closely the unconscious complicity that it provokes and the usefulness of installing it to maximize the effect of the care of resuscitative medicine, to the point that it will perhaps become a characteristic, because we will notice that other illnesses and their care in the hospital do not trigger the same attitude, made necessary by the lasting unconsciousness in which -by his illness or by the care of it- the patient finds himself plunged.

Undoubtedly, the ideal or fiction of continuity is not entirely negligible. If we think, like Hume, that any continuity of the self is an

[22] An artificial coma ordered for treatment.
[23] With the meaning of *spontaneous*.
[24] Following the words of *Isaiah*, 58, 12.

impossible chimera, or at least a highly improbable one, we also think, like Kant, that if we did not have this chimera or if we did not equip ourselves with it, we would be unable to think or put anything in order in a world that was as much our world as that of others. But this claim to repair continuity is probably not what it imagines itself to be, nor does it take place where it is fantasized.

We have suggested that the Kantian subject was not "existable," meaning by this neologism that it certainly allowed us to structure what we think and experience, not only for ourselves but also for others; however, the transcendental subject exists only for our understanding and not for our whole thinking, feeling, and willing being. The framing of theaters seems to us to be more suited to the existing and vital character of the transcendental individuality that we seek. In a certain way, the interplay of transcendental intelligence and the machine that produces artificial intelligence could be translated into Kantian terms; but the interplay of the device's overflow of the vital and the existential and the inverse overflow can in no way be thought of in these terms. The paradox is that it is easier for intelligence and the power of decision to envelop themselves in devices that replace them than for functions such as breathing and heart control to allow themselves to be thus surpassed, overwhelmed by artifices. AI is ultimately easier to accommodate to our "spontaneous" intelligence than the devices of resuscitation to the other functions of our life. Intelligence is less harsh on the intellectual productions by which it surpasses itself, and for which it is enthusiastic, than life is on the other productions supposed to save it but against which it rebels, leading to a cascade of strategies, each as dreadful as the last.

Machines and affects: the double envelopment

The notebook is therefore a stage or a series of theatre stages on which each actor who wishes to enter or leave, appears there, maintains relationships with the other actors or monologues without worrying about them and without the function of subject synthesizing and closing the play of the entrances and exits. Theatre has no subject in the sense that the spectator who would like to enjoy this synthetic function would only be adding to the theatre, bringing himself -whether he wants it or not- an element that he introduces among others. We have already suggested that the theatre has the function of dissolving a little evil and misery; of sharing the suffering of each of its participants with others, without going so far as

to deny it.[25] But the reduction of anxiety is not the only goal sought, consciously or not, by the members of the family, helped in this by the curing staff. The telos is also more generally —because suffering is not the only affect that should be shared— to create an affective envelopment of the patient's first mechanical envelope.

This question is crucial in medicine: we neither treat a body like a machine among machines, nor like a being incorporated into an entanglement of devices; we can only treat an individual who is suffering singularly from their illness and who does not go to the doctor because their machine is broken. But, in intensive care, the individualization of care is reduced in that the person, being unconscious by the very necessity of care, which can only be endured on the condition of this unconsciousness, the notion of treating someone who is not simply ill and who is not simply being treated for this illness—in other words, the notion of treating a being who has life plans—becomes strangely vague and chimerical. And yet, once again, one does not treat a machine: one must therefore (re)compose around the patient a sort of affective context that only those who know him, frequent him, love him, are capable of constituting in order to envelop the patient and make, even if this notion is vague, that one is still treating an individual and that one is not content to repair a being in pieces whose vital functions are all separated and entrusted, in their dispersion and their reunification, to an equipment of devices.[26] One must dramatize this being who, by his absence, is made a hole and a void in spite of himself; it is also necessary that the others, by becoming actors, give this being an individual existence by excepting him from being a mere appendage of a device. The one who is at the center of the scene does not know he is in this position. And this time, it is less a question of making, as in Molière's *The Misanthrope*, the one who refuses the spectacle the very center of the spectacle, than of making the unconsciousness of being an actor the very act of a spectacle so that it is bearable; of thus putting it in spite of itself in the position of an actress of its situation, whose future lies in wait. Completely stripped of its roles, unlike the ordinary patient, who is constantly distancing itself from its illness and identifying with its passions, the resuscitated person -or the resuscitator-,

[25] Except in the rare cases where artificial coma is likened to a lie-in (Notebook 11-303-MS) or refuge in intensive care as a means of having one's bills paid by others (Notebook 14-491-CJ) and a few other pleasant and rather thick diversions.

[26] "The device works for you," notes one of the writers in Notebook 22-345-CC. The functions are made so scattered by the devices that they all have to be regained one by one. "You have bowel movements," notes a nurse to a patient who is slowly regaining the functions that had been entrusted to the device.

while having the main role, cannot do otherwise than delegate it or let it be taken by others in its place. At the center of the game, he is the only one who does not play: he is sick; he becomes his illness; he becomes his treatment. The others are alone to assume in his place the distance without which a sick person is nothing more than his illness and the medicine that treats it is reduced to a mere chain of protocols. The doctor relies on the family to assume this transcendence in relation to the catastrophe that befalls the patient and in relation to what is done to him to get him out of it. Who would the doctor treat if he did not have actors to guarantee his conscience, intelligence, will and passions? The medical act would become terrifying: a monstrosity almost inclining to illegality since the last decades have seen the disappearance of a medicine that would do without the explanation given to the person concerned, both of his illness and of the proposed treatment. Substitution is a necessity. Resuscitation pushes to the limit the question of knowing how far a treatment can go in its de-individuation of the being that we submit to machines as to new authorities that do not address only his intellect but his life itself. The production by the notebooks of a character other than the one who endures the law of machines is an absolute necessity, like that of asking a person who we know to be ill how he is; because it is from there that examinations and treatment take on their meaning. It is certainly necessary that the mechanical wrapping be carried out if we want to give the patient some chance of living; but it is also necessary that this wrapping be itself affectively wrapped if we want it to have the slightest chance of being a treatment; this wrapping being provided by others than the individual so that it takes on, from his point of view, a value.

We have briefly seen that pain can be divided when it is entrusted to others. But this only concerns the pain of redactors, who are also family members or friends who care about the reanimated individual. In our view, there is a much deeper dimension to the question that is not missed by philosophers who have reflected at length on passions and who have refused to reduce them to interests, language, or some other signifier of which they are only the imaginary signified. In his book on *Passions and Interests* (Hirschman, 1977), A. O. Hirschmann demonstrates that this reduction, attempted in the 17th and 18th centuries by a large number of authors, leaves behind, as a remnant, a play of passions that has its own logic, which is neither only that of interests nor only that of language. True in its result, Hirschmann's demonstration is, in our view, too "literary" and insufficiently scientific and mathematical. It seems to us that if Hirschmann had ventured so far as to question a utilitarian like Bentham without stopping too soon at the end of the 18th century, he would have seen that the system of "surplus

value" which makes ΔS with S, which transforms S into S', by adding or subtracting ΔS to S and allows one to start again immediately by making ΔS' with S', etc., in its very logic which seems to ignore affects nevertheless inscribes them in the system itself; for, as Maupertuis (2010, 28, 36) saw well, it is more cruel, when one possesses S, to lose some ΔS than it is happy to gain it. For one is not always a winner at the game of making ΔS with S; one can also lose by indulging in it. And we then find a sort of double reading which gives meaning to the affective logic which one believed to have surpassed as being of no importance. The sequences stylized by ΔS/S, ΔS'/S', ΔS"/S", ... $\Delta S_n/S_n$ can be read as simple games of interests, but they can also give rise to affective readings, the play of pleasures and unpleasantness being inextricably mixed with the Fibonacci sequences which seem to manage the logic of surplus values.[27] In other words: that we make the affective appear as a fiction of surplus values is not enough to eclipse it as if only these should exist. Fiction is not an erasure of the passionate, as the author of *Springs of Action* once believed.

The next step that can be taken in the direction that interests us is the following: the term ΔS/S can designate completely different realities than those of interests and surplus values. If these are enveloped in affects, many other realities can indulge in a comparable type of envelopment. Bentham had begun to see this very clearly in his *Pannomial Fragments* (1828-1831), by showing that various social questions were posed in much the same terms, such as taxes and immigration questions. Is it not to the same logic that in resuscitation belongs what seems to be a rule that could be stated thus: as long as progress is to be gained and risks being lost, it is felt more strongly than it is felt as happy once gained? It is the same story as ΔS/ (S - ΔS) > ΔS / (S + ΔS), provided S and ΔS be > 0. More generally, it seems to us that the issue of balancing the benefit of resuscitation care and the risk it poses to the person who submits to it or is subjected to it is linked in roughly the same way to the prevalence of an affectivity which, admittedly, is dependent on the first game without, however, having its logic. This affectivity cannot fail to exist; it is shared between several heads, the part of the main actor of which is, for lack of conscience, precisely missing. This is where we see the role of the family emerge. Resuscitation care needs the family so that it can take hold in all its diversity of the affective game which cannot fail to accompany the mechanical

[27] It might perhaps be said here that we are seriously simplifying the affective game by reducing it to the game of agreeableness and discomfort, of pleasure and pain. We readily agree, but that is not the point, which brings affectivity to light from pleasure and pain, without making this position into some ontology, as Bentham leads it.

arrangement which grabs the body in an attempt to save it. Neither feelings alone nor medical devices alone can exclusively save, by their respective logic, the one who needs extreme care to have some chance of being snatched from death; a reciprocal entanglement is necessary here. This explains why medical personnel, so watchful to the functioning of families who come to visit patients, are pleased to see their members attentive to the fate of one of them who finds himself in difficulty that they hope is temporary, but which they know well will not remain without after-effects, if they are not even permanent disadvantages. The emotional play that results from the effect of the system of devices that replace the vital functions of the patient must be "taken over" by people whose function cannot be that of technicians; even if perfect technique is necessary on the part of the medical profession. We believe that the topos of the notebook does not only consist of where it is placed on the bedside table of the patient who will perhaps read them one day, but, even more certainly, resides at the fold of the mechanical and the affective or at what we have called the "resumption". It is not a chimerical continuity that is at stake; or if a continuity is sought, it is not that of a subject whose aim would be to repair the breaches made by the injuries of illness or accident -what would it be necessary to say to do this and what would it be necessary to talk about?-,[28] but it is of the continuity of two mutually heterogeneous notions: the mechanical and the affective. We now propose exploring a little more the double envelopment or the double encapsulation of the patient by the mechanical and of the mechanical by the affective. The emotional is so mixed and so riveted to the mechanical, that we cannot be content to treat it as the simple « supplement of soul » brought to a medical world which, in its resuscitative part at least, would be devoid of it.

To make sure of this, let us first see what is put into these terms that we have considered as two bundles that appear to us as incommensurable, but which are nevertheless only partly so. How can we not quote here the remarks of the doctor who admits the incommunicability between the world of devices whose parameters are, at least as causes -if not as effects- well controlled and the psychic world of the patient which remains largely impenetrable, even when we attribute the impressions of sensation, the impressions of reflection and the ideas to a theater? In one of the notebooks (30-337-VF), the sphinx-like silence of the patient indeed draws from a

[28] How could reporting the death of the food journalist J.P. Koffe and dwelling at length on his homosexuality repair the continuity of an interrupted consciousness? How could writing down in a notebook the results of football matches missed by the unconscious subject have this result?

doctor this confidence: "I often wonder what you perceive of what is happening and what is got into you; what you are aware of. We will perhaps have the opportunity to discuss it once the respiratory assistance stops and once we have the pleasure of hearing your voice." The story does not say whether this discussion took place or what it might have produced if given the opportunity.

Two bundles of uses: one entrusted mainly, but not exclusively, to the family (I); the other, almost exclusively, to the medical world (II).

What do these two bundles, which we will number I and II, contain? Which is the real entity of the other? Which is the unconscious of the other?

The *contents of the first bundle*, which we say to be entrusted mainly to the family, are quite composite. They are mainly reduced to two components: the vernacular language and affects. The vernacular language, in that it is the environment in which what doctors and the devices to which the continuity of care is delegated are understood in a non-technical way; in that it is also the environment in which affectivity is expressed in a privileged way. It is in a "Humean" logic that they are expressed. Never does the term *impressions of reflection* to qualify passions achieve greater precision than in the analysis of what happens in intensive care. By introducing a scene within the scene, the notebook also introduces a mirror that reflects the point of view of each person and introduces it into the scene itself. Furthermore, something happens -or at least "is felt"- between the terms of an algorithm (a subject pole, an object pole, an efficient cause pole, a final cause pole, a quality pole, an intensity pole) that can be expressed without getting too technical. The logos "identifies" the passions and participates in the intrinsic limits of each one while also limiting their number which, if indefinite, is nevertheless not infinite. The words to express passions are innumerable in all languages, although they differ from one to another; but they contribute as much to closing their field as to opening it. Moreover, we do not note enough -by taking this remark as a too particular one and not giving it enough extension- that the exquisite sensitivity to words is constitutive of affectivity. This is how the highly coded vocabulary of medical discourse, which readily speaks of a « stable state », to say that it is not getting worse but also that it is not getting better, quickly becomes an emotional issue for the family, which focuses on this seemingly terrifying word over time and waits in its place for the words "progress" and "improvement."[29] Without the language that carves them, we would probably not have passions; and for

[29] See case 22-345-CC where this language problem is explicitly addressed.

the lack of objective consistency that they have, we can substitute signs like presences of absences, unless it is a question of absences of absences. Some redactors are aware of the vanity of these words: "We talk to you, we cry. We write in this journal for this entire period that will be erased from your memory."[30] Management of emptiness and payment in counterfeit currency. The vernacular language, in which the family expresses itself, achieves both the affective expression of the more objective state of health obtained by medical devices accompanied by medical instruments and participation in the modification of this state.

It is obviously because these contents proceed by signs and substitutes for signs that they can so easily become impregnated with religion and superstition.[31] Without being able to claim to "give" strength directly, religion substitutes for a force that is at least temporarily failing to recover health. Without being totally irreligious,[32] the machine is not imbued with religion, if only because of the direct effect it has on things themselves, which at least partially exempts it from its indirect effects. Direct action is its business. By itself, it has little need of indirect envelopment and of working *in the name of* anything else, as does prayer, whose effect the praying person knows well to be indirect and which opens horizons of action only by name and verb.[33] Prayer has its power, which even the agnostic can recognize, but this power is not directly causal: it only works on inflections of action, dispositions, or inclinations toward action; but it cannot change a state of health by having a direct effect on the organs. We are in a world where "thinking very hard about" and collecting the slightest sign can have at least indirect effectiveness, which is no small feat.[34] "If I could only [extricate him from that situation] with a magic wand!" says a wife, perfectly aware of the power she would need but she does not have (11-441-RJ).

A large part of *the contents of the second bundle* is constituted by machines or devices, which separate functions, analyze them, replace them

[30] Id. One might wonder whether the nurse is echoing this desperate sentiment when she suggests that falling asleep may not necessarily be a "blank"; that there are memories of ringing, flashes of light, voices; and that, far from being mere arbitrary stopgaps, there is a rational and causal explanation for all these "memories."

[31] One finds a book in the subway on their way to the hospital and sees it as a sign for the patient's health (Notebook 02-661-LR). Elsewhere, the trinkets of faith are placed around the sick person, supposed to protect him.

[32] In designing devices, does intelligence not compensate for a deficiency that is as intellectual as it is physical, and does it not surpass itself as it would in producing gods?

[33] Let us reflect for a moment on the prayer of which Christ gives a privileged example in the Bible: "Our Father who art in heaven, hallowed be thy name...".

[34] Which he did not have in this case. (Notebook 04-311-EJ).

one by one, and unify them into a synthesis that is achieved not only in intellectual disparity with life, but also as a real substitute for it. For its effect is not a simple influence on mental dispositions; it is powerful and causal; it does not depend only on signs which constitute the essential contents that characterize affectivity. The device executes what it is programmed to do, whether it succeeds in it or not. This does not mean that it is not at all language, neither authority, nor power. But its series of powers is such that, as soon as one has been admitted, it is necessary to admit a cascade of others, each of which has its logic and can no longer be refused once the preceding one has been accepted. It is in and through the device that the small advances which we have represented by $\Delta S/S$ are inscribed, which are wrestled by the causes and which we can interpret in affective terms.

However, we would be very wrong to limit ourselves solely to the technological content of the second bundle. For this content only ever has meaning through the conceptual explanation given, at a stage of knowledge, of the illness and its treatment which results in the patient being hospitalized under particular conditions. This explanation must obviously be understandable by the non-scientist; if this last point is particularly true in medicine and especially when it comes to understanding the reasons for hospitalization, it is also true in ALL sciences without exception. This is why we would be very wrong to take the opposition we have just discussed as a clear break between knowledge and technology on the one hand and affect and the vernacular on the other. *Firstly*, because there is a knowledge, even approximate, of affects. *Secondly*, because there is an affective component in understanding, that Hume called « to conceive ». It is better instead to seek harmony between clusters I and II without allowing ourselves to be trapped in a division of the type: we non-technicians take I and leave II to the doctors; we can seize part of II by transcribing into the vernacular what is technical and scholarly symbolism; no scholarly language can be understood without trying to express itself in the vernacular languages that allow us to *realize* what we say scientifically, but also a vernacular language quickly becomes entangled in itself in saying what the symbolic language says lightly with a stroke of the pen in a half-line.[35] Nor is it a question of knowing which of the two contents prevails over the other; there is a reciprocal inter-envelopment, a bit like the way we have noticed that the machinic symbolic and the affective or the vernacular interpenetrate.

[35] We have written a text on the calculation of points in Pascal's problem of partition, in this sense, allowing ourselves some extension of the subject. See Cléro (2023; 2026)

Schemes

We call *schemes*, in a sense like that of Kant, these links that allow us to join the two bundles of meanings we have just discussed and whose need for connection we have emphasized. We had already explored some of these in depth in our first article, which need not be repeated: the division of anxiety and sadness through shared narratives of the same traumatic event, doubling, mirroring, the tendency to let slip a confidence, a confession, when it risks being one of the last, more generally, the conduct toward the soon-to-be deceased, the reactivation of dormant or stalled family ties at the time of the unexpected admission of a close relative to intensive care. We also mentioned, to turn them into "schemes," the rising of repentance, the feeling of the fragility of life, of the speed of its changes from one state to another.

Let's now focus on those that have not yet been adequately analyzed.

The disconnection puts life and death at stake

> « There is infinite chaos which separated us. A game is being played at the extremity of this infinite distance where heads or tails will turn up ». Pascal B. (1995), *Pensées*, frag. 418 « Infinite - Nothing »

The impromptu break resulting from an accident or a very serious illness reveals the way in which members of a family—whose opinions are not necessarily unanimous on this point—organize their values. Like the one depicted by Pascal when, in his problem of division <*calculation of the partitions*>, a game ends unexpectedly, it has its winners and its losers who could not expect to be definitively so.[36] Even if resuscitation suffers from the image of "falling badly," it is not deficient for everyone in the same way; it could even have its beneficiaries. In any case: nothing is more effective than an unexpected cut to understand how the interests of each are placed. The cut, which only gives rise to probabilities in terms of medical technique, reveals all sorts of valuations on the other vital points of which the family is the topos. A nurse astutely observes that "a stay in intensive care makes us discover a little about our lives, our families" (Notebook 22-345-CC).

Let's pay attention to one point: the break of grief is not the same as that of resuscitation. Let's not say that, in one case—that of resuscitation—

[36] To be winning is not yet to have won; to be losing is not to have definitively lost.

there is still a possibility of evolution while in the other—that of grief—there is none; there is an evolution of grief, just as there is a becoming in each of the effects of resuscitation, but it is not identical to it, even if there are some similarities in the course. The difference lies in the hope that remains as long as the person breathes; the point of resemblance being that, however strong the faith in the person[37] who lives, and then survives, it diminishes with the patient's decline until a point of no return: when the game is lost, all that remains is to "get used to it" and to consider what the person has been for themselves, for others and for ourselves, as a sort of totality to which it is no longer possible to add an act that could change the sum of what they have done, felt, or said. The calculation hardly differs anymore, even if the living person, in their extreme fragility and precariousness, is not a corpse. Even if certain religions speak of the *resurrection* of the dead, as if it were a fact, we believe less in it than in the probability, however tiny, than in the possibility for a patient, even in very poor condition, to come back to life. Why, indeed, would resuscitation, the medicine of the extreme, not succeed in restoring strength and energy to the organism, in resetting its path, even though these have diminished to the point of being almost zero? A breath of life is almost nothing; but, with all due respect to Pascal, the passage through an almost zero is not a passage through zero; and it is no easier to resuscitate than to be born.[38] Certainly, the resuscitated / resuscitating - has also gone too far by exceeding a limit; but if we can say to him "you are still far away",[39] it is because the thing is not irrecoverable. Hence, in addition to this Pascalian theme of the limit on the verge of crossing, that of *force*. This force is sometimes expressed in a naive mode: "you are strong" (Notebooks 01-429-CF, 02-698-BA); "not only are you strong, but you belong to the category of the strong. You resist the illness: it takes something other than what you are currently experiencing to make you submit! "You are a fighter, you will get through this" (Notebook 02-698-BA). Or, more ambiguous in its ideological background, we find the formula: "You are a leader" and "you will come back to us as leader" (Notebook 02-661-LR). The resuscitated / resuscitating experiences a situation that very few beings live, have lived or from which they have

[37] "We believe in you," family members of patients in intensive care often write.

[38] « Atheists. – What reason have they for saying that we cannot rise from the dead? What is more difficult, to be born or to rise again; that what has never been should be, or that what has been should be again? Is it more difficult to come into existence than to return to it? Habit makes the one appear easy to us; want of habit makes the other impossible. A popular way of thinking! » (*Pensées*, frag. Br. 223, Sellier 259, Lafuma, 227) (Pascal, 1995, Laf. 227).

[39] As one of the medical staff members says in Notebook 31-485-DC.

emerged: this experience can confer a particular authority.[40] It could be, however, that, behind the recognition of this strength, it is rather the family wish that the patient does not come to lack it.

There is more: as long as there is life in someone whose probability of dying has become very high, one can still, sometimes, "prepare" for their death; but as soon as the person is dead, it is no longer a question of preparing for it: others must become accustomed to their death, adapt to it as if it were an absolute necessity without any probability or room for maneuver. Sartre (1943, 578) is undoubtedly right to say, against Montaigne (1967, 79-95), that there is no preparation of the individual for his own death, but at most for the idea he has of it; it is more plausible that there is, as long as he is alive, a preparation for the death of others. Preparation for one's own death can only fulfill its role in the future perfect, as in the words attributed by Shakespeare (2023) to the *ghost* of Hamlet's father, lamenting—for some dark reason—that he had been unable to prepare for his death and had succumbed to murder without having had time to prepare for it. This notion of dying while well-disposed to one's own death is important in the Bible41 and in Pascal, who notes that the great always have, at their disposal and in residence, a confessor who conveniently facilitates their passage from life to death (Pascal, 1995, Laf. 984; Sel. 781).

There is another feature that distinguishes the break in the episode of resuscitation from that of death: the former leaves the probabilities open in a sort of tree structure of all possible paths, which is the very essence of the richness of the problem of partition <*indifferently called: the problem of points*>, while the latter removes all parties, since nothing is left to play of which we are aware. The tree and the arborescence give rise to other considerations, namely that, through its roots, the tree plunges into the devices of the second bundle, while the branches are constituted by the affects of the first. What the roots draw from is not the direct expression of what the branches produce. We must contrast the small number of effects of the devices' functions with the relative profusion of affects that can nevertheless come together to create an overall tone (it's okay, it's not okay, pleasure outweighs unpleasantness, or vice versa).

The notebooks constitute a boundary between those who are (temporarily, it is true) in the world of the living, the truly alive, and those who are on the side of the dead, the "almost dead." Like Luke's text about

[40] The theme of *force* will, as we shall see, be counterbalanced by that of law in the next section.

[41] Let us think of the episode of poor Lazarus and the wicked rich man. Luke, XVI, 23-31.

the good Lazarus and the bad rich man, in the Bible, the Notebooks are written by the "living good," not to the dead or the nearly dead, but probably, albeit in a rather surreptitious and hidden manner, to medical personnel to allow them to do their most thankless work.

Beyond might: law

> « The strongest is never strong enough to always be the master unless he transforms strength into right [...] ».
> Rousseau J.-J., *Social Contract*, Book I, Chap. 3 (Rousseau, 2016)

Let us come here to the theme of law, which would counterbalance that of force, as we glimpsed in a footnote. By *legal schemes* we mean these countless declarations: *you cannot do this to us*; *we are not ready. You still have children, grandchildren: your presence is indispensable to them.* Worse: The fact of having placed oneself beyond the dangerous line creates for the one who has placed himself there -or who has found himself deposited there- duties towards those who love him and who have remained on the side of "life." The patient is in the position of a player or an associate who would abruptly leave the game and who would have forgotten what he owed to the other partners. This scheme then takes on a market structure: when one is part of a business, one does not take back what one has put into it without often having to compensate the others for one's departure. Living is an undertaking that requires that one not have the same burdens when entering as when leaving, especially unexpectedly. The patient admitted to intensive care takes on the role of a disloyal partner, who puts himself in a position to fraudulently leave without paying the debt he has accumulated to others who deny him the right to hold him accountable. This is not a simple joke of bad taste, as we have already encountered[42]: we are precisely situated in the position of Pascalian calculation of the partition (of points). Through his coma, whether directly linked to the illness or imposed by the treatment, the patient has left a game without paying the price to his teammates. The illness is perceived by those who bear the costs as disloyalty in business law.

This duty not to leave the game without being obliged to provide some compensation to those disadvantaged by this abandonment is nuanced by the theme of "solidarity": "*We are with you.*" "*We will fight with you.*" "*We are cooperative.*" "*We want to help you as much as possible*"; *and if we*, who know

[42] In Notebooks 11-303-MS and 14-491-CJ.

nothing about medicin*e, cannot, fight alongside the caregivers.*[43] But understand that "*you cannot leave us.*"[44] "*Fight; we need you.*"[45] However, is the matter a question of nuance? Are we not remaining within the same logic, simply hidden? We will return to the question of love, which cannot be treated solely from this angle; but this affect often takes the structure of cooperation, which can take the form of a loan to someone who cannot pay. Love is not often given without a market, and if it eminently contains the dimension of the future, it is with a view to rebalancing. In the process, we activate or reactivate guilt, which lurks everywhere in the Notebooks.[46]

Let us be clear, however, that we are in no way suggesting any medical manipulation to obtain familial love with which to work. Envelopment through love is a necessity, but it cannot be decided. Nor are we talking about medical power: the Claeys-Leonetti law has generally done its work, in France at least; it is now better to speak of medical authority.

The prominent place of linguistic schemes

It is not surprising that, among the schemes, linguistic schemes occupy the largest place. Several remarks should be made here.

The cut is ambiguous: being a terrible rupture in the patient's life, it creates a fault such that, disrupting temporalities, it places, in the extension of each other, strata that do not belong to the same age. This is how the notebooks allow us to enter into complicity with the patient in the "regressive" mode of "papounets", "bichounets", "galinettes", "fillots", "famous", "doudous", "kikis", "Pounes", "tututes", "bilous", "pilous", "patous", "bubuls", "tatas lolotte", "Brubru", etc., which reveal an intimacy with the patient of which only certain individuals ordinarily have the key and of which the patient would probably be ashamed if he were aware because these nicknames are not intended to be pronounced in a public area and are rather intended to close the family universe on himself. One of the redactors reveals that this *cut* allows him to caress his father -something he had never been able to do before-; this caress sounds like a kind of abuse that takes advantage of a taboo by transgressing it. Everything is still tolerable when it

[43] Notebook 33-304-MP.
[44] Notebook 10-440-LI.
[45] Notebooks 33-431-LC, 02-661-LR..
[46] "As I'm going back to work," said a visitor, "I won't be able to come and see you as often, but as soon as I'm off work, I'll come and see you, you can be sure of that" (Notebook 09-390-LJ).

comes to the wife or partner,[47] even if the written sentences are a little embarrassing; but they become more difficult to tolerate when one dares to write: "Alex teases you by saying that he takes the opportunity to touch you because afterward [implied: when you wake up again] you won't want to anymore" (Notebook 27-421-VP). Families feel this and are happy to make fun of a situation that is at least regressive in order perhaps to defend themselves against adversity. One points out, not without a touch of irritation, in one of the notebooks,[48] that a son, already well established in the responsibility of insurer, regresses to the point of speaking of his « dad ». However, regression in the adult can be a strange opportunity for awakening in the child who understands that adults too have had and even still have a "daddy," even if they no longer called him that before he was cured of his serious illness or his terrible accident. "He's improving his language, this little one," says, in the tone of the famous "He's waking up, this child,"[49] a mother admiring her young son who, out of a kind of sympathy, begins to refer to his grandfather by his mother's name "daddy." "Putting oneself in the place of" is an attitude that can be triggered by the spectacle or by the mere presence of great suffering. By this kind of remark, we see again here that the notebook plays completely different roles than the one for which it is put into circulation. One of the most decisive signs of this point of view is, after the death of a patient, the addition of an epilogue insistently desired by a family to thank the doctors despite the death they must face. This obviously cannot be a question of ensuring any individual continuity and we dare say that it was probably never intended as anything other than a mask or a cover.

But language raises other questions as well. In our first version, we distinguished two remarkable types of language, one that we called *tragic*; the other that we called *burlesque* or *booming*. These were two states of language that we called *borderline states*. Things are obviously much more complex. We have, I believe, sufficiently illustrated the first two registers. It now seems

[47] "I like to cuddle you because it calms you down, as today you're really excited about your paws" (Notebook 11-441-RJ). These cuddles, scratches, tickles, resemble small care delegated by the medical staff to the family. Not to mention that "touching others feels good" (Notebook 34-312-PP).

[48] Notebook 31-459-LL: "Laurent gives big kisses to his dad ("my dad" as he says with the same childish tone of his ten years). Yet he is forty and he runs an insurance agency. Well, it's cute!"

[49] Sentence pronounced by Balthazar in *L'Arlésienne* by Alphonse Daudet, First Tableau, scene III.

necessary to us to note that, among so many other states,[50] there is at least a third one that is worthy of note, in that it presents itself as a type of discourse which, linked to dysorthography, seeks, by its very means and with full awareness of its user who is attempting to reverse a defect -that he holds on to- in quality, to express ethical, moral, and religious sentiments that could not be expressed without these errors that take a positive turn.

One of the oddities that we have often learned through our own teaching profession, but that we find here, perhaps even more accentuated, in reading these notebooks, is that dysorthography can be elevated to the dignity of a scheme; it sometimes falls under what one might call the art of the slip of the tongue;[51] but what is even more striking is how, without saying it in this way, those who engage in this dysorthography -because they cannot do otherwise- claim it as having a positive value, like a right. Far from being an obstacle to the expression of the situation, of one's intelligence and of the affects linked to it, the dysorthography of a text, when one takes care, at least in thought, to read it aloud, as if it were a phonetic transcription, can allow one to better understand the person who commits it than if they had submitted to the rigors of grammar. A text can be poetic through dysorthography. Taken to an extreme degree, it can encrypt a message that could not be expressed otherwise; we could almost argue that it can be elevated to the level of an art; something that the redactor we are thinking of is aware of. However shocking it may be for the literary, a prodigious dysorthography can be a proper mode of expression; its grammatical illogic can serve as a scheme between the two logics we have discussed - the mechanical and the affective. Let us quote the two main texts[52] from this point of view:

« dimanche 13 mars 2016

Une histoire de bactérie soi-disant.

Je ne suis pas venu te voir mais ta chère et tendre fille était toujours à ton chevet comme [nous l'étions] moi et ton fils par [la] pensée[. Comme]

[50] Like, for example, whispering beautiful things in the ear.

[51] This is how a doctor wishes "progrets" [« progrès » with a spelling error] to the patient who is leaving the ward. He undoubtedly means « progress » [progrès] but - at the time of writing - the word "regrets" weighs so heavily that it surfaces in its place as a French mistake.

[52] They are concentrated in Notebook 34-312-PP. The same redactor is the author of these two writings.

comme dab[53] j'ai fait mon quinté [quintet ;] tu n'aime[s] + [plus] les cafés mais ce jour la [ce jour-là,] j'avais l'impression que tu étais avec moi. Je tourne beaucoup en rond j'ai repris les mon chéri [les chocolats *mon chéri*, bien connus en France] que tu as piqué[s] dans la boite et que j'ai remis [en circulation]. Tu c'est [sais,] l'hôpital c'est [ce n'est] pas mon truc donc je ne r'este [reste] pas lontent [longtemps]. Ça me fait mal de te voir comme ça. Respire respire je t'entent [t'entends,] moi ton chiant[,] et maintenant [que le torchon brûle et que la mort est proche] matin midi soir je passerai[~~s~~] te voir dans ta chambre quitte à te réveiller. Je viens de tondre le gazon pour que les petites fifilles et m'ont étonnement m'est apparut 2 jonquilles [pour que les petites fifilles soient heureuses et j'ai eu l'étonnement de voir apparaître deux jonquilles ;] m'est pensée était [mes pensées étaient] pour toi [car c'est] ta fleur préféré[e]. J'ai mal à te voir sur ce lit branché à ne je c'est quoi [branchée à je ne sais quoi] pour que tu vive[s]. Merci à tout [tous] ces gens qui sont la [là] pour que tu vive[s]. Merci. Ton homme qui te causse [cause] toujours des problèmes ».

le 15 mars 2016

Ne me jugé [jugez] pas par mes fautes [et vous ne serez pas jugé sur les vôtres].

Comme tout le monde on peut vous jugé [juger] pour [passage biffé].

Aujourd'hui j'ai couru grace [grâce] à toi [;] j'ai oublier [oublié] de [faire] suivre mes papiers de [passage biffé] il ont oublier de me les transmètre alors moi je n'ai pas suivi[~~e~~] (Mutuel[le]). T'est où [Où es-tu ? ;] mais non tu es là je sens ton odeur dans ta chambre. Respire. Tu n'y est pour rien à ce qu'il t'inrive [Tu n'es pour rien à ce qui t'arrive ;] c'est peut-être moi ou autre [cela aurait pu m'arriver ou arriver à quelqu'un d'autre]. Respire [.] Il y a pas mal de fleur[s] qui commence[nt] à refaire surface [;] les bourjons [bourgeons] aussi [;] il manque comme dab de les voir[~~s~~] au soir [.] Que doit[~~s~~]-je faire [? C']est toi qui tent [t'en] occupe[s]. Je suis con [passage biffé] à monté sur le lit elle a pleuré. Je me demande pourquoi c'est faux [.] Je sais. La machine à laver ne tourne plus bizarr [- bizarre -,] pourtant les bac[s] à linge[~~s~~] ce remplis [se remplissent]. Respire. Je pleure. [...] Tu c'est [sais] c'est con [:] je ne me rappelle plus l'émotion de te revoir me faire des recflections [réflexions] comme dab [;] pourquoi tout ça est pour [qui consiste à] vivre heureux sans problème était il si dur[~~e~~ ?] pourquoi [?] Respire. Respire. J'ai

[53] 'dab', which is the title of the role claimed here, designates in French slang the Father, the Master.

besoin de toi. Je suis mal alors que tu as plus mal [:] pas de comparaison [.] T'inquiète tu as de bonne personne qui te suive [Ne t'inquiète pas : tu as de bonnes personnes qui te suivent].

Didi et Ludo sont pour toi [;] il m'ont raconté comment ils tont masser [ils m'ont raconté comment ils t'ont massée] [:] pour eux c'était du bonheur pour [de] te faire du bien la [afin que tu le sentes] tu sentes [;] je les aime et tous ce qui suive avec eux du bonheur [ainsi que tous ceux qui participent avec eux à ton bonheur].

[...] Je t'aime.

Merci pour mes fautes qui font souvent la personne ».

The style is purely emotional: passions seem to jostle each other; and yet no one can deny that the presence of an emotional refinement, that the authenticity of a religious feeling, surreptitiously biblical through reminiscences evoked wisely, can pass through there. Patoche's companion[54] intimates his insights; we move from one insight to another, and we feel that what is written in this way -written, rather than described- could not be said better or in a more singular way and in the appropriate rhythm than through his mistakes. The paradox is that, finding himself relatively disqualified by his mistakes, this redactor can nevertheless claim, not without legitimacy, access to writing. Through a dysorthography pushed to this excess, what we understand best is that we do not articulate our thoughts as we scan our feelings; through what appear to be the same phonemes, we want to say and read something different from each other. The schematism between words and affects (or just as easily between words and concepts for that matter) does not function at all in the same way; its universality only becomes intelligible when we see how the speaker of the language writes it. Knowledge of spelling allows us to measure the gap, not only graphic but semantic, that dysorthography makes with respect to it. Without the former allowing us to condemn the latter, because this very scriptural hirsutism does indeed function as schematism; we would not dare to say -so incongruous would the assertion be- that it is the same here as in Kantian schematism, but finally, here too, it is a matter of a work of the imagination interfering with the logical and assuming, despite their heterogeneity, a passage between

[54] Patoche, one of the important female characters in the Notebooks due to the multiplicity and variety of speeches to which she gives rise, and who will die in the intensive care unit after a long stay.

the intuitive and the discursive along obscure paths. We said, in the little "model" that we proposed, that affects followed their logic only in correspondence with that of medical techniques and devices. We may have thereby seemed to say that symbolism in its difficult and obscure aspects was on the latter side; but what the strange phonetic discourse of the passionate underlines is that it also has its symbolism, even when it is written in the bizarre way that we have just seen in Patoche's husband. Its oddity allows us very precisely to best fulfill one of the missions of the Notebooks: to reconstruct a destroyed intimacy, to recreate a family connivance which, through an opaque text, is more an establishment than a restoration, because it is not a matter of imitating what has been lost. If I say "Cros cros bisous", with a willful fault of pronunciation, I create an intimacy -even if it is annoying for a purist of the language that the school aims to make of everyone- that I could not obtain with "Gros gros bisous": by this voluntary error, I close the family circle and transform it into real support.

We should not be surprised that, on both sides -on the affects side and on the machine side- we find the same schemes at work, working on both. The business of schemes is precisely to unite heterogeneities, provided that one takes a few steps towards the other and even interferes in the domain of the other. Thus, if affect uses, as we have shown, language in order to structure, border and limit itself, it constitutes with mechanical language a sort of caduceus which is the very one of intensive care medicine. If we were to ask which, the device or the affect, plays the role of the real entity, we would doubtless have to answer that it is the device which does so, in particular through its tube which passes the oxygen; it functions as a reality, which is not confined to the symbolic and extends beyond it in all directions: through it, we strive to truly keep a boundary that may have been dangerously crossed away, or to bring the imprudent adventurer back to the right side; provided that the person it helps truly strives and "puts him/her in the effort," as the family does.

Methods of encapsulation are found on both sides. We will examine them in a separate paragraph, which is none other than the following subsection.

Let us conclude this first set of remarks on schemes. None of these schemes is "true"; they accompany the break, and a diversity of behavioral structures directly results from them. They always serve a purpose, even if they are false, because they are in the right direction for healing, for care, at least when it is aimed solely at prolonging the patient's life, without the goal

of curing them. They thus become allies of the medical profession, which encourages them as fantastic assets for care. Ultimately, the flaw in our first version, in its ethical aspects, was to view medical matters in an overly psychological light and overly focused on the patient's family. We did not focus enough on what medical staff expected from the family's help. It is now this aspect of things that we are emphasizing. It is in no way—let us note this clearly—to condemn the medical profession, which surreptitiously suggests to the family, while slyly making them feel guilty, that they should surround the patient with the love they need for the treatment to work.

Return to wraps and encapsulations

> « We are here to support you and surround you with our love and affection.»
> (Notebook 10-440-LI)

Of the two forms of envelopment that act in resuscitation, there is that of the machines: its envelopment is *first*. Without it, the person dies or survives with serious after-effects -or with after-effects more serious than those that would be left by the medical devices -. Envelopment by devices constitutes the last chance of salvation for the patient. Envelopment by affect is the *second*, in the order of time. However, and somewhat contradictorily, it remains the first in the medical order. In ordinary conditions of illness, one does not go to the doctor because one has such and such blood pressure, such and such temperature, such and such pulse, ... but because things are not going well and one would like to get better. So, in that way, the patient is first and foremost a sensitive being who feels ill and who wants to get out of this state thanks to medicine; he could not do it on his own and he is far from knowing the exact causes of his illness -if the doctor himself knows them, because they are often, while being treated, only sought-. But what to do when the patient is plunged into an artificial coma because of the harshness of the care and the constant need to change it? This sensitive origin must be found elsewhere and the question of *how are you?* addressed to the patient in intensive care loses all meaning; one could say of them, playing on words, that they are "displaced" and that this displacement must be played on by transforming it into a positive practice: this is where the family presents itself as a "way out" or a "solution". Certainly, it cannot be forced and, if it is not there, it cannot be invented; when it is there, it functions, despite all its faults, as an incomparable support for the very particular and harsh treatment of intensive care

medicine. Without removing this harshness, which is that of an ultimate medicine, it is a question of accommodating it, of transforming it into the patient's courage, into an appeal to his uncommon resilience; transforming the "mechanical" into the back of a medal struck to pay tribute to the patient's supposed bravery.[55] After all, *valere*, from which the word *value* comes, refers to health and means in Latin: *to be well*. Reshaping the situation by reversing the value of the *front* and *back*: that is the goal. Hence this transmutation of values: the fortune or destiny of the patient are not the game of statistics and probability that the care provided by medical devices are - but they are not frankly opposed to it either. The probable is a game of alliance between what is expected from care - the expectation which, whether subjective or objective, is measurable - and the emotional expectation which is not and is rather of the order of destiny. One could say the same of hope which, at the mechanical and technical level, is understood mathematically; but which is also the hope offered by the members of a family which is - or, if love has a reality, which believes itself or wants to be - loving; not without disappointment in the return because the "awakenings", especially when they result in the survival of the patient, are less enchanting for the family, the wife, the husband, the parents, the children, than when the person was asleep. Reproaches, acerbic remarks, being thrown out of the room are at least as frequent as smiles and thanks. Some of the redactors in the notebooks do not hide their embarrassment or even bitterness at what appears to them as the ingratitude of the patient who does not appreciate the sacrifices that have been consented so that they can come and see them every day, for example, or who considers them normal. In short, health, barely returned and becoming sufficient in the eyes of intensive care medicine, the daily routine submerges almost as quickly as it had been covered and lost upon entry into intensive care. Death elevates the patient, but makes the suffering of care useless; in the case of survival, the daily routine quickly discredits the high value of the medals and coins minted with the patient's image, but which turn out to be counterfeit money. The 'grumbler' takes over again, and banality imposes itself once again beyond the fantasized grandeur of the heroism of having overcome the rigors of treatment;[56] unless the specter of a survivor, more impossible to live with

[55] "We are proud of you" is a phrase often used by family members of a patient facing resuscitation. See 22-345-CC.

[56] This sequence is typical of the case presented by Notebook 31-459-LL. The wife begins by saying: "Certainly, I cannot judge their treatment but I have confidence in them"; but it is to add, a little later, and in a moment of doubt: "I have a lot of trouble imagining the thoughts that must be swirling in your head"; before complaining frankly: "You gave me a

than the living person before resuscitation was, emerges as the reverse of the patient's supposed heroism and the poorly rewarded devotion of the family. Isn't the fear that the episode of resuscitation has left some deplorable after-effects at the back of certain recriminations which certainly never go so far as to attack medicine, but which also cross the line of keeping them to oneself by refraining from writing them in the notebook? It is one of the functions of the notebook to settle on the edge of the conscious and the unconscious, as if at the threshold where repression works. Let us not forget that the recriminations we are talking about are supposed to be read one day by the patient to repair the discontinuity induced by his illness or made necessary by his care.

In intensive care, the device becomes a surpassing of life, to straighten it out, regulate it, save it; it imposes a new way of breathing, with a view to an independence that is currently impossible; it analyzes and produces figures of vital parameters. It has taken the place of the living for the salvation of the latter. This surpassing of life is not unrelated to the overwhelming of "natural" human intelligence that takes place in artificial intelligence. Simply, this surpassing involves all of life and not just the intellect. The device contains an injunction to breathe in a certain way, at a certain rhythm, to have blood oxygenated according to certain standards and freed from urea that the kidneys no longer spontaneously filter, etc. This situation is "intolerable" in the most physical sense of the term: our breathing is not that which is regulated by the machine; accommodation can only be made at the cost of an artificial coma. But the entire operation itself cannot be carried out without a "human" envelope, which gives "meaning" to the undertaking: these words "human" and "meaning" are particularly vague; but no matter: one could go so far as to say that it is because they participate in the "vagueness" that they matter and best achieve the necessary envelope. It is, once again, only too obvious that the notebooks do not fulfill the declared purpose for which they are officially made available to families and caregivers. Their true function is to make tolerable the substitution of machines—or the arrangement of devices—for life to save that life. Hence the sequence and variation of the schemes that we have been able to list and to sketch a few words of analysis about them.

less than warm welcome (perhaps it is due to the clock [passage crossed out], perhaps you forget that I come to see you every day! "). It could not be better said that one does not recoup one's costs, at least emotionally. But this case is not the only one and we find a similar situation in Notebook 10-440-LI.

Here we find our schemes with their dual value: scientific and familial. But this time, it is to ask ourselves why the latter is so highly valued. We propose to look at the latter with a more critical eye. We began to do so by suggesting that the idyllic vision presented either as a reality or as an ideal was not without the minting of fake medals and the payment of fake coins.

Back to family values

> « Therefore if thou bring thy gift to the altar, and there rememberest that thy brother hath ought against thee; leave there thy gift before the altar, and go thy way; first be reconciled to thy brother, and then come and offer thy gift. »
> Matthew, V, 23-24.

We have already pointed out that, while what we called the « cut » mechanically triggers the resuscitation devices and the patient's installation equipment that encapsulate them, it also hierarchizes values: what is the new distribution of domestic tasks? Should this person or that person stop working? Should the young people who follow them cease their studies at least temporarily? In this last regard, we are agreeably surprised to see that families prioritize children's exams and protect their work time, even if the health of a grandfather at the end of his life reaches an alarming level.[57]

This last case is very clear; but there are more sibylline cases, where things are said in the notebook in perfectly encrypted form for the reader who, like us, discovers them, but also perhaps for other family members? Thus, we can read from the pen of one of the redactors in the case of the Notebook 33-461-LC: "We love you, it will be okay. There are ways of speaking to the [passage crossed out], saddened and [passage crossed out] you keep reminding me. There it is said." For whom is it said? The symbolism of affects is decidedly encrypted. The same notebook gives rise to a strange encryption: "I know that you are strong and that you have

[57] This point is particularly evident in the case of Notebook 33-461-LC, where it is noted that the grandfather attaches great importance to the success of his grandchildren. The very high value given to school and university exams, to revision for midterms, to help given on the occasion of a dissertation, which is probably higher than the professional conscience of people who also consider it important to go and see the sick person to reassure him or even just watch over him rather than being diligent at work.

character, so you will fight"[58]; but this ordinary statement is not enough and the author of the statement adds a more secret, a more intimate element: "we also know that you are in harmony with yourself, so there is no reason why you should not get through this." One may be surprised to see these secret ghosts of sibylline morality appear in the Notebook and one understands then how far we are - once again - from the official aim of the Notebook to ensure the continuity of the subject of the patient when he leaves his intensive care unit. In the first case, it is a matter between two individuals, one of whom is the patient; in the second, the secret is most likely an open secret for the family clan, but the allusion remains opaque to the intruding reader, with the contradiction of indicating that there is something to know, while being careful not to indicate what. In other cases still, one does not have to dig very deep into the secret to learn that it is a couple's problem, or that the illness could have some connection with the consumption of tobacco or alcohol.[59] One can take advantage of the *a priori* limit of darkness and light operated by the notebooks so that their authors can play with it. Here the form of the notebook's filling induces content; exactly as the laws of perspective do, which *a priori* induce landscape contents.[60]

Let us understand that the matter is not to question the fact that the patient in intensive care is surrounded, like other patients, by a social and family environment; but it seems questionable to us that a kind of family exclusivity can serve as an envelope for that of the devices that work the sick organism, which moreover reacts to them; not only favorably. Of course, it cannot be disputed that, in adhering to the treatment of the devices, the family environment must be involved. The medical insistence on this point is considerable; and the family is often proud to respond unfailingly. The members of the family suspect that, behind the apparent description mixed

[58] Sometimes, instead of "se battre" (fight), the required verb is "s'accrocher" (to hang on) (as in Notebooks 01-341-AV or 01-429-CF). We can also have: "Tu es fort et tu vas vaincre" (Notebook 09-390-LJ).

[59] We learn by a very small detour that such and such a patient has smoker's lungs, that another has problems with drinking (Notebook 29-412-PS); that all was not well in the couple he formed with such or such a person. These elements are also part of the cut. Elsewhere (Notebook 30-337-VF), it is spoken of "the implacable" and we will never know what it is about.

[60] We had noted this point in our *Théorie de la Perception* (Clero, 2002). In a painting, not only is the perspective on the ground not the perspective on the sky, each being distinct from what happens laterally, but also because the painter's eye, as well as his act of painting, which are supposed to be outside the canvas, can be reversed and appear to themselves as coming from the background of the painting.

with admiration - "You are surrounded, and it is a pleasure to see [it]", "Your family is fighting by your side"[61] - there is a demand that obviously cannot be exercised openly, but which is sometimes barely veiled. Directly echoing a family member's note to a convalescent patient - "All those beautiful words whispered in your ear have been your strength," a nurse writes to the patient in Notebook 22-345-CC: "The energy you have within you and the support of those around you are important factors in your progress." Is this really addressed to the patient, and if he will be among those who hear it, is he the only one? The family responds to what they hear as urgent advice, even as objurgations: "Don't give up, we are with you" (Notebook 29-412-PS). What is certain and unequivocal is that the family seems to be emerging exhausted from an episode of resuscitation to which one of their close relatives is subjected - when it does not end in the death of the patient -; certainly one has to go to the patient's room, travel miles in the overload of ordinary work and various tasks that continue to accumulate (Notebook 04-311-EJ). One could, however, question the exact nature of this fatigue that follows the rhythm of expectations, moments of hope, of despair, of twists and turns from one to the other while things turn out unexpectedly well or badly without knowable regular laws that one can trust, except those of chance that do not remove hazard. Is this not one of those "false fatigues" that Lacan speaks of regarding transferences that do not go well and exhaust the analyst who suddenly frees himself from his exhaustion when, for one reason or another - vacation, illness, need to get away - the treatment must be interrupted?[62]

One might question the almost exclusive choice of family as a source of support. Is it because it is the simplest one? Because we have it « at hand »? Or because the family is still the most stable institution on which we can rely in this case? But, by making the almost exclusive choice of family, are we not arbitrarily and without any explanation directing what serves or should serve as an envelope for the work of devices? This primacy of the family, supposed to love the patient and want their best interests, supposed to know them better than their friends, colleagues, etc., is problematic because of its partisan choice. For it is indeed a choice that could have been

[61] Notebooks 22-345-CC, 09-538-DM, 14-491-CJ. Notebook 14-592-MJ speaks of a patient who is "supported," [épaulé] "coddled" [couvé].

[62] We were particularly interested in this point in our *Lacan and the English Language*, Agincourt Press, New York, p. 225 (Cléro, 2020). Lacan speaks of a difficult analysis of a man with Lucia Tower who found herself tired by the interweaving of transferences and counter-transferences and who suddenly found herself, only by taking a vacation, relieved of a fatigue that she believed to be very long-lasting.

different. Who knows us best and why would it be one or a few individuals in the family? Does the question even have any meaning? The family is worth an envelope that we cannot manage without. Rather than continuity, isn't this what is expected of the family envelope by an arbitrary and deeply conservative prejudice? Only the family is taken into account to give their opinion and participate in decisions when the patient has not given specific instructions from a trusted person; and the truth is that we did not find such instructions in a single one of the fifty-two notebooks. A rescue medicine corresponds to a rescue relationship.

The explanation for the privilege granted to the family—which does not dismiss the previous suspicion of insufficient justification—is undoubtedly the following: the will to be cured, to be treated at least, is as strong in the individual, if he were aware of it and if he could express it, as it is in the members of his family, who are directly aware of this will and can express it for him or speak in his place. This is where the crux lies, this is where the substitution takes place. The family's bundle of voices is certainly not that of the patient himself; but their consistency and their intention, especially if they are worked on by a few on behalf of others, have something comparable and similar that allows them to be taken for one another. Deprived of any symbolic function and any conscious life of relationship by very invasive care, the resuscitating patient cannot receive an explanation of his illness or his treatment; it is therefore necessary to deliver this explanation to someone else or to a few who are supposed to have the same desires, the same will and to have them sincerely. The caregivers rely on this substitution that is necessary at all costs, for lack of being able to count on advance directives which, most often, are conspicuous by their absence. The accident or the illness have suddenly made their cut without waiting for the writing of this kind of provisions. The patient must be replaced as a person in the care service: the patient who is not wanting or knowing anything for himself that is not known and wanted by someone else in his place, if the members of the family were not there, who would do it in any plausible way?

Is it entirely an unexpected coincidence that the alliance between the world of caregivers and the affectivity of the family is encouraged in cases of resuscitation to be carried out through writing, as if immediate and spontaneous expression were not enough to ensure (partially, at least) a perspective of health for the patient in intensive care? Writing seems to effect a kind of inversion in relation to more immediate and spontaneous affectivity: it is probably for this reason that it is favored in this type of care. Writing cuts out, in the emotional, what could be useful for care and

separates it from what, in the affectivity left to itself, could be an obstacle to its smooth progress. The roles must be written, even by the actors themselves, transforming into a theater where each plays his part what would, without this precaution, have all chances of being more chaotic. Moreover, what writing achieves is a commensurability of one author to another, since there is a relative erasure of the author in writing, as the author of the *Phaedrus* has so well shown.

Let us note, to conclude this section, the question of animals, which we have shown in another text (Cléro, 2025-2026) to be an essential component of ethics. Who will feed them? Who will care for them? They seek their mistress or their master. They are part of the family. In any case, this is the case in the Notebooks when a few redactors take the trouble to say a few words about them (Notebooks 11-441-RJ, 31-459-LL).

We still have a few comments to make on the special ties, even in our secular societies, to religion—or perhaps, more generally, to the *Religious*—in intensive care, as they are expressed in ethics at a crucial moment in the lives of families and, of course, of the patient.

Could religion therefore be a partner of ethics—even surreptitiously—in our secular societies? Religion in the Notebooks

> "I pray for you" (Notebook 10-440-LI)
> "I am with you in thought" (Notebook 14-592-MJ)
> "Pupil, Christ of the eye"
> (Apollinaire, 1921, 9).

Regarding the *Religious*, I had previously expressed my clear preference for "a religion that does not know itself, that does not believe itself, that does not know that it is present at the moment when it is most exercised, and which, nevertheless, criticizes and surprises itself at the moment when it seems most plausible. Dogmatic moments are not the best ones of the religions that we usually call *positive*, which, unlike the preceding ones that, by contrast, we consider *natural*, are never as good as when they criticize themselves and reconstruct themselves beyond this criticism." But the notion of "preference" is vague and dispenses with explanation of reasons. We now say that we essentially consider religious an attitude of belief that does not know that it believes; that does not strive, through some dogma or other, to pretend to believe what, ultimately, it does not believe. The unconscious belief that surfaces in the discourse is, in my opinion, the essential dimension of the Religious; what one cannot help believing to the

point that one is not (not yet, or no longer) aware of it.[63] The knowledge that one believes is already a philosophy of believing and a shift from authentic believing. Patoche's husband or companion is perhaps the person who, in the Notebooks, is closest to an attitude of authentic belief.

For there to be ethics, there must be a practical function. Yet it is precisely this characteristic that appeared only in a nebulous way in my first version, which was rather oriented towards "psychological" objectives, certainly concerning the patient (his continuity, his identity, etc.), but also the members of the family who thus shared their anguish and the means of reducing it. The question blossomed when we deliberately reversed the point of view: the notebooks serve care more directly than one might think and quite presently, I mean without there being any need for a bright future that would bring the missing continuity and identity, but as a marker that the nursing staff - and precisely the doctor - can directly and constantly consult: what does the family say to the one whose condition is failing to the point of entering intensive care? What should be done to administer care? Can we detect differences between people's oral attitude and their written attitude in such a way that it is possible to draw useful conclusions from them? Can we count on the family to endorse quick decisions that we haven't had time to advise them of? Because, unlike other types of care, intensive care isn't something we propose; it is something we impose, due to its urgency, its suddenness, and the enormity of its needs. The family must offer its unfailing strength; it knows this, moreover, and feels that it must collaborate with medical care. "We came to visit you [...] it's a way of making you feel our presence and [making sure] that you know that we're all with you."[64] What a strategy in this line and a half! How could a doctor or any other caregiver, reading the sentence, not find in it the kind of guarantee that is absolutely necessary? And how could the person writing it not suspect it either? In any case, we often see the doctor appeal to the strength of the family and the patient[65]—even if the notion of *strength* is extremely vague and of no scientific use—and confide his sadness when the family seems to have failed him in this kind of contribution. Without fully realizing it, those who accept the game of writing in notebooks accept a profound transformation of their emotions and their approach to the illness of their loved one, the

[63] This is exactly the characteristic that Locke gave of religious beliefs and by which he explained the sacrifice that tolerance represents for an authentically religious spirit.
[64] This is said by one of the family members of the case covered by Notebook 34-312-PP.
[65] Having noticed that there was still a long way to go in order to recover, the doctor writing in Notebook 10-440-LI did not hesitate to write this sentence: "We are counting on your courage and strength to get you out of this situation with the help of the whole team."

consequences of which they cannot envisage all at once; the most apparent are not the most essential.

In this text, we touch by the finger what Lacan says about religion in his Seminar VII: a management of lack. This management is cunning and skillful from very early on. The child we have already spoken about, whose mother is surprised by the rapid awakening of intelligence on the occasion of his grandfather's placement in intensive care, does not affirm that he misses his grandfather, but he asks him, thus completing a sketch of sympathy which resides entirely in an affective logic of inversion, if he, as great little self, would not "miss his grandfather." With mourning, there is certainly a lack that appears, but there is another that disappears: that according to which I miss the other. His disappearance destroys this second lack and propels me to the front row of the lack.

As practical as it is, religion does not get bogged down in the ways of causality; it leaves them to the technical and the scientific, when it has the intelligence not to measure itself against the latter. We are not really saying anything at all when we speak, to invoke it or to pretend to describe it, of the causality of God; whether by scientific or religious pretension. The world of religion is a world of signs. It is touching to see family members transform very soon after their visit to the intensive care unit into subtle seismographs of the life signs of each patient -a blink of the patient's eyelash, the opening of an eyelid, a quiver in the fingers, a tiny reaction to the enunciation of his first name-; these emissions are probably and most often imaginary. Families guess this well and are not abused by it although they continue the quest for it. The "touching" nature of this watch and this collection of signs also produces, in its own way, effects that are useful to the doctors themselves. This collection of signs takes us far from the causes and their probability, but we do not contradict them either, and doctors require them in their care.

Prayers escape the causal system; which does not mean that they have neither practical meaning nor value. Quite the opposite: when Christ is asked to give the model for one of them, he teaches remarkably, preaching by example, that a prayer is made "in the name of" (the Father, the Son), has effects only by that, giving us to do what can only be declared in the universe of language without relying on God as a power that gives some strength to the causes. Prayer wants to be powerless, imploring, ignorant, not out of contempt or hatred of causes, but because the effectuation of causes is not its domain; it can indeed (re)activate the domain of causes but without being one of them and only by indirect means: those of language, triggering or inflecting intentions, propensities, inclinations. The request for

healing or for a longer life is made *in the name of* children who have not yet been raised, of relationships with other people that have not had sufficient time to develop, of parents who would be overwhelmed with grief if they were to lose their child. Such is the "tribe" of which one of the redactors spoke and which is reconstructed on behalf of its members when one of its own is in difficulty; its "force" is other than that of the doctors and the resuscitation machines they use. These forces do not hinder one another. From all sides -families, doctors, caregivers -, their collaboration is requested. The expressions "love very much" or "think very much," whether one is close or far from the person and provided that one wishes them well, are religious formulations. The force they invoke or solicit has nothing to do with causal strength, even if one were to ask for its action through the words of the most common language. Those who pronounce them -for example in Notebook 09-390-LJ- know well that these affects or activities have no direct causal influence; but they still indulge in them and cannot help but deliver them. We believe that these thoughts have effects on our dispositions to act; not like phenomena on other phenomena. "We believe in them" to give meaning to the efforts made to heal.

No doubt, in a more superstitious way, and as thinkers of the sacred have often shown, a person becomes sacred when forces that do not belong to him and that he cannot summon by his own efforts, take hold of him. The patient in intensive care knows something that we do not know, which he has nevertheless experienced and which he will probably never share because it is impossible for him to do so, even though he has returned from his illness or his injury and their treatment as if he came from another world. Here we find the idea of a new birth; the device has something of an in-between, which is that of thresholds. "To cure the sick person," Eliade tells us, "We must make him born again."(Eliade, 1965, 106). The way to bear the care is to transform it into regeneration. The medical device would therefore only be bearable as a kind of maternal womb. Of course, one will realize, in the difficult awakening of someone finding their bearings among the existing world, that this supposed transformation—even when we call it *continuity*—is probably counterfeit money; the same counterfeit money we have spoken about and that Mary Douglas (1966) found in the circulation of religion. We pretend to be able to pay for what we cannot afford. In the same superstitious vein, we also find the idea, which transcribes the indirect nature of the powers of prayer, in a request for intercession by specific orators or saints. Isn't Saint Rita invoked in desperate cases?[66]

[66] This is what one of the redactors does, not without a certain irony.

But beyond these cases, incompatible with scientific rationality, there are others which, even in the scientific domain, concern reasons for belief that are no more direct than the path of prayer. With one important difference: however subjective the probabilities may be, they remain measurable, otherwise they would fall outside the realm of science, whereas prayer can make supplications without measurement.

Like the sciences, but in a very different way[67] from what they do, religion is a certain use of the vernacular. We had already begun to outline the problem, in the form of a kind of dilemma: does religion intrude into vernacular discourse through a sort of path of reminiscence that unconsciously follows paths already explored by so many other religious minds? Or, through the vernacular itself, is there an impulse for elevation that we call *the Religious* that occurs and constitutes itself in a fresh, new, and spontaneous way? We hesitated, and, after all, this hesitation is also that of Pascal, who acknowledged the diversity of paths and ways to believe. There are people who believe spontaneously and without any reason, fragment 382 tells us.[68] We should look at this point at how a discourse, academically very deficient, manages to grasp *the Religious* or to produce it. The two texts of which the writer -but no more the redactor- knows that he has *begrifft*, grasped something.

When we say that « Jesus conquered death », as a famous hymn says, we do not mean that Jesus did not die, but rather that things were reorganizing themselves from a place left empty. There is some analogy with what happens in intensive care where the person, no longer able to assume a certain number of important functions and without which there is no longer any life of relationship, leaves, unintentionally, a blank space that allows for the redistribution of roles. The Notebooks have, in this sense, a religious function. The scheme of *resurrection* is constantly at work in intensive care, even if - in French - the expression *réanimation* masks as best it can what the Anglo-Saxons frankly call *resuscitation*, which is the very word that translates

[67] In a very different way because, if the sciences cannot be understood without resorting to the vernacular language, they cannot remain there either, since they would become incomprehensible from the first steps.

[68] Pascal, (1995, 382). Br. 287: "Those whom we see as Christians without knowledge of the prophecies and proofs do not fail to judge them as well as those who have this knowledge. They judge them by the heart, as others judge by the mind. It is God himself who inclines them to believe: and thus they are very effectively persuaded. [...] I admit that one of these Christians who believe without proofs will perhaps not have what it takes to convince an infidel who would say the same of himself. But those who know the proofs of religion will prove without difficulty that this believer is truly inspired by God, even though he could not prove it himself." (Laf. 382; Sel. 414).

the *résurrection* of the French language. Is it not like a resurrection that families experience the moment when they can communicate again with the patient whose relationships have undergone a kind of «blank space-time» ?[69] The substitution of machines for life plays a Christ-like role that implies this kind of suspension of time -even if it is stormy and sinusoidal in intensive care- which, in the days that follow, implies either a vital salvation or a more reassured death. We almost always note this point of inflection when the situation deteriorates without possible return to a healthy life, even if it is somewhat atrophied; a bit like the way in which the survival of Christ -to be understood as a life of surpassing- takes on a different color once the death of the crucifixion has passed to become a diaphanous life that only asks to go on some ascension, several days later. The patient is no longer loved in the same way from the moment when it is no longer conceivable to support him in the ordeal, but to grow through death, as an ideal can do. Thus, after asking the patient for the strength to withstand adversity, we gradually see this ideal of virtue shift towards a request for exception: "You are a strong and exceptional person, rare therefore, come back to us just once,"[70] as if by a miracle of love, much like Christ returns to humanity after his atrocious crucifixion, if only for the famous forty days.

Finally, beyond these traits, many of which are well known, there is a small detail that intrigued us. Perfumes are mentioned several times in these Resuscitation Notebooks. Bringing their patients small elements of care, families do not forget perfumes; one brings, for example, orange blossom water (Notebook 09-538-DM); another a perfume by J.-P. Gaultier (Notebook 30-337-VF). A nurse does not hesitate to write to a patient: "My goal is to make you beautiful, presentable, comfortable, because hospitalization and illness change the physique" (Notebook 10-357-DAV-L). How could these small gestures not recall that astonishing episode of the precious perfume poured on Christ's head shortly before his death (Mark, XIV, 3-9)? This expense, denounced as wasteful by his apostles, found favor with its beneficiary who, far from considering it stolen from the poor, accepted the gift as a benefit announcing his death.

[69] Notebook 22-345-CC is, on this point, particularly edifying.
[70] This is said to the patient by one of his family members in Notebook 34-312-PP.

Some conclusions

"Small causes, big effects"
(Pascal, 1995, frag. 926)

It is not impossible that the Notebooks are panopticons, each time improvised and interesting precisely for this reason; panopticons to which it would always be possible to add layers, like a shaggy but very useful Tower of Babel. At least, this is how we now envision them; their ethical utility for care has become evident in the "afterwards" we present, whereas it tended to be confined to psychology in our first conception of the Notebooks. There is no ideal point of view for seeing things that would extract us from the shifting of points of view. This is what we have called a Bayesian method in philosophy and what we particularly advocate, here, in ethics.

Who is being treated? What is being treated? What are we treating? The difficulty of answering these various identification questions through intensive care becomes more tangible. It is obvious that it is necessary to go beyond the ordinarily accepted boundaries of individuals and the limits of diseases that fall within the commonly accepted classifications. In intensive care, the physician only gains an idea of who he is treating through indirect channels such as family and, secondarily, friends who come, who speak, and who, unwittingly, constitute an envelope that is not a mechanical device. He can gain a very precise idea of the level of awareness these people have of the illness and, through them, of his patient, even though he has never heard the patient's voice.

The family constitutes the patient's boundaries. The physician chooses these boundaries, which would be completely erased if one were to stick to the patient's individuality strictly limited to his ectoderm. Without the family, intensive care would become a kind of exceptional medicine, a barbarity that would marginalize it, given the legal thinking that is now ours in the medical field. Here, we are forced to establish and reconstitute limits at the cost of revealing secrets. Notebooks allow us to read what others have written. We can obtain details about a person's illness that we could not obtain from what happens in the medical file, which is, in principle, consulted only by caregivers who strictly need it to administer the treatment in whole or in part.

Some stories recounted in the previous notebooks end badly, sometimes after weeks of extremely intensive care administered to bodies

already terribly weakened by illness or injury. A typical case is that of the person nicknamed Patoche, for example. It is possible that the new law, being passed back and forth between the French Chamber of Deputies and the Senate, will change things considerably. If a certain latitude is given to the medical team and those responsible for a patient who has reached an incurable state, who is in extreme pain or whose care would be particularly difficult, how could the new law fail to influence intensive care and the decisions of doctors? What doctors still present to this day as courage by shining the bright side of the coin of care which has a flip side, will it retain the slightest meaning when it is possible to avoid the enormity of the hassle that must be inflicted on the patient to make him live a few more days, when - given the symptoms he presents - his probability of dying imminently is close to certainty? Could it not be that, if the new law - soon to be studied by the Senate - sees the light of day, the type of patient with whom intensive care is dealt with changes quite radically? Please understand that notwithstanding taking any "moral" position, our interest lies in boundaries shift that we foresee, for certain cases, to no longer remain relevant.[71]

Epilogue

We have emphasized this point: the envelopment of the patient rescued by intensive care, as an ultimate help, involved the family as a kind of "last resort." Of course, my purpose was not to blame medicine for making this choice; it probably has no other choice to make, and its job is certainly not to deliberately change society and its "fundamental" values. But what I wanted to do was to highlight the consequences of this choice, which, reading the notebooks, often leaves one wondering—if not shuddering—and to make one reflect on these consequences. What do we gain by making serious illness and its last-resort care the family's business? Does the process by which we want to free the patient from the status of a malfunctioning machine and treat them as someone with life plans they cannot directly assume necessarily involve the family? Do they always prove worthy of it? And does it have the capacity? One of the notebooks' writers speaks of the reconstitution of the tribe or clan in the event of a disaster; isn't that precisely what is dangerous? It might be said that we cannot prevent ourselves from living in a Judeo-Christian universe; perhaps, but both Jews and Christians have insisted on the need to leave one's father and mother

[71] We are thinking in particular of the case covered by Notebook 20-524-BP (about which the staff speak of courage, without having any illusions about the fatal outcome.

and lead one's life autonomously and openly to a universality that goes beyond family values.

To tell the truth, I have no solution to change this emergency decision system; but they worry me because of their arbitrariness, which risks seriously influencing medical decisions. I increasingly see these notebooks indicators of a bundle of problems rather than as a—meager—solution for a supposed repair of the rupture of continuity induced by a coma, whether natural or artificial. Small causes, big effects. A simple notebook placed on a nightstand is not without serious ethical consequences.

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