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CHAPTER NINE

CARE AS WORK: MUTUAL VULNERABILITIES
AND DISCRETE KNOWLEDGE

Pascale Molinier

Care is not just a disposition or an ethical attitude. First and foremost care is a form of work, work that can be done or not, chosen to be done or not, indeed something that a society as a whole can choose to do or not. To provide a formal description and a theory of this work seems to me an indispensable condition of an "ethic of care" that would fulfil its goal. Such an ethic would contribute towards the recognition of the people who perform care work in Western societies; people who in the main are females, poor and immigrant, and often the three at once,¹ without harming those who benefit from their work; that is, all of us.

This chapter will not be able to fulfil all the criteria that would enable such a formalisation. Its ambition is restricted to the concerns of the psychodynamics of work whose object of inquiry is not work taken in an objective, sociological or ergonomic sense, but the processes underpinning the three powers of "working," namely transforming the world, applying intelligence objectively, and enabling the subject to form itself. By producing goods and services the subject does not merely transform the world but also transforms itself by working. ("Working" therefore designates a major process of subjectivation, that is, creation of subjectivity).² The relationship to the world that develops through care work entails specific dimensions that can be highlighted. Only a few of these dimensions, amongst the most hidden, can be unveiled here. It is obvious that the psychological stakes of work cannot be severed from the latter's material conditions. From this point of view, this chapter restricts itself to my research with nurses and auxiliary nurses.

¹ See E. N. Glenn, "From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor," *Signs*, Vol. 18, No. 1, 1992, pp. 1-43; R. A. Hochschild, "Le nouvel or du monde," *Nouvelles Questions Féministes*, Vol. 23, No. 3, 2004, pp. 59-74; E. Dorlin, "Corps contre nature. Stratégies actuelles de la critique féministe," *L'Homme et la société*, Vol. 150/151, No. 1, 2004, pp. 47-68.

² See C. Dejours, "Travailler n'est pas déroger," *Travailler*, Vol. 1, 1998, pp. 5-12.

These two highly feminised professions stand in hierarchical relation to each other so they cannot be identified with each other. Their antagonisms but also their modes of cooperation would have warranted a broader effort of contextualisation.³ For the purposes of this particular chapter, it will be sufficient to note that in terms of the division of labour, the main aspect of the nurses' delegation of work in relation to assistant nurses has consisted in their offloading the most ungratifying aspects of care work, that is, the bodily care (*soins*) of personal hygiene and personal comfort. This part of care work belongs to the category of *dirty work* as it has been conceptualised in the 1950s by the American sociologist Everett Hughes.⁴ *Dirty work* designates those tasks that are seen as physically disgusting, which symbolise something degrading or humiliating, and/or confront some of the taboo dimensions of human existence, like the impure, the vile, the deviant,⁵ and to which I would add sexuality. The professions concerned are those that collect or deal with waste and refuse, like the cleaning work; those that entail a relationship to the body, notably bodily detritus, and cadavers; as well as those that involve a certain degree of instituted abuse and violence. In the social imaginary, proximity with what is normally held at a distance is perceived as threatening to "contaminate" those that fulfil those tasks—however necessary they are. The individuals fulfilling those tasks are seen as soiled, impure, transgressive or even evil. As Dominique Lhuillier emphasises, the notion of dirty work is heuristically useful "to address the question of the division of labour inasmuch as the latter is not just technical and social, but also moral and psychological."⁶ The meaning that can be attributed to this type of work is often precarious. Narcissistic wounds resulting from these activities are undeniable. The auxiliary nurses I organised interviews with defined themselves in bitter terms such as "shit cleaner" ("*torche-pots*" / *torcher* = clean someone's bottom; *pot* = piss pot.) It is significant that

³ In France the nursing profession is predominantly female. In 2004, 87% of nurses were female. However, this varies across different sectors: 47% of males in psychiatry; 27% in anaesthetic services; and only 1% in pediatric services. There were 740,000 assistant nurses and hospital assistants (91% and 81% female respectively). See Sabine Bessière, "La féminisation des professions de santé en France: données de cadrage", *Revue française des affaires sociales*, La Documentation française, 2005, 1, pp.19–33.

⁴ See E. C. Hughes, *Men and Their Work*, Glencoe, IL., Free Press, 1958; "Good People and Dirty Work," *Social Problems*, Vol. 10, 1962, pp. 3–11.

⁵ See D. Lhuillier, "Le sale boulot," *Travailler*, Vol. 14, 2005, pp. 73–98.

⁶ *ibid.* p. 73.

care work is also stigmatised as “dirty work” by others as well as by those who undertake it.

Conceptual Tensions

By care work (*travail de care*) I understand, following Patricia Paperman’s definition, all the activities that fulfil “demands characteristic of relations of dependence.”⁷ To “take care of (the other)” (*prendre soin*) is not to think of the other, nor to *care for* the other (*se soucier*) either in an intellectual or even in an affective sense, it is not even necessarily to love the other: it is first and foremost to *do* something, to produce a certain type of work which directly contributes to the maintenance or the preservation of the other’s life. It is to help or assist the other in his or her basic needs: like eating, being clean, resting, sleeping, feeling safe, and being able to devote oneself to one’s own interests. With the latter, I understand in particular all the activities that help to create meaning, those that relate to sublimation, in the Freudian sense of the term, and which are therefore not directly related to basic physical needs but rather to psychological needs linked to self-fulfilment. To be able to devote oneself to one’s own interests requires a certain form of psychological availability, a form of detachment from the time constraints arising from bodily needs, like having to think about preparing a meal. Indeed the production of the other’s autonomy and identity is at the heart of contemporary theories of domestic work (*travail domestique*), which emphasise its dimensions of psychological and emotional work.⁸ This is the noble part of care work.

In English there are two terms to designate care (*le soin*): *cure* and *care*, with the first referring to the curative aspect of care. Whereas the *cure* concerns only those who are sick, *care* concerns every one of us, from the beginning to the end of life. No life is possible without care. In the perspective of the ethics of care, vulnerability and dependence are at the core of what it is to be a human being. This means that one and the same model of the human being can be used to designate the person who gives care (*the care giver*) and the person who benefits

⁷ P. Paperman, “Les gens vulnérables n’ont rien d’exceptionnel,” *Raisons pratiques*, Vol. 16, 2005, p. 321.

⁸ See L. Adkins and C. Lury, “Making Bodies, Making People, Making Work,” in eds. L. McKie and N. Watson, *Organizing Bodies: Policy, Institutions and Work*, Basingstoke, Palgrave Macmillan, 2000, pp. 151–165.

from this work—whether or not that person is a “competent adult.”⁹ In this sense, “competence” designates a certain degree of autonomy, always provisional and partial, and therefore does not imply that the competent adult would be invulnerable—this would be an absurd idea—or that he or she would have exited the state of dependence that characterises him or her just as much as that of autonomy.

Some authors insist on maintaining the distinction between care work with people who are unavoidably dependent, for example, the sick or those who are invalids, as well as people who are very young (dependency care), and care work with people in good health who would be able to direct their “self-maintenance” on their own.¹⁰ Even if it is relevant under certain aspects (in economic terms in particular, or in terms of moral obligation), with the dualism “autonomy/dependence,” this distinction nonetheless risks perpetuating the fiction of a self-constitution of personal identity, whereas in fact the successful achievement of the latter is dependent on the work of a “spouse/mother whose self is oriented towards the others and demonstrates affection”, as Adkins and Lury put it.¹¹

Conversely, as the English psychoanalyst Margaret Cohen notes, respect of the most dependent of dependent people—in her case, “giving a voice to the experience” of young infants in the “neonatal intensive care” section where she works—implies recognising them as *independent* human beings.¹² By independent, she means comparable or similar to oneself, that is to say, from her perspective as a psychoanalyst; and recognised as a subject with his or her own subjectivity, a psychological life and his or her own story. The default position, given the difficulty of providing technical care (*cure*) without causing suffering, is to concentrate solely on the technical difficulty while refusing to see that the infant child is writhing with pain, without imagining his or her distress.

In the perspective of care, the categories of dependence/autonomy as well as the relationships between these categories must therefore be conceptualised anew. Is it the content of tasks which defines care

⁹ See P. Paperman, “Perspectives féministes sur la justice,” *L'année sociologique*, Vol. 54, No. 2, 2004, pp. 413–433.

¹⁰ See E. Feder Kittay, “Dependency, Difference and Global Ethics of Longterm Care,” www.carework-network.org/

¹¹ See Adkins and Lury, “Making Bodies, Making People, Making Work.”

¹² See M. Cohen, “Histoires de naissances et de mort,” *Autrement*, Vol. 10, 1993, pp. 67–87.

work? Or is it the way they are accomplished? In French there is no appropriate term to translate the concept of *care*. The French word "*soin*" is too reductive by comparison. Care is not "*sollicitude*" ("solicitude") or "*dévouement*" either. The concept of care comprises a constellation of physical or mental states, as well as activities of work relating to pregnancy, the raising and education of children, the care/*soins* of people: bodily care/hygiene, and domestic work. The most important point is that in *the concept of care the material tasks are not dissociated from the psychological work they entail*. Furthermore, *care* denotes the properly affective dimension that is mobilised in a type of activity which has to be accomplished with "tenderness" or "sympathy." We shall come back to that. The sociologist Geneviève Cresson has suggested translating the term as "health domestic work" (*travail domestique de santé*), which partly overcomes the difficulties of translation.¹³ This translation however is only partly successful. On the one hand, it manages to rehabilitate the essential part of care and concern for the other in domestic work, as well as the psychological load ("charge") associated with it. However, it is problematic on two fronts. First, the concept of "*health domestic work*" tends to artificially dissociate domestic work from health domestic work whereas from the perspective of care, all domestic work *is* health work, beginning with "sleeping in a clean bed." Second, it also tends to dissociate domestic care work that is accomplished for free in a private space from waged care work, whereas the concept of *care* overcomes this dichotomy and allows us to analyse the similarities between such disparate activities as those that concern house work, the care for the sick, education, secretarial work as well as assisting work in all its shapes and forms (for example the case of legal assistants studied by Pierce).¹⁴

If we recall that housework has for a long time been considered as a mindless type of work demanding no particular skills, the change in perspective is radical: *care defines both activities and the intelligence that is mobilised in their accomplishment*. The reason why this form of intelligence and its realisations have attracted so little interest, both on a scientific and philosophical level, mainly has to do with the fact that

¹³ See G. Cresson, *Les parents d'enfants hospitalisés à domicile. Leur participation aux soins*, Paris, L'Harmattan, 2000.

¹⁴ See J. Pierce, "Les émotions dans le travail: le cas des assistants juridiques," *Travailler*, Vol. 9, 2004, pp. 51–72.

it is difficult to establish a relationship with the concrete experience of care. This is because of: (1) The invisibility of the conditions of successful care; (2) the naturalisation of care as belonging to womanhood; (3) the emotional aspects of its discursive expression; (4) the virile defences of decision-makers. This is what I would like to show on the basis of several studies in the psychodynamics of work¹⁵ I have undertaken in several hospitals with auxiliary nurses, nurses and head nurses.¹⁶

The Invisibility of Care Work and Inconspicuous Skills

What do we learn from the psychodynamic analysis of work situations in the health sector? In order to be efficacious, care work must not appear as work (literally, it must efface itself as work). Its success depends on its invisibility. Every time one has to attempt to relieve the suffering of another person (or attempt to not add to it), the only way to avoid that person getting tired or embarrassed, and also of sparing oneself useless gestures and journeys, is to know how to anticipate the request and to hide the efforts and the work that has been accomplished to reach the desired goal. This can take very banal forms, for example putting a glass of water or a bell within the person's reach, avoiding saying "you are looking tired" and instead offering a chair. The concern for the psychological comfort of the other is always at play in this type of skill. One attempts to avoid embarrassing the other, shaming him or her, to respect his or her "modesty", his or her desire to be autonomous, to spare them the humiliation of dependence, and so on. But such inconspicuous skills (*savoir-faire*) can also mobilise technical knowledge, like when a (good) nurse hands the surgeon the right instrument at the right time, *before* he had to ask for it, or like the good secretary who prepares the right files (without

¹⁵ The psychodynamics of work studies the centrality of work in psychic functioning, in other words, the fact that work is never neutral in relation to the construction of identity and mental health. We intervene when people request it, when they seek to elucidate the reasons explaining why their work has become so difficult to bear they have become ill as a result, and others fear the same fate. See C. Dejours and P. Molinier, "De la peine au travail", *Autrement*, No. 142, 1994, pp. 138-151.

¹⁶ See P. Molinier, "Prévenir la violence: l'invisibilité du travail des femmes," *Travailler*, Vol. 3, 1999, pp. 73-86; P. Molinier, "Travail et compassion dans le monde hospitalier," *Les cahiers du genre*, Vol. 28, 2000, pp. 49-70; and P. Molinier, "Souffrance et théorie de l'action," *Travailler*, Vol. 7, 2001, pp. 131-146.

being asked) for the boss to use in the next meeting. Another type of inconspicuous skill (*savoir-faire discrets*) is that of the cleaner who manages to clean a table without upsetting the researcher's desk. Another example still is that of being able to avoid saying to parents that an important event in their child's development, for example her first steps, happened in the childcare during their absence. These skills are inconspicuous or discreet in the sense that in order to achieve their goals, the means used to do so must not draw the attention of those who benefit from them and must be mobilised without expecting gratitude for it. As a result, care work becomes visible mainly when it fails, when a smile becomes too "forced" or disappears from the nurse's face, when a gesture is too mechanical, when the response to a request takes too long, when the child comes back from childcare bitten or scratched by another or when the housewife makes the home's cleanliness a form of domestic tyranny.

The invisibility of care work, which is intrinsic to it, and belongs to its very essence, results in a chronic deficit of recognition. As a general rule recognition is difficult to obtain because it has to be granted to work that is actually accomplished (and not to its theoretical presentation in charts, protocols, job descriptions, and so on) and it relies on two separate types of judgement:

1. First the "judgement of beauty" evaluates work by assessing its conformity to the rules of the trade but also its originality, that is, its capacity to find new solutions to the problems encountered. This judgement is delivered by peers, mostly through the symbolic forms of integration within the collective, and through admiration.
2. The "judgement of utility" relates to the social, economic or technical usefulness of work. It does not evaluate the means used but verifies that the goals have been achieved. It is delivered by those further up the hierarchy, and is materialised in the form of the wage, qualification, promotion and the attribution of more resources.

The dynamics of recognition rests upon the collective capacity to make judgements of beauty and utility, with as little contradiction and as much congruence, as possible. This implies that it is possible to regularly discuss the difficulties encountered by the team, in the internal public space of the company or the institution, so that the prescription can be changed in a more realistic way and made more compatible with the demands of the task and more respectful of the meaning that

the workers attribute to their work.¹⁷ As a result, to be recognised for what one does is not an everyday experience. It is the hope to be recognised that plays a fundamental role in the possibility of continuing to work by being involved in what one does and not falling ill.

As care work is forced to efface itself as work and cannot be visible, it tends to be undervalued as a way of *doing* and overvalued as a way of *being*. Care work is generally identified with womanhood (woman-as-gifted-for-the-relational), or with the feminine side in a man. It is perceived as a capacity for self-sacrifice that would be an emanation of the feminine soul and not as a skill acquired through experience. Care work is thus referred to in terms of "moral qualities" that are also "gender qualities" and which can therefore not be codified or rewarded. As Danièle Kergoat has shown, the social definition of a professional competence cannot rest on a list of "individual qualities."¹⁸ We cannot develop this point at length within the scope of this chapter, but the psychodynamics of work can show that for nurses and auxiliary nurses, their inconspicuous, discreet skills are not perceived and represented spontaneously in the terms of competence. For example, the nurses in the operating theatre who are able to present the required instrument before the surgeon even asks for it, thus sparing him the effort of having to think about it himself, first talked about their work as "mindless work, just passing the instruments."

Twisted Vulnerabilities

Let us now change perspective and focus on the person benefiting from care. This is not hard for us since we are all in that position at one point or another, whereas we are not necessarily providers of care. Here, there appears a strange and tenacious tendency to want to be "loved" by those who serve us. We would like this part of work to be "given" to us. Even the Papin sisters who killed their employers were in this situation.¹⁹ The judge asked them: "Did you like your masters?"

¹⁷ See C. Dejours, "Pathologies de la communication," *Raisons Pratiques*, Vol. 3, *Pouvoir et légitimité*, 1992, pp. 177–201.

¹⁸ See D. Kergoat, F. Imbert, H. Le Doaré, and D. Sénotier, *Les infirmières et leur coordination 1988–1989*, Paris, Éditions Lamarre, 1992.

¹⁹ The Papin sisters were two maids who brutally murdered their employer and her daughter in 1933, in one of France's most famous criminal cases. A number of artists and intellectuals (Lacan, Sartre, Genet, De Beauvoir) discussed the case in their

No, they responded, they were serving them, "that's all."²⁰ In the article he wrote about them, Jacques Lacan thought he had discovered an anticipation of the tragedy that was to unfold in the coldness that characterised the relationship between the masters who "seem to have strangely lacked human sympathy" and the "haughty indifference of the servants."²¹ It was as though the presence of love would make it fine to be served and thus to subordinate; and as though love by itself erased the chore aspects inherent in care work. What one forces the other to endure as a result of one's own dependence is therefore veiled by the combined effects of inconspicuous skills and the justification of service work by the "love" of the provider towards the beneficiary. The relationships between love and care work are complex. To love can be a way to survive for the care giver. It is often believed that love comes first, and "causes" the involvement in care work, whereas many situations show that the attachment to the persons cared for is only secondary, or even that this attachment creates a psychological situation which makes the constraints even more difficult to endure. An example of this is the immigrant nurses from Southern countries who leave their own children to come and look after children from the North: "in the absence of my own children, the best I could do was to give all my love to this child," one of them said. Or said another: "I work ten hours a day, I do not know anyone in this area, this child gives me what I need." All this illustrates how love is naturalised by their female employers in the terms of "the loving and warm temperament of the women from the South."²²

How can we separate care work from the "love" which tends to mask it, to justify it or make it unbearable? The pragmatic knowledge of the nurses and auxiliary nurses, their inconspicuous, discreet skills and their naturalisation under the category of womanhood are not the only causes of the invisibility of their work. The ambiguous status of the

writings. In 1963, Louis Le Guillant published an article in *Les Temps Modernes* (Sartre's journal), entitled "L'affaire des soeurs Papin" (Nov. 1963, p. 868-913) [Added by the editors].

²⁰ See L. Le Guillant, "L'affaire des soeurs Papin," *Les Temps Modernes*, Vol. 216, 1963, pp. 869-913, p. 894.

²¹ J. Lacan, "Motives of Paranoid Crime: The Crime of the Papin Sisters," *Critical Texts*, No. 3, 1988, pp. 7-11, p. 7.

²² Hochschild, "Le nouvel or du monde." On the ambiguity of the feelings mobilised by waged domestic work, see also S. Esman, "Faire le travail domestique chez les autres. Transcription de l'instruction au sosie suivi du commentaire," *Travailler*, Vol. 8, 2002, pp. 45-72.

mobilised affectivity on the one hand, and the care relation on the other, constitute another motive of the invisibility of care, or more precisely of the difficulty to account for it publicly.

In my fieldwork research, the material is gathered in small groups of a few people who have agreed to talk about the difficulties of their work. A beautiful woman recounts with uneasiness that she has agreed to the request of a sick patient in intensive care who was confined to his bed through tubes and pipes. He had asked her if she could arrange her hair in a way he found suited her more. Is this still care or is it already a transgression, a kind of erotic play? How far can self-sacrifice (*don de soi* or literally, to give oneself) go before losing oneself? How do the nurses manage not to confuse everything? The erotic dimension of their relationship is not lost on the nurse. This gesture of arranging her hair made her uneasy. If however she did agree to fulfil the patient's desire, it is not out of love for him, but out of compassion. The nurses often say that the main reason they can sometimes transgress the rules is their conviction that the patients have no one else to look after them. In this particular group of nurses, this story elicits others which once again poses the question of the boundaries that cannot be crossed, even out of compassion. For instance, they tell of an old man who asked to be slipped into a short nightgown of pink lace. The nurses agreed to put it on him, but refused to wash him in it when he also requested this.

The knowledge of the nurses can hardly be formulated in the public sphere because this knowledge about our intimacy reveals not only that vulnerability is the norm, but also that as vulnerable beings we are also twisted beings: the twisted beings that have to be cared for, and those who care for them who are no less twisted themselves. Indeed the title of this chapter could just as well be "twisted vulnerabilities" as "mutual vulnerabilities." "Mutual vulnerabilities" is only an approximation, partly inaccurate, to indicate that it is more apt to think of the asymmetry characteristic of the care relation as a form of work, "*one for the other*," rather than as "*one is vulnerable, the other not*." This is because, as the psychodynamic of health work suggests, it is not possible to take into consideration the vulnerability of the other without mobilising one's own sensitivity, that is, without taking the risk of being destabilised by the twisted expressions of one's own subjectivity.

To relegate intimate bodily care into the category of "dirty work," tasks performed by the least qualified women, is therefore an easy way

out for everyone's peace of mind. Indeed, we can add that the cultural taboo relating to the activities of touching human waste and dead bodies, as well as the discourse of those who accomplish these tasks, tends to opportunely mask the taboo that goes even deeper relating to sexuality and the ambiguities of affectivity.

The nurses, and even more so, the auxiliary nurses, cannot describe their work using general representations, even less can they model it through numbers and diagrams. In order to make someone understand what they do, they have to tell a succession of twisted stories where vulnerability is in no way synonymous with "innocence," "transparency" or "goodness." This succession of stories which the nurses tirelessly tell each other as soon as the opportunity arises helps them build a common ethic that cannot be separated from a community of sensitivity. What is one to do when one keeps finding two old ladies in the same bed every morning? Can one tolerate that a patient secretly drinks alcohol? A dying patient prefers to smoke rather than eat—should one give him this last pleasure? Or should one give in to his family who refuse to accept the imminence of his death and demand that the auxiliary nurses confiscate his cigarettes and force him to eat? Making oneself pretty, tolerating another's sexuality (and a twisted one at that), letting someone drink or smoke, authorising illicit pleasures and sometimes authorising them to oneself: what these peers judge collectively is not the transgression itself, according to the norms of (well done) work and the good life, but rather the degree to which the transgression belongs to the sphere of care. What orients public deliberation is not the intimate dimension of pleasure for the person—perhaps the nurse did take some pleasure from the seduction of her raised hair—but rather the highest shared goal of health work, which consists in ensuring that the other suffers the least. Conversely, deliberation is also what enables the nurses and auxiliary nurses to avoid giving in without control to transgression and its ambiguities. Recognition by their peers unfolds in the very exercise of this community of sensitivity, via the mediation of those stories that constitute it and through which the rules of the trade are constantly elaborated. Those rules enable them to adjudicate over what belongs or does not belong to good work.

Even though care work at first appears difficult to grasp, it is accessible through narration. Transforming it into a story does not aim for truth or objectivity but it tends to give expression to what cannot be expressed, namely that which resists the dominant symbolic order.

Can any of this be said publicly? There is a great risk that the attempt to bear witness to the effects of the real upon one's own subjectivity leads one to become ensnared in the traps of confession, in a situation where the other is judge and censor of a subjectivity that would then be perceived unilaterally as inappropriate or deviant. Most models of care escape this danger because they cheat with reality by not accounting for the sexually incorrect character of the care relation, which is anything but a marginal dimension of it, or by overlooking the disgust and hate that care work sometimes causes towards recipients.²³

Politics and Practice, Virility and Femininity

The nurses' movement which emerged in France at the end of the 1980s represented an important shift in the history of this profession. It contributed to legitimacy for the nurses, of the values associated with their work. But their *collective power of action* did not reach its goal of modifying the perception of the representatives of the state. The encounter between them failed. The representatives of the state, after an initial stage where they were destabilised, eventually managed to reduce this legitimacy and the political scope of the nurses' movement by reducing it to feminine *pathos*. A member of the health minister's department summed up the misunderstanding in the following terms: "It was incredible. These girls from the nurses' coalition, they would tell you in detail the problems of their everyday life! They were quite moving and touching, but how can you negotiate with a slice of life?" Whilst on the other side: "We realised that the quality of care is not their problem. For them, things have to work without the human side being taken into consideration. They have no clue about what a hospital is really like, our life."²⁴ It is interesting to note that in the nurses' discourse, the "quality of care" and the "human" are identified. The definition of care stands at the heart of the misunderstanding. Undoubtedly the nurses' strategy was not the best one; it is important to be able to change the mode of enunciation when one shifts from the practical to the political. However, beyond their failure,

²³ See Cohen, "Histoires de naissances et de mort"; P. Molinier, "La haine et l'amour, la boîte noire du féminisme? Une critique de l'éthique du dévouement," *Nouvelles Questions Féministes*, Vol. 23, No. 3, 2004, pp. 12-25.

²⁴ The quotes are from Kergoat, Imbert, Le Doaré, and Sénotier, *Les infirmières et leur coordination 1988-1989*, pp. 107-108.

if we want to find a mode of expression more appropriate to the political expression of care, a necessary condition is to understand the obstacles to the understanding between the politicians and the nurses (and more broadly the care providers). Amongst these obstacles, some are defensive.

Indeed what the two quotes above demonstrate is that the nurses and the state (through its representatives) not only expressed themselves on different levels, but also in different registers, the virile and the feminine respectively, which made them unable to hear each other. By feminine and virile, I mean defensive positions that have nothing to do with the "essence" of men or women, but have everything to do with the arbitrariness of the social and sexual division of labour.²⁵ This arbitrariness creates different experiences leading to forms of subjectivation that are not only very distinct, but also antagonistic. There is a conflict of interest between collective defence strategies that are elaborated to support the suffering caused by care work, on the one hand, and the collective defence strategies of politicians, managers and doctors who are mainly male. What does this refer to? Research in the psychodynamics of work has shown that the involvement of workers is mostly dependent on the *symbolic resonance* that can exist between work and the inner space inherited from childhood, that is, on the possibility of using what they do to develop a sense of self and overcome the suffering inherent in their psychological development. Suffering therefore predates entrance into the world of work. Suffering is an experience that cannot be separated from embodiment—no suffering without body—and that can never be fully represented. As a result, subjective suffering is always awaiting its meaning, both to allow the subject to perform a reflexive return to its being in the world, and to

²⁵ The thesis of a simultaneous construction of gender identities and the sexual division of labour can be found in a number of authors. Lisa Adkins, "Mobile Desire: Aesthetics, Sexuality and the 'Lesbian' at Work," *Sexualities*, Vol. 3, No. 2, 2000, pp. 201–218 in particular, following Judith Butler, insists on the mobile, or even "flexible" (in the neo-liberal sense) characteristics of gender identities produced by service activities, especially in commercial activities. In contrast, my own research leads me to emphasise rather the contribution of work to the parts of gender identities and the sexual division of labour that are the most fixed and the least susceptible to change, inasmuch as these parts resist change because of their defensive function. Although I cannot develop this point further here, men (who are in the minority in a female collective) can take on "feminine" defence strategies, and women virile defence strategies. For example, women doing male work (in the social sense) are not necessarily different from men. They can well be, however, when expectations and injunctions addressed to them are different.

direct the latter towards *action on the world*. This is the point where the subject encounters work: for better, when work is such that it creates something; but also for worse, when work is an obstacle to self-fulfilment, when it borders on the absurd or confronts the subject with major psychological threats like fear. People do not all fall ill in such deleterious but very ordinary circumstances, because they are able to develop defence mechanisms between health and sickness. Our research has shown that certain ways of talking, certain behaviours and attitudes than can seem aberrant or irrational in the face of "classical" forms of rationality, become highly intelligible from the point of view of the function they fulfil in allowing self-preservation—what could be called their *pathic rationality*. In contrast to what psychoanalysis teaches about individual defence mechanisms, it appears that these odd forms of behaviour belong in fact to systems that are constructed collectively. In other words, there exist ordinary forms of cooperation whose main purpose is a defensive one, namely to prevent subjects from thinking about what makes them suffer at work.²⁶ Precisely speaking, in work situations that are dangerous for physical integrity (the building industry for example) or for psychic integrity (in particular when one has to assume responsibility for the lives of others, or accomplish a task that conflicts with one's moral sense), work collectives mostly composed of men defend themselves against fear and/or moral suffering by constructing collective defence strategies centred on:

The denial of men's vulnerability—a *real man has no fear/has no feelings*.

The disregard for the vulnerability of others.²⁷

In other words, all those who demonstrate vulnerability, whatever their biological sex, are excluded from the category of real men. Whereas from the perspective of care there can only be one model of the human being—*homo vulnerabilis*—the virile defence ideology constantly reiterates a bipartite division of human beings which opposes them and hierarchically ranks them: man/woman, strong/weak, autonomous/dependent, reason/unreason. Such an ideological construct creates a dominant system of thought we can only escape with great difficulty.

²⁶ See Dejours, "Pathologies de la communication."

²⁷ See C. Dejours, *Souffrance en France. La banalisation de l'injustice sociale*, Paris, Seuil, 1998.

If the nurses and auxiliary nurses (female or male), as in the virile model, denied their own vulnerability and devalued that of the patients, they would not be able to accomplish the work of care. Instead, care providers attempt to work through the suffering caused by care work amongst them. This suffering therefore cannot be reduced to a mechanism such as "patient suffering = carer's compassion." The angst generated by the other's suffering, or, under a more elaborate form, the compassionate identification, fail in a number of ways. The experience of such failures of compassion—to realise that one can no longer stand the patient, that one hates his/her dependence, that one in fact wishes him or her to disappear, to discover one's own indifference or cruelty—all of this is just as painful and disturbing as the experience of compassion. The most painful situations are sometimes those where the psyche of the care worker becomes like an internal threat to her and undermines the meaning of work and its established identity features; work is "Nothing to brag about." We will come back to that point.

If nurses and auxiliary nurses simply complained or described their "naked" reality, as for instance in an objective witness account, the expression of their lived experiences would be unbearable for their interlocutors and for themselves. In that case, there would be no transmission, no deliberation, no construction of a common ethic and a common sensibility. This shows the added dimension of the pathetic narratives quoted above: namely, their defensive function. In order to make the evocation of this experience bearable, one has to distance oneself from it, to alleviate its ability to create angst. This unburdening and detachment is made possible through the use of humour. The pathetic narratives of nurses are in fact tragi-comic narratives. The defensive dimension of this collective story-telling lies precisely in the fact that nothing can be said that, in the end, one would not be able to laugh about, even if one cries at the same time. But there is more. Humour in this situation must serve the capacity to support one's own vulnerability, which is in itself indispensable for care work. Against that, it would be much more economical from the psychological point of view to harden oneself, to cut oneself off, affectively, from the other's distress. Indeed such a hardening is highly encouraged by the concentration that is required of technical work (pricking, probing, cutting flesh, and so on).²⁸

²⁸ There is a conflict between the types of subjectivity that are mobilised in the *cure* and in *care*. The learning of a technical skill implies that one goes through phases

Self-mockery as a Way of Dealing with Defeat

Since what is targeted is truly the maintenance of personal vulnerability—with its corollary, unavoidable failures of subjective constructs, which cannot be boasted about—one understands why the nurses' collective defence strategies mobilise a particular form of humour, namely self-deprecating mockery. They mock themselves, "poor women," as others are being mocked for their own weaknesses. Through this medium of mockery combined with self-mockery, an entire suffering humanity is incarnated: the humanity of sweating, snoring, limping, fearfully teeth-chattering, individuals. Eventually, this constitutes a whole universe of common references where vulnerability and its diverse expressions are, if not necessarily always pleasant, at least sayable, as the very basis of any ethical demand.

The stories told by nurses and auxiliary nurses could scare anyone. For instance, one nurse recounts the day when she cleaned a dead body for the first time. As she started to panic, she unwittingly locked the door through which she had attempted to flee, thereby locking herself in with the dead body. Another nurse recounts the day when she was looking for her broom and discovered a patient hanging in an old attic full of aged equipment; she ran through the mess, knocking over old drip-stands and urinals in a hellish racket. A further nurse recounted herself walking backwards towards an open window as a huge man came near her screaming insults and death threats. The man had been rung earlier that day to collect his wife, a temporary contract worker in charge of the cleaning, who had suffered a nervous breakdown upon arriving at work that morning. In telling these stories the nurses stage themselves in episodes where they were facing an event that temporarily terrified and paralysed them, to the extent that they lost their "self-control" and made themselves utterly ridiculous. By contrast with the typical stories told by interns, the stories of the nurses do not give centre stage to obscenity or sexual references. Fear and vulnerability are

of trial and error where, as in the case of the interns described by Margaret Cohen, it is difficult not to feel persecuted by the patients or not to instrumentalise them by "forgetting" that one is making them suffer. In order to fully unfold, sensibility to the suffering of the other requires that the individual has undergone a number of phases of learning and has become sufficiently expert to be able to distance himself/herself from the technical act. Only in that case can care complement the cure. Moreover, a patient who is confident and as relaxed as is possible in the circumstances is much easier to handle.

not denied. On the contrary they are relived and domesticated through well-crafted stories, many times recounted and embellished throughout a career. These stories attempt to circumscribe the irruption of the *real*—defined as what resists mastery through conventional means—not in order to push it outside of shared representations, but rather to control its effects on the psyche. These stories help transmit and reiterate a culture of the craft/trade (*métier*) which is nothing but a way of living (*art de vivre*) with defeat. This specific ethos of the nurses' craft is all about acknowledging the limits of all things, starting with one's own limits, in the face of death, madness, the waste produced by human bodies, sexuality, and so on. It is also about accepting the failures of embodiment, first and foremost of one's own, notably in the failures of one's body, for example when the nurse feels her blood curdling, her legs become weaker, disgust, uncontrollable giggles, excitement, and so on. All of this shows that even though self-mockery coupled with mockery enables the nurses to take a certain measure of distance and detachment, the latter is anything but indifference. Rather, such detachment enables the acceptance and elaboration of vulnerability. However, the self-mockery that makes the experiences of care sayable within the collective of peers also makes it unacceptable outside this narrow circle (outside recognition by the peers). The experiences of nurses and auxiliary nurses in its authentic expression cannot be accepted from the vantage point of the dominant (virile) position—a subjective position which prohibits individuals from laughing at their own weakness or from expressing any tenderness towards the twisted individuals that we all are. These stories which constitute in fact a narrative of the experience of care are perceived as “slices of life,” as anecdotal and not quite “serious,” and paradoxically can even be taken to represent a lack of respect towards the patients. The very health of the staff providing care appears improper. How can you laugh about it?

The Contingency of Care

“Nursing is by essence the work of women,” wrote Désirée Magloire Bourneville, who as leader of the reformist doctors at the end of the nineteenth century was the main proponent of the introduction of nurses into the public hospitals of Paris.²⁹ The nurse was considered

²⁹ In *Le Progrès médical*, Vol.7, 1878, p. 388.

at the time the main vector for the humanisation of care. The candidate was to be young because that would ensure she would be "docile" and "malleable" so she could be "educated according to her own nature" (as a woman), and become an assistant that was "tender and dedicated" towards the patients. However, the rationalisation of "scientific charity" through the division of labour constantly increased during the first half of the twentieth century. Services are organised according to pathologies, the organs to be cured, the different ages of life. Health work becomes more and more fragmented: the distribution of "basins" (urinals) and thermometers is assembly-line like, and so on. What is asked of the nurses is only their obedience (they are considered solely as operational staff with no power of decision) and their composure in the face of suffering and death—not their capacities for compassion.

In the 1970s, a new wave of the "humanisation of the hospital" emerges, denouncing this organisation of work and the reification of patients designated by their room number, the name of their pathology, or even their sick organ.³⁰ Common rooms are abolished, psychiatric hospitals and nursing homes are reformed, and new types of organisation are invented, like the sectors, day hospitals, long stay, palliative care, child-mother hospitalisation, and so on. New nursing schools teach a new conception of the nurse, inspired by the Anglo-Saxon tradition of clinician nurses, which rests on a more holistic conception of the person. New tools and practices are introduced.³¹ A new profession is invented: the auxiliary nurse. Their presence, especially for the patients in long stay, brings an undeniable improvement of living conditions. On all these levels, progress is undeniable, but it is fragile. Today, political choices concerning the restructuring of hospitals are made according to management and accounting principles. In particular, the main exercise consists of counting what treatments of pathologies are cost-effective, or not based on a conception of the treatment that is entirely aligned with productivist models. The main proponent of this kind of hospital management in France writes:

It is wrong to oppose quality and quantitative evaluation. Agreed, not everything can be measured easily, but companies in the industrial sector have established quantitative measurements for the satisfaction of their clients, rates of faults in the manufacture of electronic components,

³⁰ See M. Abiven, *Humaniser l'hospital*, Paris, Fayard, 1976.

³¹ See B. Walter, *Le savoir infirmier. Construction, évolution, révolution de la pensée infirmière*, Lamarre-Poinat, 1988.

rates of error in payroll or invoicing systems. Quality can also be measured. This is exactly what the "zero default" in quality circles aims for...³²

In the hospital's case, quality indicators are rates of falls, number of iatrogenic infections, and so on—care is never mentioned. Quality means something different from the perspective of management principles than it does for nurses and auxiliary nurses. In the perspective of management, care is reduced to the mention of "basic human gestures," to quote an expression from the press during the 2003 heatwave. The term "basic" signifies not only that the complexity of care is trivialised, but also that care and the "human" could be handed over to volunteers.

Care is not rooted in human nature. It is not triggered automatically by contact with the helplessness and dependence of others. Care is produced by a collective effort, a culture of caring for others, which is contingent and can disappear. As the organisation of work no longer makes satisfactory solutions possible, new collective defence strategies have been identified in a number of auxiliary nurse collectives. These new strategies make the nurses sort out the patients between those who are deemed to "deserve" to be treated as full persons (mainly those who cooperate and show gratitude) and those who are to be treated as sub-members of the human species, or even as things, because they slow down work and make it harder without showing any gratitude: typically, senile patients who have "lost their heads," drug addicts, alcoholics who "only get what they deserve," or women the day after a suicide attempt who "are just acting." There is only a small step from care to instituted maltreatment. Tomorrow, a hospital without care is possible.

Contemporary reflection on care is rich and full of promises. However, it will only fulfil this promise if it takes into consideration the material and psychological dimensions of care work. This requires interdisciplinary work between philosophers, sociologists and psychologists. Otherwise there is a danger that an abstract, top-down perspective will be taken which will *pass moral judgement* on practices and the individuals who perform them and deem them deviant. These individuals will find it all the more difficult to make themselves heard as they are at the bottom of the social ladder. In that case, care would

³² J. Kervasdoué, *L'hôpital*, Paris, PUF, 2004, p. 109.

become the good conscience of the elites. The main tasks for this interdisciplinary reflection would therefore be the following: to account for the tensions, twists and contradictions of subjectivity and intersubjectivity; to acknowledge the impact of the organisation of work on the capacity to provide respectful handling of patients; to analyse the "cursed share" of dirty work in care work—and most importantly, not to dissociate the two; to account for the complexity of care work on a psychological level; to uncover the forms of virility in expert discourses; and to identify the blind spot of work in political analysis, especially of female work.³³

Translated from the French by Jean-Philippe Deranty and Nicholas H. Smith.

³³ This essay was first published in French as "Le care à l'épreuve du travail. Vulnérabilités croisées et savoir-faire discrets," in eds. Patricia Paperman and Sandra Laugier, *Le souci des autres. Éthique et politique du care*, Paris, Editions de l'EHESS, 2006, pp. 299–316.

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