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Study Number 6010

Public Engagement with Methicillin-Resistant Staphylococcus Aureus (MRSA), 2006-2007

USER GUIDE
PUBLIC ENGAGEMENT WITH MRSA

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Background

This research investigates how members of the public engage with the phenomenon of Methicillin Resistant Staphylococcus Aureus (MRSA). Social representations theory (SRT) is used as the theoretical framework. One of SRT’s major concerns is with the way in which new societal threats are created. In particular, it focuses on how ‘common sense’ notions are constructed by the interplay of the media and contemporary values and concerns. One of the chief means of assimilation of the new threat is ‘anchoring’ whereby seemingly similar threats from the past are used to understand the contemporary threat. An example of this is the ubiquitous use of the ‘plague’ metaphor in the early days of the AIDS epidemic. Meanings are thus transferred from an established phenomenon onto the new threat, and serve not only as a tool for understanding but to either amplify or to attenuate the seriousness of the new phenomenon. In addition, according to SRT symbols play a fundamental role in shaping how risks are constructed. For example, abstract ideas are made concrete by way of core metaphors (Augoustinos, Walker & Donaghue, 2006). Thus, a social representational study elucidates the deep-laid thoughts, feelings and symbols that circulate in the social networks that apprehend the risk.

According to Ulrich Beck’s Risk Society thesis (1992), in contemporary industrialised societies the mass media raise awareness of myriad risks, yet ‘the public’ lacks trust in experts for protection from them. For Beck, this causes anxiety, particularly since the risks produced by the momentum of contemporary innovation often surpass the know-how of the experts who created them, and lack temporal and spatial boundaries. On the face of it MRSA fits with Beck’s criteria for a post-industrial risk insofar as the overuse of antibiotic technology is a major causal factor and MRSA confounds the expertise of those who created antibiotic solutions to bacterial infections. According to Beck’s thesis, one might expect social representations of MRSA to reflect high levels of anxiety.

However, working within a framework that highlights the dynamics of lay thinking, Joffe (1999) (see also Kitzinger and Reilly, 1997 and Wilkinson, 2001) argues that Beck’s notion that we live in a heightened state of anxiety in the Risk Society makes assumptions that may not be borne out empirically. Without a gauge of public thinking, Beck’s model is incomplete. Hawking, Wood & Butler’s (2007) study of lay responses to MRSA suggests that the responses often bear little relation to the scientific knowledge of the risk. Indeed, other studies of lay responses to mass health risks (e.g. see Joffe & Haarhoff, 2002) suggest that often people feel distanced from the threat. A ‘not me, not my group’ response fosters a sense of immunity to the danger, however seriously the media and other societal institutions take the threat (see Joffe, 1999).

How have the mass media raised awareness of MRSA? In a study of MRSA in four national UK newspapers from 1995-2005, Washer and Joffe (2006) found that MRSA was described as a doomsday scenario. It was said to mark the end of the antibiotic age, and modern medicine was seen to be powerless unless a medical miracle were to
be discovered. There was little focus in the mass media coverage on the genesis of MRSA in terms of the over-prescription of antibiotics. Instead the focus was on reasons for MRSA’s spread, chiefly attributed to poor hospital hygiene. The issue of how MRSA was spread was elided with the cause of MRSA, so that dirt in hospitals was thought to generate MRSA. In the media coverage blame featured prominently, and was directed at the poor hygienic standards and practices of health care staff and hospitals, particularly the poor management of hospital cleaners.

MRSA was also increasingly politicized, particularly in the lead up to the 2005 general election, by being linked to the ills of de-regulation and privatisation of National Health Service (NHS) cleaning services. Thus MRSA became a potent political symbol of the decline and decay of the NHS and served as a rallying call for improvements in NHS funding and management. The solution to the poor state of the NHS - symbolised by the ‘hospital superbug’ - lay in the return of the matron, an old fashioned (female) authority figure, who would roll up her sleeves and return the NHS to the time when hospitals were orderly, clean and safe. Thus solutions to MRSA were not thought to be medical (e.g. new antibiotics) and this was further demonstrated by the plethora of alternative medicines and unconventional prophylaxes proposed, often linked to ‘boosting the immune system’.

Another feature of the media portrayal was the focus on personalised stories of people who had succumbed to the infection. These were generally celebrities or people who had contracted the disease under unusual circumstances, such as in maternity wards.

Does this media picture resonate with the thoughts, feelings and symbols present in its audience? This research project was designed to answer the following questions:

1. How does a British lay audience conceptualise MRSA?
2. Is MRSA represented as an anxiety provoking threat, or do people associate it with identities and practices that are other from themselves with attendant feelings of invulnerability and equanimity in the face of the crisis?
3. What (if any) link can be distinguished between the content of national newspaper reportage on MRSA and how its readerships see MRSA? Are there readership (i.e. tabloid versus broadsheet readers) differences in social representations of MRSA or is a more monolithic social representation shared across these different social sub-groups?

Objectives

The overall aim of the project was to study public engagement with MRSA as part of a wider project of building a nuanced model of public engagement with emerging infectious diseases (EID). The objectives of the project were:

- To elucidate the nature of deep-laid lay conceptualisations of MRSA and their interplay with the ideas contained in national newspapers. [The interplay between the previous media analysis (see ‘Background’) and the findings of this study (see ‘Results’) are analysed (see ‘Discussion of results’)]
- To show how MRSA has impacted on people’s thoughts, feelings and reported practices pertaining to hospital attendance, hygiene, antibiotic use, and health and biomedicine in general [see ‘Results’ and ‘Discussion of results’].
- To assess whether social representations of MRSA are associated with
heightened anxiety or whether the representations serve to mollify the public by distancing the threat [The ‘Risk’ section in the results addresses this as do the ‘Results’ and ‘Discussion of results’].

Methods

Sample
A professional recruitment company was employed to recruit a purposive sample of 60 adults from the Greater London area. The sample was split evenly in terms of gender and newspaper readership categories, with equal numbers of females and males in each readership category. Furthermore, the sampling frame ensured that half of the sample had had at least one overnight stay in a hospital within the 12 months prior to the interview. Fifteen of the 60 participants were of an ethnic minority, approximating the population distribution in Greater London (for greater detail see Appendix 1).

Data collection
The data were gathered in the course of 60 semi-structured, in-depth, tape-recorded interviews, followed by a written self-completed questionnaire. The interviews took place in either the participants’ homes or in residential facilities provided by the recruitment agency. Initially participants were presented with a grid containing four empty boxes. They were verbally prompted to write in each box any word, emotion or image that came to mind when they heard the term ‘MRSA’. If they replied that they did not know what ‘MRSA’ was, the researcher first elaborated the acronym. If that proved of no help, the researcher said ‘hospital superbug’. Five percent (n=3) needed elaboration.

Once first associations had been written or drawn, participants were asked to talk about the content of each box (for greater detail see Appendix 2). At the end of the interview, participants were asked to fill out a questionnaire that ascertained the demographic data.

Each interview was transcribed professionally and emailed to the researchers in a format that allowed for easy corpus building using the Atlas/ti data analysis software.

Data analysis
A coding framework was designed to guide the thematic analysis of the textual corpus (for greater detail see Appendix 3). Having analysed the lay sample’s most prevalent themes and their interconnections, comparisons were drawn with the pre-existing content analysis of the national newspapers.

Results
Results are ordered according to the prevalence of themes among the participants, other than the ‘information and media theme’, which is presented at the end of the results. Report of each theme begins with a quotation that typifies it and is followed by a network chart that summarises its components and indicates how many participants raise each aspect. The charts indicate some of the links between
components but this is elaborated more fully in the thematic content that follows. Within each thematic area, participants were compared across gender, age, newspaper type, ethnicity and whether or not they had been hospitalised in the past year. Generally, cross sub-sample similarities in thematic content dominated but where areas of difference were found they are reported.

**Theme: Dirt**

*I just had this image of every hospital being disgustingly dirty and you’re more likely to get ill, more ill than you were when you went in. So that’s why [the first association in my grid is ‘dirt’]. So it was a bit of a worry. And I’m, I’m associating it with infection and germs and, you know, places that are not very clean.*

[Female, 38, white British, broadsheet, hospitalised]

Almost all participants represented MRSA via a framework that hinged around conceptions of dirt within NHS hospitals. At the core of their thinking lay a story of MRSA being caused by the lack of hygiene within NHS hospitals, explained by deficits in hand washing practices (involving doctors, nurses, patients and visitors) and/or deficits in resources (including funds, staff, and training). In particular, staff supervision was regarded as lacking with the consequence that staff hygiene procedures were not enforced.

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1 There was an attempt to keep linkages to a minimum in the charts in order to facilitate their purpose as devices with which to gain an instant, albeit simplified, overview of the content of each theme.

2 These identifiers, following interview excerpts, indicate the gender, age, ethnicity and newspaper choice of the participant cited as well as whether the person had been hospitalised in the previous year or not.
While the bulk of the attributions regarding the neglect of hygiene were centred on various workers’ failings (also see structural theme), the old, faulty NHS buildings were also implicated. Not only were decrepit hospitals thought to be harder to clean, their aging air conditioning systems aided the spread of germs. In addition, a lack of fresh air and bad smelling air were linked with MRSA by a considerable minority of participants.

Related to the ‘lack of hygiene’ attribution and also highly prevalent in the data were mentions of a wide range of ‘contamination sources’. The hospital environment, including wards and canteens were seen as contaminated and therefore contaminating for those who entered them. Within this environment two generic categories provided the major sources of contamination: hospital equipment (e.g. medical equipment and eating utensils), and people (patients and visitors). Furthermore, certain locations were singled out as sources of MRSA, particularly floors, showers, toilets, bathrooms and beds. A vast array of other contamination sources was mentioned.

When participants spoke of body products acting as sources of contamination, blood was most readily mentioned followed by faeces and urine. A few participants mentioned phlegm, skin, pus, vomit, and hair flakes. Mention of body products, lack of hygiene and dirty hospitals was sometimes followed by expressions of disgust.

Improved hygiene was proposed as the key solution for eradicating MRSA. The primary means of implementing this involved use of anti-bacterial gels and cleaning agents on hands before entering wards and touching patients. Other dominant aspects of this solution were the wearing of protective clothing by staff, and improved hospital cleanliness. Many participants suggested that hospital cleaners be paid more as an incentive to clean well. Related to this was giving cleaners better training in hygiene practices, seen to have the potential to increase professionalism and pride in the job.

Another noteworthy strand of the ‘solution-hygiene’ theme involved patients taking their own action in relation to MRSA. This was constituted by three primary strategies: bringing wipes and cleaning agents into hospitals when arriving, avoiding potentially contaminated surfaces and objects and being vigilant regarding staff hygiene.

In relation to the dirt theme, men tended to favour technological solutions such as creation of appropriate bug-killing cleaning products, where women tended to mention ‘people-based’ solutions. The older women emphasised bringing back matrons (see structural theme below) while the younger women tended to blame nurses and doctors for hygiene problems and to want them to make the necessary changes.
And I think a lot of people who have to go into hospital are more afraid of catching something like that than probably they are of what they’re going in with, you know, especially if it’s sort of minor surgery and things, which is pretty awful. And now of course there’s, there’s another superbug going around as well I think, isn’t there.

[Female, 66, white British, broadsheet, hospitalised]

The most prevalent way that participants spontaneously characterised their sense of risk was one of going into hospital with a minor condition and, rather than being cured, possibly dying of MRSA because the hospital was dirty and thus filled with infection. They were absorbed by the notion that the purpose of the hospital had been transgressed. However, paradoxically, while people felt there was a hypothetical ‘risk to self’, in the main they felt personally distanced from the risk that MRSA posed. Most felt that it was a ‘risk to other people’, particularly ‘the vulnerable’, a category that included babies and children, the elderly, the sick, patients in hospitals, and, occasionally, people who worked in hospitals or those with ‘weakened immune systems’.

A minority of participants expressed that they were at no risk at present but might be when they went into hospital or became elderly. Several said that because of MRSA they would only go into hospital if it were essential. However, the majority expressed being at no risk from MRSA, stating that they would not think about or worry about MRSA even if they were to go into hospital. Other risks associated with hospitals, such as that of surgery, were more frightening.
Both those who had been hospital patients in the past year and those who had not overwhelmingly made a similar point about their own invulnerability to MRSA, with a sense of risk being talked about in the past tense by the ‘hospitalised’ sample; they felt they had been at risk when they were hospital patients but were not now. Several people in the sample said they would feel at less risk in a private as opposed to a NHS hospital, and only a couple mentioned sources of infection outside hospitals (i.e. public toilets, schools and workplaces).

In terms of emotions expressed, participants felt worry and anxiety in relation to hospital admittance and stays, especially pertaining to hygiene (e.g. worry at the sight of blood-stained walls) and invasive procedures. They also stated that media coverage made them worry. Their fear was evoked particularly by the prospect of surgery within this dangerous environment. However, in general, it was only the aforementioned ‘vulnerable’ groups that were thought to contract MRSA, though the threat of leakage between such groups and the self was mentioned. Participants also talked of anger, primarily in relation to a government that had ‘let the NHS go to the dogs’ and not taken responsibility for MRSA’s prevalence.

**Theme: Structural failings**

*I think it’s tragic, we had good hospitals and it’s only when the managers took over that things started to go wrong. It’s only from that date really, if you look at it properly. So they sit in their luxurious office having a new carpet down every year, I think that’s for when people have to come in and kneel down before them, they think they’re God’s gift to whatever. Instead of working for their money, sitting there doing nothing. After all, that is who the problems should fall back on, because that is what they’re there for, a manager is there to manage and he doesn’t manage properly.*

[Male, 78, white British, tabloid, non-hospitalised]
The causes of this hospital risk were reported to stem, in large part, from an interaction of different ‘ills’ of the NHS. The actors blamed for these ills were primarily cleaners, followed by NHS management, the government and politicians, and finally doctors and nurses (in equal measure). The end result of this institutional failing was a lack of hygiene, the key cause of MRSA. Thus the hygiene and structural themes are embedded within one another. There is an immediate move from identifying dirt to attributing responsibility and blame for it.

The NHS was seen to be lacking in resources due to government under-funding, misuse and waste of resources. Lack of resources were felt to lead to sub-optimal recruitment, particularly in regards to cleaning services, as well as general staff shortages, which in their turn were felt to result in poorer quality healthcare. The prime example of recruitment deficiencies was said to be the tendering out of cleaning service contracts. The low pay and status of sub-contracted cleaners were linked to low incentives to perform well. Their poor training and supervision were said to produce incompetence, negligence and a lack of institutional loyalty.

Parallel to this, the management tiers of the NHS were widely perceived to be incompetent, wasteful, overly large, inefficient and according to some participants, dishonest and corrupt. In addition, participants identified a general lack of accountability in the NHS hierarchy. Many spoke of the lack of a defined ward hierarchy, a culture of ‘shifting the blame’, which led back to the theme of lack of supervision and monitoring of ward hygiene and care. A sizeable minority of participants reported that they had little or no trust in the NHS, mostly as a result of the perceived lack of hygiene and the prevalence of MRSA.

The most widely shared proposed solution to these NHS ills was to bring the matron back into hospital management, as she was seen as the traditional guarantor of discipline, efficiency and cleanliness. The fear-instilling Matron character played by the actress Hattie Jacques in the 1960s ‘Carry On’ comedies was referenced by a number of participants as the ideal type to restore faith in the NHS. Calls were also made for more ward staff, and diminished bureaucracy.

A contrast to the descriptions of the present-day NHS as a failing organisation came via reminiscence of its supposed ‘golden age’. The matron featured prominently as guarantor of hygiene and authority in these descriptions of the past. The nostalgic picture depicted clean hospitals with nurses and cleaners who were hard-working, disciplined and caring. The past was portrayed as a time when the public were proud of and had confidence in NHS hospitals.

In terms of differences in responses between the sub-groups, the bulk of the data on structural failings were generated by the older subset of the sample (over 45) of both genders. They were in broad agreement that the main components of the structural failings were a) a lack of accountability, b) subcontracting out of hospital cleaning. Lack of accountability also featured in the representations of younger women, whereas they were rare in the representations of the younger men.
MRSA was anchored to a range of infectious diseases, sometimes characterised as superbugs. The key infectious illness that acted as an anchor was ‘the flu’ or the common cold. The content of this linkage took at least two forms. Firstly, flu and colds were regarded as everyday-type ‘bugs’ where MRSA was regarded as a more virulent and serious ‘bug’ or superbug.

While this aspect of the flu anchor likened MRSA to a highly serious condition, others functioned to diminish its seriousness. Thus, and in a different vein, MRSA was not likened to flu in and of itself but in relation to the media scare it generated, analogous to that generated by bird flu. The flu and colds were also deemed analogous to MRSA inasmuch as each has various strains. Other anchors were less widely shared, including ‘flesh eating bug’; Legionnaire’s disease; Tuberculosis; and E Coli, HIV / AIDS, pneumonia, BSE, bubonic plague, small pox, syphilis, cancer and measles.

While the abovementioned anchors built on representations of past infectious illnesses in an attempt to make sense of the seriousness of MRSA, a further one characterised MRSA as a new or modern disease with no links to existing illnesses. Participants spoke of it in terms of a time frame, stating that it had not been around when they were younger, or linked it to more specific time frames that characterised it as being anything between 3 and 40 years old. Generally, MRSA was regarded as a ‘recent thing’ that was ‘unheard of ten years ago’.

[Male, 38, white British, broadsheet, non-hospitalised]
The superbug was conceptualised as ‘super’ primarily in terms of its invincibility. A sizeable minority of respondents contrasted this invincibility to the lack of the power of antibiotics to eradicate it. These people talked of the overuse of antibiotics and of the ability of the superbug to keep mutating.

In terms of sub-group differences, it was noted that broadsheet-reading men all anchored MRSA to one of the infectious diseases, as compared to a little more than half of the rest of the sample. In addition, broadsheet-reading men tended to refer to the biomedical discourse of antibiotic resistance and comparatively little to MRSA as a modern disease.

**Theme: Foreigners and the ‘superbug’**

_I blame, I blame staff as well, I mean you’ve got certain people, you know, they’re coming from different countries...using bad practices...importing them here. Now you should, what, what made to me my viewpoint and this is really funny coming from someone of Asian origin, but my, but my viewpoint what made Great Britain great were the people ...they were passionate about what they did and they were dedicated and they had principles and that's been lost. And that’s not only lost in, you know, in terms of immigration or the type of people coming in, it’s the generation of people is wrong. And I just see people slack and lazy and I blame, that’s part of the blame I blame on MRSA, because it’s just simple principles, being passionate about what you do, being meticulous, washing your hands, cleaning the hospitals._

[Male, 28, Asian, broadsheet, non-hospitalised]

The prevalence of MRSA in the NHS was symbolised as a microcosm of a more general national and cultural decline. Coupled with this was a representation that causally linked the failings of the NHS and the rise of MRSA to changing demographic and immigration patterns in the UK. Firstly, foreigners were described as bringing in diseases, including MRSA, from abroad. Secondly, they were perceived...
to be a drain upon the scarce resources available to the NHS. Thirdly, foreigners working as NHS staff or as subcontracted cleaners were represented as deficient in knowledge, good practice, communication skills and personality traits such as diligence and commitment. This framing was bolstered by references to the NHS as ‘falling behind the top countries’ and even more pointedly by comparing the NHS unfavourably to the healthcare systems in less developed countries. Participants used epithets such as ‘Third world’ when describing the state of the NHS.

Foreign cleaners constituted the sub-group of foreigners to which the strongest blame was attached. They were represented as the cheapest, lowest quality, least knowledgeable and least motivated of the NHS workforce. Similarly, foreign nurses and doctors were represented as a cheap, substandard labour force lacking in communication and social skills and hence contributing to the spread of MRSA. Racial slurs, although only present in a small minority of interviews, pictured foreigners, and especially people of non-European backgrounds, as dirty, fat, stupid, loud, insensitive, lazy and comparable to monkeys (depicted in the phrase ‘pay peanuts, get monkeys’).

In terms of differences between sub-groups, white British participants and those from ethnic minority backgrounds shared a representation of foreigners as lacking in motivation, but the antecedents of this were different between the two groups. Participants of an ethnic minority tended to focus on negative characteristics of foreigners in general and foreigners working in the NHS in particular, holding them to be vectors of disease. They contended that they lacked dedication, passion and professional knowledge. For white British participants foreigners’ putative lack of motivation was mostly linked to the idea of subcontracted workers being less able and dedicated than permanent NHS-employed staff. Although not an issue for participants from ethnic minorities, White British participants also mentioned their dissatisfaction with perceived low levels of language skills among foreign workers.
Theme: MRSA-related information and the media

I don’t know the cause of it. I really don’t know the cause of it. It’s a superbug, it may have been imported, it may have been grown here, um, it may be something, what do they call it when one bug develops into something else ... Um, I should have done my research because I don’t really know.

[Female, 66, white British, tabloid, non-hospitalised]

A central paradox in the data was that a majority of the participants said that they had little or no knowledge of MRSA - what it is, what causes it and how it spreads - yet all produced thousands of words on the topic during their interviews. This professing of own and others’ ignorance was often accompanied by claims of the need for more information about MRSA in the mass media, and public information campaigns in NHS locales and other public spaces. Indeed, this call for more MRSA-related public education was the second most popular solution proffered by the participants (the first being better hygiene) to the MRSA threat.

The role played by the mass media in the sample’s engagement with MRSA was also paradoxical. Almost all participants said they acquired most of their information about MRSA from mass media, yet they denigrated the quality of this information; mass media were accused of scaremongering, dishonesty and sensationalist reporting, with newspapers consistently cited as the lowest quality source and TV the highest. Despite the overwhelmingly negative depiction of the media, participants thought it was advantageous that the issue had been covered by the media, insofar as this forced the government and NHS to take preventative actions.

In terms of sub-group differences, one pattern dominated: Younger women were the group most likely to proclaim themselves or others ignorant and in favour of more public education, and the group second most likely (after older men) to comment on the mostly negative quality of mass media information.
Discussion of the results in light of the research questions

1. How does this lay audience conceptualise MRSA?

MRSA is associated, first and foremost, with dirty hospitals. The putative MRSA crisis is regarded as a consequence of the neglect and mismanagement of the modern NHS, which, in part, is seen as a microcosm of the state of the country as a whole. Decline is attributed to ‘management culture’ having seeped into national institutions and increases in immigrants. While people profess ignorance regarding what MRSA is they feel confident to make such judgements.

The key solutions proposed are straightforward at the denotative level, namely improved hygiene in hospitals, better public education and bringing back the role of the matron. However, a number of symbolic threads underpin these: The matron figure, who was explicitly visualised as Hattie Jacques in the ‘Carry On’ comedies, expresses a nostalgia for a supposed golden age of the NHS, in particular, when nurses were white. This contrasts to the picture painted of the modern NHS with its ethnic minority staff whose practices contribute to people contracting MRSA.

2. Is MRSA represented as an anxiety provoking threat, or do people associate it with identities and practices that are other from themselves with attendant feelings of invulnerability and equanimity in the face of the crisis?

Unlike many other emerging infectious diseases, there is no shared anchor for MRSA (e.g. in the way that plague acted as an anchor for AIDS) that might raise or attenuate the sense of threat. Rather, this ‘superbug’ is seen as a new phenomenon without antecedents. It is ascribed an invincible quality that makes people feel concerned in a general sense, which corroborates Beck’s (1992) Risk Society thesis, but not personally at risk unless they enter one of the ‘risk groups’ such as becoming elderly or a hospital patient. The hospital is feared as a place that can leave one with a worse condition than that which one sought to cure. However, the social representation that confines MRSA to hospitals leaves those outside of hospitals with a negligible a sense of risk.

3. What (if any) link can be distinguished between the content of national newspaper reportage on MRSA and how its readerships see it? Are there readership (i.e. tabloid versus broadsheet reader) differences in social representations of MRSA or is a more monolithic social representation of MRSA shared across these different social sub-groups?

For the most part the media MRSA message strongly resonates with the lay sample’s representation: That MRSA is associated with dirty hospitals; that it reflects a microcosm of Britain and/or the NHS’s failings; and that the solution to the ‘superbug’ problem is the return of the matron. However, the most pronounced difference is that in the newspapers there is little if any blaming of ‘foreigners’ for MRSA (in contrast to other infectious diseases, which tend to be blamed on ‘others’). Furthermore, only a third of participants allude to a
doomsday scenario often via mention of ‘superbug’, while this conceptualisation was fairly ubiquitous in the mass media. These differences indicate that people come to the media with an ‘already known’ (see Kitzinger, 1998) that protects their identities by associating major dangers with ‘others’ and thereby allays their own sense of vulnerability and risk, corroborating Joffe’s (1999) ‘not me, not my group’ thesis. This result is surprising since media analyses had led the researchers to believe that the social constructions of certain EID (including MRSA and ‘mad cow disease’) may not fit with this thesis.

There are very few discernible differences between tabloid and broadsheet reader representations but this can also be said of differences in the newspaper reportage of MRSA. Overall, a relatively monolithic representation of MRSA exists in this lay sample.

In the biomedical sphere the chief cause of MRSA is regarded to be the overuse of antibiotics, leading to antibiotic resistance. The absence of allusions to this in the lay accounts (apart from among a portion of the broadsheet men), corroborates Hawkings et al.’s (2007) finding that lay responses to mass health risks often bear little relation to the scientific knowledge of the risk. However, while lay thinking about MRSA is not necessarily linked to this aspect of biomedical understanding, the link between dirt and infection also has its history within the biomedical sphere. It is this aspect of the spread of bacteria that the public has engaged with.

Activities

Abstract submitted to British Psychological Society conference in Dublin, 2008, and plans to disseminate it in the Medical Sociology sphere.

Outputs

See three publications in preparation on the accompanying form. A description and sample of the data have been submitted to the UK Data Archive to determine whether they meet the acquisition requirements.

Impacts

PW is in negotiation with an independent production company (JustRadio) to produce a series of radio documentaries for the BBC World Service. The proposed series is called Epidemic! and will examine the phenomenon of emerging infectious diseases including MRSA from biomedical, cultural and political perspectives. The proposal has got through the first round of the approval process, with a final decision expected in October 2007.

Future research priorities

HJ recently gained EPSRC funding for studying social representations of earthquake risk and CS is research assistant on this. This interdisciplinary, cross-cultural, five year study will further explore the link between representation and action, as well as representation and experience.
HJ and PW have prepared a grant proposal for submission to the ESRC on the impact of waxing and waning EID media constructions on public thought/feeling/practice.

REFERENCES


APPENDIX 1

Sample – Descriptive statistics

Gender: 50% (n=30) of the sample was male, 50% was female.

Age: Mean age of participants was 49.17 years, with a range from 27 to 85.

Ethnicity: 25% (n=15) of the participants came from an ethnicity other than white British.

Highest educational qualification: 32 of the participants were educated to O- or A-levels or had vocational qualifications. 22 had a degree or a post-graduate degree. 2 reported no qualifications and 3 reported other qualifications.

Occupational status: 43 reported that they had been or were employees. 7 were or had been self-employed with employees, 8 were self-employed or freelance workers without employees and occupations of 2 were missing.

Political leanings: 31.7% (n=19) identified as Conservatives, 21.7% (n=13) as Labour, 11.7% (7) as Liberal Democrats, 3.3% (n=2) as Green, 3.3% (n=2) as “other”, and 28.3% (n=17) said they had no political leanings.

Readership: 50% were identified as primarily reading tabloids, and 50% as reading primarily broadsheets.

Health insurance: 30% (n=18) of the participants had private health insurance at the time of the interview.

Hospital attendance: 50% (n=30) has at least one overnight stay in a hospital within the 12 months prior to the interview. 50% had not.

APPENDIX 2

Interview aims

The aim was to elicit subjectively relevant material, with a minimum of interference. Only if the researcher felt that any of the following topics had not been touched upon was it raised by way of one of the following prompts\(^3\):

“*What do you feel causes MRSA?*”

“*Do you do anything differently as a result of MRSA?*”

“*Do you feel at risk of contracting MRSA?*”

“*How do you feel about taking medicine?*”

“*In light of what you feel and know about MRSA, how would you feel about being admitted to a hospital?*”

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3 The interview and questionnaire had been piloted on 2 people to ascertain how best to tap data relevant to the research questions.
“What would be your main media sources of information about MRSA?”

The research attempted to gain a balance between eliciting naturalistic data and answering pre-defined research questions. Thus it utilised a mixture of free associative methods and prompts where key areas of research questions had not been covered. Although this allowed for the objectives to be met, it may have meddled with the ‘purity’ of the accounts.

APPENDIX 3

The coding process

The coding frame was developed on the basis of: inductive codes grounded in the specific content of the data; the coding frame developed for the content analysis of MRSA in national newspapers (see Washer & Joffe, 2006); and social representational work on responses to newly emerging infectious diseases. After having defined and operationalised what content was to be coded under each code, two of the researchers coded the same 20% of the data-set (12 interviews). Having identified where inconsistencies lay, the definition of certain codes was honed. The aim was to increase the reliability, systematicity and transparency of the coding process. The full data-set was then coded by the research assistant.
ACTIVITIES AND ACHIEVEMENTS QUESTIONNAIRE

1. Non-Technical Summary

A 1000 word (maximum) summary of the main research results, in non-technical language, should be provided below. The summary might be used by ESRC to publicise the research. It should cover the aims and objectives of the project, main research results and significant academic achievements, dissemination activities and potential or actual impacts on policy and practice.

The overall aim of the project was to study public engagement with MRSA (Methicillin Resistant Staphylococcus Aureus) as part of a wider project of building a nuanced model of public engagement with emerging infectious diseases (EID) (e.g. AIDS, SARS, Ebola & ‘bird flu’). The objectives of the project were:

• To elucidate the nature of deep-laid public conceptualisations of MRSA and their interplay with the ideas contained in national newspapers.
• To show how MRSA has impacted on people’s thoughts, feelings and reported practices pertaining to hospital attendance, hygiene, antibiotic use, and health and biomedicine in general.
• To assess whether social representations of MRSA are associated with heightened anxiety in line with Ulrich Beck’s ‘risk society’ theory or whether the representations serve to mollify the public by distancing the threat.

In this light, the project results answer the following questions:

1. How does this British lay audience conceptualise MRSA?

MRSA is associated, first and foremost, with dirty hospitals. The putative MRSA crisis is regarded as a consequence of the neglect and mismanagement of the modern NHS, which, in part, is seen as a microcosm of the state of the country as a whole. Decline is attributed to ‘management culture’ having seeped into national institutions and increases in immigrants. While people profess ignorance regarding what MRSA is they feel confident to make such judgements.

The key solutions proposed to contain MRSA’s spread appear straightforward, namely improved hygiene in hospitals, better public education and bringing back the role of the matron. However, a number of symbolic threads underpin these: The matron figure, who is explicitly visualised as Hattie Jacques in the ‘Carry On’ comedies, expresses a nostalgia for a supposed golden age of the NHS, in particular, when nurses were white. This contrasts to the picture painted of the modern NHS with its ethnic minority staff whose practices are represented as contributing to hospitalised people contracting MRSA.

2. Is MRSA represented as an anxiety provoking threat, or do people associate it with identities and practices that are distant from themselves with attendant feelings of invulnerability and equanimity in the face of the crisis?

Unlike many other emerging infectious diseases, there is no shared anchor for MRSA (e.g. in the way that plague acted as an anchor or comparative phenomenon...
for AIDS) that might raise or attenuate the sense of threat. Rather, this ‘superbug’ is seen as a new phenomenon without antecedents. It is ascribed an invincible quality that makes people feel concerned in a general sense, which corroborates Beck’s ‘risk society’ thesis, but not personally at risk unless they enter one of the ‘risk groups’ such as becoming elderly or a hospital patient. The hospital is feared as a place that can leave one with a worse condition than that which one sought to cure. However, the social representation that confines MRSA to hospitals leaves those outside of hospitals with a negligible sense of risk.

3. What (if any) link can be distinguished between the content of national newspaper reportage on MRSA and how its readerships see it? Are there readership (i.e. tabloid versus broadsheet reader) differences in social representations of MRSA or is a more monolithic social representation of MRSA shared across these different social subgroups?

For the most part the media MRSA message strongly resonates with the lay sample’s representation: That MRSA is associated with dirty hospitals; that it reflects a microcosm of Britain and/or the NHS’s failings; and that the solution to the ‘superbug’ problem is the return of the matron (see Washer & Joffe, 2006). However, the most pronounced difference is that in the newspapers there is little if any blaming of ‘foreigners’ for MRSA (in contrast to other infectious diseases). Furthermore, only a third of participants allude to a doomsday scenario, often via mention of ‘superbug’, while this conceptualisation is fairly ubiquitous in the mass media. These differences indicate that people come to the media with an ‘already known’ (see Kitzinger, 1998) that protects their identities by associating major dangers with ‘others’ and thereby allays their own sense of vulnerability and risk, corroborating Joffe’s (1999) ‘not me, not my group’ thesis. This result is surprising since media analyses had led the researchers to believe that the social constructions of certain EID (including MRSA and CJD) may not corroborate this thesis.

There are very few discernible differences between tabloid and broadsheet reader representations but this can also be said of differences in the newspaper reportage of MRSA. Overall, a relatively shared representation of MRSA exists in this lay sample.

In the biomedical sphere the chief cause of MRSA is regarded to be the overuse of antibiotics, leading to antibiotic resistance. The absence of allusions to this in the lay accounts (apart from among a portion of the broadsheet men), corroborates Hawkings et al.’s (2007) finding that lay responses to mass health risks often bear little relation to the scientific knowledge of the risk. However, while lay thinking about MRSA is not necessarily linked to this aspect of biomedical understanding, the link between dirt and infection also has its history within the biomedical sphere. It is this aspect of the spread of bacteria that the public has engaged with when conceptualising MRSA.

The researchers are preparing to submit three papers (and two conference presentations) related to different aspects of this project: One analyses the public’s engagement with EID using MRSA as a case study, another looks at the public engagement/public understanding distinction and reports on the links between mass media accounts and public engagement, and a final one delves into the symbols evident in the social representation of MRSA (i.e. superbug, matron and foreigner). A longer term aim is to publish a paper that elucidates and evaluates the free associative methodology developed.
The independent production company (JustRadio) has shown interest in producing a series of radio documentaries for the BBC World Service on the researchers’ work. It is called *Epidemic!* and will examine the phenomenon of EID including MRSA from biomedical, cultural and political perspectives.

In terms of potential impacts, the call for more public information identified in this data has not been addressed in policy and practice. Such information might, among other aspects, inform the public that the government has been working on reintroduction of ‘modern matrons’ since 2001. This knowledge might appease anxieties concerning the spread of MRSA.
We are conducting research into how people understand certain public health issues. We would like to interview you and ask you your opinions about this. No specialist knowledge is expected or required.

The interview will normally take between half an hour and forty-five minutes and we will give you a monetary token of appreciation.

The interview will be tape recorded and then the tape will be transcribed (typed) out into a computer. All information which could personally identify you will be removed.

You have been identified by a market research company as a suitable participant in our study. You will be free to change your mind and withdraw from the study without penalty at any stage.

If you have any comments or concerns, please feel free to discuss these with either Dr Helene Joffe on 0207 679 5370, Mr. Peter Washer on 0207 288 3389 or Mr. Christian Solberg on 0207 679 5362.

If you wish to complain about any aspect of the way you have been approached or treated during the course of this study please write to the Chair of UCL Committee for Ethics of non-NHS human research, The Graduate School, UCL Gower St., London WC1E 6BT.
Informed Consent Form

This form to be completed independently by the participant

Title of Project: Public Engagement with MRSA

Have you read the Participant Information Sheet?        Yes / No

Has the project been explained to you orally        Yes / No

Have you had the opportunity to ask questions and discuss the study?        Yes / No

Have you received satisfactory answers to all your questions?        Yes / No

Have you received enough information about the study?        Yes / No

Do you understand that the interview you have will be tape recorded and that the recording will be transcribed and then the tape destroyed?        Yes / No

Do you understand that all information that could personally identify you will be removed and will not be used in the study?        Yes / No

Do you understand that you are free to withdraw from the study without penalty at any stage?        Yes / No

If you have any comments or concerns please feel free to discuss these with either Dr Helene Joffe on 0207 679 5370, Mr Peter Washer on 0207 288 3389 or Mr Christian Solberg on 020 7679 5362.

If you wish to complain about any aspect of the way you have been approached or treated during the course of this study please write to the Chair of UCL Committee for Ethics of non-NHS human research, The Graduate School, UCL Gower St., London WC1E 6BT.

Signed:

Full Name in capitals:

Signature of witness:

Full name in capitals:

Date:
INSTRUCTIONS:
We are interested in what you associate with MRSA. Please list the different images and words you associate with MRSA using these boxes. Include everything you associate with one image and/or word into one box. Don’t worry how good an artist you are, a really simple drawing can be a great way of portraying your thoughts and feelings. You can use any word more than once in different boxes.

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Participant No:…….
INTERVIEW SCHEDULE FOR "PUBLIC ENGAGEMENT WITH MRSA" PROJECT

• Introduction
  Thank you for agreeing to be interviewed. Before we start I want you to know that there are no right or wrong answers in this interview. I am merely exploring your thoughts and feelings about the issues that get raised. If you have any questions you would like to ask me I would happy to answer them at the end of the interview.

• Association grid
  ○ Use as basis for interview, then ask questions if topics not covered

• Interview questions
  1. In light of what you’ve said, can you talk about being admitted to hospital?
     • Prompts: Any other associations? Anything else? Before I move on, is there anything else you want to say about that?
  2. Again, in light of what you’ve said about MRSA, how do you feel about taking medicine?
     • Prompts...
  3. Do you do anything differently as a result of MRSA?
     • Prompts...
  4. What do you feel causes MRSA?
     • Prompts...
  5. Can you talk about your own risk of contracting MRSA?
     • Prompts...
  6. You’ve talked about [insert name here] media sources of your ideas about MRSA; have you any other media sources for your ideas?
     • Prompts...
Participant number: .......... Date .... / .... / ....

Thank you for your responses in the interview. Please can we ask you to complete the following questionnaire, which should take no longer than 5 minutes. This is a confidential questionnaire and the information you give will not be able to be traced back to you.

1. a) Are you: ☐ Male ☐ Female

   b) What is your date of birth? ___ / ___ / ______
      dd / mm / yyyy

   c) What is your ethnic group?
      (please specify if 'other')
      ☐ White (British) ☐ Asian (Pakistan)
      ☐ White (Irish)    ☐ Asian (Bangladeshi)
      ☐ White (Other)   ☐ Asian (Other)
      ☐ Mixed (White and Black Caribbean) ☐ Black (Caribbean)
      ☐ Mixed (White and Black African)  ☐ Black (African)
      ☐ Mixed (White and Asian)           ☐ Black (Other)
      ☐ Mixed (Other)                      ☐ Chinese
      ☐ Asian (Indian)                     ☐ Other

   d) Please indicate your highest qualification:
      ☐ O levels / GCSE ☐ Postgraduate Degree
      ☐ A Level        ☐ Degree / Professional Equivalent
      ☐ Vocational Qualification (please state type and level) ☐ None of these
      ...........................................................................
      ☐ Other (please state) ...........................................................................................................
The following five questions refer to your current main job, or (if you are not working now) to your last main job. Please tick one box only per question.

e) Do (did) you work as an employee or are (were) you self-employed?

- Employee
- Self-employed with employees
- Self-employed / freelance without employees (go to question 1.h)

f) For employees: indicate how many people work (worked) for your employer at the place where you work (worked).

For self-employed: indicate how many people you employ (employed). Please go to question 1.h) when you have completed this question.

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2. Broadly speaking, what are your political leanings?

☐ Conservative  ☐ Green
☐ Labour  ☐ I don't have political leanings
☐ Liberal Democrat  ☐ Other (please state) .................................................................

3. Which of the following newspapers do you read at least once a month?

(please tick as many as apply)

☐ Daily Express  ☐ Evening Standard  ☐ Sunday Mirror
☐ Sunday Express  ☐ Financial Times  ☐ Sun
☐ Daily Mail  ☐ Guardian  ☐ News of the World
☐ Mail on Sunday  ☐ The Observer  ☐ Times
☐ Daily Star  ☐ Independent  ☐ Sunday Times
☐ Daily Star Sunday  ☐ Independent on Sunday  ☐ Morning Star
☐ Daily Telegraph  ☐ Metro
☐ Sunday Telegraph  ☐ Mirror
☐ Other (please state) ........................................................................................................

4. a) Do you have private healthcare?  ☐ Yes  ☐ No

b) If yes, why? ..........................................................................................................................
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Thank you for completing our questionnaire.