Social Science & Medicine 67 (2008) 1047–1055

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The habitus of hygiene: Discourses of cleanliness and infection control in nursing work☆

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ARTICLE INFO

Article history:
Available online 17 July 2008

Keywords:
Bourdieu
Hygiene
Nurses
Matrons
Cleanliness
UK
Discourse
Infection control

ABSTRACT

This paper reports upon a qualitative interview study of 22 matrons, infection control staff and operating theatre staff who were questioned about their working lives and the role they played in the control of healthcare acquired infections such as MRSA virus in the UK. A theoretical framework drawing upon the work of Bourdieu is deployed as his notion of habitus captures the combination of practical work, physical disposition and ways of looking at the world which are displayed in the interview accounts of labour in the healthcare field. Three themes emerged from the analysis: first, the 'securitization' of healthcare work, concerned with control, supervision, 'making sure' and the management of risk through inspection, audit and the exercise of responsibility; second, the sense of struggle against doctors who were seen to represent a threat to the carefully organized boundaries, through such alleged violations as not washing their hands, wandering between theatre and canteen areas in soiled clothing and thinking the rules did not apply to them; third, in a 'back to basics' theme participants emphasised the fundamentals of what they saw to be nursing work and were concerned with cleanliness and practically based training – the habitus of hygiene itself. This was formulated in nostalgic terms with reminiscences about basic training earlier in the participants' careers. The preoccupation with hygiene and its 'basic' processes can be seen as a way of managing uncertainty, accumulating a certain kind of symbolic capital and constructing and maintaining boundaries in the healthcare field. It also makes for self-governing, self-exploiting individuals who accrue responsibility to themselves for implementing the 'habitus of hygiene'.

Introduction

In this paper we consider accounts of nurse managers and infection control staff talking about their working lives, and how they try to implement practices which are encouraged by national and organisational policy to enhance safety in relation to healthcare acquired infections. The control of infection, particularly MRSA (methicillin-resistant *Staphylococcus aureus*), is a contentious issue that attracts considerable publicity in the UK and efforts to control it have exercised policymakers, managers, infection control staff and other healthcare practitioners for some time.

In 2007 UK newspapers presented headlines such as 'Shame of the filthy wards' (Daily Mail, 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

☆ The authors gratefully acknowledge the support of the ESRC (research grant no. RES-000-23-1306) for the project 'Talking cleanliness in health and agriculture' which facilitated the fieldwork.

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doi:10.1016/j.socscimed.2008.06.016

Commission, 2007). Gordon Brown commenced his premiership with a commitment to reduce infection rates in hospitals, seeking to halve the number of people diagnosed with MRSA by April 2008 (Revill, 2007). As Revill reports, 300,000 people a year were then being diagnosed with a hospital acquired infection. The UK news media also reported that a growing proportion of death certificates were issued which mentioned MRSA or *Clostridium difficile* (Waterfield & Fleming, 2007). Press reports linked the specific microbes to the state of cleanliness in hospitals (Crawford, Brown, Nerlich, & Koteyko, in press; Washer & Joffe, 2006). This has been accompanied by a preoccupation with means of reducing the incidence of infection. The clinical research literature has historically had some difficulties in demonstrating a clear link between infection rates and appearances of cleanliness (Collins, 1988; Maki, Alvarado, Hassemer, & Zilz, 1982). More recently, however, infection control specialists like Dancer (2008) have highlighted the importance of hospital hygiene, because hospitals have become dirtier in the past decade. Dancer also stresses the role of skin particles and microbes on surfaces such as bed frames, tables, furnishing fabrics and door handles, from which they can be passed to patients. Policy is pushing hospitals both towards improved standards of cleanliness (Department of Health, 2004a, 2004b, 2004c; NHS Estates, 2001, 2004) and higher bed occupancy rates (House of Lords, 2005). The latter may be at odds with lowering rates of infection (Cunningham, Kernohan, & Rush, 2006). Policies have advocated several new initiatives, procedures and ways of working, such as the Matron's Charter (Department of Health, 2004a, 2004b, 2004c), and mechanisms to ensure that senior managers are informed of rates of infection (Healthcare Commission, 2008). These initiatives mean that the practice of infection control in hospital settings takes place in a field rich with multiple narratives and meanings. It is our intention to show how the discursive and social practices in one particular UK hospital trust can be brought into focus using the theoretical formulations of the social theorist Pierre Bourdieu.

In understanding work in healthcare, Bourdieu is particularly apposite (Bourdieu, 1990, 1999; Bourdieu & Wacquant, 1992; Fowler, 1997). For our purposes, the key elements in Bourdieu's thinking are his notions of *habitus*, *field* and *capital*. The notion of *habitus* denotes an acquired, collectively held pattern of thinking and acting. Habitus is an embodied reality which often is taken for granted by a particular social group (Rhynas, 2005: 185). It may include traditions, manners and practical ways of doing work, and acknowledges how an agent's or group's actions and choices are shaped by their respective histories. 'Habitus captures the way the social is internalized individually; integrating all past experiences in the form of durable, lasting and transposable dispositions to think, feel and act' (Ahmed & Jones, 2008: 60).

Yet what is *produced* through the habitus is not merely a passive replica of a dominant ideology but rather a *generative principle*, a disposition towards experience within the fields of practice that the actor must address (Bourdieu, 1990: pp. 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. This shapes tastes, desires and systems of morality in a manner which often escapes conscious attention.

Although some of these ideas have been received critically (Mouzelis, 1995: pp. 100–116; Sayer, 1999), the notion of *habitus* helps to characterize and resolve some apparent paradoxes. The field of healthcare work in hospital settings is one with which doctors, nurses and other practitioners as well as patients and their families, health educators, journalists and many others engage actively and creatively (Power, Edwards, & Wigfall, 2003). That engagement does not happen entirely *de novo* and the healthcare 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).

In Bourdieu's work, social practice takes place in what he calls a *field*. Societies are internally differentiated into many separate fields or 'spaces', each of which has a distinct logic and dynamics, and are characterized by particular structures, institutions, authorities and activities (Bourdieu, 1998; Bourdieu & Wacquant, 1992; Rhynas, 2005). 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, affording distinct possible outcomes. In our case, we may consider the field in question to involve policies, procedures and knowledge relating to hygiene, some of which we have outlined above, the organisational structures of the hospitals where participants work, and the different groups of players within them. Within the field, each person's habitus – perhaps as a nurse, a matron or operating theatre worker – encompasses their 'feel for the game'.

Bourdieu's third major construct is *capital*. Not all the players have the same resources at their disposal. As many have argued, healthcare has been dominated by a 'medical hegemony' (Coombs & Ersser, 2004; Hyde et al., 2006). Medical discourse then constitutes a form of symbolic or cultural capital imbued with status and value. Those who deploy the most powerful cultural capital are advantaged: 'knowledge of and access to those practices put some people in potentially more powerful positions than others' (Thornborrow, 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 symbolic capital which privileges or grants power to the speaker within many officially sanctioned heath care encounters. This privilege may operate on a variety of levels, as healthcare expertise involves not only the language of healthcare 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 so that they can become 'competent' and 'successful' practitioners within the healthcare facility. For both Bourdieu and Mary Douglas (1966), human consciousness and practice are shaped by social structure and shared cultural predispositions. For Douglas, life involves many rituals, and decisions about 'dirt' link to perceptions of whether they are anomalous from the point of view of the systems of classification in use in a particular situation. Dirt is matter which transgresses geographical, spatial and architectural boundaries (Campkin & Cox, 2007) or boundaries associated with social taboos (Cohen & Johnson, 2006). These factors may inform judgments in a hospital setting.

One consequence of drawing upon Bourdieu for sociological understandings of healthcare is to enable 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, perhaps where choices concerning infection control, hygiene and cleanliness are concerned. Another of Bourdieu's terms pertinent to the exploration of infection control and cleanliness is that of 'doxa', or the participant's 'commitment to the presuppositions' of the game they are playing (Bourdieu, 1990: p. 66); an 'undisputed, pre-reflexive, naïve, native compliance' (Bourdieu, 1990: p. 68) that gives us our 'feel' for what is intuitively proper, fair, excellent, clean or prestigious. Or alternatively, the ingrained history and spatial arrangement of boundaries between cleanliness and filth facilitate a grasp of things that are wrong, dirty or profane (Campkin & Cox, 2007; Cohen & Johnson, 2006). Bourdieu adds that competitors in political power struggles often appropriate 'the sayings of the tribe' (doxa) and thereby acquire 'the power the group exercises over itself' (Bourdieu, 1990: 110; Wacquant, 1999).

We believe that close attention to the narratives of participants involved in healthcare work will provide insight 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.

Methodology and procedure

The interviews in this paper formed part of an ESRC funded study of discourses of 'biosecurity' and infection control. Analysis was informed by thematic analysis (Braun & Clarke, 2006) and grounded theory. Semi-structured interviews were conducted to capture narratives of professional life (Charmaz, 2002) in relation to infection control. Explorations based on participants' own understanding and the themes to which they allude are particularly valuable for nursing research (McCann & Clarke, 2003). We examined:

(a) the nature of the participants' role within their healthcare organization, and 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) how participants were addressing the 'problem' of MRSA.

Data exploration and theory-construction were combined and theoretical developments were made in a 'bottom up' manner so as to be anchored to the data (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Therefore, whilst we initially assumed that organized social practice would be disclosed, we attempted to be open-minded concerning the precise shape and form in which it might emerge. The strength of this approach yielded unanticipated findings, particularly, as we shall explore, relating to doctors as potential vectors of infection. Moreover, there appeared to be broader issues at stake, including the focus on practice; the idea that particular symbolic or cultural capital was attached to precautions taken against infection; or that practical working life was animated by a particular notion of surveillance, 'making sure' and exercising authority. This then prompted our re-reading of Bourdieu and Douglas to make sense of the findings. Participants' ideas could then be related back to the process of securing hygiene, 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. 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.

Participants

The participants were all working nurses attached to a teaching hospital in England. Some worked partly in the community or across different hospital sites. They were selected on the basis of involvement in infection control and willingness 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 indicated at the end of each interview excerpt.

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 discloses about the social construction of infection control and how this relates to broader interrelationships in the healthcare field.

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.

The 'securitization' of healthcare work

An initial, readily detectable feature of the discourse of our participants was the issue of 'securitization', where safety involves, in participants' formulations, a continual process of checking, 'making sure', 'ensuring' and auditing. Discourse in many public service and policy circles has undergone this 'securitization' (Ibrahim, 2005) in that it is increasingly formulated in terms of risk, and threats to security and safety, to which practice and policy are directed. Securitization involves a meticulous process of detecting and accounting for threats – in this case those represented by MRSA – and exercising authority to characterize and control them.

The securitization process of checking, making sure and auditing involves the production of a certain kind of truth or cultural capital and is 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:

> …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. (Interviewee 22, female, Matron)

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

> …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. (Interviewee 1, female, Infection Control Nurse Educator)

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

> 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. (Interviewee 1)

Thus, as well as the management of hazards, there is the management of patients, personnel and activities. Participants describe attempts to align colleagues and students with policy emphases on hand hygiene (Department of Health, 2007a). Whilst this might imply a more traditional task of supervision and control, participants underscored the scale of the task and its demands:

> 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. (Interviewee 7, female, Senior Matron, Theatre Department)

Organizations under neoliberal regimes stress the importance of this kind of personal resourcefulness and flexibility on the part of their employees. Moreover, this 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. This competition is extended to individuals themselves, through the individualisation of performance objectives and evaluations. The consciousness and habitus this fosters tell us much about healthcare environments. Participants described regular evaluation and strategies of 'delegating responsibility' so that staffs are held accountable for their domain within the organization as though they were independent contractors. For example:

> 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. (Interviewee 10, female, Ward Sister)

From the socio-political point of view, this interviewee's comments resonate with neoliberal ideologies where 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 'self-exploitation' 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. Nationally mandated policy on infection control emphasizes monitoring and self-assessment (Department of Health, 2004c, 2007b); so proficiency in assessment of the organization and the environment, in addition to its effects on microbial risk, represents a way of demonstrating allegiance to important and powerful interests, and thereby an enhancement of one's capital. Thus, this self-examination and reconfiguration of work in the face of audit was not entirely unwelcome:

> …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. (Interviewee 7, female, Senior Matron, Theatre Department)

This corresponds to what Brown and Crawford (2003) call 'deep management', where involvement in the organization's work occasions self-monitoring and self-control (Du Gay, 1997). The value attached to the controlled, clean environment and the success measured through the audit process 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 which resonates with historical traditions of moral worth attached to cleanliness (Smith, 2008).

However, a satisfactory level of performance in relation to audits and indicators cannot be taken for granted. Control over the environment, one's colleagues and oneself can only ever be provisional and must be constantly worked for.

> 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. (Interviewee 22, female, Matron)

These 'horrendous' things serve as a reminder of problems which might be revisited upon one's own domain if vigilance lapsed. This ability to constantly scrutinize oneself, colleagues and environment represents embodied cultural capital which is valued in the hygiene field, or perhaps an embodied 'hygiene capital'.

Struggling against delinquent doctors

In participants' accounts, the maintenance of 'hygiene capital', that is, the securitizing, checking, making sure and exercising responsibility, is punctured by other occupational groups. Doctors were singled out as major vectors of disease.

> The doctors are not good at washing their hands. (Interviewee 5, female, Matron, Children's Surgery)
>
> 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. (Interviewee 9, female, Matron, Elective Orthopaedic Department)

This disapproval of the medical staff by the nurses might seem surprising. Nursing was traditionally seen as a feminised, handmaid or subaltern role and much literature describes medical hegemony (Coombs & Ersser, 2004). Yet doctors were often characterized as wandering vectors of contamination:

> 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. (Interviewee 13, male, Theatre Auxiliary Nurse)

In Douglas's (1966: xi) understanding of the taboos surrounding dirt and contamination attention is devoted to the way that things perceived to be dirty and dangerous are often those that cross boundaries, a theme reinforced in scholarship on the architectural and geographic management of dirt (Campkin & Dobasczczyk, 2007). Doctors' tendency to breach symbolic barriers between the presumably hazardous and contamination-rich operating theatre and the orderly domesticated world, such as the ward or the canteen, was mentioned regularly:

> …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 "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. (Interviewee 16, female, Theatre Sister, Elective Orthopaedics)

Thus the doctors are constructed as deviating from the implicit hygiene norms. They are breaching boundaries, potentially spreading infection. Their actions, bodies and accoutrements are somehow insanitary, clumsy and intrusive in the hygienically constructed world of nursing. The problem for nurses, given their historically subordinate status (Porter, 1992), is in challenging them. As Douglas (1966: 4) reminds us, 'pollution beliefs can be used in a dialogue of claims and counter claims to status'. Doctors can be challenged as a result of the meticulously self-audited hygiene capital the nurses have gained:

> …nurses need to be able to feel confident to challenge doctors and ask them 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. (Interviewee 22, female, Matron)

A picture emerges of situations characterized by uncertainty. One's medical colleagues may unexpectedly assault the carefully audited hygienic habitus and act like ritually impure entities, breaching the spatio-architectural

and bodily boundaries. This means matrons and infection control staff have to know when and how to challenge medical staff, suggesting parallels between Schon's (1983) concept of reflection-in-action and Bourdieu's notion of habitus.

In Bordieu's terms also, there is perhaps a distinction being made here, between the culture of doctors – described as if they were maladroit, unhygienic vectors of infection – versus the implied symbolic hygiene capital of nurses:

> So you come in and you just check, make sure everything is reasonably tidy, you know the floor clean and if there's any blood you know left or something like that. (Interviewee 14, female, Infection control theatre staff)

One of the advantages of exploring this kind of experience in relation to Bourdieu is that it allows us to ask questions not just about whether nurses have imbibed the policy, but the relationship between this practical knowledge and the social, symbolic and political framework of nursing. Perhaps these accounts represent competition between different factions for prestige, credibility or 'symbolic capital' in the healthcare field. Indeed, the symbolic organization of blame in the event of accident has been found in other public services (Dorn & Brown, 2003). Nurses therefore ensure that they have defensible, credible and capitalised positions, through accumulation of hygiene capital, so that their commitment to cleanliness is unimpeachable. Thus violations of this can be attributed to other boundary-crossers like patients, visitors and doctors.

The habitus of hygiene: the basics of nursing

Participants returned repeatedly to the issues they saw as fundamental to nursing, where hygiene and cleanliness have played an important role since the 19th century (Helmstadter, 2006; Porter, 1992). Where infection control is concerned, expert opinion and national policy do not insinuate themselves directly into the nurses' craft. The assimilation of new knowledge and initiatives occurs through practitioners' shared reflective understanding (Ekebergh, 2007). The sense a professional body has of itself involves images of history. Participants regularly said there was something 'basic' or 'fundamental' about the practical activities of hygiene. Interviewees' accounts reflected the tensions that have often been noted in the literature on nurse education between academic learning and practical training (McNamara, 2008). Yet in their view, there was something distinctively valuable about the 'basics' of hygiene:

> 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. (Interviewee 9, female, Matron, Elective Orthopaedic Department)

One of the advantages of seeing nursing work in terms of a shared habitus is that views like this need not represent a backward-looking mindset opposed to theoretical or technological innovations in nurse education. Rather, the notion of habitus emphasizes nursing's distinctive practical knowledge base and activities (Rhynas, 2005). As outlined by our participants, the key features of this habitus included keeping one's bodily hygiene intact, for example by means of hand hygiene contributions to infection control. In this, new nurses were seen as somewhat suspect:

> …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. (Interviewee 2, female, Head Nurse Matron, Ear, Nose and Throat and Maxillo-Facial Department)

Whilst informed by a sense of history, the discourse of 'basics' is aligned with contemporary accounts of expertise (Callaghan, 2008). Security, certainty and infection control were emphasised as being achievable through 'basic' or 'fundamental' practical activities – especially if emphasised early in training. Participants' view of this 'basic' aspect of practice involved bodily dispositions and actions – maintaining sterile fields, changing dressings, washing one's hands – which were vital to the habitus of hygiene. This was individual to the participants, and sometimes opposed the organisational fabric of the hospital:

> 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. (Interviewee 13, male, Theatre Auxilliary Nurse)

Individuals' efforts can be jeopardized by the hospital's physical and organisational qualities:

> 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 do 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." (Interviewee 7, female, Senior Matron, Theatre)

The security and cleanliness achievable through official means are limited by lack of time and equipment and ambiguity over the securitization of the workplace:

> 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. (Interviewee 9, female, Matron, Elective Orthopaedic Department)

Thus, despite promises in the 'Matron's Charter' (Department of Health, 2004a, 2004b, 2004c), authority over physical, social and economic factors in work environments may be limited. When the organisational environment and other professions thwart hygienic efforts, the 'basics' offer hope because they are something within one's own professional habitus that one can control:

> 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. (Interviewee 19, female, Matron, Mental Health Wards)

Like with category systems discerned by Douglas (1966), threats can be symbolically (and practically) controlled by rendering them within the familiar, in this case soap and water and emphasizing practices deemed to underlie good nursing:

> 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. (Interviewee 22, female, Matron)

The terms underscore the originatory quality of cleanliness – 'starting at the beginning' with the 'basics' – inculcated early in the career which will endure through the introduction of more complex knowledges:

> 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. (Interviewee 22)

The practical habitus of hygiene is seen as predating more academically sophisticated types of knowledge. Yet this does not mean that the habitus of hygiene is itself unsophisticated since 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). Moreover, the habitus of hygiene has received powerful backing from UK Department of Health policies (e.g. 2003, 2004c, 2007a, 2007b) as these relate to hand hygiene and sterile procedure. Through their emphasis on basics, participants also offer commentary on educational and socialization aspects of their craft – one which is practical, embodied and localized: the very aspects which are also central to the notion of habitus.

Conclusions

The habitus of hygiene informs nursing work in infection control, and is described as relying upon many 'basic' processes. Bourdieu claimed that habitus often worked below the level of awareness yet we can see that this is also a reflective process. Habitus can hybridize with reflexivity, such that social actors can give detailed accounts of what they think they are doing and how it relates to their identities (Adams, 2006). Indeed, in conditions of uncertainty, health professionals can be thrown back upon their sense of professional identity (Brown & Crawford, 2003); in this case what it means to be a nurse and the harbinger of hygiene. Cleanliness, orderliness and control are aligned; making sure of things, checking that protocols are implemented and sterile procedures followed, checking hand washing and tidying – all these activities lead to a sense of security. The reflexive awareness is promoted through policies and officially mandated processes of audit which make cleanliness visible to the organization.

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 capital acquisition is related to how and where we place boundaries amidst our network of subjective preferences, tastes and styles (Lizardo, 2005) and involves valorising some configurations and demoting others.

Many authors have identified a curiously nostalgic quality to nursing such that new activities are supported by reference to their apparent interconnectedness with its history (Tovey & Adams, 2003). Yet here the habitus of nursing appears also to be attuned to contemporary struggles for status and symbolic capital and debates about nurse education. Material and conceptual perceptions of dirt and cleanliness are intertwined and shape social borders and hierarchies (Douglas, 1966).

Therefore, acquiring the 'habitus of hygiene' and accruing 'hygiene capital' can assist professional groups in defining 'edges' in their symbolic field and assimilating policy guidance so as to manage the hierarchical relationships in healthcare. The treatment of doctors in participants' accounts may be enabled through their own accumulation of capital and be a way of creating and retaining a sense of value in their work as nurses. Doctors are depicted as curiously liminal beings, inhabiting a realm between the clean and the filthy, performing medical work yet being agents of disease transmission by breaching boundaries and allegedly flouting rules. This may not represent a literal picture of doctors, however. Occupational groups may create images of one another as they compete for credibility and try to secure positive professional identities through labour and accretion of hygiene capital.

The value of Bourdieu's notions of habitus, field and capital to the sociology of heath care and nursing lie in their focus on practice. In the past, nursing sociology has often concentrated upon the relevance of macro-sociological concepts (Porter, 1998) or the value of sociology in illuminating topics in the study of health and illness (Morrall, 2000). Bourdieu's concepts illuminate the minutiae of everyday work, whilst placing these practical elements in their institutional and organisational contexts (Rhynas, 2005). Bourdieu offers a means of capturing and explicating the less visible practical and material aspects of healthcare. Understanding a professional group's habitus and how to build upon this may make it easier to design effective educational or policy interventions where complex issues such as infection control are concerned.

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