Hygiene as Habitus: Putting Bourdieu to Work in Hospital Infection Control

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1. Introduction

This chapter takes as its starting point accounts of nurse managers and infection control staff as they talk about their working lives and how they try to implement practices which are believed to enhance safety in relation to healthcare acquired infections. The control of infection, particularly MRSA (methicillin-resistant *Staphylococcus aureus*), in hospital work is a contentious issue that attracts a good deal of publicity in the UK and efforts to control it have exercised policymakers, managers, infection control staff and other health care practitioners over the last several years.

In mid 2007 UK newspapers presented headlines such as 'Shame of the filthy wards' (Daily Mail 18/6/2007), prompted by the release of Healthcare Commission data to the effect that 99 out of 384 hospital trusts in England were not in compliance with the UK's hygiene code (Healthcare Commission 2007). Gordon Brown commenced his premiership with a commitment among other things to reduce rates of infection in hospitals, seeking to halve the number of people diagnosed with MRSA by April 2008 (Revill 2007). As Revill goes on to report, 300,000 people a year are currently diagnosed with a hospital acquired infection. Reports have also surfaced in the UK news media concerning the growing proportion of death certificates issued which mentioned MRSA or another important healthcare acquired infection, *clostridium difficile* (Waterfield and Fleming 2007). In press reports, and arguably in public opinion too, a link is made between the specific microbes and the general state of cleanliness in hospital accommodation. This has been accompanied by a preoccupation on the part of healthcare professionals, researchers and policymakers with means of reducing the spread of healthcare

acquired infections. This has been actualised through a variety of new initiatives, procedures and ways of working in hospitals and the community. It is our intention here to show how the discursive and social practices in one particular midlands hospital can be brought into focus using the theoretical formulations of the late French social theorist Pierre Bourdieu.

In understanding the work of differing groups of people in health care settings, Bourdieu's work is particularly apposite (Bourdieu 1977, 1990; Bourdieu/Wacquant 1992; Fowler 1997). The notion of *habitus* is appropriated by Bourdieu to deal with this kind of problem. The concept has a long history within both sociology and philosophy (Camic 1986; Crossley 2002). It seeks to capture the manner in which an agent's or group's actions and choices are shaped by their respective histories. In Bourdieu's account, *habitus* is the 'product' of socialisation and cultural induction in particular institutional settings characterised by material inequalities in power relations. By the same token, habitus refers to the manner in which actors' choices and actions will themselves have durable effects upon the actor's manner of being-in-the-world, thus informing further, future choices.

Yet what is *produced* is not merely a passive replica of a dominant ideology but rather a *generative principle*, a disposition towards one's experience within the fields of practice that the actor must address (Bourdieu 1990:. 52–53). It embraces culture, imagery and historically predisposed means of understanding the world as well as patterns of action and conduct. The biographical and historical trajectory of an individual will predispose them to specific ways of perceiving, conceiving, reasoning and acting.

These trajectories shape tastes, desires and systems of morality and, according to Bourdieu (1984), do so in a manner which escapes conscious attention or control and may

involve a variety of rules of thumb and taken-for-granted assumptions which shape practical reason.

Although some of these ideas have been received critically (for example, Mouzelis 1995: 100–116; Sayer 1999), the notion of *habitus* helps to characterise and resolve some of the apparent paradoxes that interest us. The field of health care work in hospital settings is one that doctors, nurses and other practitioners as well as patients and their families, health educators, journalists and many others engage with actively and creatively (Power *et al.* 2003). That engagement does not happen entirely *de novo* and the health care field is not just plastic to the participants' will: it imposes limits. In other words: ' … the *habitus*, like every "art of inventing" is what makes it possible to produce an infinite number of practices that are relatively unpredictable … but also limited in their diversity' (Bourdieu 1990: 55).

As sociologists since Durkheim (1964) have noted, societies are internally differentiated into many separate 'spaces', each of which has a distinct logic and dynamics. Bourdieu (1998; Bourdieu/Wacquant 1992) writes of different 'fields' into which social life is divided, the literary, the educational, the political, and importantly for us the field of health care (Brown *et al*. 2006). In each field we may find a different kind of social game being played, requiring different competencies and resources from its 'players', and involving different 'rules' of engagement and, in turn, affords distinct possible outcomes. Each field presupposes certain dispositions and competencies on the part of those who engage in it and a taken-for-granted appreciation of its rules, procedures and meaning structures – a different habitus. This habitus - perhaps as a nurse, a matron or operating theatre worker - encompasses one's 'feel for the game' and in the experienced participant, it functions almost without conscious thought as one goes about one's duties.

In health care, as with many other fields, not all the payers have the same resources at their disposal. As many authors have argued, healthcare has been dominated by a 'medical hegemony' (Coombs/Ersser 2003; Hyde *et al*. 2006). The medical discourse then constitutes a form of symbolic or cultural capital, of a kind that has been imbued with status and value. As Thornborrow (2002) notes; those who deploy the most powerful form of cultural capital are advantaged: 'knowledge of and access to those practices put some people in potentially more powerful positions than others' (2002: 6). As Shields (1991: 261) argues, these forms of cultural capital have 'a degree of robustness, despite internal schisms and margins of opposition, which allows them to be treated as social facts. They have empirical impacts by being enacted – becoming the prejudices of people making decisions'. Correspondingly, the language of infection control has acquired a kind of symbolic capital which privileges the speaker within many officially sanctioned heath care encounters. This privilege may operate on a variety of levels – health care expertise involves not only the language of health care personnel but it has acquired positive moral connotations, and this hybridity has perhaps contributed to its power (Harrison/Lim 2003). Individual practitioners may learn the appropriate choreography to perform with the key terms in order to accrue capital for themselves so that they can become 'competent' and 'successful' clinicians within the health care facility. In this view, it is through language that power relationships are acted out: 'linguistic exchanges are also relations of symbolic power in which the power relations between speakers or their respective groups are actualised' (Bourdieu 1991: 37).

One of the advantages of drawing upon Bourdieu's notions in developing a sociological understanding of health care is that it enables an account of the moral and strategic stances ('*prise de position*') that actors may assume, which permit certain forms of improvisation while

inhibiting or disallowing others. In our case, where choices concerning infection control, hygiene and cleanliness are concerned. Another of Bourdieu's key terms pertinent to the exploration of sensibilities about infection control and cleanliness is his notion of 'doxa', or the participant's 'commitment to the presuppositions' of the game that they are playing (Bourdieu 1990: 66), an 'undisputed, pre-reflexive, naïve, native compliance' (p. 68) that gives us our 'feel' for what is, among other things, intuitively proper, fair, excellent or prestigious. Or alternatively what is wrong, dirty or profane can be intuitively grasped in much the same way. Bourdieu adds that competitors in political power struggles often seek to appropriate 'the sayings of the tribe' (*doxa*) and thereby to appropriate 'the power the group exercises over itself' (Bourdieu 1990: 110; Wacquant 1999).

We believe that close attention to the narratives of participants involved in health care work will provide valuable windows into how the symbolic capitals of infection control, patient safety and cleanliness itself are creatively reconstructed and have important implications for how we think about the human dimension of infection control.

2. Methodology and Procedure

The interviews on which this paper is based were undertaken as part of a larger ESRC funded study of discourses of 'biosecurity' and infection control. Analysis was informed by an approach based in thematic analysis (Braun/Clarke 2006) and to a lesser extent grounded theory. In-depth, semi-structured interviews were conducted with a view to capturing narratives of professional working life (Charmaz 2002) in relation to infection control. Explorations based on participants' own understanding and the themes to which they allude is believed to be particularly valuable for

nursing research (McCann/Clarke 2003) especially under conditions of uncertainty such as are unfolding in the UK. We examined:

(a) the nature of the participants' role within the healthcare organisation where they worked, and the fine grain or detail of what they thought of their jobs, both in terms of their everyday working lives and their relationship to colleagues in other roles;

(b) how the participants identify the central tasks of their occupation;

(c) the steps participants were taking to address the 'problem' of MRSA both on their own and with colleagues.

With the analytic strategy of thematic analysis, data exploration and theory-construction are combined and theoretical developments are made in a 'bottom up' manner so as to be anchored to the data (Braun/Clarke 2006; Glaser/Strauss 1967; Strauss/Corbin 1998). Therefore, whilst we began with an assumption that organized social practice would be disclosed, we attempted to be open minded as to the precise shape and form of the 'habitus' which might emerge. The strength of this approach is illustrated by the way that novel findings that were unanticipated by the researchers emerged, particularly, as we shall explore, relating to doctors as potential vectors of infection. Moreover, there appeared to be broader issues at stake. For example, as we shall see, the idea that a particular kind of symbolic or cultural capital attached to the precautions taken against infection, or that working life was animated by a particular notion of surveillance, 'making sure' and exercising authority. These ideas could then be related back to the notional process of gaining capital, status and prestige in a potentially volatile social field in a way which was unanticipated at the outset.

In making sense of what the accounts elicited in this study represent, let us clarify what we are taking them to mean, and the ontological status of the accounts. Practitioners' reflective accounts are sometimes taken to give access to the raw material of practice, but this 'naïve' approach (Taylor 2003) does not take account of how language may be imagistic and metaphorical and may constitute rather than merely reflect social reality (Gould 1996). Accounts by participants of their work may be artfully and meticulously constructed and may be performative in the same way as any other use of language. They give access to how professionals construct their identities and their practices but they are not by themselves a literal record of what may transpire in the workplace. Therefore our account here is concerned with theoretically intelligible meanings and the implications of these for how we understand the social world of healthcare work.

3. Participants

The participants were all working in a nursing role and were attached to a large university teaching hospital in the UK midlands. Some had a role which involved an element of work in the community or across different hospital sites. They were selected on the basis that they had some involvement in infection control and would therefore be able to explore with us the nature of their work in this area. That is, of the 22 participants 10 were matrons and a further 6 were infection control staff. Two were sisters and the others were operating theatre staff part of whose work was to ensure standards of hygiene. The participants' roles are summarised in table 1.

Table 1 Participants' descriptions of their roles

Interview number	Job role as described by the participant
1	Infection Control Nurse Educator so my responsibility is to create, formulate and disseminate a programme of education for all employees, patients, relatives, visitors, within this Trust,
2	I'm a Head Nurse Matron for Ear, Nose and Throat and Maxilla Facial within the hospital. . . part of that job . . . is to look at cleanliness, infection control and standards within the hospital but particularly within the area that you work.
3	. . . the title of my job is Head Nurse Matron and I am responsible for managing the, a department which has a surgical speciality as its main role. It encompasses in-patient ward, day case, out-patients and casualty.
4	I'm the head Nurse Matron for neurosciences. . . Neurosciences are diseases and trauma to the central nervous system. So principally neurosurgery and neurology
5	I'm the Matron for Children's Surgery and the lead nurse for children's services. . .a mixture of specialities which covers most of what the adult services would do but is in one small unit and just for children.
6	. . .my job title is an Infection Control Nurse, but that can include a wide range of duties. A big part of my remit is education, so I do a lot of teaching sessions, mandatory training sessions on infection control.

7	I'm a senior matron in the theatre department, main theatres of the [hospital]. My remit is for all general surgery theatres.
8	I'm an Infection Control Nurse and I've also got responsibility of audit lead. So . . . 50% of my time is focussed clinically. . .
9	Yes I'm a Head Nurse Matron for the elective orthopaedic department. So that covers the Fracture Clinic and Orthopaedic Out-patients Service
10	I'm what is called a ward sister and basically I run neurology, neurosurgical ward, twenty eight beds, I manage about thirty full time, or whole time equivalent nursing staff.
11	I'm the Senior Nurse Infection Prevention and Control. So I have overall operational responsibility for infection prevention and control at the moment at both of the campuses.
12	I'm a Head Nurse Matron for Theatres, currently I'm lead for this campus, lead nurse for this campus, the theatres at [this hospital] campus
13	I'm a theatre auxiliary nurse which means I'm, I assist the trained staff and any surgical staff I mean doctors, GPs and so on who happen to come in.
14	I am infection control person in our theatre. I'm an HCA in main theatres. And I do a little bit of . . . teaching medical students.
15	I'm a senior operating department practitioner, basically that is an

	anaesthetic assistant as well as on the scrub side. . . . a multi role, so we can actually do any job in theatres
16	I'm a theatre sister specialising in elective orthopaedics, which means I do a lot of hip and knee joint surgery, that kind of thing.
17	Yes I'm an auxiliary nurse in theatres and my responsibility is setting up for each case.
18	matron of the Renal Directorate so that means that I've got responsibility for all the nurses within our directorate. That involves two renal wards, three haemodialysis units and an out-patient area.
19	My role is Modern Matron attached to the three acute mental health wards . . . at the [hospital] site which has a large acute hospital.
20	I'm infection control nurse, our Trust is very big geographically and it's split into forensic services and local services.
21	I work as an infection control nurse and I work for the Healthcare Trust and the area that I cover is something that's called local services and that is for patients and staff who are in the [city and nearby town] area of the Trust.
22	My role is modern matron and I'm very newly appointed, I have been in post for three months. Prior to that I was a ward manager, I've been a ward manager for ten years.

Whilst we cannot make strong claims for the demographic representativeness of the participants, the interview material elicited here is of interest because of what it may disclose about the social construction of infection control and how this may relate to broader patterns or interrelationships in the health care field.

4. Results and Discussion

The findings are presented here in terms of three major themes, namely

1 The securitization of healthcare work

2 Struggling against delinquent doctors

3 Back to basics: The habitus of hygiene.

4.1 The 'Securitization' of Healthcare Work

An initial, readily detectable feature of the discourse of our participants was the issue of what we might call 'securitization' where the practice of safety is, in participants' formulation, contingent upon a continual process of checking, 'making sure', 'ensuring' and auditing. Discourse in many public services and policy circles has undergone what has been termed 'securitization' (Ibrahim 2005). That is, discussions of public service are increasingly formulated in terms of risk, and threats to security and safety, to which practice and policy is directed with a view to minimizing the proposed threat.

The process of securitization involves a meticulous process of detecting and accounting for threats – in this case those represented by MRSA - and exercising authority so as to bring them within a realm of discourse where they can be characterized and controlled.

The process of checking, making sure and auditing is, in a sense, the production of a certain kind of truth or cultural capital. This implies that the production of this sort of truth, or the creation of knowledge through a discourse, is an exercise of power. This is the power-knowledge nexus. Thus, the securitization of hospital hygiene can be seen as a discourse through which relations of power are exercised. In participants' accounts of this process of control, the technology of making sure and its accompanying surveillance was formulated as both necessary and salubrious.

Interview 22: . . . we spend a lot of money as an organization making certain that the organization is, you know we've got a nice environment but sometimes it's about like just making certain that it's really kept sort of as clean as it possibly can be.

The securitization of healthcare work includes differentiating the patients and placing them in the environment optimal for the containment of their state of infection:

Interview 1: . . .every day we will go and see patients who've been diagnosed with MRSA, Clostridium, tuberculosis, scabies etcetera and make sure they're being nursed in the right environment.

This extension of control extends to new health care personnel in training too:

Interview 1: So I've worked very hard, very passionately with one of the doctors in the medical school and now the first year medical students have to undergo a hand hygiene

examination to ensure that they are competent to continue with their training, just the same as nursing students have for many, many years.

Thus, as well as the management of hazards as they might affect patients, there is the management of patients, personnel and activities. Whilst this might imply a more traditional task of supervision and control, participants were at pains to express the sheer scale of the task and the personal resourcefulness demanded:

> Interview 7: I manage the night staff, and at present I manage the two trauma theatres as a colleague is on long term sick leave. So I've got, really I've got six theatres and then the night capacity really for surgery so that's another two teams of staff that I manage. I'm looking at 75 people.

As Bourdieu (1998) proposes, organizations under a neoliberal regime stress the importance of this kind of personal resourcefulness and flexibility on the part of their employees. Moreover, this kind of operation often involves repeated corporate restructurings and, within the organization itself, competition among autonomous divisions as well as among teams who are encouraged to perform multiple functions and exercise manifold responsibilities. Finally, this competition is extended to individuals themselves, through the individualisation of performance objectives and evaluations. Bourdieu's account of organizational life and the kind of consciousness and habitus it fosters has much to tell us about healthcare environments (Bourdieu 1998; Fuchs 2003). In his vision of the organization, like in our participants' accounts, there is regular evaluation, and strategies of 'delegating responsibility' are implemented so that staff are

held accountable for their domain within the organization as though they were independent contractors. For example:

> Interview 10: So basically I got, my ward was audited by a load of people who there's no warning whatsoever, which is fair enough and did absolutely abysmally so suddenly we were there, I felt like we were the big bad wolves that you know oh we've let the side down and stuff whereas if you looked at this stuff that they sort of not reprimanded us for but criticised us on it was just beyond my control whatsoever, it was stuff like you know no storage space. Well I can't build storage and just really almost nit picking and as far as I was concerned they weren't addressing real issues such as lack of cleaning staff which I've got no control over.

Indeed, as with Bourdieu's vision of organizations in neoliberal economies, individuals' rewards and status within the organization are linked to their performance on these kinds of assessments. Aside from any influence it may have on their career progression, the performance of this onerous yet curiously truncated responsibility has other consequences. It means that people who even at matron level are wage labourers have a tendency towards what Bourdieu (1998) calls self-exploitation, and a measure of self control which extends their involvement, according to the techniques of participative management. This imposes a kind of 'over-involvement' in work as staff grapple with emergency or high-stress conditions. This self examination and reconfiguration of work in the face of audit, inspection and grading was, curiously, not entirely unwelcome:

Interview 7: . . .and we're really pushing up the scores now and I think the last one we got about 95% I think it was. And when you think about we were scoring 60 and 62 we've made massive, you know we've made a really big difference. I want 100% this time but I'm not telling them that. "Try your best, you will do it, you will, you will, or else," [laughs]. So yeah these, they're really helpful these reports because you can see exactly what's scored where so you know exactly what you need to pull up on. So I mean they're brilliant, they're brilliant, we've really come on massively with the use of these reports.

This corresponds to what has been called elsewhere 'deep management' (Brown/Crawford 2003) such that a person's involvement in the organisation's work comes to be self monitoring and self controlled, so as to rely 'for its effectiveness upon the self regulating capacities of its employees as subjects' (Du Gay 1997). Moreover there is a sense of having progressed as a result of undertaking these exercises, so that the personal story of individual or team career progression becomes aligned with the notion of progress in the competitive audit. The controlled, clean environment and the success at the audit game is closely allied to the accumulation of what might be called 'hygiene capital', the control of the habitus of hygiene, and the control of the self.

A satisfactory level of performance in relation to audits and indicators is not something that can be taken for granted however. Control over the environment, one's colleagues and oneself can only ever be provisional and partial and must be constantly worked for.

Interview 22: I can be responsible for my wards and I'm aware of what's happening on my wards and we work closely with infection control and our facility staff to maintain a standard but some of the things I've seen have been quite horrendous.

These 'horrendous' things serve as a reminder as to the problems which might be so readily revisited upon one's own domain if vigilance were ever to be relaxed. This ability to undertake constant scrutiny of oneself, one's colleagues and one's environment could be seen as a kind of embodied cultural capital which is of value in the hygiene game, or perhaps even an embodied 'hygiene capital'.

4.2 Struggling against Delinquent Doctors

In participants' accounts, the maintenance of 'hygiene capital', the security of this process of checking, making sure and the process of exercising responsibility is punctured by other occupations groups with whom nursing has historically been in competition. Doctors were regularly singled out as the major vectors through which disease was spread.

Interview 5: The doctors are not good at washing their hands.

Interview 9: We recently had a report where they'd done a check audit on one of my areas so they'd split the results down into nurses, professions allied to medicine, doctors, like this and the medical staff hand washing was absolutely terrible, terrible, terrible.

This kind of disapproval of the medical staff by the nurses interviewed here might at first seem surprising. Nursing has traditionally been seen as occupying a feminised handmaid or subaltern

role and a great deal of literature describes medical hegemony (Coombs/Ersser 2004). Yet the

identification of doctors as wandering vectors of contamination was a pervasive theme:

> Interview 13: I mean that's where infection comes from in theatres because people walk
>
> round with gloves on you know they don't think to change till they get to the coffee room
>
> and think oh yes I've got my gloves on. Oh don't worry about it you know get a coffee,
>
> have a sandwich, oh yes. And they're all sitting there thinking why am I getting ill?   That
>
> happens, I've seen it happen, you know I've seen blood in our coffee room for God's sake
>
> on the floor because surgeons forget to wipe their feet when they've been standing in a
>
> pool of blood.

This tendency of doctors to breach the symbolic barriers between the presumably hazardous and

contamination-rich realm of the operating theatre and the more orderly domesticated world, such

as the ward or the canteen recurred regularly:

> Interview 16: . . . you've got patients to see, you've got 10 minutes of a sandwich if you're
>
> lucky, it's pressure of work I think. And some people just think, particularly I think the
>
> doctors think that rules were made for everyone else but not them, it's the doctors who are
>
> particular offenders. I stopped a doctor in the WRVS canteen a few weeks back, now it
>
> says in the protocol you can go out in clean scrubs, well he had a ring of blood across his
>
> belly and I approached him and said "Do you know who I am?" "No," he said. I said
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> "Well I'm one of the theatre sisters and you should not be out dressed like that, get back
>
> upstairs and," and I really got sanctimonious on him "Get back upstairs and change those

scrubs, you shouldn't be dressed like that, you shouldn't be out in a public area dressed

like that." And he went "Oh right, oh I didn't realize." So doctors do seem to think that

rules are made for everyone else but they're exempt, they are particular offenders.

Thus it is as if the doctors are constructed as deviant from the implicit prescribed set of hygiene

norms. They are breaching boundaries, potentially spreading infection   their actions, bodies and

accoutrements are seen as being somehow insanitary, clumsy and intrusive in the hygienically

constructed world of nursing. Yet their transgressions can be challenged through the acquired

'hygiene capital' of nursing:

> Interview 22: . . . nurses need to be able to feel confident to challenge doctors and ask them
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> why they haven't washed their hands when they're, and why their tie is hanging in a bowl
>
> of urine when they're bending over the nurses' station.

The picture of practice that emerges is of situations characterized by unpredictability and

uncertainty, where one's medical colleagues may unexpectedly assault the carefully audited

hygienic habitus and breach the boundaries this relies upon. This means that matrons and

infection control staff have to make rapid and intuitive judgments in order to know when and

how to challenge medical staff, suggesting parallels between Schön's (1983) concept of

reflection-in-action and Bourdieu's notion of habitus.

In Bordieusian terms also, there is perhaps an effort at distinction being made here,

between the culture of doctors – described as if they were maladroit, bumbling, unhygienic

vectors of infection - versus the implied symbolic hygiene capital of nurses, whose craft is meticulously organised:

> Interview 22: . . . the basic stuff was around being tidy, being clean, organising yourself and organising the person that you were caring for.

One of the advantages of exploring this kind of experience in relation to Bourdieu's thought is that it allows us to ask questions about the relationship between these excerpts and the social, symbolic and political framework. What kind of social business is being played out in these accounts? Perhaps one could imagine a kind of battle between different factions competing for prestige, credibility or 'symbolic capital' in the healthcare field. Indeed, the symbolic organisation of blame in the event of accident or failure has been found in scholarship on accidents in other public services such as the police (Dorn/Brown 2003). So it behoves a professional group like nurses to ensure that they have a well defended position in the field where, through the meticulous accumulation of hygiene capital, their commitment to cleanliness is unimpeachable. Thus any violations of this can only, in this logic arise from elsewhere, perhaps patients and visitors, but most particularly, doctors.

4.3 The Habitus of Hygiene: The Basics of Nursing

In the interviews, participants returned repeatedly to the issues they saw as somehow fundamental to nursing, where hygiene and its particular manifestation in cleanliness have played an important role since then mid 19th century (Helmstadter 2006; Porter 1992). The idea that there were important fundamentals of nursing – the 'basics' as participants called them - that

defined the profession was a frequent occurrence in the interviews. This basic quality of hygienic

procedure was identified as having been instilled in training:

> Interview 9: And for me, with nursing I mean my nursing was very practically based
> training and then we moved towards the more academic training and they're now moving
> back towards the balance. So they went from one extreme to another and they're bringing
> it back now to where it probably should be sitting in the middle. But when it was the
> extreme of the theoretical bit you know you had nurses coming out and qualifying who
> actually didn't really even know the basics in terms of practical stuff. And you know I can,
> you know we were taught the importance of hand washing and infection control and
> cleanliness and you know aseptic technique and all of those things and they were
> absolutely, you know had to be spot on whereas it seemed to get very, very slack.

The basis of nursing, then - what Bourdieu might have seen as its habitus, - lies in the bodily

aspects of practice,for example in hand hygiene's contributes to infection control. Intriguingly, in

interview 9 above, this notion of the basics is itself seen as threatened by the academic,

theoretical turn in training. Moreover new nurses themselves are somewhat suspect:

> Interview 2: . . . .they'll cross infect themselves because they don't really, they don't know
> the principles of it because they're not taught that any more which is something I've
> brought up on a few occasions with people that do, do the training. So I'm hoping that
> eventually somebody will listen and it will come back . . . It's very fundamental thing that
> if you can start when somebody is training they're going to take that with them for the rest

of their life. And learning the aseptic technique and about cross infection and you do your practical and then you sit down and you talk to them and you assess them, in theory and you talk about micro biology and you know all sorts of different bugs and how different infections might look. . . . they may do theory about that but it's the practical application that is missing. So that worries me really because that is good basic grounding then for a lot, to stop a lot of what I think is bad practice now.

The excerpts comprising this theme present security and certainty as if these could be achieved by the application of a range of reassuringly domestic and familiar 'basic' or 'fundamental' procedures and their emphasis early in training. This theme elides the knowledge and practice of cleanliness into the very core of nursing. Like habitus in Bourdeusian formulations of social practice, it involves a set of bodily dispositions and actions – how to maintain sterile fields, how to change dressings, how to wash one's hands and so on - which are ingrained into the very fabric of nursing. This basic or fundamental quality however is seen as being under threat, from an insufficient emphasis on these issues in training or from other professional groups who might puncture the boundaries established through nursing. The vitality of this work to maintain the habitus of hygiene was peculiarly individual. It had to be so, in a sense, because the organisational fabric of the hospital could threaten this carefully acquired hygienic security:

Interview 13: . . . they were in obstetrics, obstetrics where the baby is delivered, that sort of thing, has to be sterile, has to be a clean area obviously for new born babies and the senior sister in there was telling me that she actually left some rubbish in theatre and it was there for two days and also in toilets and those sort of things and she knows they were there.

The efforts of individuals can be placed in jeopardy by the physical and organisational qualities of the hospital too.

> Interview 7: . . . we have to make sure that the area is cleaned absolutely, totally and we don't seem to necessarily have the sort of domestic or cleaning staff that are allowed to that any more properly. And I think properly for them as well because a lot of them that you speak to will say "You know I wish I'd got the time and the equipment even to do this properly."

The level of security and cleanliness achievable are therefore compromised by the limitations in the authority. There is a lack of time, equipment and ambiguity over the extent that one can practically securitize the workplace:

> Interview 9: . . . they tell me I have responsibility for the cleanliness in my areas but I don't have any input over the staff that provide that service. So therefore you can't, you can't be held responsible for something that you haven't got control over.

In the face of the complexities imposed by a protean and transitional work environment where one's authority over the physical, social and economic factors is limited, despite one's being a .'matron'. Thus, when the environment as well as other professional groups may be thwarting efforts toward cleanliness, the 'basics' offer some hope of salvation.

Interview 19: I think you know we all know that the soap and water is the best sort of infection control in terms of hand washing. So I think sometimes it's how we just remind people to do the basics.

A homely familiarity is evoked by soap and water, which also helps set the stage for a primordial revisiting of aspects of practice which were said to underlie good nursing care:

Interview 22: . . .the basis of good practice was starting at the beginning which is good cleanliness and hygiene standards. And that's stuck with me right though my nursing career. You can't go and do complex nursing tasks and look after people unless you start on some, with some basics things like cleanliness and hygiene tidy, that's my perspective and it's stuck in my head.

The lexical choices here underscore the originatory quality of cleanliness - 'starting at the beginning' with the 'basics'- and the idea that these activities and disciplines can be inculcated early in the career at the point of training and will somehow endure through the introduction of more complex knowledges. The habitus is 'that which one has acquired, but which has become durably incorporated in the body in the form of permanent dispositions (Bourdieu 1993: 86). As this participant went on to say

Interview 22: . . . .you started very much, the important things were the basic things and that was drummed very much into us over my three years of general nurse training that the basic things were the important things, tidying up after yourself you know and we were

assessed on those factors. We didn't know anything, I wouldn't have known anything about research and application and all those things around evidence based practice, we wouldn't even have been introduced to those concepts until we'd learnt how to do the basic skills.

The practical habitus of hygiene is seen as predating the overlaying of more cerebral and academically sophisticated knowledges. Ye at the same time this does not mean that the habitus of hygiene is itself unsophisticated. On the contrary it involves the resolution of paradoxes and it 'apprehends . . . the form of probabilities . . .' and inculcates the 'art of assessing likelihoods' . . . of anticipating the objective future, in short, the 'sense of reality', or realties, which is perhaps the best-concealed principle of their efficacy' (Bourdieu 1999: 113).

5. Conclusions

The habitus of hygiene informs nursing work in infection control, and is described as relying upon many 'basic' processes. Yet for all that Bourdieu claimed that habitus often worked below the level of awareness we can see that this is not entirely an unreflective process. As Adams (2006) reminds us, habitus can hybridize with reflexivity, such that actors in the social field can give detailed verbal accounts of what the think they are doing and how it relates to their biographies and identities. Indeed, in conditions of uncertainty, as Brown and Crawford (2003) argue, health professionals can be thrown back upon their sense of professional identity; in this case the image of what it means to be a nurse and be the harbinger of hygiene. Cleanliness, orderliness and control are aligned such that one can make sure of things, check that protocols are being implemented and sterile procedures followed, check that you and your colleagues have

washed their hands and tidied up after themselves and thereby enjoy a sense of security. Yet this securitization is fragile as one's authority over others is limited and provisional. Hence, the importance of so-called 'basics' in the habitus of hygiene.

In a policy context sensitised to the human and economic cost of hospital acquired infections this self portrait of a profession preoccupied with cleanliness can be a valuable asset. The concern with 'basics', 'fundamentals' and cleanliness becomes a kind of symbolic or cultural capital – a hygiene capital - in Bourdeusian terms (Samuelsen/Steffen 2004).This cultural or symbolic capital acquisition is related to how and where we place boundaries amidst our network of subjective preferences, tastes and styles (Lizardo 2005) and involves investing in and valorising some configurations and demoting others. Once these boundaries have been established, and the techniques for the control of dirt and the mastery of audit and rating systems has been achieved, the boundaries have to be controlled against assaults from other groups such as doctors. Ibrahim's (2005) concept of the 'securitization' of discourse concerning the boundaries maintained by public services chimes in with this process whereby boundaries are identified and policed in participants' accounts.

Many authors have identified a curiously nostalgic quality to nursing such that new activities are supported by reference to their apparent interconnectedness with the historical core of nursing values (Tovey/Adams 2003). In the present study as we sought evidence of the habitus of nursing, it appeared that it was nostalgic yet was also attuned to contemporary struggles for status and symbolic capital. For Douglas (1969), material and conceptual perceptions of dirt and cleanliness are intertwined: Ideas about physical cleanliness have a major role in shaping social borders and hierarchies.

Therefore, exercising the 'habitus of hygiene' and acquiring 'hygiene capital' can assist professional groups with a shared history and position to define 'edges' in their symbolic field and manage the hierarchical relationships which arise in the course of health care work. That is, the treatment of doctors in participants' accounts may be a way of creating and retaining a sense of value in their work as nurses. The doctors on the other hand are curiously liminal beings, inhabiting a realm between the clean and the filthy, performing medical work yet, in the nurses accounts presented here, being agents of disease transmission through their breaching of the boundaries and their alleged sense that the rules don't apply to them.

Of course, rather than representing the literal truth about doctors, this is an image created by a group competing for credibility amidst a situation where the stakes are high and any suggestion that they might be responsible for the spread of infection could be catastrophic. Yet the important feature here is that their account of self, identity and their occupational habitus works to securing a positive professional identity both through their labour and their accretion of hygiene capital. The redevelopment and securitization of nursing work under conditions of threat from hospital acquired infections involves some profound reconfigurations of nurses themselves, which are warranted through nostalgic evocations of the basics of the craft.

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