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Revue européenne de psychologie appliquée

Revue européenne de psychologie appliquée 58 (2008) 215–225

Original article

Thwarted activity in geriatric care: The uncertain development of a profession

Activité empêchée dans le soin en gérontologie : le développement incertain d'un métier

M. Litim *, K. Kostulski

Équipe clinique de l'activité, laboratoire de psychologie du travail, Cnam, 41, rue Gay-Lussac, 75005 Paris, France

Abstract

Based on an intervention of the Clinic of Activity conducted in a geriatric ward, we attempt here to characterize the links which exist between the job activities and the profession from a developmental point of view. Effectively, this intervention shows that without the support of a common heritage of ways of doing things, health care professionals must necessarily "take it upon themselves" and wear themselves out in an incessant, uncertain and deleterious attempt to answer the prescription with the risk of "making a state about it". More precisely, we questioned the function of group work, and the workgroup, as an instrument of developing each one's activity as well as the profession, based on an extract of crossed self-confrontation between a nurse and a nurse's aid. We will show how a transgressive activity, reported in an activity analysis with health care professionals, is blocked by the impossibility of being transformed into a resource for job development. Faced with a derealized prescription (i.e., the sense of reality is removed), this transgressive activity is potentially subject to repetition. The absence of a workgroup is deleterious for development: each one strains individually to find, by themselves, a way to get around the problems. In conclusion, we return to the question of ill-treatment. Effectively, according to the authors, the results make it possible to offer new insights concerning this phenomenon.

Résumé

Dans cet article, nous tentons de caractériser, d'un point de vue développemental, les liens qui existent entre les activités de travail et le métier, à partir d'une intervention en clinique de l'activité faite dans un service de gériatrie. Cette intervention montre, en effet, que sans un patrimoine commun de manières de faire sur lesquelles s'appuyer, les soignants doivent nécessairement « prendre sur eux » et s'usent dans une incessante, incertaine et délétère tentative de répondre à la prescription, au risque d'en « faire une maladie ». Plus précisément, nous interrogeons la fonction du travail collectif et du collectif de travail comme instrument de développement de l'activité de chacun, mais aussi du métier, à partir d'un extrait d'autoconfrontation croisée entre une infirmière et une aide-soignante. Nous montrerons comment une activité transgressive, rapportée dans une analyse de l'activité avec les soignants, bute sur l'impossibilité d'être transformée pour devenir une ressource pour le développement du métier. Face à la prescription déréalisée, cette activité transgressive est potentiellement soumise à la répétition. L'absence de collectif est délétère pour le développement : chacun s'use individuellement à trouver seul les moyens de sortir des difficultés. En guise de conclusion, nous reviendrons sur la question de la maltraitance. En effet, les résultats de notre travail permettent, selon nous, de renouveler l'intelligibilité de ce phénomène.

Keywords: Work analysis; Geriatrics; Activity; Job; Development

Mots clés : Analyse du travail ; Gériatrie ; Activité ; Métier ; Développement

The summer of 2003 highlighted a major social problem. The number of deaths among the elderly during that scorching summer raises questions regarding the system of assistance that is dedicated to them. The care of dependent elderly individuals has since become the object of particular attention,

* Corresponding author.
E-mail addresses: malika.litim@wanadoo.fr (M. Litim), kostul@cnam.fr (K. Kostulski).

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doi:10.1016/j.erap.2008.09.005

and at the same time creating a focus on ill-treatment in gerontological establishments (Debout, 2003). While the transformations in the hospital environment are quickly put into place, they leave less "high return" activities in the eyes of society which remain unresolved. Such is the case of long-term stay wards, which remain largely in the background of hospital changes and beyond social preoccupations (Pellissier, 2003).

Our intervention began in the winter of 2002–2003 in a ward for medium and long-term stays in an *Assistance publique–hôpitaux de Paris* (AP–HP)[1] hospital where the general ill-being of the health care professionals seemed to resist all attempts to find a solution for it. We observed, quite quickly, the absence of a workgroup and, consequently, of group work (Caroly and Clot, 2004), leaving each of the health care professionals[2] alone to face work dilemmas. Questions concerning the profession are no longer raised except through interindividual conflicts, leaving the workgroup even more devoid of any consistency.

1. The nursing activity, but which one?

Numerous theoretical perspectives of the nursing activity see in it an activity which strongly mobilizes the subjectivity of the health care professionals. By referring more or less explicitly to the concept of 'burnout', the majority of these perspectives emphasize the difficulty of the relationship between health care professionals and patients. A perfectly illustrative point comes from the psychiatrist-psychoanalyst Goldenberg (1998): "if it is necessary for someone to take charge of the elderly and death and that this someone be a health care professional, then it is not surprising that this health care professional suffers" (p. 25). Burnout would then be an illness endemic to the relationship of care itself. In the face of this observation, the different perspectives aim at answering an overwhelming demand to reduce the effects of suffering in a significant way. One of the most common answers is to set up talk groups which aim to "remove the health care professional's guilt before he takes refuge in mechanical work" (Ruszniewski, 1999, p. 33). However, talk groups are not sufficient to find a solution for abusive acts of which the patients are often victims, and, at the same time, the handbook of "good practices" aims specifically to "make a norm" out of the health care professionals' behavior (Debout, 2003). Thus, the conceptualization of nursing activity is the object of a social consensus: on the one hand, it is a behavior, and on the other hand, it is an intersubjective relationship.

But this dualistic vision of the nursing activity fails to bring lasting changes to the environment (Clot et al., 2005), and at the same time renews the classical dichotomy which exists in psychology between behavior and subjectivity.

[1] Publicly owned hospitals.

[2] The generic term 'health care professional' designates, in fact, three categories of personnel: nurses, nurse's aids and the administrative staff.

1.1. Activity as a unit of analysis

In a perspective which he defined as historical psychology, I. Meyerson (1987) viewed work as "one of the principal activities of human societies, perhaps the principal, as the basis of society" (p. 252). From a cultural point of view, J. Bruner (1996) claims that "it is the most human activity there is" (p. 201). The activity of work is an activity which allows a subject to be a part of the society and to develop it (Clot and Litim, 2003). It then carries a social meaning of which each individual is a producer and answerable to. From our perspective, activity is social and psychological: it is at the center of humanity, always addressed to the other and to oneself. It puts the subject, the others and the objects of his activity in contact, and always in a singular manner.

This point of view is always taken in conflicts of criteria. What appears to be fundamental values in the hospital are opposed: profitability versus the quality of care, euthanasia versus prolonging life by technical means, ill-treatment versus compassion, etc. From our point of view, these confrontations, these "conflicts" of values, of interests, are central to the individual and collective work activity, a driving force of its development. In other words, we propose to look at the activity, not as a behavior determined in advance, but as the center of the conflicts which is directed at behavior (Vygotski, 2003). If, for all that, working is answering a prescription, fulfilling one's task, the activity can never be reduced to what was done. The *actual work* (of which one can find traces) does not have a monopoly on the activity. The activity is also the *real activity*, in other words all that one could not do and what one would like to do, all that one no longer does, all that one does in order not to do what is to be done, etc. The actual activity is the activity which conquered all of the possible activities most of the time, that which makes it possible to fulfill one's task in spite of everything. However, the other activities do not cease to be possible ones, and press with all their might on the actual activity (Clot, 2002a). Thus, the suspended or adverse conflicts remain present. Our developmental point of view is largely inspired by the works of Vygotski and the historical-cultural school which aims at explaining historical, social and cultural processes in the realization of activities and the development of human activity. These processes must not be regarded as only constraints but also as the "*organizers of the activity*" insofar as they are components of the functioning of the activity (Deleau, 2004).

We can pinpoint four organizers of work activity, four *authorities* which preside over conflicts of work activity (Clot et al., 2005), as follows.

1.1.1. The impersonal authority

The *impersonal authority*, in other words the tasks and procedures, is on the side of the prescription. First of all an endogenous prescription, it contains the rules of the profession, the common values, etc. An exogenous prescription, it contains the rules produced by the Institution whose vocation is the organization of work activities from a societal perspective. The impersonal authority is not uniform, homogeneous. On the

contrary, it carries in itself the fragile and faint conflict between two sources of tasks.

1.1.2. The transpersonal authority

The second is the *transpersonal authority*. It is the result of the history and the reorganization of work by those who do it at a given, but never a fixed, moment. It states how to handle things and people in the situation, what one must do and what one must not do. From this point of view, it is a prescription stemming from the workgroups, a result of group work [the *professional genre* (Clot and Faïta, 2000) of which it is both the source and a constraint for the action. It is prescriptive, but also a resource (it enables effectiveness)].

1.1.3. The interpersonal authority

The *interpersonal authority* is characterized by interindividual relationships, whether they are hierarchical relationships, between peers and larger relationships with those who have the same job or the same work objective. To these are added relationships with the direct or indirect addresses of the actual work.

1.1.4. The personal authority

Finally, the *personal authority* is composed of the entire subjective and personal dimension of a subject involved in an activity: his personal history, particularly his professional history, that he seeks to bring back into play.

The discrepancy between these four authorities, and also within each, is the opportunity for development, on the condition, one could say, that it is a creative discrepancy (i.e., a resource for the situation). Thus, in his relationship with the patient, the health care professional is not only in an intersubjective relationship. Nor is he not only in a behavioral relationship predetermined in advance. The health care professional aims to use all of the resources available: what he has the right to do, how he has the right to do it, why he does it.

When the activity does not have the resources to be developed, it is enveloped by suspended conflicts whose psychological cost is important. A prisoner of repetition (Clot, 2002b), it imprisons the professional in his possibility to transform the task into an experience, as a means of living new experiences. This isolates him and he wears himself out by taking it upon himself to manage to do what is to be done, or more precisely what he thinks must be done.

1.2. Workgroup and group work

The workgroup is a mediator in that it participates in cultivating the real: confronted by that which exceeds tasks and procedures, the professional uses the group resource, effective compromises elaborated over time. He is then never truly alone in carrying out his tasks, but enriched by ways of doing and ways of talking that have been tested in the course of the history of the profession and reconfigured by the history of his work environment.

However, this collective resource is never something fixed or finished. It must be constantly transformed in order to continue to be the work tool. In other words, the development of the collective resource as a work tool is a condition for the realization of work activities, of developing the profession as well as developing the individual. The workgroup, as a means of transformation, comes in between the prescription, the organization of work on the one hand and the professional on the other hand: restructuring the organization and restructuring the group work activity. Caroly and Clot (2004) emphasize that "the absence of a group production of shared obligations between professionals in order to confront tests of the real lead to a transgressive circumvention of the regulation. This circumvention leads one to 'wander alone across the expanse of possible blunders' (Darré, 1994, p. 22) (p. 50). Based on *group work*, the *workgroup* develops its power to act in the different situations encountered. One could say in return that the collective elaboration of the individual and collective experience is developed even more so since the workgroup remains alive, confronted by a reality from which it attempts to emancipate itself.

The two possible futures of a workgroup should be noted here: a future which develops or a future which envelopes (Clot, 2005). From another perspective, it is this last point that the psychodynamics of work demonstrates when it conceptualizes the way in which workgroups can elaborate *collective defense strategies* against a reality that they no longer succeed in civilizing, in order to avoid becoming ill (Dejours, 1993).

1.3. Work activity and the profession

When underlining the singular and unpredictable character of the activity, we must also note the dynamic character of the profession. We can look at it as a task, as a history. First of all, the profession is impersonal because it is a task. It says what must be done and how to do it. But here it is necessary to look at the task as an automatic activity, as the compromise of activation at a given moment (Clot, 2002a). In other words, at an exact moment, the profession is considered as the result of the possible actions done to fulfill a mission. Continuing along this line of thought, the profession is also a history: a history of its development, its transformations, its breakdowns, its work environments etc.

In short, the profession is always the result of work activities. Practicing one's profession is also aiming to fulfill one's task by following procedures (i.e., by aiming to develop its impersonal dimension). But it is also transforming – as history – as an activity which is always singular, but in which one puts "oneself". From this point of view, work is a resource for the profession.

The job, a work tool, is also the result of the work of workgroups. In this sense, it also has two futures: eventually it both remains alive and in the service of its "practice"; or it disappears. We agree here with the sociologist M. Descolonges (1996): "A profession does not exist in spite of people (. . .) A profession is only perpetuated on the condition that the *people make* it live" (p. 249).

2. The intervention in a long-term stay gerontology ward

We were contacted in 2002 by the *Comité d'hygiène, de sécurité et des conditions de travail* (CHSCT)[3] and the management of a Parisian hospital complex to attempt "to improve the working conditions and to reduce the feeling of ill-being of the health care professionals" in a medium and long-term stay geriatric ward[4].

When we met with a workgroup composed of members of the CHSCT and the management to consider an intervention, all of the members agreed that certain indicators were a source of concern: a significant rate of job vacancies; strong mobility; a high rate of absenteeism; numerous accidents at work; Musculoskeletal disorders (MSD) etc. The decision to "put themselves in the hands" of exterior interveners was motivated by the fact that, at that point, all of the actions carried out with the aim of changing the situation had ended in successive failures.

2.1. A ward "in pain"

Two years earlier, following the arrival of a new chief of service and a new senior manager in the gerontology ward, new medical directions were taken, particularly concerning the population of patients admitted. Prior to that, the ward functioned as a "small nursing home", it now admitted patients who were very dependent and suffering from severe pathologies and dementia. The opening of a nearby geriatric hospital accelerated the change since the most able-bodied residents were transferred there. This change disrupted the ways of caring for patients, thereby highlighting their ineffectiveness or inadequacy in the new situation. Several employees, considered to have exhibited non professional practices with patients, were transferred to other wards. Moreover, this change was accompanied by the closing of several wards and a restructuring of the teams.

Actions were carried out to follow up the restructuring. An ergonomist intervened in order to provide the ward with "ergonomic material" which has been stored since then in junk closets. Training courses as well as accompaniment were offered to the health care professionals with the goal of developing their methods of confronting these new multidependent patients requiring attentive treatment. Finally, a talk group, animated by a clinical psychologist, was proposed to allow the professionals to talk about their problems at work. In spite of these measures to reinforce the professionalization of caring for the elderly, complaints concerning the conditions for the realization of work persisted among the health care professionals. Moreover, the ward continued to have serious problems. In addition, it had a difficult history, referring to a specialty in medicine which had been degraded for a long time.

[3] Committee for hygiene, safety and working conditions.

[4] We quickly agreed to orient our work uniquely on the long-term stay wards since the health care professionals there were in much greater difficulty.

2.2. The intervention in spite of everything

In this context, the management, unions and us (the authors) hypothesized that the ward's history was too difficult to allow for a satisfactory development of the ward and the health care professionals' ways of working. Nevertheless, the chief of service and senior manager saw, in this hypothesis, the denigration of their own work. We then agreed upon a second working hypothesis: *the conditions for performing work appeared to be so deteriorated that the changes carried out over the past two years did not seem to be sufficient to decrease the ill-being of the health care professionals in a significant manner*. Our intervention, projected to last 18 months, aimed at understanding the hypothetical link between the current ill-being at work and the history of the ward in order to then collectively reconstitute the base on which the health care professionals could take in hand the future of their profession and their professional activities.

2.2.1. Methodology and method of intervention

The Clinic of Activity is characterized as a fundamental research method in the field, "linked on the one hand to the transforming action of situations and the elaboration of appropriate instruments and, on the other hand, to the knowledge of these transformations in a combination yet to be constructed (Clot et al., 2005, p. 16). Our methodology aims to take up the history, to show the pathogenic conflicts in the deteriorated work environments in order to make those who work transform the future. Thus, one can show the developmental possibilities. However, such work can only be done in an indirect manner. Effectively, taken up by his daily activities, the professional uses automatic reflexes of which he is no longer conscious. But these automatic reflexes are the result of experience: individual and collective experiences of work. They are the fulfillment of activities of which the real is not accessible in the course of action. These are in the service of efficiency in most of the cases, but they can also act as brakes on efficiency. If our methodological aim is to develop the workgroups' power to act, our tool is the movement that the professionals implement in the face of their work activity.

Thus the method of crossed self-confrontation makes it possible to install a dialogic framework of co-analysis. This is done in three distinct phases which are presented here from the point of view of their objectives. The first phase has several aims: in addition to identifying problematic situations and constituting a small working group, it makes it possible to understand the professionals' work in their everyday life and to listen to the different representations of one and another concerning their profession and its conditions for achievement. We then attempt to push the health care professionals to go beyond the preconstructed rationalizations which would explain the situation. This being done, they are invited to rethink their collective and individual capacity in order to be able to act on the situation. But, in addition, the professionals have two new activities during this phase. The first consists of being constrained by the researcher who pushes to go further than what one sees. Our observations, our questions bear as often as possible on the

discrepancy between what one can see and what is really done. The health care professionals then complete the first experiment on the substance of the activity, "intrinsically" not reducible to the realization. The second is the result of the observation situation itself. In the eyes of others, the observed becomes the observer of his own activity, which then becomes the object of reflection. H. Wallon (1983) explains this remarkably well: "By some sort of very elementary contagion, the attention that the subject feels fixed on him, seems to force him to observe himself. If he is acting, the object of his action and the action itself are suddenly supplanted by the purely subjective intuition that he makes of his own person. It is like anxiety, an obsession with the attitude to adopt. It is a need to adapt oneself to the presence of others, which is superimposed on the act of execution" (p. 287).

The second phase, strictly speaking, is that of the self-confrontations of the small working group. Sequences of activity are filmed. In the first stage, the professionals are "confronted" with their images in the presence of the interveners. These are the simple self-confrontations. Then, two by two, they are again confronted with their images as well as those of their peer: these are the crossed self-confrontations. The co-analysis, such as it had been set up in the crossed self-confrontations, encourages the development of thought which one can pinpoint in the dialogic sequence (Kostulski, 2005). What was a source of dialogic activity in the simple self-confrontation could become a resource for two new dialogic activities in the crossed self-confrontations (Clot, 2004). Through this work of "generalization" – the passage from the source to the resource – the health care professionals can examine the elements of the real of their activity by using the escape hatches proposed by the dialog, by reexamining the possibilities of the performed activity.

Finally, during the third phase, the results of the small working group are then discussed within the work teams. These results are still provisional, the realms of possibility still indexed on transforming into the achievable. The professional controversies and debates between theories are decisive: the activity of each individual draws its paths of development from the group work.

2.2.2. *The intervention caught up in the history*

The first phase of the intervention had been particularly chaotic. The civil service employees went on strike for several days and there was work done in the building which required moving the wards repeatedly, thereby disrupting work. Several weeks after our arrival, the management took disciplinary action against four nurses for "extraordinary ill-treatment". Finally, the managing head nurse of the ward, who was respected by the health care professionals, found himself evicted from the ward under pressure from his fellow ward managers. Thus, we met with health care professionals who showed indifference or skepticism and even suspicion about our intervention. The change in the hospital management, followed by the scorching summer, also had effects on the course of the intervention, which did not incite much more interest among the steering committee than among the professionals themselves.

We considered ending the intervention at the end of the first phase in conformity with our commitments[5]. Only two health care professionals had expressed a desire to work with us. Others had renounced when we found pitfalls along the way. We then announced our departure to the union representatives (who were behind our intervention), the Chief of Service, the head managing nurse and to the health care professionals. While most of them expressed a desire to leave this ward, our announcement reinforced this: according to their experience, it was impossible to work in this work environment, and it was the same for the external interveners. This reinforced the feeling among them of having reached a dead end. However, four health care professionals did not accept this renouncement and committed themselves to initiate working with us in the hope that others would join us. Since the ward included more than one hundred health care professionals, this small amount reinforced the marginal character that the steering committee appeared to give to our intervention. Nevertheless, the second phase could be carried out almost as normal[6].

However, the intervention stopped before the deadline. In addition to the institutional and organizational instability, the hospital manager decided to close the long-term stay ward, thereby preceding the national directives. The heatwave in the summer of 2003 had shown serious deficiencies in the system of assistance and care for the elderly. According to the management of the AP–HP, the long-term stay wards were not adapted to the structure of the *Centre hospitalier universitaire (*CHU)[7] and the decision to "relocate" these services to specialized structures proved to be less costly. Today, only acute geriatrics[8] remains a specialty of the CHU.

The work we had begun found itself cut off from legitimacy. If we ourselves were convinced that the issue of developing the nursing activity in gerontology exceeded the framework of the local situation that we had met, the disengagement of the hospital authorities obliged us to renounce its pursuit. Today it seems that the clinical benefits of our intervention were only personal benefits for the four health care professionals concerned.

3. The nursing activity in gerontology: a poorly evaluated activity?

Returning to our hypothesis, according to which the conditions for the achievement of work appeared so deteriorated that the changes made about two years ago seem insufficient

[5] We had agreed that if the health care professionals did not want to participate in our intervention, we would stop at the end of the first phase. We had already pushed the date back several months.

[6] However, we added some modifications. As a rule, we organize crossed self-confrontations between work peers. In this way, unresolved questions about the job which drastically reduce its natural development can emerge through these controversies. In addition to self-confrontations between nurses on the one hand, and between nurse's aids on the other hand, we decided to organize crossed self-confrontations between the two categories of health care professionals. We attempted to bring up the subject of gerontological care with its daily constraints, to go beyond the technical jobs of the nurse and the nurse's aid.

[7] A university teaching hospital.

[8] In fact, the research found its resources in this specialty.

to reduce the ill-being at work in a significant manner. A large majority of the health care professionals referred to the history of the ward to explain or justify the current situation, its obstacles, contradictions and its insufficiencies. Nevertheless, when one attempts to obtain more precise explanations about this history, it was "stifled" even though everyone had been a 'spokesperson'. Even if we had been aware of some elements, it appeared to us that the essential parts were intangible or unspeakable.

When we asked one of the last guardians of the history of the restructuring of the ward, who was resigning, what he would say to his hypothetical replacement, he even refused to mention it for the sake of not "*dragging down the job with the history*". The history that he had in his possession because of his experience in the ward was, according to him, "*a bad thing that one keeps inside*".

The nursing job in gerontology is extremely difficult. Being confronted daily by old age, physical and psychological dependence, the deterioration of the body, the violence of dementia, the social and familial isolation of the patients, and also death cannot be reduced to triviality. Consequently, the questions which are raised by the nursing activity are continually aggravated because they cover dimensions which go beyond the "technical" practice of a medical specialty. At the same time, these questions refer with great ambivalence to the desired solicitude concerning the elderly, the fear of growing old, but also and particularly to the former strategies of defense constructed collectively and maintained in the history of caring for the elderly.

3.1. The "plagued" history of the ward

The history of a professional environment is the crystallization of compromises which it was necessary to make at a given moment to be able to continue working. It contains the stories, ruptures and developments in this professional environment. It allows each one, in his present activity, to be rich with the common heritage of appropriate ways of doing. Thanks to this heritage, the professionals do not have to reinvent the professional acts each time. In return, the history can be enriched at each moment by the most effective compromises of the activity. The history is present in each act, and it is exactly on this occasion that it is renewed in order to remain alive. The history that we are speaking about is in fact the crossing of several histories: the history of the ward (i.e., the successive organizations of the work, of its different teams and the patients that it admitted); the history of the hospital; and finally the history of geriatrics. The job of nursing in gerontology is found at the center of this history.

> Since the 19th century, at the same time when hospitals provided medical care, hospices were founded to take in the disabled, the elderly and the unfortunate. Then the evolution of the distinction between care and taking people in within these hospital missions ended in 1958 with an order concerning hospital reform which encouraged the creation of nursing homes, but without real consequences. The hospital institutions continued to provide both care and lodging in the hospices. Until the late 1950s, the only public measure taken in favor of the dependent elderly was to place them in a hospice in very precarious material and sanitary conditions. The Laroque report on "the policy towards the elderly" published in 1962, constituted the first step towards a reform in health care for the elderly, and was followed by the law of December 31, 1970 which redefined the mission as a unique mission: "to give medical care", thereby liberating it from its mission of lodging. But beginning in 1983, the transformations of the hospices into a place to live with appropriate hotel-like comforts and good living conditions were largely amputated by the financial constraints set by health insurance which forced the hospitals to continue the service of lodging. Nevertheless, it thereby implicitly established the distinction between the fields of health and the social, consequently the "lodgings" in the hospital were transformed into "continuous care", thus creating a division between the hospices and the nursing homes. The law of January 4, 1978 clearly stated that the hospitals could include "hospital wards for medium-term stays for convalescence, course of treatment, rehabilitation or treatment of mental illnesses" and "wards for long-term stays insuring lodging for individuals who were no longer autonomous and whose state required constant medical supervision and support", thus setting out the criteria for disability among the elderly. Finally, the hospital law of July 31, 1991, which modified the law of December 31, 1970, clarified the objectives of the medium-term stay wards "with a goal of rehabilitation" and the long-term stay wards as those of "giving long-term medical care".

The Medium and Long-Term Stay Ward (MLS) has had a "bad reputation" in the hospital for a long time. Its geographical location within the hospital (in the back, next to the psychiatric ward) somewhat reinforced the idea that it was not an important ward. Care for the elderly had been discredited for many years. It seems that the MLS had been abandoned by the Institution, the latter permitting the use of non professional practices, or what were judged to be so later. Excluded from their professional world, the health care professionals who worked there could not rely on the developments in their profession, in other words on the rules of technical and relational acts which are at the base, and upon which they could have found ways to do what had to be done individually and collectively in their everyday work life. The young nurses in training had no desire to begin their careers in this ward: later on, they would have risked losing a position in an "ultramodern" ward dominated by technology. Management strategies attempted to make up for this retreat from the specialty: a nurse was hired at the hospital by negotiating with him a position for several months in gerontology followed by a transfer.

Finally, the history of the ward itself is formative. The choice of a chief of service to take in residents with new pathologies naturally had an effect on professional practices. Accepting residents with serious pathologies, particularly those linked to dementia and dependency, required new technical acts and new relational methods. A consequence for the health care professionals was the reevaluation of the professional acts, which seemed impossible or continually suspended in the situation.

Consequently, it had become impossible to transmit the profession. Because speaking about the profession – in the sense of its praxis – means to say precisely what the proper thing to do is in its daily practice, in other words the ways of doing things in each situation. Hence, it involves informing about past arbitrations, it involves raising history. But the latter does not seem capable of being spoken about. More precisely, we realized quite quickly that raising it meant taking a risk. In fact, it remained tacit and could no longer be a resource for the activity, and therefore the new arrival was left to "carry out his own experience", in other words to confront the enigmatic rebus that the organization of work had crystallized based on this history, but moreover without great hope that he would manage to find a way out of the impasses which the experienced professionals themselves did not succeed in doing, stifling the transmission and condemning the renewal of the profession.

3.2. A thwarted activity

According to the health care professionals in this ward, the greatest difficulty is being unceasingly under tension, a contradiction between what one thinks should be done and what is prescribed or what the work organization allows. It is also not being able to evaluate the result of one's individual activity because it does not have a collective respondent, it is attempting to answer only the prescriptions of a continuously changing context[9], at the risk of losing the endogenous prescriptions of the profession. Thus, it is, in fact, often no longer knowing what must be done, and quite often giving in to the temptation of defensive answers.

In a real life situation, doing correctly what one has to do and insisting upon it supposes being able to find resources in the job and thus intercalate the rules of the profession between oneself and the other (the patient, the co-worker, the hierarchical supervisor). These rules remain alive on the condition that they are discussed and renewed within the work teams while keeping in mind the patient's interest. In this way, the protocols of health care to which everyone is attached can be rethought collectively, and a health care professional can know what must be done and, at the same time, give meaning to his activities, a meaning which offers the possibility of individual and collective development.

However, this collective work of renewing the rules is absent in the long-term stay ward. A protocol of health care can be lost among the individual activities which are sometimes contradictory and are also never carried through. For example, each nurse establishes and practices her treatment for bedsores as a function of her schedule: if she knows that she will be there for three consecutive days, she will take the time to measure the effectiveness of what had been done in order to adjust the treatment to the evolution of the bedsore. However, after time off, since she cannot count on the workgroup which could enable her to guide her acts, she repeats her act exactly as before, a derealized act in the sense that it is no longer conforms with the evolution of the bedsore (i.e., the sense of reality is removed). This is not without consequences from the point of view of the effects on the patient's state, but also on the psychological level of the nurse. Here, the effectiveness and the very sense of the nurse's activity are harmed: by answering only to a prescribed task without being able to share the content with the others, the nurse abandons her profession. Her work activity is no long meditated except by impersonal authority (the prescription) and personal authority (her own point of view). She is cut off from the sources which guide her and give her meaning.

We also found this paradox in maintaining continence. While one health care professional will attempt to maintain the continence of a patient, she will hear her co-workers telling the same patient, "go in your diapers" when he or she has a desire to go to the bathroom or at a time when everyone is busy. She can then be forced to stop maintaining continence, which in the situation becomes a strictly individual motive (Leontiev, 1984) of her activity without her having found a respondent in the profession. She can also wear herself out trying to hold onto what she judges to be the best way of doing, but the difficulty is increased: how to continue thinking that one's act is pertinent if it is not shared?

The consequences of a profession which can no longer be a resource in work situations can also result in no longer knowing how to do what is to be done. Hence, while the hierarchy continues to repeat that long-term stays are places for living, and it must be accepted that the patients are at home, the profession remains silent, making it impossible to discuss this definition of the world. Consequently, health care professionals can be led to dictate the rules of "good behavior" to the patients. Thus, in another example, we had been surprised by the manner in which the health care professionals forced a newly arrived patient to put on his slippers. The anger in her voice allowed no reply. Of course, it was necessary to protect the patient but using violence ensures that protection does not relate to the job but to a defensive response which allows one to insist on the patient's "good behavior" at any cost. The defensive response compensates for the depreciation of the profession, and it also falsely protects the health care professional's power to act at the cost of annihilating the meaning of the work.

4. An attempt at a professional dialog: "I can't let a patient die"

In the long-term stay ward, the impossibility of finding a solution for the conflicts caught up in its history hinders any work of "civilizing" the reality of the work. Each one can then take refuge in a defensive activity, abandoning the organizational prescription borne by the direct supervision of the ward without responding. The obligations are no longer those of the job but those of a professional act conforming to the injunctions of the organization, leaving each one to run the risk of a disintegration of the sense of one's job.

[9] Since 1999, the MLS ward has had four managing head nurses (plus one interim manager) and eight nurses. The lack of managers can also be noted: only three out of five positions are filled.

4.1. The rule and the emergency

Based on a very short extract of a crossed self-confrontation between A., a nurse, and M., a nurse's aid, we will attempt to expose a conflict of activity which deals precisely with the question of transgressing the rules.

The discussion was already underway when we saw the video of A. pumping[10] a patient in a terminal stage. The dialog will then be centered on the question of rules and the "floating" tasks. Furthermore, the boundary between the jobs of the nurse and the nurse's aid is unclear, particularly concerning the treatments which do not require very specialized technique and knowledge. Thus, what was a part of one's job is now also a part of another's job[11]. The uncertain limit between the two jobs becomes evident as soon as a problem arises.

A dialog begins by breaking down this shared representation of the nursing activity.

4.1.1. According to the rules: "one must call a nurse no matter what"

1. ***Ch 1***[12]: As a nurse's aid, do you know how to use a pump?
2. ***M:*** No.
3. ***Ch 1:*** In case of emergency?
4. ***A:*** No nevertheless you learned how? (inaudible) It's not difficult.
5. ***M:*** (answers A.) Yes but OK/.
6. ***Ch 1:*** But are you obliged to run after a/?
7. ***M:*** Oh yes, **one must call a nurse**. . . **no matter what.**
8. ***A:*** (incomprehensible).
9. ***M:*** Anyway, you know, you see them do it, but OK. . . **since it's not our own role, we don't have the right to either**. . ./But in case of emergency, one is obliged to find a nurse because **we don't have the right to.**
10. ***Ch 1:*** And if you don't find a nurse?
11. ***M:*** I couldn't/.

This dialog is centered on the activity of the nurse's aid.

M. claims that she *does not know how* to use a pump (2). But A. questions the pertinence of M.'s statement (4), which offers her the possibility to qualify it, in other words by not only being content to state the principle but to tell the reality: M. *knows how* to use a pump (5). Nevertheless, M. insists on the principle: this act is not part of the nurse's aid's job, it is not part of the nurse's aid's own role[13] (9). M. knows this act, but is not authorized to carry it out. She claims that it is forbidden to practice it, even in case of an emergency (9, 11). In other words, M. clearly sets down a rule which directs the organization of work. The impersonal character of the rule appears sufficient to suppress any conflict of activity.

The rule, clearly stated, closes this exchange and the dialog could have ended there.

4.1.2. Transgressing the rule

11. ***M:*** **Anyway, I couldn't, er**. . . like the aerosol. . . of Mr. Q., for example, one doesn't have the right to do it either/.
12. ***Ch 1:*** But you do, I've already seen you do it/.
13. ***M:*** Yes, exactly.
14. ***Ch 1:/***The aerosol when there's no nurse.
15. ***M:*** So er. . ./**But it's true that the pump, I never did that however**. . . **anyway er**, there's always a nurse at my side.

Nevertheless, this exchange creates an uncomfortable state for M. By ending the exchange in this way, she prevents herself from exploring a suspended conflict in her job activity, which poses exactly the question of the inviolability of the rule. At the same time, she returns to her proposition.

The rule is clear and clearly stated and does not only apply to the act of pumping: it is the same for the aerosol, for example, that is an action which makes it possible to facilitate the patients' breathing. The use of the subjunctive by M. allows the creation of a gap between the performative character of the rule and her own work experience (11). She then refers to the case of a patient, Mr. Q., for whom she frequently breaks this rule and gives him the aerosols. Nevertheless, she again claims that she does not break the rule as far as using the pump is concerned, in any case, not without being accompanied by a nurse (15).

In other words, based on her work experience, M. tells the way in which the rule's own role is not applicable to all of the cases although it is in command of the organization of work. The rule fails to become an organizing authority of the activity.

4.1.3. The history of Mr. Q.'s aerosol: a conflict of activity

15. ***M:*** But Mr. Q.'s aerosol, one day. . . One morning when I arrived, there wasn't a nurse, she was er. . . I don't know what happened but/. He was suffocating. But really suffocating.
16. ***A:*** Yes, that happens to him.
17. ***M:*** I call the nurse downstairs, she tells me, "Yes, but the head nurse hasn't arrived". I tell her, "What should I do?" I said, "What should I do, Mr. Q. is suffocating". She didn't answer me er.
18. ***A:*** That doesn't surprise me.
19. ***M:*** So this is what I did. **My co-workers tell me, "But no, one doesn't have the right, one doesn't have the right". I said, "I can't let a patient die".** I took it, I did the aerosol, I gave it to him. Mrs. H. (the head nurse) still hadn't arrived, so I did it. When she arrived, she came upstairs. I said to her, "I beeped you, you weren't there. Well then, er, I used the aerosol, now I say it's at my own risk". She tells me, "You did the right thing". I said to her, "But if. . . if something happened it would be my problem". That's for sure (addresses herself to A).
A: Yes, of course, of course.

In order to back up her statement, M. will bring up a situation that she experienced in the dialog. Her co-worker, A., far from

[10] This technique allows pumping out the mucus from a patient's lungs to facilitate breathing.

[11] For example, it is common to see the nurse's aids put retention bands on the elderly. Nevertheless, this act is a precise technical act: the bands on the patients' legs must be neither too tight (to avoid cutting off blood circulation), nor too loose (which makes them useless).

[12] Ch 1 and Ch 2 designate the two researchers.

[13] The term "own role" is one of the results of an important nurses' strike in 1988. Nurses, fed up with being considered as mere executors of medical prescriptions, claimed tasks which were a matter of their own competence through the recognition of their profession. The expression "own role" has since exceeded the context of the nurse's profession to extend to the profession of nurse's aid in particular.

being surprised by the exposed situation, will on the contrary underline the plausible character (16, 18, 20), thereby facilitating the presentation.

M. then tells about the event: when she began her shift, she discovered that Mr. Q. was suffocating (which happened to him often). However, that morning, although M. searched for a professional who could intervene, in other words the head nurse, she found no one: the head nurse had not yet arrived, there was no nurse on the ward and the one who was in charge of another ward did not want to or could not intervene (17).

M. then has a conflict which she expresses in two distinct voices. Her co-workers recall the rule, "*one doesn't have the right*" while she falls back on another rule: "*I can't let a patient die*" (19). Thus, on the one hand, the impersonal authority of the institutional prescription takes the upper hand: "*one doesn't have the right*". Here this "one" is evidence of the generality of the rule, its impersonal character. On the other hand, M. uses the "I" to oppose the rule. Nevertheless, this "I" does not only refer to the person of M., but to a rule of another nature: can *one* let a patient die without looking first to help him? M. attempts to show this conflict in the rules: on the one hand, the rule of her own role and respect for the organization of work, and, on the other hand, the rule of assisting a person in danger.

Moreover, she ends her history with the question of responsibility. Assured by the head nurse of the legitimacy of her act, she nevertheless doubts the share of responsibility in such a case (19). Conflict between the rules, such as it was exposed by M., appears suspended: if M. seemed to have acted correctly in the situation, what would have happened if she had committed an error or if she had followed the rule recalled by her co-workers?

4.1.4. The limit of the rules and the question of responsibility

21.	***Ch 1:*** As a result, you can understand your co-workers who do not want to take that responsibility.
22.	***M:*** Yes, I understand, I understand, but for myself, I can't let er/You know, Mr. Quentin he was suffocating, you don't do anything. That's even worse for me.
23.	***A:*** No it's true that/.
24.	***M:*** For me, it's worse than. . . than transgressing the. . . the. . .
25.	***Ch 1:*** The rules.
26.	***M:*** The rules in fact.
27.	***A:*** OK, if pushed/.
28.	***Ch 2:*** But if you hadn't done something, if he really had a (inaudible), who would be responsible?
29.	***M:*** Good question.
30.	***A:*** That's a very good question.
31.	***M:*** That's a good question.
32.	***A:*** OK, yes, that is, exactly, it's very vague.
33.	***M:*** **OK, who is responsible, oh, one never knows.**
34.	***A:*** There wasn't a nurse, whatsit, no head nurse, whatsit. . .
35.	***M:*** One never knows, one says to me, "It's good. You did it." But afterwards, if. . . if one doesn't do it, if he suffocates one's in a jam. Who's going to be in a jam? I think that one would also be responsible, no A.?
36.	***A:*** I think so.

The dialog will continue in this sense based on these questions. In examining her co-workers' stand, M. reaffirms by "I" the choice that she made (22). It would be "*worse*" in her eyes to let a patient die (22, 24, 26) than to "transgress" the rules. Thus, without discussing the rule, without taking up its history, in other words its "justification", the rule will be broken by an individual decision. Since the event had a happy outcome – if we dare say so – examining other possibilities remains hypothetical. At this point in the dialog, neither of the two professionals can argue about another event which would not have had the same outcome. Hence, it is impossible for them to envisage the consequences of breaking the rule on the one hand, but also the consequences of applying this same rule (28 and s.). Not being part of the base of common experiences, nor even to the individual experience of the two health care professionals, the rule nevertheless belongs to the real of their work activity itself. More precisely, if it is issued from the Institution and it marks its impersonal character, it is also heard in the voice of the peers[14]. The institutional rule weighs heavily on the choice that M. made by ignoring it.

The question of "justifying" the rule is, however, not retained, even if it is a question of the profession. By examining the question of responsibility, the dialog will be continued (28). The health care professionals judge this question to be pertinent (29, 30) precisely since it is never discussed in the ordinary course of the work activity (32, 33). And even more, M. seems to say that she is voluntarily suspended (35): the successful transgression is not a sufficiently "visible" event to cause the rule to be questioned. This exchange concludes with A.'s approval: approval of M.'s statements as well as approval of her own act.

4.2. A successful transgression of the rule and the suspended development of the profession

In this extract of crossed self-confrontation, during the course of the dialog in which the discussion bears on the risk of breaking a rule, another underlying dialog takes form: the function of the workgroup. Nevertheless, the first intention does not govern the choice of the event that the nurse's aid, M., reports. Rather, her intention seems to be on the rationalization of her acts, even when these are "forbidden" by the rules of the work organization.

According to us, one must look at this dialog from "between the lines". The workgroup, far from fulfilling its function, leaves M. to judge alone the good "act of work". In the situation that she recounts, she finds herself in a conflict of activities:

- respect the rule *and* risk making a professional error? – by "letting a patient die";
- or break the rule *and* risk being judged responsible for one's act in doing all that is possible to save the patient.

The opposition between two possible activities is clear: one of them would be a type of renouncement of the profession by accepting a professional error, the other a renouncement of the rules based on individually decided criteria. The opposition between these two possible activities is based on their mutual removal. It is the same activity in a certain way, seen as an

[14] We will return to this point.

unfolding activity (i.e., without successive acts of liaison and de-liaison). The nurse's aid has a direct relationship with the organization of work while at the same time, she has a direct relationship with the patient. According to her, the choice of one determines the choice of the other in a strictly individual activity.

As we know, without a living genre, the professional wears himself out by compensating for the generic deficit, and could even "wander across the expanse of possible blunders" (Darré, 1994). This unfolding activity is a removed activity: the activity of the group does not fulfill its function.

But that is not all: M. also mentions the reaction of the head nurse and her co-workers.

From the point of view of the organization of work and the managers who are the respondents of it, M. refers to the way in which the head nurse swept aside the question of responsibility: "*you did the right thing*" leaving M.'s question about the responsibility without an answer. We can then wonder about the nature of responsibility: professional responsibility or civilian responsibility? More likely, the reaction of the head nurse left the nurse's aid even more "alone" faced with the reality, thereby reinforcing the idea that the work organization and the institution from which she emanates are derealized, in the incapacity of being a resource for the job. In addition, two questions remain in suspension: what would have happened if M. had respected the rule and the patient had died? And what would have happened if M. had failed in breaking the rule?

From the point of view of the workgroup, more than a generic deficit, we can create the hypothesis of a *defensive genre*. In the situation reported by M., the co-workers did not ignore the situation, but they also did not collectively reevaluate the rule in relationship to reality. The workgroup had taken account of the interdiction to depart from the rule, although it is "derealized". However, the workgroup must be able to support breaking an institutional rule if it is in conflict with a rule of the profession. In the situation reported by M., the workgroup is not able to support the conflict and then adopts a defensive attitude. Moreover, the generic "one" can be confused with the impersonal "one".

5. Ill-treatment: symptom of suspended developments?

Thus collectively, the health care professionals have a defensive attitude. The group resource has not been developed, although it is the condition for achieving work activities. The health care professionals must then confront reality individually, although they do not succeed in civilizing it collectively. Each one takes it upon himself "to do what has to be done" if, of course, he finds the means to succeed. In the situation reported here, the nurse's aid is constrained to break the rule in order to manage to do what she *thinks* must be done. The gap that is widening between *the impersonal of the institution* and what the nurse's aid judges to be *the transpersonal of her profession* is precisely filled by the *personal* – "*I can't let a patient die*" –. The effectiveness of the work activity is strained by not being able to confront the *transpersonal*. And each health care professional is worn out by not finding a respondent which gives meaning, a *helping addressee* as used by M. Bakhtine (1984). Even more so, he is deprived of the possibility of transforming and developing his own professional history. But not only that, he is also deprived of his contribution to the development of the profession. Not succeeding in "confronting" it, in "measuring" it, insofar as "what is to be done" is not discussed, his work activity is not a resource for the profession. Not taking what each one brings to the collective history – a resource for the development of the profession – makes one run the risk of a "derealization".

Likewise, we can understand how in the particularly deteriorated situation that we have encountered in the long-term stay ward, one cannot succeed in restoring (or in instituting?) satisfactory working conditions for the development of health care professionals and their activity.

We approach the question of ill-treatment from this point of view. This is classically defined as an inadequacy of the health care professional's behavior towards the patient – the health care activity fulfilled – and "good care" (Debout, 2003). But it is to ignore the extent to which the behavior is a "system of reactions which have conquered" (Vygotski, 2003, p. 74) leaving in suspension the unfulfilled possibilities. The reality of the activity is exactly what is necessary to apprehend in order to attempt to understand the origin of ill-treatment. In addition, in the situation reported here, the question of ill-treatment can be posed in these terms: is inadequate behavior respecting the rules or assisting a patient in pain? If one follows M. Debout, ill-treatment is "manifested to the detriment of an elderly person *by a physical, psychological, material or moral constraint*[15]" (2003, p. 6). The entire issue is then to know if the constraint represented by the rules should be judged as ill-treatment.

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[15] Underlined by the author.

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