Soft authority: ecologies of infection management in the working lives of modern matrons and infection control staff

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Abstract   This paper discusses the role of modern matrons and their work in the reduction of health care acquired infections. Based on in-depth interviews with 10 matrons in a health care trust in the UK Midlands region, we explore how they construe their working lives and their view of the powers they have to enhance cleanliness and reduce infection. Despite claims in policy documents that modern matrons would have considerable authority, participants felt their control over the environment was limited, and could be accomplished only through reflecting, communicating and liaising. The lack of formal structures of accountability and personal authority meant that participants could be characterised as working in what Courpasson calls a 'soft bureaucracy'. Moreover, in the light of limited power to command cleanliness, participants described their role in terms of reflexive work upon themselves and their interpersonal environment, involving self-scrutiny of their activity, channelling information, empowering, facilitating and remodelling the emotional environment of care delivery. This aligns with accounts of the self in the workplace from Anthony Giddens and Nikolas Rose where it is seen as a reflexive project. We explore why the project of the self seems to have eclipsed the managerial role as the major focus of matrons' work.

Keywords: matrons, management, soft bureaucracy, HCAI (health care acquired infection), self-identity

Introduction

In this paper we will be concerned with how modern matrons describe their working lives and in particular how they tackle the issue of health care acquired infections (HCAIs), and consider what this means for notions of management, leadership and bureaucracy in health care. The role of modern matrons and their ability to tackle HCAIs has been brought into particularly sharp focus in the UK with a sustained media outcry about dirt in British hospitals. Modern matrons were introduced in 2001 within a policy context which actively promoted the executive aspects of their role, for example through the Matron's Charter (Department of Health 2001, 2002b, 2003, 2004). The charter focuses on how modern matrons can help reduce infection rates and improve hospital cleanliness, and includes recommendations for creating stronger cleaning teams, making roles and responsibilities

clear, identifying how patients' views can be heard and the creation of a direct line of contact for patients to domestic services (Department of Health 2004).

Our focus on the modern matron and the role they are enjoined to play in infection control is particularly interesting from the point of view of theories of how organisations work and how bureaucratic lines of authority are sustained and subverted in contemporary institutions. Recently, researchers on both public and private sector organisations have written of 'subtle governance' or 'soft leadership' (Sheaff *et al.* 2003), as well as 'soft bureaucracy' (Courpasson 2000). In this view of organisations, a relatively rigid external appearance may be maintained to satisfy the expectations of key stakeholders, yet interior practices and roles may be less exacting. As Sheaff *et al.* (2003) note, this description is apt for health care work, as different occupational groups in the field regulate their 'interior practices'. Yet at the same time there are attempts to apply structure and control to the organisations in which they work by managers and policymakers, which often appear 'loosely coupled' (Jermier *et al.* 1991: 170) compared with the more rule-governed and authoritarian ways in which non-professional employees are managed.

In contrast to this, when the modern matron role was first defined by policymakers, it was much more oriented towards command and action. The role was first highlighted in the NHS Plan (Department of Health 2000: 138) and described as 'someone to get things done, someone patient focused', and 'a strong clinical leader with clear authority at ward level' (2000: 89). Moreover, they would 'have the authority to make sure wards are kept clean and that the basics of care are right for the patient' (2000: 23). The hope was that these new nurse managers would be able to capitalise on the current popularity and visibility of the term matron to ensure that the fundamental management function within the NHS is directed to the needs of patients.

This ambition resonates with more pervasive demands on the part of policymakers who perceived failings in the public services should be addressed by means of 'leadership' (Currie and Lockett 2007), and the valorisation of leadership styles allegedly found in the commercial sector (Newman 2002). Managers, like idealised CEOs in private industry, are enjoined to adopt a heroic, transformational role, enacting change with 'vigour', 'drive' and 'enthusiasm'. This is accompanied by a burgeoning literature on nursing concerned with the value of 'transformational leadership', which is believed to involve the leader in raising the aspirations of followers, fusing the leader's and the followers' goals 'in a mutual and continuing pursuit of a higher purpose' (Burns 1978: 20, Bass 1985). Transformational leadership is said to involve four components: charisma, inspiration, individualised consideration and intellectual stimulation, and has been advocated as a means of strengthening cultures of safety in nursing (Wong and Cummings 2007). From our point of view, the intriguing feature of transformational leadership is its focus on the personal and interpersonal dimensions of work in social life, rather than on bureaucratically mandated lines of authority.

Nevertheless, the new version of the matron identified in UK policy documents brought with it the traditional attributes of authority, and was positioned by policy and media response as a guardian of cleanliness and propriety. The modern matron was appointed with specific responsibilities for ensuring wards were kept clean and as key combatants in the battle against superbugs such as MRSA (methicillin-resistant Staphylococcus aureus) and latterly C.diff (Clostridium difficile). As part of their authority, something the public demanded (McDonald 2004), the original formulation of their role attributed to them the power to withhold payments to contracted cleaning companies (King's Fund 2005).

Such moves, of course, alluded to longstanding and idealised public perceptions of a 'golden age' of health services when matrons were seen as providing visible leadership and ensuring high standards of cleanliness (Watson and Thompson 2003); a return to 'the good

old days' (Barrett 2003); harking back to when 'matron knew best' and 'wards were spotless, uniforms were starched and you knew who was in charge' (Snell 2001). To some extent this recollects the legacy of Florence Nightingale as an embodiment and metaphor of nursing itself. Popular representations of the matron frequently allude to the no-nonsense and dominant Hattie Jacques (*e.g.* Dent 2006) who starred in a series of films including Carry on Nurse (1959), Carry on Doctor (1967) and Carry on Matron (1971). Even though the first of these premiered nearly half a century ago, such fictional representations have informed popular and policy representations of what the job involves and the kinds of authority it is believed to encourage.

In introducing the 'modern matron', NHS Trusts have usually either created new posts or adapted and redesigned existing senior nurse posts (Department of Health 2002a). In so doing, variation has occurred in the range and make-up of their roles across different clinical sites. As such, the modern matron has been seen by some simply and perhaps rather cynically as a 'quality initiative' (Savage and Scott 2004) responding to patient inter-pretation of quality as 'clean and tidy environments' (Savage and Scott 2004), 'limiting harm' to patients (Keeley *et al.* 2005), and leading and supporting clinical teams and infection control nurses in prevention of HCAIs (Department of Health 2001, 2002b). Like the nurse consultant role created at approximately the same time (Abbott 2007) this is done with 'a focus on giving nurses the authority to improve health care environments, improve cleanliness and develop infection control practice' (Hill and Hadfield 2005: 42). The modern matron is therefore cast as dealing authoritatively with a 'complex interplay of factors' surrounding HCAIs (Gould 2005).

The image of nurses as active managers of this ecology of cleanliness, with the matron in charge, has played a part in the public perceptions of nursing (Hallam 2000, Salvage 2006, Takase *et al.* 2006). It is as if popular perceptions and policymakers themselves are curiously nostalgic, imagining a structure of rigid and effective line management of person-nel, with the matron as a supreme authority figure, holding the kind of moral power associated with mothers superior, policing both the private and public lives of nurses, ensuring that care environments, right down to nursing uniforms, are pristine. Yet this traditional strong and often fearsome leadership that came to an end with the Salmon Report in 1969 has not been revived in the modern matron. In line with the predictions of theories of soft bureaucracy and subtle governance, a diffusion of power is evident in contemporary incarnations of the matron role, with a clear shift to the newer and more relationally-oriented aspects of health care work. As such the modern matron does not achieve the singularity and totemic grandeur of the earlier manifestation. Nor is the new role exclusively feminine with male modern matrons accounting for some of this popula-tion. Furthermore, while there is a clear parallel in that both the traditional matron and modern matron directly influence ecologies of cleanliness, they do so rather differently.

Modern matrons sit in a much less dominant position in a flattened health care hierarchy, with more senior nurses above them and often working within a team of matron-peers and alongside rather than above personnel such as infection control and hotel services who remain outside their direct line management. The Department of Health (2001) indicates that the role is more administrative than involving direct patient care and has limited managerial power. Butler (2001) notes, 'Matrons will be essentially ward sisters with extra responsibilities including the management of ward level budgets for cleaning, catering and general ward environment'. Thus, the hierarchical display of the newer role is less impressive. The modern matron is granted the rhetorical gravitas and iconic status of the traditional matron but left with more muted power. In an era of 'clinical governance of the soul' (Brown and Crawford 2003) where staff are sometimes left with little sense of

organisational support, modern matrons are left isolated and exposed, and, like their colleagues the nurse consultants, with a measure of uncertainty over their roles.

Instead of the minatory power attributed to their predecessors, modern matrons are supposed to exercise their authority through collaboration with medical colleagues (Girvin 1996) and fellow practitioners from other disciplines. As it is uncertain how the authoritative management style of matrons in the past fits into today's nursing and health care culture and the focus on empowerment of colleagues (Oughtibridge 2003), it was suggested that the role could be seen as enabling, rather than strictly authoritarian, using transformational leadership styles (Senior 1997). As a result of the lack of formal management responsibility for their fellow clinical staff (Dealey *et al.* 2007, Shanley 2004), a crucial element of the role of a modern matron is credibility – clinical staff should have confidence in them. Credibility is believed to be based on expertise and knowledge, but trust and mutual respect are also vital (Mullally 2001). Ashman *et al.* (2006: 50) cite a variety of factors that they say show evidence of matrons' impact. Among these are a great many features redolent of the soft bureaucracy mode of organising, where the relational and psychosocial aspects of work are primary. For example, 'encouraging reflection', 'empowering staff', 'improved networking and communications', 'oiling organizational wheels', securing 'effective relationships' and 'creating an open environment' are identified as positive outcomes, just as much as any practical impact upon physical levels of cleanliness or rates of infection. Now an improved psychosocial work environment may bring benefits for patients and staff alike, but the key point is that these soft bureaucracy activities are foregrounded and valued in evaluations of matrons' working lives.

In this paper we therefore will explore the accounts given by a group of matrons discussing their working lives. The development of roles such as the modern matron, with their particular embeddedness within a structure of 'soft' authority and infusion with discourses of 'transformational leadership', means that issues of workplace identity and persona are especially important. In the case of the matrons whose accounts are presented here, we shall examine how the processes of communication, lines of authority and means of getting things done which they identify relate to their objective of reducing HCAIs and improving cleanliness. We shall explore how modern matrons in league with other key players in ecologies of hospital cleanliness try to resolve discursively the inherent contradictions of authority as they work to deliver a patient-centred service and seek to reduce HCAIs.

Methodology

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 on thematic analysis (Braun and 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 and 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 health care 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 and how they attempted to organise others to accomplish those tasks; (c) the steps participants were taking to address

the 'problems' of their work, especially in the context of the policy-driven need to combat 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 and Clarke 2006, Glaser and Strauss 1967, Strauss and Corbin 1998). Therefore, whilst we began with an assumption that organised social practice would be disclosed, we attempted to be open minded as to the precise shape and form of the work which would be described. The strength of this approach is attested by the way that novel findings that were unanticipated by the researchers emerged, particularly, as we shall explore, relating to the way that the emphasis of participants' work was seen to fall so heavily on their formulation and management of their relations with others and indeed upon their own consciousness itself. Moreover, there appeared to be broader issues at stake, relating to how organisations work when there are a variety of competing professional groups, whose hegemony is incomplete and whose authority to organise one another is limited. These ideas could then be related back to the notional process of work in soft bureaucratic systems, policy documents outlining the matron's role and scholarship on nursing in ways which were not anticipated 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. 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 bureaucratic social world of health care work.

Participants

The participants were all working in a matron role and were attached to a large university teaching hospital in the UK midlands region. 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. The participants' roles are summarised in Table 1.

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 matrons' roles, what it tells us about the formulation and implementation of the tasks of infection control and how this may relate to broader patterns or interrelationships in organised, socially co-ordinated human activities in the health care field.

Results

The interview material yielded a rich layering of themes concerned with the nature of the role and the kinds of tasks which were involved. As we shall see it was clear that the lines of command were not as straightforward as classical images of bureaucracies would suggest.

Table 1 *Participants' descriptions of their roles*

Interview number	Job role as described by the participant
1	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.
2	. . . 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.
3	I'm the head Nurse Matron for neurosciences . . . Neurosciences are diseases and trauma to the central nervous system. So principally neurosurgery and neurology.
4	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.
5	I'm a Senior Matron in the theatre department, main theatres of [the hospital]. My remit is for all general surgery theatres.
6	Yes I'm a Head Nurse Matron for the elective orthopaedic department. So that covers the Fracture Clinic and Orthopaedic Out-patients Service.
7	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.
8	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.
9	My role is Modern Matron attached to the three acute mental health wards . . . at the [hospital] site which has a large acute hospital.
10	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.

Images of leadership

When asked to describe what they did in their work roles, the participants were apt to describe their occupational lives in terms of leadership. As one participant introduced herself:

> Interview 7: 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. So that's where I am at the moment until the new structure, that's where we're going and what we're doing.

Equally, others were keen to emphasise the leadership aspects of their role:

> Interview 9: So the role is sort of very much leadership, a sort of, I think when the modern matron agenda was developed it was very much on the acute hospitals, you know like you'd be cleaning the wards, you'd be tidying the beds, you'd been managing the staff, you'd be doing everything.

The kind of leadership emphasised was the sort that involved hands-on work as well as directing others to do the work that was necessary. As interview 19 indicates, there was a

tendency to relate the role back to the policy context and what this 'agenda' was believed to specify. Yet, at the same time, there was a reflexive detachment from the policy context in some cases:

> Interview 3: And my role as head nurse matron, as I see it, is to support the staff, the patients and the relatives in providing them with the optimum level of care. Now the modern matron role, as described by DoH, a modern matron, it sounds like Thoroughly Modern Millie but it seems very focused on cleanliness, on the ward environment, on food, you know certain aspects like that.

Thus, this aspect of their work identity for the matrons was neither wholly embraced nor monolithic. Indeed, they were apt to allude to other sources of imagery about matrons and the kind of authority they were presumed to exercise. The kind of matron played by Hattie Jacques a generation ago was a fruitful source of ideas, even though this was a parody. This notion of the matron was partly defined in physical terms: what she looked like, her stance, and her imagined physical control over the environment:

> I: . . . you know the old fashioned type of matron.

> Interview 9: Yes, the Hattie Jacques.

> . . . the matron figure a lot of cartoon type people you know sort of the lady with the big boobs who walks around saying do that, do that, do that. I don't think any of us would want to do that but it's like leading by example.

The persistence of this image across the decades was noted by several other participants. The nature of the responsibilities attributed to the matron role is informed by this kind of imagery.

> Interview 10: . . . I mean people still think Hattie Jacques is modern matron and that it is. And there is an expectation from users and carers that I will appear in a uniform and I will be you know bossing people around which I do do, but I don't wear a uniform.

As we have seen, the policy context itself is aligned with this kind of imagery. As the NHS Plan (Department of Health 2000: 138) indicated, policymakers too had a sense that the matron could be defined in terms of decisive physical action. They proposed 'the return of "Matron" – with authority on the ward, in charge of getting the basics right, without getting bogged down in bureaucracy'. Hence, the role is visualised as enjoying a kind of authoritative freedom, to command cleanliness and excellent patient care whilst being liberated from bureaucratic constraint.

Doing the job: 'visibility' and 'audit'

Yet, in contrast to this sheer physicality and minatory power, the interviewees disclose that modern matrons see their practical role in rather different terms. The physical aspects of the job are still present but these were reframed in terms of 'visibility' or in communication terms, facilitating 'liaison' between different groups of people, facilitating learning and education. For example, one participant described her role as:

Interview 7: . . . having a highly visible clinical lead and that's, that was about visibility to the patients, staff, other professional colleagues, and I think the matron role is about having a point of contact and somebody who you knew would address concerned issues.

The 'visibility' of the matron is mentioned in the 'Matron's Charter' (Department of Health 2004: 9) too – a state of being which might once have been taken for granted is now formally specified as part of the job description. Yet the ability to organise, manage and command was often curiously muted.

Interview 9: I don't manage any of the staff, what I do is work with all the wards on site, so work with the ward managers, give clinical leadership advice, offer support, offer supervision. So I work with them but I don't line manage them, they're managed through a service manager and I'm managed through the general manager. So I don't actually manage any of the staff but what I do do is work with the staff very closely on the in-patient areas.

Instead, liaison was the likely mode of getting business done.

Interview 8: I mean I tend to liaise with the nursing staff the majority of the time because that is my, my role is to look after them.

Whilst direct, authoritative leadership was not apparent, another variant of leadership was much more conspicuous. This operated via the collection of information, and the process of 'audit' figured prominently in participants' accounts of their working lives.

Interview 2: We have quarterly audits within the hospital looking at the environment and that incorporates aspects of reducing cross infection and hand hygiene. And periodically there are sort of one-off hand hygiene audits which are done by infection control.

Interview 4: As matrons we did audits every three months on all our wards with the supervisor of hotel services so that we can both see if the domestics are doing a good job.

Interview 1: I could talk, I mean particularly because you know you're interested in infection control and cleanliness, part of my role as well is to audit that so I do regularly audit.

Audit represents a particular technique for the construction and acquisition of knowledge, through which the work of management can be performed. Rates of handwashing, dust under beds and even more intangible qualities are measured and re-measured. This is actively encouraged also in the policy documentation. The Department of Health enjoins teams to 'audit their practice – not just in terms of inputs and outputs, but in respect of culture and philosophy' (Department of Health 2004: 7). Even culture and philosophy, then, are susceptible to this kind of technique, which enables them to be measured, shaped and reconfigured. As Courpasson and Reed (2004) note, these forms of organisational life and their self-scrutiny raise perplexing political questions about the complex, flexible and hybridised regimes of accountability and control in 'post-bureaucratic' or 'network organisations'. The bifurcation of structures of authority means that any kind of leadership has to speak across organisational divides within an institution which is a kind of archipelago

of differentiated groups of workers. The information provided by these audits, rather than direct command, is a means by which these loosely coupled groups can attempt to co-ordinate themselves. This does not, however, entirely resolve the complexities of accountability:

> Interview 7: So in fact that's what makes it very challenging, you've got lots of different people that feel that you are accountable to them and that is I think one of the challenges of the matron anyway is quite who, who is your boss, who are you reporting to and accountable to. There's lots of people who want a bit of you and it seems that you know there's the HR bit, there's your divisional nurse bit, there's the finance bit and you seem to be accountable to lot, lots of different people and I think most head nurses would probably say the same kind of thing.

Rather than the direct physical control which might have been imagined as a characteristic of earlier matrons, the present-day experience is a more fragmented one of negotiating a pathway through a complex network of accountability and responsibility. In addition, there are other challenges to the modern matron's authority, where attempts at any kind of direct control are even less likely to succeed – not least with patients' families who must nevertheless be enlisted in the precautions relating to infection control:

> Interview 4: Yes, yes we manage all the nurses that cover all the wards. The challenge for us as well is managing the families, particularly with regard to infection control and although they have responded very well to the hand washing campaign.

This process of managing through the intangible processes of talk, reassurance and liaison was an important feature of participants' descriptions of how they worked and how they accomplished the tasks involved.

> Interview 10: When you talk to users and carers, and I do talk to users and carers a lot, a lot of my role is liaising between users, carers and staff teams. If you could hear some of the things people say, I mean it's, about their view of what the environment is like, what cleanliness is like it's quite shocking and my, part of my role is to make sure that staff on the shop floor know what's being said and understand what's being said and feed, mirror that back to them you know.

The role then is one of being a kind of conduit between what users and carers say and the 'staff on the shop floor'. The information about what users and carers say can be reflected back to the staff responsible for cleaning, yet the possibility of taking decisive action in the process of being a matron tackling infection control is mitigated by the organisational and managerial constraints of the role. Sometimes participants drew a distinction between this image and their experience of everyday working life:

> Interview 6: . . . I think when they implemented the role of the head nurse matron there was a lot of, there was lots of media attention and publicity around what we would be able to do in relation to hygiene, infection and all of those sorts of things. And I don't feel that, I feel as if I've done everything that I can do, that is within my own gift if you like. But because we were never given the budget or the control to manage the people who cleaned our wards, all of those things, there's only so much you can do. So I think it's made an impact and I think it's a positive impact but I think the impact could be greater if the infrastructure had been sorted out accordingly really.

The nature of the structure of accountability, or as this participant puts it, the infra-structure, means that action other than 'feeding' information or 'mirroring' is difficult to accomplish. The work that being a matron involves is therefore, in an important sense, work upon the self. Indeed, as we have seen, this is also a pre-eminent theme in the discourse of transformational leadership. One is positioned as a 'visible' person, as a 'lead', as a means by which the organisation can scrutinise itself through audit or as a reflector of views – a kind of periscope through which one stakeholder group can see another.

This preoccupation with work upon the self chimes in closely with a good deal of recent inquiry on the subject of identity and sense of self at work which deploys the idea of reflexivity. This often takes its cue from Giddens's (1991: 52) argument that self-identity is 'the self as reflexively understood by the person in terms of her or his biography'. To this, Cremin (2003: 119) argues that it is important to consider how biography itself is shaped and reinterpreted as a result of labour force pressures. Thus self-reflexivity is developed and expressed through the framework of policies, procedures and organisational avenues for self-development. One such document through which a professional biography could be constructed was the Matron's Charter itself:

> Interview 9: . . . we talked earlier about the Matron's Charter and I think the charter makes it quite clear that the matrons should be really the champions of particularly the proactive bits of infection control.

Yet as the participants described their work, it was clear that it was not readily intelligible through the lens of management or as their playing a role in a chain of command. The Hattie Jacques figure, the 'bossing around' and even the control over cleaning budgets recommended in government policy documents were all chimerical. Thus, participants were not attacking the physical dirt of the hospital themselves but instead their role appeared to be that of managers, engineers and architects of the communicative environment.

In the round of audits to generate information about levels of cleanliness, hand hygiene, compliance with policies and culture, the modern matron is as much managed as she is managing. Participants both undertake and are the subject of audits, as well as being conduits of information between patients, their carers and colleagues working for different branches of the organisation or subcontracted to it. In a sense they are vectors of information flows within the organisation. Within this process of negotiation and reassurance, control becomes as Courpasson (2000) would have it, a barely visible, soft social process, whose results may or may not appear at an unspecified future time. One's involvement in this process is enforced by its opacity, and by the managerial principle of the 'deferred sanction' (Courpasson 2000) such that compliance can very rarely be formally enforced. It is reinforced by the moral effects from the 'liaison', from the 'audit' and the process of reflecting the views of different stakeholders that there may be if any form of disagreement were to damage the carefully contrived accord and the necessary solidarity against external threats such as the lurid reporting of HCAIs in the press.

Following the logic of 'soft bureaucracy' it may even be speculated that the nature of direct lines of command, instruction or reporting would be disruptive to the running of the organisation as it would occasion the potential for a loss of accord. Moreover, if a matron were to 'order' cleaning to be carried out, rather than 'liaise with hotel services' this might expose the difficulty of deploying resources and the problems involved in prompting action. It might expose also the weaknesses of the infrastructure of accountability.

Managing the territories of the self

Instead of this potentially problematic territory of physical work upon the environment then, the territory to be managed becomes interpersonal in that it is concerned with 'liaising' and 'talking', and is internal, in the sense that the nurses manage their own and others' frustrations and fears.

> Interview 7: I think it's made me much more aware of the importance of what we do to minimise and prevent infection because it can potentially be so catastrophic really and it can have such an effect on patients and their families. And I've also experienced it myself quite some years ago and that will be with me forever really. So I must admit I do, it's probably a bit acuter to me mainly but MRSA does have a sort of always there in lights flashing really thinking that we need to do whatever we need to do to try and make sure that it doesn't happen which I do find it very upsetting when we're looking at you know pushing more patients through an area and cleaning services are being cut and nursing numbers are being cut.

Awareness, catastrophic effects upon families and upset, then, are the stuff of nursing work at senior nurse or matron level. Indeed, the socio-emotional and aesthetic aspects of the role are significant, in that the subjective feel of the environment, rather than its material pathogenic properties, and people's responses to it are foregrounded in participants' descriptions of their working lives. Here is an interviewee describing relations with patients and their families:

> Interview 8: . . . So reassurance, ask them what their main issues are as well you know have they got any concerns, make sure that we give them time to ask us any questions of what's causing a problem. It may be for example that they feel that the cleanliness isn't as good as it could be so you know we'll work with hotel services who'll explain sort of cleaning regimes of the hospital, discuss that with our counterparts as well.

Cleanliness then is aligned with the more intimately manageable domain of feelings and it was in this field of work that participants were able to provide accounts of their practice in reducing fears, reassuring and moderating the sometimes particularly stringent demands of patients. The solution to concerns about cleanliness then becomes a matter of explaining how cleaning regimes work, rather than making the establishment perceptibly cleaner.

General discussion

The role of the matron as described by our participants then is different from the decisive picture of action described in the policy documents published by the Department of Health. In their accounts here, post holders struggle with the contradictions involved in organising the delivery of modern health care which is responsive, innovative and patient-centred and which minimises infection risk in contexts where they have little formal authority. Perhaps the role of the modern matron as a figure of authority is muted by the dominant and historically enduring representations of nursing as women's work involving caring, nurturance, housekeeping and cleaning (Bolton 2005, Porter 1992). The very name 'matron' derives from the Latin 'mater' for mother. Thus, the modern matron role was

created with a view to giving the post-holders authority, yet it remains tied into a history of 'feminised' subservience and handmaid deference to medical power. Thus, the picture of capability, where it was anticipated that experienced senior nurses would be empowered to deal decisively with problems in hospital life, has been challenged and rendered ambiguous by the way that the role has been played out in practice. Despite their difficulties in exercising formal authority, modern matrons have been cast as scapegoats for failing health care services even as they struggle to restore some nursing control of hospital environments. Yet any such possibility of control may have formally been lost as a result of contracting out of services (Barrett 2003).

Some commentators have tendered explanations for failure which specifically highlight this lack of authority to make changes (Hewison 2001, Barrett 2003). Others contend that matrons are overstretched in terms of workload and responsibilities with inadequate support structures, resources or mechanisms (Barrett 2003, Watson and Thompson 2003). Instead, they fall into a 'hybrid manager' role (Savage 2004), split between clinical and corporate agendas and struggling to meet key responsibilities identified by the Department of Health (2003). Moreover they are 'subject to competing understandings of quality' (Savage and Scott 2004: 420).

This then is the picture of the difficulties facing holders of the modern matron role. The interview material presented here gives some further clues as to what has happened. The tasks of being a matron have been formulated in terms of self scrutiny, liaising, communicating and acting as a conduit for information and communication from other stakeholders. The importance of this personal and interpersonal realm is underscored by the fact that it is also foregrounded in some of the more popular contemporary theories of leadership in nursing. For example 'transformational leaders motivate and energise staff to pursue mutual goals, share visions and ensconce an empowering culture, where personal values and reciprocated respect are fundamental principles' (Murphy 2005: 131). Hill and Hadfield (2005: 44) describe the modern matron role in terms of its holders' ability to facilitate 'a culture of "ownership" of infection control issues by clinical teams' and in their work 'empowering others to take responsibility for infection control practice'. Hill and Hadfield also underscore the importance of 'encouraging an open working culture'.

The pattern of organising typified as 'soft bureaucracy' (Courpasson 2000, Sheaff *et al.* 2003) is particularly well suited to the exploration of these accounts of health care work. Yet this kind of thinking does not wholly characterise the experiences described here. The participants' accounts were informed too by historical imagery including the 'Hattie Jacques' figure, as well as encouragements from policymakers toward the exercise of authority over cleanliness and cleaning budgets. In addition to the insights gained from the notion of soft bureaucracy, a further intriguing insight concerned the focus of the managerial efforts of the matrons. The limitations on their material powers in the workplace meant that their management was refocused upon themselves. This alludes to Foucault's (1998) preoccupation with *techniques of the self*, the 'models proposed for setting up and developing relationships with the self, for self-reflection, self-knowledge, self-examination, for the deciphering of the self by oneself, for the transformation one seeks to accomplish with oneself as object' (1988: 29). Indeed, the focus upon the self identified here is brought especially to the fore because the new leadership roles in nursing tend to involve working across organisational or administrative boundaries. Thus, without precise formulations of roles and structures of authority, it is the personal functions of identity and communication that become paramount under conditions of soft bureaucracy.

Conclusion: managing in nursing and managing oneself

A major part of the description of their working life activity furnished by our participants concerned the personal and interpersonal realm. Following Rose (1999), we could argue that our participants are describing themselves as having implemented and participated in a variety of procedures by means of which they can act upon their practice, their emotions, their beliefs and their forms of conduct in order to transform themselves and autonomously achieve the requirements of their role. There are techniques for examining and evaluating the self, and the hospital: modes of self-inspection, vocabularies for self-description, ways of rendering the self and the working environment into thought. As Rose (1998, 1999) proposes in his work on making the modern self, these entail attending reflexively to different aspects of the occupational self, as one leads, empowers, facilitates and liaises ways of marking differences and making them notable. What is also notable is that the conditions appear to have made possible particular ways of disclosing the self – new ways of speaking about working life and organising the self. Indeed, it could be argued that a major part of the role of the modern matron, in the absence of authority or material powers to implement change, is to work upon the self, as it is this that can be most readily organised, disciplined and reconfigured.

Furthermore, there are intimations that this style of work upon the self and the interpersonal environment is common to other leadership roles in nursing. Abbott's (2007) nurse consultant informants had to act as boundary spanners, and devoted considerable energy to 'negotiating priorities' and forming relationships, and Carryer *et al.*'s (2007) advanced nurse practitioners led through the example of their own 'professionalism' rather than through any officially mandated powers.

The emphasis on transformational leadership theories represents another way in which the matron can be enlisted into the proliferating languages for evaluating the self and the organisation, diagnosing its shortcomings, calibrating the failures and strengths in a variety of areas from cleanliness to culture. This regime also involves self-directed techniques for curing the organisational body politic, through the purgative effects of audit. If the focus of the job becomes the self then the authenticity of that self is the thread that binds organisational careers. Indeed, this has been affirmed in recent calls for 'authentic leadership' (George 2003, Svejenova 2005). As the same time, leadership itself is democratised so that it may involve what everyone does. Barbour and Dodd (2007: 31) quote the Scottish Executive Health Department (SEHD 2005) that leadership should not be simply 'the preserve of a few people at "the top"' but instead must 'permeate each ward team, community team and functional team,' and must 'support front line leaders to deliver improvements'.

These technologies of the self are facilitated by soft bureaucracy where chains of command are radically uncertain and the occupational and organisational bonds between different groups of workers are fragile and provisional. This predisposes a constant and intense self-scrutiny, as was discovered in community mental health staff by Brown and Crawford (2003), where internally-located professional identities facilitate the compliance of staff in relation to occupational images of fulfilment and autonomy. Thus, managing the process of infection control is in an important sense about managing oneself. In this sense, the soft bureaucracy and the process of reflexive self scrutiny and self-identity construction are closely related.

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