
‘This wound has spoilt everything’: emotional capital and the experience of surgical site infections

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Abstract In this article we explore the experience of suffering from a surgical site infection, a common complication of surgery affecting around 5 per cent of surgical patients, via an interview study of 17 patients in the Midlands in the UK. Despite their prevalence, the experience of surgical site infections has received little attention so far. In spite of the impairment resulting from these iatrogenic problems, participants expressed considerable stoicism and we interpret this via the notion of emotional capital. This idea derives from the work of Pierre Bourdieu, Helga Nowotny and Diane Reay and helps us conceptualise the emotional resources accumulated and expended in managing illness and in gaining the most from healthcare services. Participants were frequently at pains not to blame healthcare personnel or hospitals, often discounting the infection’s severity, and attributing it to chance, to ‘germs’ or to their own failure to buy and apply wound care products. The participants’ stoicism was thus partly afforded by their refusal to blame healthcare institutions or personnel. Where anger was described, this was either defused or expressed on behalf of another person. Emotional capital is associated with deflecting the possibility of complaint and sustaining a deferential and grateful position in relation to the healthcare system.

Keywords: healthcare associated infection, emotional capital, Bourdieu, surgical site infection, stoicism

Introduction

In this article we will explore the experience of surgical site infections (SSIs), a hitherto neglected area in the social study of illness, and examine how this experience is assimilated into the lives of sufferers and their families. In order to make sense of the human process of coping with an SSI, especially where it is borne with stoicism or fortitude in a field where sufferers are often less powerful than practitioners, we will draw upon some developments of the work of Pierre Bourdieu. As is well known, Bourdieu (1986) popularised the idea that economic capital in the form of wealth is only one of a variety of forms of capital to be found in social life. A person’s social networks and the social resources they can mobilise represent social capital, while cultural capital refers to their educational or intellectual assets. In Bourdieu’s scheme, symbolic capital represents resources of honour, prestige or recognition. Here, however, we draw especially on an elaboration of these notions by Helga Nowotny (1981) and Diane Reay (2000), namely, the idea of emotional capital. Developing Bourdieu’s conceptual

framework, Nowotny identified the concept of emotional capital as a variant of social capital, but characteristic of the private, rather than the public sphere. The notion of emotional capital offers a framework for understanding the socialisation of emotions and the broader role that this plays in reproducing inequalities (Cahill 1999, Reay 2000). Reay defines emotional capital as something that is accumulated and sustained in social relationships and may be passed from one family member to another. Reay develops the notion to help understand the energy expended by families in maximising their children's gains from the education system. In a related adaptation of the concept, Froyum (2010) borrows from Bourdieu's (1984, Bourdieu and Passeron 1977) theory of cultural capital, and sees emotional capital as a way of managing emotions as a kind of skill or habit that may translate into social advantages. Like Katz's (1999) analyses of phenomena such as crying or road rage, these perspectives show how emotions – or at least emotions deemed appropriate for a particular institutional context – can be thought of as interactionally managed events and as resources for dealing with and for commenting on the social business at hand in situations contoured by patterns of inequality. As Reay (2000) remarks, it is sometimes difficult to relate the idea of emotional capital to Bourdieu's original work, and it is also difficult to see direct links between this and social class or social power. However, key links can be seen in the idea of social relationships which underlies both emotional and social capital. Relatives, friends and acquaintances can yield emotional aid, companionship, advice, information, economic help, and help frame and make intelligible anomalous situations (Hurlbert *et al.* 2000, Wellman and Wortley 1990). This is especially important in times of personal, family or social crisis. Working together, people can actively negotiate and activate the stock of emotional resources or emotional capital (Reay 2004) potentially available through these social bonds. Gendron (2004) goes further and argues that emotional capital underlies other kinds of capital and plays a role in potentialising, energising and empowering social and cultural capital.

While it has mainly been used in making sense of educational attainment and social class, the concept of emotional capital can provide a conceptual tool to researchers in health too, enabling an account of how emotions-as-resources are accumulated, circulated and exchanged for other forms of capital. The idea also offers a means for thinking about the ways in which emotion practices are managed in a healthcare context, based on norms, rules and patterns of power in the social field. Emotional capital is both generated by and contributes to the generation of the habitus – or learned dispositions, skills and ways of acting – appropriate to a particular healthcare context. Furthermore the notion of field in Bourdieu's thinking sensitises us to the possibility that different actors in the healthcare setting may be differently equipped with capital and have differing powers available to them. For example, Dixon Woods *et al.* (2006) provide a Bourdieusian analysis of how patients find themselves giving consent to surgery despite their misgivings, perhaps as a result of their sensitivity to the rules of the hospital 'game' and their awareness of the more powerful forms of capital mobilised by staff through routines and the tacit rules of the hospital. The idea of emotional capital can assist us in understanding the way that people might expend personal and familial resources in attempting to optimise their involvement with complex systems with uncertain payoffs, where institutional actors have power to superimpose a particular world-view as a result of being socially and practically positioned as 'knowing what they are doing'. Moreover, as patients and practitioners have different powers available to them in the healthcare field, as Nowotny (1981) suggests, there may be different rules at work concerning how they may convert capital from one form to another. In our case, the invisible labour undertaken by surgical patients in support of the transition to recovery can perhaps be understood as an individual and collective expenditure of resources. What might appear variously as stoicism, fortitude or – following the stoics themselves – as a philosophical attitude to suffering may be understood as part of an active

process of resourcing one's engagement with healthcare systems and one's identity as a 'good' patient.

Surgical site infections represent a subgroup of healthcare associated infections (HCAIs), which are acknowledged to represent a major problem in many of the world's healthcare systems. For example, the European Centre for Disease Prevention and Control (2008) estimates that four million people throughout the European Union will acquire an HCAI each year, of whom 37,000 will die as a result. Epidemiological surveys typically report that around 8 or 9 per cent of patients in hospital acquire an HCAI (Health Protection Agency 2012). The subset of HCAIs known as SSIs has been gaining recent scientific and scholarly attention, and is believed to account for around 25 per cent of HCAIs, affecting 5 per cent of surgical patients (Leaper 2010, National Institute for Health and Care Excellence 2008). The nature of the infections, the pathogenic agents involved and the procedural work necessary for their elimination present fresh challenges for healthcare personnel, managers and public health policymakers and has demanded distinctive innovations in aseptic technique, surgical practice and wound management (Health Protection Agency 2011).

While much attention has been devoted to operating theatre practice, wound care and microbiological issues, the experience of the sufferers themselves has largely escaped scholarly attention. The field of HCAIs has produced very few studies of what these conditions mean at first hand for patients and their families. Yet a detailed account of the illness experience of sufferers is vital if we are to characterise the psychosocial burden associated with these conditions and determine the optimal nursing and post-hospital response. Moreover, from a sociological viewpoint, the near-invisibility of these conditions invites questions about how it is that they are absorbed and accommodated into the fabric of social life. HCAIs represent a particularly intriguing problem for the social study of health and illness. As with many iatrogenic problems, they disrupt the expectation that health care will be reparative, recuperative or healing and instead involve the patient in suffering an additional burden of pain and impairment: it interrupts the expected progress towards health recovery (Gardner and Cook 2004).

The few relevant studies highlight several factors that appear to be characteristic of the experience. Patients highlight their desire for information and communication from healthcare personnel (Burnett *et al.* 2010, Skyman *et al.*'s 2010) yet this is not always forthcoming (Gardner and Cook 2004). Patients with HCAIs have also reported a sense of violation or betrayal at having contracted an infection while in hospital (Skyman *et al.* 2010). In Andersson *et al.*'s (2011) study, participants identified what they saw to be a lack of knowledge on the part of staff where HCAIs were concerned and the staff were blamed for inconsistent and ineffective hygiene procedures. In Skyman *et al.*'s 2010 work, patients were additionally put out by the cancellation or postponement of the treatment for their original complaint as a result of their infection. As might be expected, patients suffering an infection reported more depressive and anxious symptoms than those without (Tarzi *et al.* 2001) as well as a loss of confidence in the health service where HCAIs are concerned, and their dread of going back to hospital (Burnett *et al.* 2010). These concerns are widespread in the healthy population, too. Easton *et al.* (2009) found that 74 per cent of a large sample of respondents expressed some degree of worry about contracting methicillin-resistant *Staphylococcus aureus* (MRSA) if they were to be admitted to hospital, with a significant minority believing it to be untreatable. For those in hospital, the negative effects of being nursed in isolation may compound their distress at having an HCAI (Gammon, 1999). In a study by Andersson *et al.* (2011) patients with MRSA felt somehow dirty and a threat to others, and that their condition was akin to leprosy or plague in terms of the stigma it might incur. In Gardner's (1998: 212) study, participants found themselves in a position that 'defies normative categorisation and is thus situated outside the patterning of society' and were thus 'in an embodied state of liminality'. Some of these

themes are echoed in work on the broader social representation of HCAs in the mass media, professional and policy discourse. HCAs are represented as alien and monstrous (Brown and Crawford, 2009) or as characters in a moral drama as agents to be defeated through rigour, vigilance and ingenuity (Crawford *et al.* 2008). In this drama, the perspective of the patient and the patient's family is often underrepresented and the kinds of cultural and symbolic resources at their disposal are unclear. It has often been noted that experience, knowledge and the opportunity to frame the situation are contoured by the relative power of the groups and individuals involved in the field of health care (Currie and White 2012). Yet emotions, as well as knowledge, are tied in with the identities that emerge via the patients' trajectories through the healthcare system. For Katz (1999) emotions are informed by, but also construct and structure, the relationship between people and institutions.

To examine these issues in detail, the present study was conceived to explore the kinds of coping resources people were able to deploy in the relatively less powerful role of patient and how this brings them into particular kinds of relationship with family carers, healthcare professionals and institutions, thereby addressing some of the gaps in our understanding of this experience via an exploratory, qualitative approach was likely to offer fresh insights into the experience in a field which has been neglected by researchers so far.

Methodology

The interviews on which this article is based were undertaken as part of study funded by the UK's Infection Prevention Society, a body whose stated aim is to 'inform promote and sustain expert infection prevention policy and practice' (Infection Prevention Society 2011) into the experience of SSIs. While this article is informed by a Bourdieusian theoretical perspective the data collection exercise was based on interviews and the analysis was informed by thematic analysis (Braun and Clarke 2006) and grounded theory. In-depth, semi-structured interviews were conducted to capture narratives of hospital stays, engagements with health professionals and illness experience (Charmaz 2006) in relation to the SSI. Explorations based on participants' first-hand understanding are believed to be particularly valuable for nursing research (McCann and Clarke 2003), especially under the conditions of uncertainty that are apt to unfold when an adverse event has occurred. In line with grounded theory, the interview evolved as the research progressed and was adapted to include further prompts and issues as they were brought up by participants themselves. Initially, three main issues were discussed. The first was the nature of the participants' initial health problems that had brought them into hospital and had necessitated surgery in the first place, and the fine grain or detail of what they thought of their illness, both in terms of their everyday lives and their relationships with health professionals and with relatives. The second was how the participants identified the central problems of their infection and how they attempted to respond to these challenges. Finally, we asked about the steps that the participants were taking to address the problems of their condition, especially in relation to their feelings about the hospital and its personnel and the possibility of grievance and complaint.

In thematic analysis, data exploration and theory construction are interrelated 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, while we began with an assumption that organised social practice would be disclosed, we attempted to be open-minded about the precise shape and form of the experience that would be described. The value of this approach is demonstrated by the way that unanticipated findings emerged; particularly, as we shall explore, the stoicism that was expressed in the face of iatrogenic problems.

Moreover, there appeared to be broader issues at stake, relating to how family members are implicated in the definition of the situation by participants, how a variety of competing responses to the infection were resolved and how this related to participants' resources, the possibility of conflict between themselves and the health service and how healthcare organisations themselves respond to grievance, complaints and litigation. These ideas could then be related back to the notion of emotional capital in relation to experiences of illness and adverse healthcare incidents and scholarship on healthcare 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. Participants' reflective accounts of their illness experience are sometimes taken to give access to the raw material of events, but this 'naive' 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 experience may be artfully, meticulously and even humorously constructed and, just like any other use of language, may contain a performative element. They give access to how participants construct and narrate their identities and their illnesses, but they are not by themselves a literal record of what might have transpired in the clinical setting. Therefore our account here is concerned with theoretically intelligible meanings and the implications of these for how we understand the phenomenal and social world of those with HCAs.

Following ethical approval by the authors' host institution, and the UK's integrated research application system, potential participants were identified from among patients in a large Midlands Hospital Trust who had sustained a SSI according to the SSI surveillance system in operation in the trust. In total, 17 participants responded affirmatively to the invitation and agreed to be interviewed. Basic data of the participants are shown in Table 1. In all, 15 interviews took place in the participants' own homes, one interview took place at the local university and one interview took place in hospital.

Findings

The initial reading of the interview transcripts by the researchers suggested that the experiences described were characterised by several features, some of which were unanticipated at

Table 1 *Baseline characteristics of participants (N = 17)*

Sex	
Male	8
Female	9
Age group	
31–40	2
41–50	2
51–60	2
61–70	8
71–89	1
81–90	2
Operation type	
Orthopaedic joint replacement	4
Caesarean section	2
Cardiac	3
Large bowel	8

the outset of the research process. In this findings section we attempt to describe a patient's journey through the experience. While the elements we identify were not present in all transcripts, the chronological sequence presented here highlights the operation of collective and individual emotional capital at a variety of levels. These are both to do with the experience itself, and how it might be effective in allowing the processual work of health care to take place without the patient's dissatisfaction leading to overt conflict between patients and staff.

We have organised the trajectory of the participants through the experience of SSI as follows: first, the discovery that an infection had been sustained, then the attribution of causation and the negotiation of blame, the management of anger, and finally gratitude and unwillingness to complain.

Discovering that there is an infection

Participant 5, who had acquired an infection as a result of a Caesarean operation, described her discovery in the following terms:

Interview 5: The day before was the Thursday and we had gone to register the baby in town and I was sort of OK and had a gentle walk round. And then on the Friday morning I struggled to get up and it was uncomfortable, we went to Sainsbury's to do a bit of shopping and half way round I couldn't walk. I was shuffling and I was in such a lot of pain I said, 'I don't know what's wrong, something is not right'. And it really frightened me. We came home and I was struggling to get up off the settee and I said, 'Something isn't right, I don't know if it's an infection or what it is'. I went to bed that night and struggled to get out of bed in the night to get him up to feed him. My husband had to get up and get him out while I went back to how it was first was. I felt like I had stepped straight back to the day after I'd had my operation because I had to be careful how I got out the bed, the pain was really bad. By Saturday morning my husband said, 'We need to ring the hospital' because I was in so much pain, we didn't know what to be. Because it was a weekend you don't know who to ring, I had been discharged by the midwife, I didn't know what to do. So in the end we toughed it out over the weekend and I went to the doctors on the Monday and she had a look and she said she suspected I had got a womb infection from the surgery and the wound itself was infected.

Participant 3, who had also contracted an infection via a Caesarean described the growing awareness that something was wrong as follows:

Participant 3: I remember saying to Paul [husband] 'Does it smell funny?' Because I could smell something. And although I was washing it and using the sterile soap in the hospital, and then using antibacterial soap at home it was still feeling a bit sore and a bit tender. And then went back on the Thursday I think it was, because I kept saying 'It feels a bit itchy and a bit tight'.

Negotiating the vicissitudes of the healthcare system is a collective process mediated through family members such as one's partner. It is through these social processes that participants describe themselves managing the initial awareness that something is amiss and, with the aid of family members, the symptoms are defined as being more severe than ordinary post-surgical impairments and thus as ones which merit further medical attention. The collective quality of

the emotional capital involved is underscored by phrases like, ‘We toughed it out’, ‘We need to ring the hospital’, or, as in participant 3’s account, it was through dialogue with her partner that the suspicion that something was amiss was condensed into a degree of concern that mandated further action.

While some degree of capacity to accommodate pain and impairment is necessary as part of engagement with services, the specific resourcefulness here – or capital – involves a jointly mounted challenge to the implied medical judgement that all was well and the matter was safe to be dealt with at home. The recognition that something is wrong is also a recognition that the situation has become actionable in a different way, such that instead of merely managing the wound, one needs to bring oneself into a new set of relationships with more powerful institutional actors in the field.

The attribution of blame

A striking feature of the participants’ accounts, and an important part of their emotional relationship with the hospitals and their personnel was the degree of stoicism expressed by the participants over their problems. This is an area that is of particular interest from the point of view of emotional capital and its implications for patients’ coping capabilities, because it concerns two significant aspects of the phenomenon. The first is the degree to which suffering can be absorbed by the person and their social network and the second, as in Reay’s families, is the way that hardship is constituted by and helps to constitute the relationship between the sufferer and the institutions. Stoicism in the face of health problems has not so far generated a very large literature in its own right, but it has certainly been noted in earlier work, for example on diabetic renal disease (King *et al.* 2002) carcinomas (Boyland and Davies 2008) and menstrual symptoms (Santer *et al.* 2008). In our case, the participants’ stoicism can be seen as a part of the emotional resourcefulness they brought to bear on the situation. Rather than, say, feeling indignant or that they had being treated like an object, as with Gardner and Cook’s (2004) participants, our participants deflected these possibilities in a variety of nuanced ways, and stoicism seems to be a manifestation of emotional capital in these circumstances. How the disease burden and psychosocial burden can be managed is crucial to maintaining the relationship between the patients themselves and the hospital system. Rather than simply reflecting fatigue after an operation, or that a medical definition of the situation has been superimposed on it, this process represents the work of patients as active social agents shaping their continued engagement with personnel and institutions in the healthcare field.

Part of the participants’ resourcefulness in dealing with the SSI experience and in maintaining an attitude toward the infection that did not involve blaming the hospital or its staff involved constructing a story which foregrounded other possible causes. Often the infection was ascribed to chance, rather than a failure of infection control procedure. For example, Participant 1 sustained an infection as a result of a knee operation:

Interviewer: Why do you think you got an infection?

Participant 1: I don’t know. It was just of those things. I think it happened when I was in the operating theatre because the surgeon said ‘you’ve broken my record, you’re my first patient to get one of these’. The doctors and nurses were very good, they were very concerned. I don’t think it was the surgeon’s fault. I think it was just something that happens, during the operation, it’s just germs flying around and they picked me.

The notion that infection strikes as a result of some imponderable happenstance seems to be an important factor in this stoical attitude that a number of participants expressed. If there is

nothing to blame but chance, then this obviates an angry or resentful response. Indeed, Participant 1 quotes with approval what he says the surgeon said, implying that the adverse outcome could not have been the fault of a surgical team with such a good record.

Participant 12, who had acquired an infection while having part of his bowel removed, also put it down to chance, or 'bad luck' and the fact that the removal might have left a 'space' in his abdomen, again obviating the possibility of anger at the surgical team or the aftercare:

Participant 12: There'd be an awful lot of organ and tissue removed during that operation and you can sort of see how the tiniest little bit could have got left and caused the infection or, I don't know, I know it was within the pelvic cavity that the infection occurred. I would imagine there's always a risk of that when you've had a large organ removed, left with a big space. So that's how I would imagine it occurred, just a bit of bad luck really that it developed.

Even where the participants identified a cause for grievance, this could be reformulated as a mistake, rather than representing genuine culpability. Participant 7, who had sustained an infection while in hospital with appendicitis and had experienced delays in diagnosis and treatment, put it this way:

Interviewer: Do you think things went wrong when you were in the operating theatre?

Participant 7: I don't know whether it was in the operating theatre and that's why it's difficult, somewhere between. I accept the fact that we all make mistakes and the GP who misdiagnosed that was OK. That cost me 24 hours.

The relationship between these accounts of why the infection had occurred, the notion of stoicism and emotional capital becomes clearer if we consider the stoic notion of emotions. In stoic philosophy, for example in the thought of Chrysippus (279–206 BCE), emotions represented, and were occasioned by, value judgements. These often involved evaluations of our rights and duties and other people's duties towards us. This theme has more recently been taken up by Bedford (1957) and Harré (1986). Harré (1986: 5) writes of the 'moral judgements in the course of which the emotional quality of encounters is defined'. In the light of this, what is particularly interesting here is that the cause of the infection is formulated as something for which no-one was culpable. Instead it is attributed to 'germs flying around' or the 'tiniest little bit' of necrotic tissue left behind, or even a 'mistake'. If no one is to blame, then there is no one with whom to become angry.

The attribution of an event to chance, fate or mistakes, then, is part of the participants' emotional resourcefulness and an important precursor of the stoical outlook. The focus of the question is shifted away from personal or organisational blameworthiness, and, as in classical stoicism itself, becomes more or less a matter of fate. Rather than coincidental, these judgements are vital in enabling the continued engagement of participants with the healthcare system with a degree of equanimity. As in Bourdieu's work, judgement represents a process of keeping one's thinking and feeling aligned with the *doxa*; in this case the medically self-evident natural and social world. It is akin to Bourdieu's deferential process of 'self subordination' (Bourdieu and Wacquant 1992: 136), an 'immediate complicity between position and dispositions'. The participants are in this manner enabling themselves to 'consciously master the relation they entertain with their dispositions' (p. 137).

Another variant of the process of discounting the possibility that the hospital, its personnel or procedures might be culpable was to place an emphasis on one's own resources or 'capital' in order to mitigate the potential for infection. Participant 3, whom we described above talking about her experience of an infection following a Caesarean, talked about the additional

resources that she herself could supply to reduce the possibility of infection. When asked whether, if she were to have another baby, there would be any other items she felt she would need, she used this as an occasion to describe her shopping list:

Participant 3: I think I would probably, I got some talcum powder, you know the antibiotic talcum powder you can get, that's a definite buy as and when and if.

Interviewer: Did you get that this time?

Participant 3: No I had it the first time when I had Katy [her first child]. They gave me a little bottle of talcum powder to put on the wound to dry it off after you've had a bath. So I think maybe that would be something that I would go and invest in. But I don't know, probably some more soaps or more wound care would be a good idea. Although the nurses were saying wash it with this stuff they weren't actually telling me... I know they are really busy. I think maybe a bit more wound care would be a good idea and maybe some more dressings to come away with.

Thus, the likelihood of infection is here construed as something that the participant herself has to deal with, through her acquisition and application of powder, dressings and the like. This self-focus, and the use of one's own economic and coping resources represent the deployment of a kind of personal or emotional capital as a way of attending to the possibility of infection. Later in the interview with participant 5 it became apparent that there were other ways of absorbing the burden of infection, namely taking the responsibility on oneself:

Participant 5: What did I do wrong? I do wash! I did kind of worry thinking, 'Maybe it's my fault: what have I done wrong? Was I not cleaning it enough'? But Paul [partner] was like, 'You did what you can: it's not your fault'.

Interviewer: It's just one of those things.

Participant 5: But yes, it takes it out of you, doesn't it? When you have got an infection, you just think, 'Oh, I feel like pooh anyway, and then with everything else on top'. So yes.

This sense that one's own personal hygiene rather than the hospital's infection control process may be responsible for the infection once again underscores the view that this is a personal burden to be absorbed at an individual level rather than one that can be offloaded onto other people or institutions. The experience of infection depletes the stock of emotional capital, which may be at a low ebb anyway, because of postoperative fatigue and having a new baby. You do what you can, and as in classical antiquity, the rest is a matter of fate. Yet this is, in our participants, more than just resignation or exhaustion. As we argue later, the attribution of the cause of the infection and the 'being at a low ebb' are both meticulously crafted and play a vital role in the participants' ongoing involvement with the health service.

Participant 10, who had an infection after surgery for a blockage of the bowels, explained that he did not feel critical of the treatment or the events associated with his infection:

Participant 10: You can be critical, you can be hypercritical and I am not that way inclined. You could say, 'Why didn't the stitching hold? Why did it leak?' You could ask that question. Who knows?

You could ask the question, but who knows? The radical uncertainty attached to the search for causes means that any critique is pointless. As Harré and Gillett say of emotional positions: 'they are embodied expressions of judgements and in many cases, though not in all, they are also ways of accomplishing social acts' (Harré and Gillett, 1994: 146). Thus, taking a view

that one is disinclined to be critical facilitates one's continued involvement with the healthcare system, one's moving on and transcending the experience. Even where the impairment suffered was considerable, blaming the hospital was assiduously and resourcefully avoided: 'to sum up, this wound has spoilt everything otherwise... apart from that I can't fault anybody else' (Participant 6).

This deployment of a kind of emotional capital – setting the causal story up so as to deflect or pre-empt the necessity of anger and substitute instead the unfolding of a stoical acceptance – was paralleled by some participants who questioned the very idea that they had an infection at all. In doing this they engaged in a process akin to what Pestello (1991) calls 'discounting', a process where exceptions or threats are minimised to sustain the view of oneself as a healthy or uninfected person. Here is Participant 8, a woman who had contracted an infection while in hospital for vascular surgery:

Participant 8: I asked the nurse what the result from the swabs was. She looked at my notes and said it was coliform bacillus. Later she came back and said the medical staff had told her to tell me that my wound was only colonised with coliform bacillus, not infected with it.

Participant 9, who had developed an infection as a result of a knee injury, insisted that her symptoms were 'just a rash' and were addressed successfully with antibiotics and routine wound care.

Like the deflection of possible attributions of culpability above, the potentially problematic status of the inflammation or the presence of microbes in the wound is deftly resolved. This discounting process allowed some participants to maintain a favourable definition of their situation while acknowledging the existence of untoward symptoms. The identification of potential participants to this study was based on their having had an infection recorded in their medico-nursing notes; consequently, we may infer that there was some certainty on the part of hospital personnel about their infected status. Nevertheless, some participants were able to undertake a considerable degree of resourceful interpretive work to discount the symptoms and render them benign. The notion of emotional capital sensitises us to the possibility that these manoeuvres are not merely a matter of not noticing that one is infected but may be the result of a reflexive deliberative process.

The avoidance of anger

Harré and Gillett (1994: 146) say that 'a display of anger, irritation, or annoyance expresses a judgement of the moral quality of some other person's action. Such a display is also an act of protest, directed toward the offending person'.

Moreover, according to Stearns, the history of emotions suggests that emotional experiences may be conditioned by and attuned to particular political, ideological and institutional arrangements (Stearns 1995, Stearns and Knapp 1996). Eliciting, say, anger involves a process of making a judgement that there is something to get angry about – that there has been some violation of one's rights or expectations. In the present study, as we have seen, in some cases the question of whether the symptoms represented an infection in the first place, or whether it had arisen by accident or mistake sufficed to pre-empt the expression of anger. In other cases, while there were expressions of anger and irritation, they were successfully muted, deflected or contained. One way in which this was accomplished was by saying that the experience was somehow a step removed from what would have been a necessary or sufficient condition to elicit anger. Anger, then, would have been the response had things been worse, or had the infection been caused by a different pathogen. This was apparent in Participant 13's account:

Interviewer: If you happened to get something like MRSA how do you think you would have felt?

Participant 13: I think I would have been quite angry about that. And I know, in one way, my husband said 'They shouldn't have sent you out with the infection', but I think they do because of the risk to getting anything else. They say you are better off at home than being in hospital with an infection.

At least the infection was not MRSA and the early discharge, remarked on by the participant's husband as being inappropriate was described by her as being for the best, anyway. Getting angry, then, was a possibility, but not one merited by the present circumstances. Participant 10 described himself as getting more angry over his wife's care with a terminal illness than his own condition: 'I was so angry about it'. The interview with Participant 7, who spoke to us jointly with his wife, provides an even more graphic example. Here his wife describes becoming angry on his behalf; describing losing her temper at his treatment in the following terms:

Participant 7's wife: I did on occasions but I am not one for keeping my mouth shut very well. I did and he [her husband with the infection] got upset because I was saying I wasn't happy with the way his care was being dealt with, and that made Andy [her husband] snap and say 'You have got no right, keep quiet'. A young doctor came at one stage and because he is 61 spoke to him as if he was 91 and was shouting at him. And I said 'Excuse me, my husband is not deaf or old and I don't wish the whole ward to know what is going on'.

While she was vocal on his behalf, he was described as trying to quieten her down. Not only does this highlight the joint nature of the coping process and the possibility that it is easier to get angry on one's partner's behalf than on one's own, but it also displays how the upshot of this joint process of generating emotional capital may be for the patient to seek to reduce the impact of the grievance upon the hospital staff rather than magnify it. The emotional capital in this case then mitigates the grievance and facilitates the continuation of processual hospital work and the resumption of appropriately deferential patient roles.

A similar incident was related by Participant 6, who had had abdominal surgery to deal with a tumour and suffered from a wound that would not stay closed due to infection. Despite his suspicion that this had resulted from poor surgical wound closure techniques, he had decided against complaint:

Our eldest daughter, who was a nurse for 30 years, said I should write a letter of complaint but I don't feel like sitting down writing it. And where is it going to get me? The surgeon, I understand, is about the top man in the infirmary so he ought to know what he is doing. Thus, thinking about the consequences, and the possibility that complaint will be ineffectual, anyway, discourages a written submission. It suffices that someone has got annoyed on his behalf and this helps obviate the need for a complaint to the hospital.

Gratitude and the avoidance of complaint

The desire not to complain was also tied up with a measure of gratitude in some cases. Participant 8, a woman who had contracted an infection while in hospital for vascular surgery, said she would not complain:

Participant 8: No and I wouldn't, because essentially my life has been saved by Valley Hospital and although I came home and I have a good moan at my husband about everything I wouldn't complain because I am still here.

And later:

I don't want to make a formal complaint about anything or anybody because I am still alive and I am only too grateful to still be here.

Participant 11, a man who had sustained an infection in his chest after heart surgery, said he would not be

putting a claim in to sue them. Because, to me, they saved my life twice, once when they did the op and gave me a second chance. OK, if I did get it in the hospital, it happens; it's a mistake, it happens; nothing can be 100 per cent. And I don't blame the hospital for it

This was also evident with Participant 4, who had had surgery on his colon:

Participant 4: Well, I assume anybody my age that goes through two fairly large operations, you are bound not be singing and whistling a fortnight after. And they did tell me, Dr Bennett said 'We had got you down for ... '. After the second op I went down to the ITU, and they have got me down 40 per cent coming out in a wooden overcoat. So, I am still here; so you have got to be grateful for the fact that I am still here.

In this case then, the consideration of worse things that could have happened, including the likelihood of his death, placed the events in perspective such that the appropriate response was gratitude, rather than, say, resentment. The incapacities incurred are further placed in context by his age. Thus, the resolution and coda of the SSI story is that one is still alive, and enjoying the sort of level of health one might expect at that particular time of life. This, then, serves to predispose and capitalise a grateful response rather than, say, an aggrieved one.

Discussion

We have highlighted several important aspects of the experience of infections contracted via healthcare systems that have largely gone unrecorded so far in the literature. Patients' and families experiences of the additional burden of extended hospital stays, follow-up treatments, pain and impairment have rarely been explored in this field. Yet these factors contribute to the overall experience of the patients' journey and illness episode. The limited literature on this subject identifies aspects of the experience, such as a sense of anger, violation or betrayal or a tendency to blame staff (Andersson, Lindholm, and Fossum 2011, Burnett *et al.* 2010, Gardner, 1998, Gardner and Cook, 2004, Skyman, Sjoström, and Hellström 2010). By contrast, in our work, significant themes of stoicism and gratitude were apparent, with apparently little ill-feeling or blame directed towards the institution or the staff involved. The puzzle of why this should be the case therefore drew us towards the notion of emotional capital, which has been widely used in the study of education but has not hitherto been used in the study of health care. The process of coping with an HCAI is, in Katz's (1999: 231) phrase, 'hermeneutically dense'. To work their way through it, participants adopt a mode of acting that takes a stance towards the trajectories of the other actors' they encounter through the patients' journey. Even while suffering from iatrogenic complaints, participants still seek to secure the involvement of healthcare organisations and personnel in their troubles and respond positively to the

healthcare system's efforts to invite them to further procedures and treatment. While it is possible that those who agreed to be interviewed were exceptionally forgiving of the hospitals and their staff, we have no reason to suppose from records kept by the hospital that those not involved in the study have fared any worse.

The value of emotional capital as a construct with which to explore the experiences of health care is that it enables us to situate these experiences within the central sociological concerns of power and inequality. As Nowotny (1981) claimed, emotional capital arises in response to adversity, and as Reay (2000) and others have noted, it is accumulated by those in less powerful positions. While stoicism was the most evident response in our data, it is possible to imagine the creation and display of emotional capital taking different forms, such as humour, satire, spirituality or even a more emancipatory commitment to changing the world. The relative disadvantage of patients and carers in relation to healthcare systems is well documented, and Dixon-Woods *et al.* (2005, 2006) have used Bourdieu to show how the relative powers of medical actors in the health field can lead to patients signing consent forms for surgery they do not want. Emotional capital therefore offers a tool for thinking about the ways in which emotional practices are shaped in a healthcare context. Assembling the resources necessary to cope with pain and impairment, deflecting the implication that the hospital was at fault and configuring the overall response to one of gratitude represent, as we have attempted to show here, a kind of accumulated labour, undertaken in conditions of limited empowerment. In that respect, the phenomena described here contribute to the creation of an identity as a 'good patient', an ideal recipient of care that some commentators have seen as more likely to elicit further helpful engagement from health professionals (Buckwalter 2007).

Our participants' accounts here underscore the quality of emotions as social phenomena. The choices made and the opportunities available for establishing the legitimacy of particular views of the experience inform what is felt, narrated and shared, as well as the tenor of ongoing and future involvement with healthcare systems. Ascribing an infection to chance rather than being someone's fault may have to do with the legitimating symbolic power of healthcare personnel and institutions (as in Dixon-Woods *et al.* 2005), but also represents a process of constructing a particular kind of narrative for shaping the emotional journey. Our participants have allowed us to examine the socially disciplined patterns in which people, in pursuing particular emotional trajectories, draw upon the routinely hidden social and corporeal resources of conduct (Katz 1999: 222). These processes of attribution, such as where the infection came from or what more the participant could have done to avert it, often appear to be natural, immediate and non-reflective. As Katz notes, 'judgement is often not a deliberative process but is undertaken sensually and aesthetically' (Katz 1999: 34). Just as in Ahmed's account of emotions in culture, the feelings expressed here are not in either the individual or the social realm, but instead produce the surfaces and boundaries that afford the individual experiences and render them intelligible (Ahmed 2004). As with Bourdieu's (1962) early work on the house in Kabyle culture, the healthcare experience involves managing a number of different compartments and divisions, which are in opposition to and tension with each other. The clean, decisive world of the hospital retains its symbolic value as a place of healing, whereas the pain and impairment of the SSI is managed in the private, personal space of the home and familial relationships.

Ahmed's (2004: 117) notion of 'affective economies' is also relevant here as it provides the insight that emotions do not reside in a single individual but instead circulate, involving relations of difference. Emotional capital can be built up or depleted through relational processes. Interaction with family members, encounters with healthcare personnel and cumulative experiences with illness may enable sufferers to accumulate the emotional capital with which to address the experience, rather than merely leaving the sufferer depleted and exhausted. The involvement of family

members in the decisions and engagements with the hospital highlight the relational aspects of the labour expended to support the process of recovery and sustain the narratives of healing and progress that are so central to these efforts, even in the face of setbacks.

As Reay (2000) and Skeggs (2004) point out, emotional capital has value, and is 'worth' the labour of accumulation in that it has the potential to be exchanged. This invites the question of what stoicism, accommodation and restraint might gain for the participants in this study. According to the Equality and Human Rights Commission (2011) many elderly people stoically endure poor care as they are grateful to have any care at all, and they are concerned about retaliation from healthcare professionals if they complain. But the quietism of our participants is not simply the result of a fear of reprisals. Their accounts here are comparable to the descriptions of stoicism in relation to other kinds of illnesses such as cancer, where, despite patients describing considerable difficulty, their narratives also imply or explicitly claim a substantial degree of stoicism (Dixon-Woods *et al.* 2003).

This is perhaps also an example of what Froyum (2010) refers to as 'deferential emotional capital' reflecting the diminished powers of patients in hospital settings. Blaxter (1997) has persuasively argued that a perceived moral duty to be healthy and the stoical concept that health consists of 'not being ill' can explain why people could claim that their health was good in spite of an obvious disability. In addition, as Brown and Baker (2012) note, the idea of being a responsible citizen, capable of managing one's own health needs and minimising one's demands on the public services, has become a powerful political trope. This, combined with Blaxter's observation, suggests that a range of pressures may be at play to compartmentalise the SSI experience away from the more powerful public space of the hospital and into the private sphere of home, family and self.

It may be that a good deal of low-level dissatisfaction with health care does not come to light; what Soderberg *et al.* (2012: 144) refer to as a 'hidden kind of suffering'. The fortitude with which people coped with SSIs and their aftermath might allow them to pursue a more auspicious path in the future. It might enable the production of a collaborative body rather than the body isolated by disease, pain or illness; a body reconfigured as one susceptible to the collectively embodied process of treatment and restitution. At best, then, sufferers from HCAs might hope to transform emotional capital into a restituted 'bodily capital' (Bourdieu, 1986: 241). Being able to maintain one's secure position as a patient within a healthcare system that seems to offer one the best hope of improvement and survival is an important consequence of accumulating deferential emotional capital that may lead to payoffs in terms of ultimately improved health. Maintaining face by underreporting problems has been seen by some authors as a disadvantage, masking symptoms of clinical significance that could assist in diagnosis and making treatment plans (Pollock 2007). Yet here we would suggest that deploying emotional capital so as to assimilate adverse experiences is part of being able to sustain a productive involvement with the healthcare system.

Patients were, in large measure, relying on their own and their family's emotional capital in order to ease their interactions with authority figures such as doctors, nurses or hospitals themselves, and in choosing not to pursue grievances. These largely deferential deployments of emotional capital seemed to serve as 'emotional bridges' (Schweingruber and Berns 2005: 683) between the participants' current selves – purportedly incomplete as a result of their incapacity – and their future selves, healed and restored after having let go of their putative resentment, like Participant 10 above. In the affective economy they may be exchanging their emotional capital for the hope of a restored bodily capital in due course. The immediate personal emotional or identity costs are less important to them than the material stability and promise of a restoration of their former identity conferred by their continued engagement with the hospital.

The movement of emotional capital within the field involves the construction and embodiment of particular kinds of emotion and the fashioning and display of the body and its affects. The ability of patients to absorb a good deal of unhappiness and disability assists in the smooth running of the healthcare system and the maintenance of structured systems of power and privilege within this kind of field. The healthcare system is akin to Bourdieu's (1962) outdoor space in his study of Kabyle society, where important public business is transacted, whereas the indoor, familial space is more affectively messy, and are akin to the private spaces in our study where the experiences of health and disease are negotiated, formed and re-formed so as to occasion productive engagement with the public, institutional system of health care. As with Reay's work (2000, 2004), emotional capital mobilises and facilitates continued investment and engagement with institutional – what Bourdieu might call objective – structures, such as systems of education and health care. Indeed, following Manion (2007) we could suggest that the experience of marginality or adversity actively catalyses the formation of emotional capital. In this way the present study aligns with Bourdieu's (1999) contention in *The Weight of the World* that broader social categories and processes are exposed in ordinary suffering in hitherto neglected experiences such as, in our case HCAs, in the complex interplay between life-worlds and in broader fields of power relations.

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