Climbing invisible ladders : how nurse's aides craft lateral careers

Anne-Marie Arborio

Ethnography, vol. 5, n° 1, 2004, pp. 75-105.

Climbing invisible ladders

How nurse's aides craft lateral careers

Anne-Marie Arborio
Aix-Marseille Univ., CNRS, LEST, Aix-en-Provence, France

ABSTRACT

Based on a field study combining biographical interviews and direct observation, this article examines the types of 'career' available to French hospital staff working under the title 'aide-soignante' (nurse's aide) but exercising a variety of duties in different establishments and wards. Whether their careers lead them to practise as 'quasi-nurses' where they perform nursing tasks without having the status and remuneration of a nurse, or to fulfil varied functions in a variety of working conditions within a 'horizontal career', they testify to the ambiguities of this occupation: it occupies an intermediary location within the paramedical hierarchy, yet it is difficult to move up from it to the level above; it is a devalued job, yet it has some value for those who practise it in the light of their past occupational and social trajectories; it is an occupation whose very fuzziness helps the institution to adjust staff numbers and skills according to its own needs. Under such conditions, the mobility of aide soignantes between differentiated posts enables them to make the best of difficult working conditions and to 'make a career' for themselves without changing their official status.

KEY WORDS

work, occupations, career, hospital, nursing, nurse's aide, paramedical sector, France

ANNE-MARIE ARBORIO is Maître de Conférences in Sociology at the University of Aix-Marseille and a member of the Laboratoire d'Economie et de Sociologie du Travail (LEST) of Aix-en-Provence. Her interests are in the sociology of work, medicine, social stratification and research methods. She is the author of *L'Enquête et ses méthodes: l'observation directe* (with Pierre Fournier, 1999) and *Un Personnel invisible. Les aides-soignantes à l'hôpital* (2001), as well as articles published in *Genèses* and *Sciences sociales et santé*. [email: arborio@univ-amu.fr]

The nurse is often seen, along with the doctor, as a key figure attending to the hospitalized patient. However, the division of labour process in the modern hospital has led other agents, sometimes equally numerous,[1] to play a part in everyday patient care. Under a variety of labels and with a variety of tasks assigned to them, different occupations have grown up with direct dependence on the nurse. The nurse thus finds herself surrounded by ancillaries as the result of a process akin to that described by Hughes (1951a) in the early 1950s. The delegation of some of the nurse's tasks has been seen as a solution to the expansion and diversification of his/her workload, stemming both from certain technical developments and from the greater concern for patient comfort and hygiene. They concern the least prestigious tasks, what (Hughes, 1951b) calls the 'dirty work'. Depending on the way the hospital was previously organized, this happened in two different ways: either there were already subordinate categories available to be given this 'dirty work', or new categories were invented for the purpose.

In France, a mixed route was followed: a new label, '*aide-soignante*', was invented (literally: 'care assistant', corresponding to 'nursing auxiliary' or 'nurse's aide' in translation), but it was used to designate staff who were already working carers, due to the restricted access to the title of nurse. In 1946 the title was restricted to state registered nurses, at a time when the shortage of skilled staff in French hospitals meant that they employed, under the title 'nurse', a personnel that was very heterogeneous in terms of educational qualifications and socio-occupational background. These employees, who were certainly not formally qualified but who had acquired a degree of experience from contact with patients, risked being discouraged by the new law that took away their title of nurse. Transitional measures were therefore put in place to prevent flight into other sectors: exceptional authorizations to practice as a nurse, and special examinations for entry into nursing school. The creation in 1949 of the rank of *aide-soignante* was aimed at those who had not been able to take advantage of these measures. The title, which indicated their participation in the task of patient care, distinguished them from the 'hospital service agents' (*agents des services hospitaliers*, A.S.H.), at the lowest level of the hierarchy, and entitled them to slightly more pay. What may now appear as an occupation in its own right, with its specific title associated with a qualifying training, was thus initially a simple administrative category designed to reclassify subordinate staff in the immediate post-war context: no precise content was assigned to it in terms of tasks, and no particular training was required in order to work under this title, which was intended to be provisional. Various factors nonetheless combined to perpetuate it. On the one hand, the existence of this new layer in the hierarchy gave a hope of promotion to staff taken on as 'A.S.H.', who rarely succeeded in gaining the diploma to move into the category of nurse. On the other hand, the existence of a new group bringing together staff trained 'on the job' made it possible to rethink the division of labour around the patient: why not reserve for nurses the tasks requiring a specific technical training and delegate the least skilled jobs to the *aides-soignantes*? The creation in 1956 of a 'Certificate of proficiency in auxiliary nursing' (*Certificat d'aptitude à la fonction d'aide-soignante*, CAFAS), and then of a year's practical training, completed the consolidation of the category, making the *aide-soignante* an auxiliary to the

nurse, responsible for the hospital's 'domestic' provision (supplying meals, cleaning and tidying around the patients), for assisting patients with their daily needs (helping them wash, emptying bedpans, helping them make their way to the toilets, helping them to make phone calls, etc.) or the everyday observation of their state of health (taking urine samples, taking their temperature, or simply glancing regularly into their rooms, etc.).

Aides-soignantes thus constitute an intermediate category in the hierarchy of the paramedical staff, between the nurse and the A.S.H. But there is no real continuum between these three categories: *aides-soignantes* work under the control and the instructions of the nurse; in terms of their socio-demographic characteristics (see Box 1) they are closer to the A.S.H. who are responsible for cleaning and other support tasks; few *aides-soignantes* manage to rise to the status of nurse in the course of their careers. Despite their subordinate position and their assignment to what are seen as unrewarding tasks, *aides-soignantes* manifest a certain stability in their employment, especially in comparison with the A.S.H. who have a very high rate of turn-over, and in comparison with nurses, who have various career opportunities before them – becoming specialist nurses, becoming 'head nurses'[2] or instructors, or going freelance. 'Making a career' in the traditional sense of advancing through a hierarchy of posts requires an *aide-soignante* to change her category in order to become a nurse, by overcoming the hurdles of the competition for entry to a *baccalauréat*-level nursing school and the diploma for state registration marking completion of three years of post-*baccalauréat* study. This is extremely difficult for individuals who have been recruited on the basis of very modest educational requirements. The best that most of them can look forward to is to find some improvements in a job that enjoys little prestige and in which the working conditions are often arduous. Are the possible changes in working practices or posts that may be observed in the course of hospital working life part of such improvements? More precisely, do these forms of mobility make it possible to analyse the trajectories of *aides-soignantes* within the hospital in terms of 'career', in the 'horizontal' sense that Becker gives to the term (Becker, 1952a)? I am interested here not, as I have been on other occasions (Arborio, 2001), in careers as trajectories running from entry into an activity (starting on the basis of a past social and occupational trajectory) to departure from that activity, but rather as successions of differentiated working practices, possibly involving changes of post within the hospital institution. The 'play' that is possible between titles and the posts occupied under those titles (Bourdieu and Boltanski, 1975) offers opportunities for changes of activity for an individual and change of position for an occupational group as a whole. Beyond the concrete conflicts around the division of labour that can be observed in a single workplace, the macro-social context has its importance in understanding the process of professionalization of the group that is in question here. Moreover, in the case of France, the state plays a particularly significant role as the source of the legitimation of occupational groups (Abbott, 1988: 193), especially for hospital occupations where the state defines titles and attributions and is the main employer. But it was decided here to concentrate on the individual forms of mobility of *aides-soignantes* within the hospital institution, taking into account the constraints stemming from the functioning of the institution within which they are set, and on the assumption

that these trajectories contribute to the definition of the social position of the group at the same time as being its product.
Start box

A category to fall back on in the years of job shortage

Aides-soignantes are the second-largest group of non-medical health professionals after nurses: according to the 1999 employment survey by the French national statistical institute (Institut National de la Statistique et des Etudes économiques, INSEE) in that year there were more than 330,000 of them. The growth rate of this group (53 percent between 1983 and 1999), is greater than that of the nurses (38 percent over the same period), and much greater than that of the A.S.H. category (whose numbers have remained stable for several years as more work has been outsourced), has increased its relative weight in the structure of the paramedical professions (Roumiguières, 2000).

In the context of a labour-market crisis that was particularly severe for the least qualified women, the employment-creating capacities of an occupation seen as 'women's work' (92 percent of *aides-soignants* are female) and requiring a modest initial level of education,[3] made it a job that was much sought after. In 1999, 84 percent of *aides-soignants* had qualifications lower than or equivalent to the BEP (*Brevet d'études professionnelles*, a technical school certificate), and 14 percent even had none at all. Increasingly, in the younger generations that have benefited from the opening-up of the school system, access to training to become an *aide-soignante* follows on immediately from their obtaining a BEP or a CAP (*Certificat d'Aptitude Professionnelle*, a vocational training certificate) (61 percent of *aides-soignantes* had one of these qualifications in 1999). The *aide-soignante*'s diploma, which allows a rapid entry to the labour market with a recognized qualification, is then seen as a way of rounding off a school career which may hitherto have been somewhat difficult (Arborio, 2001: 154–72). The young entrants with the highest qualifications, particularly those with the *baccalauréat*, do not aim to stay in this category but hope to use it as a 'springboard' for entry to training to become a nurse.

For most of those who are now *aides-soignantes*, entry into the occupation came later in life, after very varied experience in employment and sometimes after 'bumpy' vocational or family trajectories, marked for example by divorce or unemployment (for themselves or their spouses). *Aide-soignante* training courses have moreover been used in: employment policies as a way of moving some of the long-term unemployed out of that situation; in the context of policies of social re-integration for beneficiaries of the *Revenu Minimum d'Insertion* (guaranteed minimum income allocation); or for ex-prisoners. Working in the hospital, and *a fortiori* becoming an *aide-soignante*, can be read as an entry into 'therapeutic employment' (Arborio, 2001: 185–90).

Most of the people concerned are women of working-class origin. Like the A.S.H., *aides-soignantes* are predominantly the daughters of blue-collar workers (44 percent in 1999), of clerical workers or of farmers (14 percent and 15 percent respectively). The daughters of the intermediate occupations (12 percent) or

senior executives (4 percent) are not absent, but they are less strongly present than among nurses and they have not increased in relative terms over the last few years, even though those groups have increased proportionately within the population.

Unemployment is low within this category. Their wages are not high within the overall range of wages, but, for the *aides-soignantes* who were interviewed, they were often higher than the wages they had earned in their previous jobs. According to the 1999 INSEE survey on employment, the average net monthly wage of *aides-soignantes* amounted to 7800 francs (almost 1200 euros), with differences between the public and private sectors (the average wage in the public sector is 20 percent higher than in the private sector). Among the nurses who worked alongside them, 73 percent earned more than 9000 francs (almost 1400 euros) a month, according to the same survey, when the average net monthly wage in France was equivalent to 1600 euros.
End box

With the aid of biographical interviews it was possible to reconstruct retrospectively the trajectories of 51 *aides-soignantes*, through discussions that were sometimes repeated and were always recorded, with particular attention paid to the processes, and to the career sequences marked by modes of adjustment to the institution. The analysis is based on the 'two-sidedness' which gives its interest to the concept of career (Goffman, 1961: 119), exploring both the objective dimension, which here means the succession of statuses and clearly defined tasks in a situation in which the workers in question do not rise in the hierarchy, and the subjective dimension, in other words the perspective in which the person sees his/her life as a whole and interprets its meaning in relation to decisive events, with particular attention to the 'moral career' of these workers (Goffman, 1961: 119). The interviews were conducted mainly in three establishments: a public hospital in Paris – referred to below as H1 – in which other materials were also collected at the same time (archives of regulations, staff files, etc.); and two establishments in Marseilles, a public hospital and a private clinic – which I shall call respectively H2 and C – in which observations were also carried out. In both Paris and Marseilles there are enough establishments to allow staff to move from one to another independently of any residential mobility, and they are large enough to allow staff to move from one post to another within the establishment.

The material collected grew in quantity and variety, from leaflets handed out at the door of the establishment, to participation in staff 'drinks parties' marking various occasions, and including sources such as conversations snatched in corridors. The analyses are based on the combination of these materials, in which direct observation of working practices played an important part.[4] Systematic recourse to observation was necessary in order to move beyond discourses about practices and to appreciate the dynamics of the everyday division of labour and the negotiation processes involved in it, as well as to discover the range of types of posts occupied by *aides-soignantes* and their different ways of occupying them. The research took the form of a real

participation in work activities. It seemed to me to be inappropriate to be a mere observer, albeit in uniform: standing aside when an *aide-soignante* is struggling to lift an immobile patient, or to push a very heavy trolley, or to answer multiple requests or bells, is not something he/she can readily accept, especially since the tasks to be performed are often too simple for the observer to be excused on the grounds of technical difficulty. It seemed preferable to adopt an already existing role, identical to that of the people I was interviewing.[5] This participation did not aim to try and make me feel what *aides-soignantes* feel by assuming their position, but to enable me to be accepted as an observer and to give me a role that would guarantee the intensity of the observation. I therefore obtained the authorization to work with a similar status to a trainee, alongside the declared intention of making a study, asking, for that purpose, to be treated as an *aide-soignante* in training, who needed to be initiated into the work without being regarded as competent from the outset.

The choice of ordinary wards (internal medicine and general surgery) was important in order to be able to observe banal situations, corresponding to the frequent, if not 'normal', conditions of the job of *aide-soignante* and to consider the homogeneity of the work on the basis of comparisons between units and between establishments but also between different situations in the same units – depending on the teams, the staff, the type of patient, etc. The variety and intensity of the activity in a hospital ward limited any handicap due to the brevity of the observation: in contrast to observation of the life of a village, for example, where public events do not occur in a continuous or concentrated way, in a hospital ward many things happen in a single day. I further increased the intensity of the observation by adopting the same schedules as the *aides-soignantes* but taking almost no rest periods. This enabled me to be integrated into several teams, while at the same time the relaying of teams meant that this 'over-eagerness' went unnoticed. By observing the working hours of the ward[6] I was able to be present at all moments of the day – the 6 am coffee-break seemed to me to be as important as the waking of the patients and the distribution of thermometers at 7 am. Following the arrivals and departures of the patients day by day, I acquired a good awareness of the composition of the 'clientele' compared to that of an *aide-soignante* who, after two days off, has to take the time to catch up.

The presence of a succession of different trainees in the hospital facilitated my integration: I was just one more person learning the job in the ward. In the first few days I had to explain to each team who I was and what I was there for, which generally aroused astonishment: 'Well, it isn't often that anyone takes an interest in us *aides-soignantes*!' and sometimes some reluctance: 'I'll show you and then you can work on your own, you don't need to be with me all the time.' My respect for the exact schedules and the rhythms of the group helped to overcome this reluctance and to integrate me into the team, if only because people do not generally decline the help of an extra pair of hands if they are offered when there is hard work to be done.

My participation had nonetheless to be renegotiated throughout the fieldwork, in particular when I had to integrate myself into a new team. Each time, however, I had stronger 'arguments' to put forward: on the one hand, I

could point to tasks already performed in other wards or with colleagues in another team in the same ward; on the other hand, real participation in those tasks gave me a certain 'know-how' that was reassuring for the *aide-soignante* who had to work with me but not so great that my presence could be interpreted as a monitoring of the quality of the work. The situation did, however, remain ambiguous, since because I was providing an extra pair of hands relative to the normal teams, I was observing a situation in which the ordinary workload was alleviated by my participation. The *aides-soignantes* themselves feared that I might be seen by outsiders as a full assistant, while at the same time they appreciated my sharing in the work. One scene among others illustrates the ambiguity of the situation: when a head nurse asked her to help the nurse prepare the medication, the *aide-soignante* replied: 'Just because I've got this girl with me today, that's no reason to pile on the work, is it?'

My position as an observer was known to the staff, but it was effectively *hidden* for the patients, to whom I appeared, in my uniform, as a member of the ward staff, and most of the time *unspoken* for the doctors, for whom an *aide-soignante* may sometimes remain entirely 'invisible' (Arborio, 2001: 113–17). My integration 'on the ground' and my understanding of the various situations was facilitated by my status as a 'semi-insider', linked to my background.[7] This reduced the distance between our respective social positions and, above all, I was able to avoid some of the clumsiness of intellectuals who are plunged into a setting very remote from their own by knowing in advance some of the procedures, some elements of the 'jargon', the techniques of social interaction, the topics of conversation or jokes. It also gave me permanent contact with a privileged informant in a position of continuous observation.

One aspect of these careers, which are seen as a succession of differentiated practices, is the concern of some *aides-soignantes* to accumulate proximity to the nurse, even if this remains unofficial. But, for others, the main objective seems to be to cope with difficult working conditions, through a mobility between posts that takes them a significant distance away from the most specific work of the *aide-soignante* and testifies to the existence of some 'play' around the division of labour.

Nurse's assistant or quasi-nurse? The effects of a 'variable geometry' post

A move from the category '*aide-soignante*' to the category 'nurse' may be a rarity, but observation of work in a nursing ward shows that the performance of nursing practice by *aides-soignantes* is much less uncommon. This discovery is somewhat surprising, given that the occupation of *aide-soignante* was invented to draw a clear line separating the state registered nurses from other staff who had previously worked under the title 'nurse' without having a specific training, and that the subsequent regulation of activities has constantly separated the two and assigned specific roles to each. Although it contradicts the official rules on the assignment of tasks, the fact that *aides-soignantes* take on some of the tasks of nurses is sometimes clearly written into the establishment's organization of work. For example, at clinic C, the *aides-soignantes* are systematically responsible for preparing and distributing medication; they also take patients'

blood pressure and temperature. For other tasks, this slippage is sometimes allowed only for one particular *aide-soignante* and never for his or her colleagues. For example, at C, Michèle (age 36, qualification: first year of a BEP in hairdressing, divorced, two children) is the only one allowed to change dressings.

> The first time I had to work in a team with Veronica, she explained to me in the morning, as we were putting on our overalls, that she does not work at all in the same way as Michèle ('who is crazy, she'll do anything'), that 'there is no question for [her, Veronica] of playing the nurse, since [she is] not responsible'. She nonetheless performs tasks, such as taking blood pressure, that are often reserved for nurses, and she follows with interest the technical demonstrations that a head nurse provides for a new nurse. So, one *aide-soignante*, Michèle, 'stands in' as a nurse, whereas the other, Veronica, endeavours to do only her 'own' job. But she gains no additional rest-time on that account, since she has a broader definition of each of her tasks: for example, it is a point of honour with her always to re-seat the disabled patients in an armchair after helping them to wash – by which means she distinguishes herself from Michèle – and she was more willing to call on my regular assistance so as lighten the tasks of lifting and moving that we performed together, than to give me some autonomy and to delegate to me, as Michèle did, some tasks that I could perform on my own in her place. (Notes from observation at C)

Elsewhere, the slippage of tasks is observed only in certain posts, such as those of the night shifts, when there are fewer qualified nurses on duty, or by way of an exception, when there is an emergency or an organizational problem (for example, when the nurse with whom she normally worked was replaced by a temporary nurse whom the head nurse judged to be incompetent, Michèle carried out injections and other technical procedures), or because a given *aide-soignante* has learned a technical procedure and wants to keep it up:

> One afternoon, when the two *aides-soignantes* were sitting in the staff-room, having a break, Amandine (a young nurse) put her head round the door and said: 'Anita, will you come now? I have a catheter to insert'. Anita calmly got up to follow her and then turned to me: 'You come too, it's interesting'. Seeing a slight hesitation on my part, she added: 'It's no big deal, you know, we do it all the time'. At that moment I had not yet realized that she was going to perform the procedure herself, I thought she was simply going to assist Amandine, if only by talking to the patient. In the patient's room, Amandine had brought in all the equipment on a trolley, Anita put her gloves on and it was Amandine who got the patient into position and talked to

> him, while watching what Anita was doing: 'OK, that's fine, carry on'. It was the first time I had seen this procedure carried out by an *aide-soignante*, and I remarked on this to both of them as we left the room. Amandine answered for Anita: 'You know, with all the things that she has actually . . . '. 'There's not much right now, but when we have a bit of time and when she enjoys doing it . . . '. 'Yes, that way I am still in charge, but, well, there are quite a few things I wouldn't know how to do any more'. (Notes from observation at H2)

These are practices performed regularly by a few *aides-soignantes*, if only because in order to gain the expertise needed to perform technical procedures that require a certain familiarity to do them properly, one has to do them regularly. Can access to these procedures be analysed as a discontinuity in the occupational trajectory of the *aides-soignantes* concerned?

Advantages in working more?

Because of the framework of rules which defines the attributions of each occupation with implications in terms of responsibility, the *aide-soignante* cannot be officially allowed to practice as a nurse, and this 'career move' therefore remains *unofficial*, which prevents him/her from receiving the higher pay given to the nurse. In the public hospital sector, which employs some 75 percent of all *aides-soignantes* (Roumiguières, 2000), the *aide-soignante* receives a monthly bonus of about 150 euros compared to the pay of the A.S.H., and his/her remuneration increases in the course of his/her career in accordance with a scale defined by collective agreement, making no allowance for the procedures he/she performs. In the private sector the rules are more flexible and enable Michèle (mentioned above) to be paid more than her colleagues on account of the services she renders. Another – male – *aide-soignant* is also paid more than the other *aides-soignantes* in the clinic: he negotiated it on the basis of his practical skills, since he was hired to replace an operating-theatre nurse. When he learned that his pay was still 350 euros a month less than the nurse's pay, he managed to secure a further bonus.

These non-systematic material advantages are not sufficient to explain why *aides-soignantes* take part in nursing activities beyond their traditional role. The value set on technical procedures in hospitals and the corresponding devalorization of most of the tasks habitually performed by *aides-soignantes* also play a part in this. It has to be said that the *aide-soignante* is charged with 'dirty work' in a more literal sense than that in which the term is normally used: he/she is given tasks universally regarded as unpleasant and degrading, in particular those involving human excreta.[8] Taking on some of the tasks of a nurse is also a way of securing the right to refuse these less desirable tasks, leaving them to other *aides-soignantes* or even to the nurse him/herself. The nurses are willing to lend a hand in, for example, washing patients in exchange for the help of the *aides-soignantes* in more technical acts at times when this relieves the monotony of the work or reduces its unpleasantness. This makes it possible to reintroduce teamwork at times of low staffing levels, for example at night and over weekends.

It can be a way of avoiding the invective or groans of a patient undergoing nursing procedures by creating a diversion or allowing a nurse to act out his/her power. In return, it can reduce the intense efforts of the *aide-soignante* to make the bed of a patient who cannot get up. This reciprocity implies a proximity between *aides-soignantes* and nurses which is not self-evident in all wards or in all teams: 'handing-over notes' are often exchanged only between nurses, the times and places of social interaction at work are sometimes clearly demarcated and the *aides-soignantes*, unlike the nurses, are not invited to the visit of the doctor in charge of the ward.

While some *aides-soignantes* may find it advantageous to let their jobs expand in this way, it would be a mistake to suppose that they are all motivated by a desire to become nurses or, even occasionally, to act as nurses. Every aspect of their training encourages them to stay in 'their' place: the *aide-soignante* learns as much what he/she is forbidden to do as what he/she has to do. Taking on tasks for which one sees oneself as less than fully competent can have a negative impact on self-esteem.

> At H1, the general manager of all paramedical staffs, the *infirmier général*, tried to establish the use of a standard document for liaison between *aides-soignantes* which would formalize their hand-overs in the same way as for nurses. The staff reacted in a variety of ways to this exercise. They all said it was an extra demand on their time. For some of them the situation created a real fear that was perceptible in their discourse and in the strategies to which they resorted to avoid the exercise. For example, when Maryse (age 45, with a *Certificat d'études primaires* (Certificate of primary education), married to a blue-collar worker), was questioned informally about this initiative, she replied: 'I never fill in the form. I don't have time and there's no point. People talk to each other and that's the way it has always worked.' A bit later in the conversation she said: 'The other day, one of the *aides-soignantes* had left and the others said, "Let's have a look at her notes." Then they said they couldn't read them, or that there were spelling mistakes . . . So you can understand why someone wouldn't want to write them'. (From fieldwork notes at H1)

In contrast to those who start to pursue an unofficial career, these *aides-soignantes* tend to differentiate themselves clearly from the nurses. They take refuge in a discourse which valorizes their tasks, such as the washing of patients, emphasizing the monopoly that they claim it gives them on emotional relations with the patient.[9]

Acceptance of an unofficial career

The role of quasi-nurse, albeit unofficial, has to be accepted by the *aide-soignante*'s colleagues. In particular this happens at the nurses' discretion: for certain specific acts, acquisition of technical mastery comes through informal 'on the job' apprenticeship provided by the nurses. Becker and Strauss (1956) have

pointed out the dilemma faced by nurses in diffusing this know-how, the monopoly on which is a source of power for them. In the case of Michèle or others, the head nurses took charge of their training on the job. In the case of another, who has the task of applying dressings, the training was given by the operating theatre nurses instead, supervised by the surgeon.

But it is not enough to learn certain actions. The *aide-soignante* has to be working in a context in which he/she can make use of these possibly very considerable competences. Private establishments are sometimes presented as more favourable to such practices, but I have seen that they are by no means absent from the public sector. In either case, it depends on the nature of the ward: intensive care units are exemplary in this respect, since emergencies sometimes create overriding needs. It also depends on the shift: there are fewer qualified staff on duty at night. The organization of work that prevails in the ward seems to be the important factor in determining whether these practices are allowed.

The tendency will be much greater where the head nurse accepts this organization and even perhaps facilitates it, sometimes by training the *aide-soignante* to do certain things him or herself, and by taking on the responsibility for them. The problem of responsibility for the *aide-soignante*, who is supposed to work under the authority and supervision of the nurse, through delegation of work, is crucial both for establishments and for staff in these situations.[10] In the operating theatres of clinic C, the head nurse explained that, in her presence, there is 'no problem', since she considers that every act performed has been delegated by her. The problem arises for weekend duties, which she did not want to deny to the *aides-soignantes* 'standing in' as nurses on account of the additional pay this gives them (although their status does not allow them to assist a surgeon except in the presence of nursing staff): 'If there is the slightest problem, I'll say that I was there'. So this *unofficial* career must, paradoxically, be known and recognized, at least at this level of the hierarchy. It implies a social equilibrium that is negotiated on a daily basis.

Such practices are sometimes more than accepted, they are encouraged. Indeed, they are indispensable to the functioning of the hospital, if only in budgetary terms, because of the difference in pay between a nurse and an *aide-soignante*. This is particularly true for private establishments. For example, in clinic C, even the *aides-soignantes* who presented themselves as 'staying within their limits' performed many more nursing tasks than were observed in public hospitals. It is also a means of smoothing the ups and downs of recruitment: nurse departures are not always foreseeable and in a professionalized universe in which the labour markets are segmented and closed (Paradeise, 1988), the inflows are regulated by the number of places offered in the competitive examinations for entry to the nursing schools leading to the state diploma, with a three-year time lag. When there is a relative shortfall in the supply of nursing for which there is no short-term remedy (for example, through a simple increase in the pay that is offered), the 'stand-ins' take on the workload normally reserved for the professionals without acquiring either their titles or their rights.

A fragile position

The presence of experienced *aides-soignantes* capable of standing in for the nurse in some or all of his/her tasks makes it possible to cope with possible 'breaks in production'; to respond to the emergencies or difficulties that any newly qualified young nurse encounters; and to make good any inadequacies that may result from his/her lack of experience. The relative reversibility of the position of quasi-nurse gives a little extra flexibility to personnel management. This no doubt explains in part why the institution accepts it without officially recognizing it. But the position of the *aide-soignante* concerned is made more fragile as a result of this.

This is because when the conditions for working as a quasi-nurse are no longer present, or when the nurses or head nurses no longer accept the situation, the gap between nominal identity – *aide-soignante* – and real identity (Bourdieu and Boltanski, 1975) – nurse – is likely to be called into question in a lasting way. Roselyne (age 38, secondary schooling to the level of the BEPC (certificate of first part of secondary schooling), parents and spouse are clerical workers, three children) started but did not complete the course in nursing school. When she returned to H1, she willingly took on a number of tasks (taking blood pressure, etc.), which led her to think that she had advanced. However, when she returned from maternity leave, taking the view that 'with the new nurses, things aren't the same' (in other words that the condition of reciprocity was no longer fulfilled), she chose to no longer perform nursing tasks. But the reversal of situation may be more imposed than elective.

> Josette has spent virtually her whole career in the blood bank of a Paris hospital and then at H1. When she was expecting her second child, unmarried, in the 1950s, having only her certificate of primary education and some experience of child-minding, she left her native region and her parents' farm for Paris, attracted by the possibility of living in a hostel that accepted pregnant girls and the prospect of working in a crèche that needed wet-nurses.
>
> Seeking a steady job, she presented herself in a Paris hospital and was recruited to work in its blood bank. In a context of a shortage of nurses and at a time when great uncertainty still surrounded job titles and attributions, she was soon trained to take blood samples, an act normally entrusted only to nurses. She asked for a transfer to be closer to her home, when her 'boss' (the consultant in charge of the unit, a figure of some renown) found her a post in another blood bank (at H1). Likewise, she trained to become an *aide-soignante* only when she had the assurance that she could return to her post (and even that she would spend most of her practical placements there) and refused even to discuss training as a nurse, which would take her away from that unit for a long time. She has done the same job for more than 30 years, first as an A.S.H. and then as an *aide-soignante*. The title *aide-soignante* means nothing to her,

> compared to the performance of nursing tasks and the recognition of a prestigious consultant.
>
> The recent arrival of a new nurse, in the context of a crisis over blood transfusions (following the HIV-contaminated blood scandal) which has reduced the activity of the unit, has led Josette – in the absence of formal qualification as a nurse – to abandon blood sampling, which is now reserved for the new nurse, and to restrict herself to the maintenance of equipment and administrative activity while waiting for her retirement, which was imminent at the time of the interview.

The position apparently achieved through an unofficial career thus turned out to be very fragile. The uncertified competences of the 'quasi-nurse' depend on his/her continuation in the unit that has recognized them. Even then, a downgrading of the position acquired cannot be ruled out if the organization of the unit changes. This sudden denial of the right to practice competences acquired in the course of a career is no doubt a source of malaise for the *aides-soignantes* who found some interest, more symbolic than financial, in this identification with nurses: it brings to light the 'positional suffering' (Bourdieu et al., 1993: 11 [1999: 4]) of these subordinate staff, assistants to health professionals who are themselves enveloped in a prestige from which they do not benefit.

In hospitals, nominal differences therefore sometimes mask real identities, in accordance with the logic of the 'stand-in' (Bourdieu and Boltanski, 1975). For the *aides-soignantes* who thus work unofficially as quasi-nurses, the label *aide-soignante* does not have much value except as a substitute for the title 'nurse'. Are there other routes, perhaps more official, less fragile ones, available to *aides-soignantes* to modify their conditions of practice under the same nominal identity?

From post to post, under the same title

Most *aides-soignantes* work in wards where nursing care is provided, in accordance with the regulations, and thus use the skills acquired during their training. However, some of them perform tasks somewhat remote from the formal definition of the activity, when it is neither a case of a simple variant of the same occupation that could be interpreted as an application of specific social skills, nor a case of 'standing in' for a nurse through an unofficial career, but rather of quite different administrative or technical functions. For example, an *aide-soignante* in a paediatric ward is assigned to the infant formula room, where he/she assists the dietician in preparing the children's food. In H1, *aides-soignantes* called 'hospital secretaries' assist the head nurse: they plan staffing schedules, place orders for equipment and supplies for the ward and arrange appointments. In the emergency ward at H2, an *aide-soignante* is in charge of the reception of patients; a male *aide-soignant* does a similar job for the whole hospital at the main reception desk. The *aides-soignantes* assigned to the operating theatres are often restricted to tasks of sterilization and cleaning. In

the outpatient department of some wards, they admit patients and clean the instruments. Some *aides-soignantes* even occupy posts in departments whose work is entirely administrative or technical: in H1, some are assigned to the personnel department and the management of the staff mutual insurance scheme, others to medico-technical or technical services such as radiology, the laboratories, the pharmacy or equipment management.

In these areas, do they perform tasks requiring a competence specific to *aides-soignantes*, a knowledge of the hospital units that is not possessed by staff untrained in nursing care? Not really, since the posts occupied by the various categories of staff in this type of unit are often identical in all respects. The need to know about medical equipment is put forward by the head nurse in charge of the 'store' (logistical unit) to justify the presence of nursing staff – his/herself, since he/she is a head nurse, or his/her deputy, a nurse. The presence of (male) *aides-soignants*, responsible for the handling of heavy equipment, is harder to justify: at most it can be said that their years of service and their experience facilitate relations with the units in which they deal with former colleagues. Everywhere, these posts are equally well filled by other categories of staff, with other statuses (administrative staff, A.S.H., sometimes also nurses). In other words, one finds in hospitals various kinds of 'free zones' from the point of view of occupational status.

A rapid inventory of the positions occupied by *aides-soignantes* in a single organization brings to light a relative diversity of duties, posts and working conditions: the nominal identity covers real differences (Bourdieu and Boltanski, 1975: 95). It is thus reasonable to hypothesize that under a single title, that of *aide-soignante*, there is room for a degree of mobility obtained by changing post between positions sufficiently differentiated for it to be possible to speak of horizontal careers (Becker, 1952a). This dimension is not necessarily exclusive of the vertical career dimension: doctors, for example, are well known to have an interest in working in a particular prestigious unit or establishment in order to secure promotion. However, when the vertical dimension, which is normally privileged, is limited, as is seen to be the case for the *aides-soignantes*, the horizontal dimension takes on its full importance.

Posts sought after by aides-soignantes?

In order for it to be possible to speak of 'careers' here, the different positions accessible under the same name must present different attractions, depending on the problems they present to those who occupy them and the symbolic benefits they derive from them. For operatives in the automobile industry, in a context in which the old system of internal promotion has seized up, the only hope of mobility lies in avoiding the rigours of the production line (Beaud and Pialoux, 1999: 111 ff.); for postal workers, a change of 'delivery round' or permanent assignment is decisive, because the characteristics of the neighbourhood in which they work has such a bearing on their working conditions and their social status (Cartier, 2003: 103 ff.). What dimensions of the posts offered to *aides-soignantes* can be identified as capable of determining comparable preferences?

Since the title *aide-soignante* is valid for employment in this capacity throughout France in all public or private establishments, the differences between establishments constitute a first argument justifying mobility. This

needs to be interpreted first in relation to the residential or family trajectories which play a part in orienting it: especially for *aides-soignantes* working in the hospitals of Paris, as given the characteristics of the Paris housing market, the search for new accommodation to meet an increase in family size sometimes requires a move into the outer suburbs. The burden of commuting then leads to requests for transfer to more outlying establishments. This form of mobility is facilitated in the largest cities by the large number of public establishments managed within the same administrative structure.

In the private sector, the move from one establishment to another, when the two are under different managements, can be understood as the product of other constraints, more directly linked to the operation of the labour market. 'Making a career' means seeking the 'best' establishment, in terms of working conditions for the type of tasks to be performed or for the financial remuneration that is offered. Mobility between establishments sometimes corresponds to a circulation between establishments with different status – public and private. Some of the *aides-soignantes* interviewed who were working in the public sector had first worked in the private sector; and some of them had even continued to do so, with occasional night-shifts, after appointment to a public hospital.[11] The private sector is seen as the site of the first appointment, perhaps easier to enter than the public sector, access to which is regarded as relatively closed. The assistance of third parties, particularly relatives, is mobilized in either case, either in the form of direct approaches, or to point out potential vacancies, or to persuade someone of the possibility of benefiting from them.

The objective oppositions between the statuses are well known: the public sector offers job security and professional advancement is encouraged. However, in the private sector, finding a job and changing establishment are presented by the *aides-soignantes* as being relatively easier, especially with the *aide-soignante*'s diploma (the CAFAS), although here too it seems that use is often made of a network of social relationships. A job in the public sector offers a status whose symbolic effects are recognized as particularly important, especially for *aides-soignantes* who have entered the hospital world as a result of a biographical accident. Once experience of the job has been gained in the private sector, the status of public-sector employee is often sought for all these reasons. Those *aides-soignantes* who pursue their careers in the private sector stress the greater value that is placed on the professional skills that are acquired, making work in that sector a necessary condition for their unofficial careers. The differentiated statuses of establishments thus constitute a strong reference point in the discourse of evaluation of careers and the job.

Mobility between establishments or between units can also be a tool in the pursuit of the best possible working conditions, especially as regards working hours. Confronted with the requirements of hospital work, which calls for the presence of staff 24 hours a day, seven days a week, the *aides-soignantes*, 90 percent of whom are women, tend to try and negotiate better working hours within their unit, in relation to their personal criteria, or to seek a transfer to a unit where the conditions are more compatible with their family life. In hospital H1, where staff members are assigned on a long-term basis to a single type of shift (morning, afternoon or night), preferences between the different shifts are

decided by a waiting-list system. The afternoon shift seems to be the hardest one to fill: the rules giving priority according to years of service mean that the afternoon duties are assigned to staff starting out in the unit (possibly after being transferred into it) or to staff returning from training. If the shift is not readily compatible with domestic life, the *aide-soignante* will make strong requests for a change of post and will watch out for the publication of vacant posts. 'Career' is sometimes presented as a progression through these different timetables. However, on this point, like others, there is no universally shared hierarchy of preferences, given the variety of personal situations and the changes in expectations through the lifecycle. For example, Roselyne was initially employed for the afternoon 'watch', which she always disliked because of the very late journey home to a remote suburb. She then secured a morning shift, but later asked to be moved to the night shift so as to be able to take her children to school. She is considering giving up this night post once the children are older, but knows that she will be back on the afternoon shift until a morning shift becomes free again.

At hospital H2, by contrast, there is a rotation in the course of each week between morning and afternoon shifts (this rotation sometimes includes the night shift for the nurses). In this case, on the basis of the schedule drawn up by the head nurse, the optimum calendar is worked out through negotiation between colleagues or with management. This negotiation also covers the distribution of weekly rest days and annual leave on dates to suit everyone: one *aide-soignante*, the mother of three children, has a regular day off on Wednesdays (when there is no school), in a unit where the other *aides-soignantes* are all single or the mothers of pre-school children. At hospital H2, during the breaks taken in the staff room, providing a chance to snack or have a cigarette, the colleagues would sit together around a table that stood against a wall on which was displayed the monthly schedule and also a provisional calendar of the summer holidays; each break was an opportunity to comment on the schedule, to express pleasure at the chance to go out somewhere on a day off that had been hard to win, or to complain at being prevented by the rigidity of the timetable. The simultaneous presence of the group of colleagues made it possible to negotiate new arrangements, in various combinations, often contingent on the agreement of an absent colleague, in which case the discussion has to be adjourned until the next day. Peneff observes and describes similar scenes as a 'marketplace for timetables' (1992: 190). The breaks are also an opportunity to agree the hours to be made up, or to calculate the pay one can expect for the coming month, which can be significantly enhanced by bonuses of 50 euros for working on a Sunday. The introduction of this bonus has changed the perception of Sunday work: far from being avoided, these better-paid days are often sought after by the staff, who take care to share them out equitably and comment indignantly on any unfair distribution planned by the head nurse.

For an *aide-soignante*, whose wages are lower than those of a nurse, the quest for optimum working hours is not necessarily aimed at giving him/her more time with his/her family or more leisure for him/herself, but sometimes at freeing up time for a second job providing additional income. The 12-hour day is presented as an advantage by the *aides-soignantes* at C, in particular because it

enables them to pursue a second activity, whether educational – like Claudine, who is studying for an examination that will give her the equivalent of the *baccalauréat* – or professional, like Michèle or Veronica, who work to supplement wages that they regard as inadequate. Michèle works for an old person whom she helps to go for a walk two or three afternoons a week, but she also earns additional income within her own establishment by covering for absent colleagues in her own unit and indeed anywhere else in the clinic whenever this is compatible with her basic timetable. In the course of one of the weeks when we were working together, she twice did a night shift in addition to her normal day shift, making a total of 72 hours in the week, including two periods of 24 consecutive hours.[12] Others supplement their income by registering with a 'temping' agency and regularly accepting assignments. The need to seek additional sources of income often puts *aides-soignantes* in situations of illegality by forcing them to work undeclared, and it gives a harder edge to negotiations over timetables.

When this necessity is less pressing, an individual solution to the question of working hours consists of securing one of the specific posts with hours close to the 'norm' of work from 8 am to 4 or 5 pm, with even, for some, regular weekly time off, grouped at the weekend, the disadvantage being that one no longer works exactly like an *aide-soignante*.

> I work alone here, so you see . . . Like today, I've got ahead of my work for tomorrow, and even a bit ahead for the day after, because tomorrow I need my whole day. And then, here, I have all my weekends off. Because I have more than my working life to think about. I can only see my fiancé at weekends, and if I had to work . . . Here, I don't feed all and sundry, I don't wash patients, I don't make beds. . . . Becoming an *aide-soignante* was of no help to me, I could have done it by correspondence. Besides, the colleague I replaced was an A.S.H. (Christine, age 30, BEP in 'health and social subjects', father and spouse are blue-collar workers, no children)

Relations with the clientele are the third determinant of the mobility sought by *aides-soignantes*. This is a central question for all occupations dealing with 'clients', especially the self-employed (Hughes, 1963; Hasenfeld, 1972). For *aides-soignantes* as for other hospital paramedicals, the 'clients' are imposed: by definition they have little power over the inflows of the hospital 'clientele', despite attempts at negotiation with the emergency ward (Camus and Dodier, 1997) which plays the role of a 'people-processing organization' (Hasenfeld, 1972). Mobility between services nonetheless makes it possible to get closer to or avoid a particular type of clientele. Analysis of the careers that flow from it brings to light the principles of a categorization of patients – by social group, by age group, by pathology – that has previously been used to understand the working practices of *aides-soignantes* (Arborio, 1996).

Some establishments or wards have specific clienteles, such as retirement homes or long-stay hospitals, crèches or paediatric wards; this is also true of the

maternity ward, which implies exclusive contact with women, generally in good health. The clientele of one hospital is also marked by its geographical catchment area, but there is still a degree of diversity, at least in the establishments in which this fieldwork was done, which marks a difference from the analysis of the careers of Chicago schoolteachers between establishments with small, homogeneous catchment areas (Becker, 1952b). On the other hand, even within one establishment, the clienteles of the various wards can be differentiated[13] according to their age, pathology, length of stay, sometimes even their social characteristics, with effects for the work practices of the *aides-soignantes* and perhaps, therefore, for preferences which partly explain mobility between wards.

Some 'clients' are sufficiently specific to make up sometimes the almost exclusive clientele of particular wards: children, healthy or sick, may be sought or shunned, old people, psychiatric patients and alcoholics may be feared. But, here too, one cannot draw up a universally valid hierarchy of preferences. Contact with these patients is variously appreciated by the *aides-soignantes* and their view can change in the course of their careers. The work of social evaluation and categorization of patients (Arborio, 1996) – understood as the appreciation not only of a social position, but also of a degree of integration, of participation in ordinary social functioning (from the exclusion of all social life in some psychiatric patients or intubated patients, to taking charge of minor 'housework' for oneself and even for neighbouring patients)[14] – is another of the guiding principles orienting the routes taken by *aides-soignantes* through the units of a single establishment, or at least of the justification that they choose to give of them.

If contact with some patients is experienced as something that is hard to take, its absence, which characterizes some of the posts accessible to *aides-soignantes*, presents them with a problem in defining their occupation: relations with patients are sometimes put forward as the main argument valorizing their position, and at other times presented as disagreeable to the point of being shunned in favour of specific posts which do not entail them. But the absence of contact with the ordinary clients often reinforces contact with other categories of agents – agents who are not necessarily more congenial: the 'hospital secretary' works with the head nurse; in the laboratory the *aide-soignantes* work with the technicians; in the anaesthesia department they work with the anaesthetists; Josette, in the blood bank, works with the doctors. The strength of reference to the patient in the *aide-soignante*'s self-definition, at least when he/she has worked in an ordinary ward, paradoxically asserts itself even in discourses on work that entails no direct contact with patients, such as the processing of specimens in the laboratories, where the work is presented as being done 'for the patient'.

Explanation in terms of attraction to or avoidance of all or part of the clientele is, however, rather summary. Just as the possibility of contact with patients serves as an argument to legitimate the 'choice' of this occupation or to valorize the speaker's position, so the relations with particular categories of patients characterizing certain posts open the way to other arguments, or to at least converge with other criteria of choice. For example, the low technical level of the acts to be performed for old people or for healthy children in the crèche

does not favour the unofficial career, whereas conversely this is easier to achieve in an intensive care unit. Some clienteles give 'prestige' to a service: this is true not only for doctors looking for a 'fine case' (Herzlich, 1973) but also for the *aides-soignantes*. For example, Claudine (age 26, qualification BEP, single, father is a foreman) explained that she rarely talked about her job until the day she realized she 'was proud to say [she] worked in intensive care'. But, here too, this is sometimes accompanied by better working conditions than in other wards, with, for example, more staff or better equipment. Not having to work directly with patients means escaping from the working conditions which result from the need for continuous work to ensure uninterrupted care: some 'hospital secretaries' at H1 start work at 7 am, glad to be able to retain the ordinary schedule of nursing posts which allows one to avoid the morning rush hour, and others start at 8.30 am, having had enough of getting up early in the morning. The different criteria in the ranking of posts are thus intricately intertwined.

The cartography of the more or less attractive posts gives some indication of the preferences and expectations of the *aides-soignantes* relative to their occupational position, as a product of their social characteristics and past trajectories, including those in the hospital system. They presuppose the implementation of strategies around these posts, mobilizing a set of varied social resources, the most important of which is the network of internal relationships within the institution, combined with the emphasis placed on length of service as a proof of loyalty to the institution (Arborio, 2001: 281–90). Do these strategies mesh with the demands of the institution?

Diversity of staff and diversity of posts offered by the institution

The fact that the particular forms of work performed under the title *aide-soignante* are sometimes translated into specific posts proves that these marginal situations correspond to the normal functioning of the hospital and are even indispensable to it. When one examines the point of view of the hospital administration, particularly as expressed in the discourses of its representatives – human resource managers or other senior management – three non-contradictory logics can be seen in these work assignments.

First, the title '*aide-soignante*' serves as a *filter* for selecting, among the less qualified staff, the persons capable of occupying particular posts. An economically rational management of staff would assign the *aides-soignantes* on the basis of the 'caring' skills developed by their training, or such other skills as were revealed in the execution of their tasks. Thus, for certain posts which in one hospital are filled indifferently by *aides-soignantes* or by A.S.H., and where the competences acquired in the training of the *aide-soignante* are indeed little used, another hospital, which has a sufficient number of male *aides-soignants* on its payroll, makes the CAFAS a requirement, on the grounds that a basic knowledge of the manifestations of troubles in the patient and the appropriate first-aid measures is required to cope with any problem arising during transport.

The title '*aide-soignante*' is also used as an argument for the attribution of the title to posts far removed from nursing care. These posts, for which no formal mode of recruitment has been laid down, could equally well be assigned to ordinary A.S.H., but the title *aide-soignante* offers a kind of guarantee regarding the persons to whom they are entrusted. It is evidence of the basic educational

level that was required to undertake the training, and especially of loyalty to the institution whose rules have been well learned. The asset of length of service may also be demonstrated, in as much as it reveals qualities tested in the various posts occupied; and the various assessments which figure in the staff files, sometimes accompanied by the directly solicited opinion of the former head nurses. Some specific assignments to posts can thus be read as springing from an optimal human resource allocation, with the competences of each employee being matched to the posts to be filled. The post of 'hospital secretary', for example, requires a good knowledge of the ward and good relations with the administrative hierarchy: length of service is an important factor and is added to the title of *aide-soignante*, the only quality officially initially required in order to occupy this post, for which the *aide-soignante* course does not, however, provide training. At H1, in the 1960s, the 'hospital secretary' replaced the 'senior nurse' in assisting the head nurse, essentially in his/her administrative tasks. To replace the nurse by an A.S.H. would have looked like a total down-grading of the post: therefore it was decided to assign it to an intermediary, the *aide-soignante*.

It is not always educational qualifications, or 'in-house' qualifications such as the CAFAS, that serve as guarantees in the allocation of these posts. In the example of patient transport, the physical strength required sometimes makes the male sex the only condition for working in the internal patient-transport service, whether one is an *aide-soignant* or an A.S.H. In hospital H1, most of the male *aides-soignants* have been assigned to patient transport for a certain time, their masculine strength being perhaps regarded as 'wasted', or at least misdirected, in the ordinary performance of the job of *aide-soignant*, although this is very demanding when it involves lifting and moving patients in situations in which it is sometimes difficult to get a good grip. The strong tendency to assign the men to 'central services', the operating theatres or the emergency wards, where the physical demands are especially great (Peneff, 1992: 70–2), reflects this aim of taking advantage of their specific 'natural' qualities. Even when these specifically masculine competences are not translated into terms of post or when management does not build in a specific use of them in the organization of the unit's work, the pressure of female colleagues often makes the male *aides-soignants* working in nursing wards the specialists in lifting and shifting (Angeloff and Arborio, 2002). These 'natural' qualities are sometimes an argument used by the men themselves for moving out of the traditional nursing units, so as to distant themselves from the 'caring' roles which appear to them, conversely, as feminine in nature and, as such, devaluing.[15] But for others, the reference to gender-specific competences represents at the same time a negation of the qualification they thought they had acquired with the CAFAS.

> Jacques, first employed as 'a cleaner' ('*homme de ménage*' – and even a 'cleaning lady' ('*femme de ménage*'), as he says with bitterness, became an A.S.H. after his naturalization as a French citizen. He thus shed his precarious status and a title that he saw as humiliating. He very quickly obtained the CAFAS thanks to his previous educational level (he received general schooling until the age of 17 and has no language problems since he is from a

> French-speaking country). He then secured a title and tasks which satisfied him, until the 'boys' were all reassigned to patient transport: 'I was an *aide-soignant* in my ward. I was fine there. And then one day they decided to put all the men together for patient transport. No one asked my opinion. Just like that. I started to do this [he explains how the service operates]. I was walking 12 or 15 kilometres a day. I don't know if you've seen the size of this hospital. And that's how I did my back in. . . . This hospital can't work without trolley-pushers, but you don't need much brain to do that.'

Assignment to patient transport is then seen as arbitrary by the male *aides-soignants*, for whom acquisition of the CAFAS had been a significant symbolic advance.

For the allocation of other posts, the title *aide-soignante* plays a second role, which is not so much qualifying or certifying as *instrumental*, and which can also be interpreted as dictated by a logic of optimal resource allocation. Within the framework of a policy of encouraging staff to move into the category above, which is particularly strong in public hospitals, the title *aide soignante* could be used to compensate, towards the end of a career, for the stagnation of pay increments related simply to years of service, or to retain young employees at times when the institution found it difficult to recruit staff who would stay for any length of time. As a consequence, the title was obtained fairly easily by employees who were finally judged to be incapable. They are the 'broken arms of the hospital', as one head nurse called them. The existence of posts characterized by the absence of direct dealings with patients thus allows the sidelining, the *relegation*, of some *aides-soignantes* who are judged unworthy to occupy a position that would bring them into contact with patients. The unit to which an agent is attached does not in itself indicate the logic by which the post has been assigned: in the laundry at H1, an *aide-soignante* stigmatized as a notorious 'broken arm' by her head nurse and by her colleagues has for long time sorted the linen, while another has been put in charge of running the linen store, a managerial post which she has been given, according to her, because she once started accountancy training. Her head nurse describes her as 'outstanding', and regrets the presence, on linen-sorting duties, of the other, 'problematic', *aide-soignante*. Thus respect for the rules of staff development – at least in the public sector – is accompanied by the possibility for management to use palliative measures of marginalization, which explains, in a certain number of cases, the presence of *aides-soignantes* in 'non-standard' posts, for the sake of the 'good running' of the institution. The diversity of *aide-soignante* posts provides the means for both 'protection *of* the inept' and 'protection of the group *from* the inept' (Goode, 1967). Posts seen as requiring little skill are thus assigned according to a logic of maintenance of the institutional order, by the promotion of all in terms of title but the exclusion of some in terms of posts.

Thirdly, the assignment of particular posts can be used as a kind of *recompense*, when the institution has not been able to provide 'model' *aides-soignantes* with a career crowned by access to the title of nurse.

> Sonia (57) first worked as a cleaner in a clinic, then as an A.S.H. in Paris hospitals. After various 'support' jobs (in the kitchens, the laundry, etc.), she joined a nursing unit in H1, where she was soon doing the work of a nurse. Becoming an *aide-soignante* did not change the content of her activity. It guarantees that she no longer works in the support jobs that she shuns, and it provides her with the higher wage that, as a single mother, she badly needed. Her head nurses encouraged her to take the qualifying test (she only has a certificate of primary education) so as to be able to enter the competitive examination for entry to nursing school. After one failed attempt she decided she would never be able to pass, and she resigned herself to remaining an *aide-soignante*. Her head nurses then suggested that she take a newly vacant post of hospital secretary. This change of post was presented to her as a second chance of promotion, a symbolic one but also one that has effects on her working conditions, a kind of reward for her long hospital career:
>
> 'After six or seven years [in ward X], I acted as a secretary.'
>
> 'Ah yes, of course. How did that happen? Did you put yourself forward?'
>
> 'No, it was offered to me. The head nurse offered it one day, just like that. And since it was hard work in the wards . . . and I was pushing 50 . . . She said: 'You ought to come and do a spell in the office, it will be less tough.' And it *was* much less demanding.'
>
> Sonia admits however that she hesitated to accept a post so different from her former position, both because of its impact on her relations with her fellow workers and because of the kind of work involved. Someone who is seen as 'privileged' or too close to the managers runs the risk of being excluded from the networks of sociability, and, when she started, she was so unfamiliar with administrative work that she feared she might not cope.

The unfolding of Sonia's objective career and her way of presenting its different stages show how, right up to the final moment when she became a hospital secretary, the common feature of the various positions she had held had been that she 'worked at the hospital', implying that she had a steady job, that she did work for patients the value of which was recognized outside the hospital institution, and which guaranteed membership of a certain community. The question of the title and the competence it is presumed to certify counts for little. It is not at all obvious to her that the position of hospital secretary is to be seen as a reward, beyond the physical working conditions that she mentions –

it is one of the 'chair jobs', as they are called in the insiders' language, the 'soft jobs' that have nothing hospital-specific about them but which have the virtue of providing continued work for *aides-soignantes* towards the end of their careers, when many of them suffer from back pain. The idea of this post as a reward is not self-evident; it can only come from the way Sonia finds to adapt to the post and the way the institution finds to continue to benefit from her services.

The competences presumed to have been acquired by A.S.H. promoted to *aides-soignantes*, in the course of their training, should lead them, in terms of an economically rational use of those competences, as has been said, to work 'on the wards', in other words, directly with patients, following the line laid down by the *infirmier général* (head of paramedical services) at H1. Budgetary rationality, as institutionalized, would require that administrative posts be reserved for administrative agents, who are less expensive than hospital staff in the strict sense. But the title *aide-soignante*, mingled with other criteria, plays the role of a right of access – awarded *a priori* or *a posteriori* – to posts which seem to constitute break-points in careers.

Conclusion

The presence of *aides-soignantes* in very varied posts within the hospital is oriented by the objectives of the institution. On the one hand, the institution has to ensure that certain posts, without which it cannot function but whose definition does not specifically indicate how they are to be filled, will indeed be occupied. On the other hand, it has to assign its labour force and manage the diversity of the personnel who are led to work together under one title as a result of varied social and occupational trajectories. However, to take real effect, decisions regarding assignment to posts have to be ratified by the *aides-soignantes* themselves. The occupational trajectories observed among *aides-soignantes* who have successively occupied varied posts constitute a form of objectivation of a system of preferences among these marginal posts, among the conditions of work and remuneration associated with them, or at least of the adjustment between these preferences and the needs of the institution.

All the posts offered to *aides-soignantes* are in principle equal, in terms of status and remuneration, but the marginal benefits inherent in each are varied, whether symbolic or material, in terms of working conditions, for example, whether these are alleviated or, on the contrary, make it possible to 'do more' than an ordinary *aide-soignante* within the logic of an unofficial career that brings him/her closer to the nurses. This mobility is akin to a vertical career except that the hierarchy of positions has no external recognition, as the hierarchy of ranks may have, for example. It depends on preferences that are socially constituted, particularly in connection with the trajectory accomplished within the hospital institution and earlier. The possibilities of attaining these positions depend on non-formalized resources and not on academically certified competences; they also depend on the convergence between individual strategies and the various institutional logics.

For the *aides-soignantes*, these choices of post are one of the ways of making the best of a difficult occupation, where the low starting level of educational qualification required makes advancement towards the category of

nurse a major challenge that few take up, while the practical proximity to that category does not entirely exclude performing some of its practices. The arrival of new generations of *aides-soignants* who are educationally rather more qualified (20 percent of *aides-soignantes* in training now have the *baccalauréat*) may give rise to new aspirations. These may be expressed in an individual way through more frequent use of the pathway of promotion to the category of nurse. They may also be expressed collectively, in particular through a mobilization within the traditional trade unions,[16] or within the professional associations that have emerged in the last 15 years. These associations express specific demands aimed at the creation of a state diploma and the authorization to work in a self-employed capacity, but the negotiations with the authorities are at present deadlocked over the first stage – that of official recognition of the competences actually implemented on a routine basis. The failure to obtain from the state a recognition of a specific area of operation reserved for *aides-soignants* cannot be understood without reference to the groups of adjacent occupational groups: the nurses, who are concerned to keep the monopoly of the freelance provision of nursing care, but also newly emerging categories such as the '*auxiliaires de vie*' ('home aids') who are seeking to carve out a space for themselves between the nurses and the *aides-soignantes*, as least with regard to home-based care. If, however, that stage were one day attained, this could lead to the break-up of the occupation into various different functions, at which point another category might come to take on the role of a loosely defined, catch-all occupation which, as has been demonstrated, has well served the interests of the hospital institution as it has changed over time.

Notes

1 This is the case in France, where *aides-soignantes* make up a large proportion of hospital staff (Vassy, 1999).

2 *Surveillante*: after some years' service, or through a competitive examination and specific training, nurses can be appointed to this position of responsibility for the management and organization of work within a ward.

3 The training course is in fact open to candidates with qualifications such as the BEP for 'health and social careers' or the CAP in 'work with young children'; and, for those with no qualifications, on the basis of two or three years of work experience in this sector.

4 In France, after the groundbreaking post-war studies based on participant observation in industry, the sociology of work neglected this method (Peneff, 1996). In the context of a renewal of French ethnography (Weber, 2001), the hospital was seen as a possible terrain for such a sociology of work. The publication of Jean Peneff's book (1992), derived from a year's observation working as a 'patient transporter' in an emergency ward, and the French translation of various American works (in particular Goffman's *Asylums* in 1968, Freidson's *Profession of Medicine* in 1984 and a collection of texts by Strauss in 1992) no doubt played a decisive role in this movement. Hitherto, hospitals had been the object of intermittent incursions or isolated works (for example, Herzlich, 1973; Chauvenet, 1978). Since then, various academic studies, coming either from ethnology (for example, Véga, 2000; Pouchelle, 2003) or sociology (for example, Camus and Dodier, 1997; Peneff, 2000; Arborio, 2001) have been based on in-depth fieldwork in hospitals.

5 The role of patient, distinct from that of the agents who are being interviewed, is one that may be adopted, even inadvertently (Coenen-Huther, 1991). This position – which I have had occasion to adopt several times – offers a quite different point of view on the work of the *aides-soignantes:* the patient is the object of a treatment that is *a priori* differentiated by the different categories of staff whose differences he or she does not always distinguish.

6 Specific teams are assigned to the night shifts. I met them, in these phases of my observation, only at the time of 'handing over', when the successive shifts meet as a result of overlapping schedules in the evening and in the morning.

7 My mother, who had previously worked in a shoe factory and then at home after the birth of her first child, looked for regular full-time work after her divorce. After various jobs as a shop assistant, she started hospital work as an A.S.H. in 1973, and became an *aide-soignante* in 1976. She stayed in that occupation for 20 years, until her retirement.

8 Doing 'dirty work', in this literal sense, brings the *aides-soignantes* low prestige but no moral condemnation. One ambiguity of their position lies in the fact that they could just as well be praised for their sacrifice to the patients' well-being. Indeed, some of them attempt this 'stigma reversal' in the public self-presentation they make of themselves.

9 The vagueness surrounding the definition of the occupation *aide-soignante* allows a certain heterogeneity of trajectories, which, as with the new or renewed occupations or some already established professions of the 'petite bourgeoisie' – of which nurses are an example – distinguishes groups separated in terms of their social origin and the associated dispositions (Bourdieu, 1979*:* 415–16).

10 The responsibility linked to certain acts is not necessarily sought after: for example, it forces the nurse to wait to be relieved at the end of his/her working day, whereas the *aide-soignante* can occasionally slip away when all his/her tasks are completed, even when he/she is working in close collaboration with the nurse.

11 It is strictly illegal for these public employees to have another job. Sometimes, however, the *aides soignantes* will admit that they do, so long as the interviewer, who is familiar with this world, shows no surprise. The extra work often involves night shifts, but also some jobs not in hospitals, and often work done at home.

12 When I expressed concern for her health, she explained to me that she rested for part of the night with the agreement of the nurse. 'We do the round together and then she calls me if anything comes up.'

13 Hierarchization according to speciality, with its effects in terms of the orientation and treatment of socially differentiated clienteles, has been particularly well studied in the case of French hospitals in the 1970s (Chauvenet, 1978).

14 At C, some hospitalized able-bodied women have taken to making their own beds. One of them even helps her recently admitted neighbour to wash herself, which relieves the *aides-soignantes* of some work.

15 Compared to male nurses, another minority in a 'women's job', who tend to occupy the management posts offered within the profession itself (Williams, 1992), access to this type of post is the only possibility of 'promotion' for male *aides-soignants* within their category.

16 *Aides-soignantes*, like other health professions, are, however, not a strong presence within these unions, and the unions are little inclined to put forward their demands as a category.

References

Abbott, A. (1988) *The System of Professions: An Essay on the Division of Expert Labor*. Chicago, IL: Chicago University Press.

Angeloff, T. and A.-M. Arborio (2002) 'Des hommes dans des 'métiers de femmes': mixité au travail et espaces professionnels dévalorisés', *Sociologia del lavoro* 85: 123–35.

Arborio, A.-M. (2001) *Un personnel invisible. Les aides-soignantes à l'hôpital*. Paris: Anthropos-Economica.

Arborio, A.-M. (1996) 'Savoir profane et expertise sociale. Les aides-soignantes dans l'institution hospitalière', *Genèses. Sciences sociales et histoire* 22: 87–106.

Arborio, A.-M. and P. Fournier (1999) *L'Enquête et ses méthodes: l'observation directe*. Paris: Nathan.

Beaud, S. and M. Pialoux (1999) *Retour sur la condition ouvrière. Enquête aux usines Peugeot de Sochaux-Montbéliard*. Paris: Fayard.

Becker, H.S. and A.L. Strauss (1956) 'Careers, Personality, and Adult Socialization', *American Journal of Sociology* 62: 253–63.

Becker, H.S. (1952a) 'The Career of the Chicago Public Schoolteacher', *American Journal of Sociology* 57: 470–77.

Becker, H.S. (1952b) 'Social-Class Variations in the Teacher-Pupil Relationship', *Journal of Educational Sociology* 25: 451–65.

Bourdieu, P. (1979) *La Distinction*. Paris: Minuit. [(1984) *Distinction: A Social Critique of the Judgement of Taste*. Cambridge, MA: Harvard University Press.]

Bourdieu, P. and L. Boltanski (1975) 'Le titre et le poste: rapports entre le système de production et le système de reproduction', *Actes de la recherche en sciences sociales* 2: 95–107. [(1981) 'The Educational System and the Economy: Titles and Jobs', in Charles C. Lemert (ed.) *French Sociology*, pp. 141–51. New York, NY: Columbia University Press.]

Bourdieu, P. et al. (1993) La Misère du monde. Paris: Seuil. [(1999) *The Weight of the World*. Cambridge: Polity Press.]

Camus, A. and N. Dodier (1997) 'L'admission des malades. Histoire et pragmatique de l'accueil à l'hôpital', *Annales. Histoire et sciences sociales*. 52(4): 733–63.

Cartier, M. (2003) *Les Facteurs et leurs tournées. Un service public au quotidien*. Paris: La Découverte.

Chauvenet, A. (1978) *Médecines au choix, médecine de classe*. Paris: Presses Universitaires de France.

Coenen-Huther, J. (1991) 'Observations en milieu hospitalier', *Sociétés contemporaines* 8: 127–42.

Freidson, E. (1970) *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. New York: Harper & Row.

Goffman, E. (1961) Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Pelican Books. 1974.

Goode, W.J. (1967) 'The Protection of the Inept', *American Sociological Review* 32: 5–19.

Hasenfeld, Y. (1972) 'People-processing organizations: An exchange approach', *American Sociological Review* 37: 256–63.

Herzlich, C. (1973) 'Types de clientèle et fonctionnement de l'institution hospitalière', *Revue française de sociologie* 14(1): 41–59.

Hughes, E.C. (1951a) 'Studying the Nurse's Work', *American Journal of Nursing* 51, in Hughes (1971), 311–15.

Hughes, E.C. (1951b) 'Work and Self', in Hughes (1971), 338–47.

Hughes, E.C. (1963) 'Professions', *Dædalus* 92(4): 655–68.

Hughes, E.C. (1971) *The Sociological Eye: Selected Papers*. New Brunswick, NJ: Transaction Books.

Peneff, J. (2000) *Les Malades des urgences. Une forme de consommation médicale*. Paris: A.-M. Métailié.

Peneff, J. (1996) 'Les débuts de l'observation participante ou les premiers sociologues en usine', *Sociologie du travail* 2: 25–44.

Peneff, J. (1992) *L'Hôpital en urgence. Etude par observation participante*. Paris: A.-M. Métailié.

Pouchelle, M.-C. (2003*) L'Hôpital corps et âme. Essais d'anthropologie hospitalière*. Paris: Editions Seli Arslan.

Roumiguières, E. (2000) '330 000 aides-soignants en 1999', Etudes et résultats. Direction de la Recherche, des Etudes et de l'Evaluation Statistique, 54.

Schatzman, L. and A.L. Strauss (1973) *Field Research Strategies for a Natural Sociology*. Englewood Cliffs, NJ: Prentice-Hall.

Vassy, C. (1999) 'Travailler à l'hôpital en Europe. Apport des comparaisons internationales à la sociologie', *Revue française de sociologie* 2: 325–56.

Véga, A. (2000) *Une ethnologue à l'hôpital. L'ambiguïté du quotidien infirmier*. Paris: Editions des archives contemporaines.

Weber, F. (2001) 'Settings, Interactions and Things: A Plea for Multi-Integrative Ethnography', *Ethnography* 2(4):

Williams, C.L. (1992) *Still a Man's World: Men Who Do Women's Work*. Berkeley: University of California Press.