

MANAGING STIGMA: A RELATIONAL  
ANALYSIS OF WOUND HEALING IN  
THE UK

By

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## Summary

This research explores the relationships between wound healing clinicians and patients in the context of dirty work. The relationships between people who do dirty work and their clients have hitherto been under-researched and theoretically under-developed, especially with regards to managing stigma. Therefore, this study mobilises the critical realist notion of the relational subject developed by Pierpaolo Donati and Margaret Archer that frames social relations as objects of care and consideration in and of themselves. Specifically, this concept is applied to understand how the dynamics of clinician-patient relations help them deal with wound stigma, both personally and professionally. The research draws on observational and interview data from a ten-month ethnography of three specialist outpatient wound healing clinics in the UK, conducted between 2016 and 2017. The retroductive analysis identifies the relational aspects of wounds and dirty work of wound healing. It also recognises the manifold ways in which clinicians and patients operate together within their dirty and stigmatised social context. Finally, it distinguishes between three clinician-patient relational configurations that differ in terms of their emergent outcomes for the stigma associated with wounds, the relational reflexivity, and relational goods and evils they generate. This study argues that the alleviation of the stigma associated with the dirty work of wound healing and living with wounds is, in and of itself, a special type of relational good produced by clinician-patient relations. This research contributes to social theory and dirty work scholarship by showing that clinician-patient interactions delimited within professional relations can generate relational goods, which, in turn, can help alleviate the wound stigma. Moreover, the critical realist emancipatory agenda that underpins this thesis provides a means through which to explain clinician-patient relations as both avenues towards patient empowerment in wound healing, and mechanisms for developing wound healing into a recognised clinical specialty of 'woundology'.

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## **Dedication**

I dedicate this dissertation to Rhys. He encouraged me to start this doctorate and I know he would be very proud to see me graduate.

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# 1 Introduction

No man is an island entire of itself (Donne 1624).

No human individual is a monad because each person is in relation with other persons (Donati and Archer 2015, p.16).

As evoked by this famous quotation from John Donne's (1624) poem and the kindred excerpt from a book entitled "The relational subject" by sociologists Pierpaolo Donati and Margaret Archer (2015), our social life is embedded in our relations with one another. To strive for well-being, happiness and emancipation – an activity-dependent human condition captured in the critical realist philosophy of social science through the term 'flourishing' (Smith 2010; Sayer 2011; Donati and Archer 2015; Gorski 2017) – people must form positive and enduring relationships with things that matter to them. However, modern Western social theorising has overlooked the long-known significance of social relations and how individuals form them by virtue of being ontologically relational subjects who can generate common goods through their practices (Donati and Archer 2015). This research is a direct response to Donati and Archer's injunction that social sciences approach social phenomena in a relational mode to redress the neglect of the various ways in which "we are all profoundly interdependent" (2015, p.15). I offer an empirical response to this agenda by applying a relational mode of understanding social phenomena to the study of everyday interactions and relations between clinicians and patients, undertaken through a ten-month ethnography of three specialist outpatient wound healing clinics in the UK.

To provide a rationale for my empirical focus in this research, it is important to place this study into context. Wound healing – "the study of wounds and their impact on health and disease" (Harding 2008, p.597) – is a new clinical specialty. It attends to an increasingly common and expensive medical problem, which according to the most recent calculations affects two million people in the UK and costs the National Health Service (NHS) approximately £5.3 billion a year (Today 2018). Despite its prevalence, globally it has been over-shadowed by higher-profile conditions (Wound Care Alliance Canada 2012). It has often been dubbed a 'Cinderella' condition, in the sense that "wounds and their care remain in the shadows - yet to enjoy the same limelight as the more media-savvy public health challenge" (Sandoz 2016). Wound clinicians have encountered manifold challenges in their ongoing efforts for

specialist status, professional and academic legitimacy in healthcare, greater public awareness and timely across-the-board patient access to wound healing services (Madden 2012; Harding and Queen 2017b; Queen 2017b; Queen and Harding 2017). Not without significance, here, is the fact that wound care publications frequently acknowledge the grisly corporeal reality of caring for wounds, from malodour to discharge and then gangrene (Wilkes et al. 2003; Lo et al. 2008). As a result, various commentators have highlighted the social stigma affecting individuals living with wounds (Today 2018) and observed that wound healing fits with the concept of dirty work (Bates 2006; Thomas 2014), which designates unpleasant and stigmatised forms of work that are relegated to someone else (Hughes 1958; Ashforth and Kreiner 1999).

According to Harding and Queen (2017b), tackling these challenges to wound healing requires engagement with manifold forms of innovation pertaining to diagnosing, treating and providing care for patients with wounds, all of which are hampered by the current status of the specialty. Of especial importance for this study's focus on clinician-patient relations, is the authors' recognition of the "forgotten ... need for citizens in our society to engage in social innovation. This could include patients becoming more involved in their own care and for family members and friends to act as care givers to patients where and when appropriate" (2017b, p.5). This view testifies a broader shift in healthcare away from paternalistic hierarchical models towards horizontal clinician-patient relationships. This shift has permeated wound healing through an increased emphasis on clinician-patient interactions characterised by respect, empathy and patients actively participating in their own care (Schoeps et al. 2017, p.344). The healthcare professionals' attention to patients and their respective family's engagement with wound care (Queen 2017b) resonates with the sociological significance placed on relations as a resource or a support for realising common concerns (Donati and Archer 2015, p.14). When insights into the salience of relations are applied to stigmatising situations in wound healing, they conjure up positive relational phenomena whereby stigma can be managed by clinicians and patients who are jointly concerned with it.

When situating the practical significance of clinician-patient relations in wound healing in the context of sociological designations of wound healing as dirty work (Bates 2006; Thomas 2014), it is important to stress that, albeit with a few exceptions (e.g. Stacey 2005), extant dirty work literature does not examine the relationships between people who perform dirty work and those who are referred to

in the literature as their clients, consumers or customers (Ashforth and Kreiner 1999; McMurray and Ward 2014; Neal 2018)<sup>1</sup>. Neal (2018) observed that studies of dirty work have hitherto focused primarily on workers, whilst saying very little about how stigma concerns clients. Moreover, even when they are considered, clients are mostly mentioned briefly as a source of dirty work stigma that workers seek to combat (e.g. Thompson and Harred 1992; Tracy and Scott 2006). Therefore, the portrayal of worker-client relationships in dirty work is limited and negatively skewed. This is in contrast with the generally positive status of social relations outlined in Donati and Archer's (2015) social theory. Given the acknowledgements to wound stigma in relation to patients and dirty work stigma associated with clinicians in wound healing literature, developing a focused understanding of whether and how worker-client relationships might link with the management of wound stigma requires further empirical exploration.

In this study, I contend that there is value in analysing the social interactions between clinicians and patients in wound healing, particularly in terms of the interdependence presupposed by the relational subject framework, rather than, say, in terms of the kinds of worker-client confrontations that are invariably presumed in dirty work literature. More specifically, a concern with the relational subject, which defines human collectives constituted by the relations people care about (Donati and Archer 2015), legitimises honing the analytical gaze onto the underexplored meanings of such relations for clinicians and patients' needs, decisions, choices and actions, the outcomes of the relationships for patients, clinicians and their communities, as well as their transformative potential for the 'dirty' context in which these relations are embedded (Donati and Archer 2015, p.15). Moreover, by "broadening the analytical lens from the workers, to view the worker-client relationship as a whole" (Neal 2018, p.132), through recourse to relational steering in the style of Donati and Archer (2015), it is possible to reflect not only on the transformative potential of clinician-patient relations for dirty work stigma associated with wound healing, but also on the social stigma of patients suffering from stigmatised wounds. Therefore, this study asks:

How is the stigma associated with wounds (re)produced or alleviated in UK wound healing clinics?

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<sup>1</sup> For the sake of consistency with this literature, when clinician-patient relations are discussed in this research in terms of debates around dirty work, patients are alternatively referred to as 'clients' and clinicians as 'workers'.

The remainder of this chapter is structured as follows. First, I offer a brief outline of the dirty work literature in the field of organisation studies, noting the paucity of studies on wound healing. I highlight the abundance of research exploring the challenges that dirty work stigma poses to workers' identities, as well as scholars' overriding preoccupation with workers' reactive, discursive coping strategies for positive identity redefinition. Subsequently, I delineate how these strategies are predominantly explored on the work-group occupational level, and, as such, exclude clients from the analysis. The lack of consensus over clients' role in relation to managing stigma offers an expedient opportunity through which to mobilise the relational subject framework as a potential solution, the assumptions of which fit with the emergent emphasis on partnerships between clinicians and patients in wound healing. After elucidating the study's aims and research questions, the chapter outlines its principal contributions, before ending with presenting a plan of the thesis.

## **1.1 Dirty work**

The sociological concept of dirty work (Hughes 1958) refers to those occupations that are stigmatised because of their association with problematic physical, social, moral, and/or emotional issues, or taints (Ashforth and Kreiner 2014, p.423; McMurray and Ward 2014). The tasks that individuals doing dirty work engage in are commonly regarded as grubby, disgusting, humiliating, undesirable, undignified, immoral, degrading or unethical (Hughes 1951; Hughes 1958; Ashforth and Kreiner 1999). Research on dirty work has focused on a variety of occupations, such as refuse collectors (Hughes et al. 2017), psychiatric emergency workers (Emerson and Pollner 1976), casino employees (Lai et al. 2013), and doctors and nurses (Strong 1980; Shaw 2004; Bolton 2005; Chiappetta-Swanson 2005), to name only a few.

Tellingly, dirty work is defined as work that "*wounds* [emphasis added] one's dignity" (Hughes 1958, p.49). At first glance, given its "embodied nature" (Waters 2016, p.1), wound healing appears to fit with the concept of dirty work. Its physical taints manifest in clinicians' proximity to wounds that are generally perceived as distressing or as carrying stigma due to malodour (Today 2018). Published evidence in the areas of wound care and management identifies themes emanating from patients' reported experience of wounds being 'dirty' (e.g. Briggs and Flemming 2007) and offers similar phenomenological accounts of wound care work

(e.g. Wilkes et al. 2003; Lindahl et al. 2008; Lindahl et al. 2010). Anecdotally, although many healthcare professionals working in wound care refer to it as dirty work if asked about it, “in terms of that being evident in published literature there does seem to be a gap” (Holloway 2017).

In organisation studies, where the concept of dirty work remains a novel sensitising tool for understanding tainted occupational worlds (Ashforth and Kreiner 1999; Slutskaya 2017), wound healing has hitherto been an unexplored setting. Consequently, scholars of work and organisations have scarce knowledge about this occupational group. This raises several questions: What are the taints in wound healing work and how are they reflected in stigma? Why is the work tainted? Are clients tainted, too? How do taints impact upon how healthcare workers conduct their work vis-à-vis clients? How does the association with taints shape the worker-client relationship and vice versa? When work is stigmatised, do relations between clients and workers contribute towards this stigma or can they help to alleviate it? Therefore, the examination of wound healing as a specific type of dirty work is primed for further investigation from an organisation studies perspective.

In the following two sections, I sketch out the most conventional possible avenues through which to explore these aforementioned questions. Given current debates in the dirty work literature, I suggest that the most conventional approach would be to examine, first, the challenges posed by dirty work designations and, second, the coping strategies employed by workers. The section that follows this offers a critique of these avenues as being insufficient for developing a sound sociological understanding of client-oriented work, of which wound healing is a specific example. The section concludes by arguing that these avenues run the risk of marginalising the transformative emancipatory potential of clinician-patient relations in wound healing.

### **1.1.1 Challenges and coping strategies in dirty work**

In emergent discussions of dirty work, organisational scholars have placed especial import on the unique difficulties that dirty work attributions cause for workers. The most frequently cited challenge pertains to workers’ awareness of their occupation’s stigma, which may be reinforced through reminders from other people, such as judgemental and debasing questions, critical remarks, unjust perceptions and social avoidance (Ashforth et al. 2007). Clients of dirty work also constitute a source of

negativity by virtue of their disparaging or abusive putdowns and behaviours towards workers (Hamilton et al. 2017; Hughes et al. 2017). These taints are said to engender a desire in people to distance themselves from dirty workers, despite their feelings of gratitude for performing work they deem to be distasteful yet necessary (Ashforth and Kreiner 1999). Scholars researching dirty work generally assume that societal projections of stigma transfer onto the people who perform it (Hughes 1951; Hughes 1958; Hughes 1962; Ashforth and Kreiner 1999), which, in turn, has consequences for workers' activities, their relationships at work and their sense of self (Sanders 2010, p.244).

Consequently, an influential assertion in dirty work scholarship, originating from Ashforth and Kreiner's work, is that workers adjust to stigma associated with taints or counter the stigmatising work attributes by employing various coping strategies that "transform the meaning of "dirt" and moderate the impact of social perceptions of dirtiness" (1999, p.413). The prominence of this assumption in the field has spawned voluminous research into how people who do dirty work maintain a positive sense of identity through developing coping strategies to manage the taints associated with their work (Ashforth and Kreiner 1999; Kreiner et al. 2006; Ashforth et al. 2007). For the most part, this research focuses on workers' constructions of reaffirming ideologies in those groups affected by the discourse of dirty work, as well as examining how phenomena, such as talk and text, can nurture exclusive occupational cultures confined to the internal relationships between workers. As the next section demonstrates, the possibility that some coping strategies can develop through relational support from clients has been overlooked.

### **1.1.2 Relationships in dirty work: locus of support and stigma**

Although literature on dirty work recognises that workers' relations and relationality to other people can help them cope with the challenges of dirty work stigma, the most pertinent of these explorations are delineated to "an inner circle of vetted people" (Ashforth et al. 2007, p.160). In general, research has advanced understandings of how intra-group social networks within the same occupation operate as spaces in which workers can form closed, inward-facing and exclusive cultures centred around the distinctiveness of what they do (Bolton 2005; Ashforth et al. 2017). Members of dirty occupations have been shown to jointly build social buffers that guard them against the negative views from outsiders (Ashforth and Kreiner 1999). Behind such bulwarks, workers seek to neutralise stigma by



employing predominantly symbolic, discursive strategies to imbue it with value and uphold their association with the specifics of their job (Dick 2005; Stacey 2005; Tracy and Scott 2006; Hamilton et al. 2017). Relevant dirty work accounts are rich and in-depth, drawn from workers' first-hand reports and often framed via social identity theory. On the contrary, research on workers' relationships with clients has been less common within the dirty work literature. As the subsequent paragraphs attest to, the concept of worker-client relationships remains empirically ambiguous, circumscribed, and relatively under-theorised.

Most dirty work research focuses on the antagonistic worker-client relationship. Workers are shown to blame clients for their problems and distance themselves from them (Thompson and Harred 1992; Tracy and Scott 2006; Juhila et al. 2010; Cassell and Bishop 2014). Clients are portrayed as verbally abusing workers and asking them, debasingly, 'how they can do it' (Ashforth and Kreiner 1999; Cassell and Bishop 2014). Other research considers the ambivalence of worker-client relationships. Clients might be offensive out-loud, vocally neutral or feel grateful to workers, and affirm their value through occasional positive comments. Conversely, workers might experience mixed feelings towards their clients, seeking emotional detachment while retaining sensitivity towards their perspectives (Hamilton and McCabe 2016; Hamilton et al. 2017). Further research conducted mostly within caring occupations stresses the theme of relational positivity through identifying workers' micro-level discourses about helping others (Chiappetta-Swanson 2005). Finally, most recent studies have begun to explicitly recognise that the arena of worker-client relationships can also be analysed in terms of friendliness, stressing workers' proactivity in seeking associations with their clients, who may, in fact, represent a vital source of social validation for workers (Cassell and Bishop 2014; Ashforth et al. 2017; Hamilton et al. 2017).

Therefore, despite a strong emphasis on worker-client opposition, there appears to be a subtle nascent realisation in the literature that workers' relationality to people outside of their immediate occupational community can also be a key feature of how they deal with the negativity of dirty work. However, there is a relative dearth of conceptual or empirical research that analytically prioritises how workers adjusting to the stigmatising attributes of their occupations deliberately address their relationships with clients. For example, Ashforth et al. acknowledged that they did not routinely ask workers about their relationships with their clients when studying their strategies for normalising dirty work (2007, p.162). As a result, the idea that

clients might offer support for coping with dirty work stigma still appears to be no more than a collection of ponderings about random leads inducted from workers descriptions of their interaction with clients.

This oversight is intriguing, because a common denominator of dirty work is that it is fittingly relational, in that it comprises reactions from the public and clients (Goffman 1963; Douglas 1966; Ashforth and Kreiner 1999). Therefore, including these people in sociological analyses of dirty work may generate richer insights into the nature of dirty work stigma. In fact, involving clients in research about the nature of customer-oriented work is crucial for understanding its social dimension (Whyte 1946; Korczynski 2003). As Whyte succinctly put it, “when workers and customers meet, that relationship adds a new dimension to the pattern of human relations in industry” (1946, p.123). The importance of clients for taint management has been stressed by Cassel and Bishop, who showed that the “construction of work as “dirty” or otherwise is located within the customer service interaction” (2014, p.254). However, in contradistinction to Whyte’s (1946) advice, most dirty work literature has paid cursory attention to the customer service interaction and instead, almost invariably, focuses on interpersonal remarks as a source of stigma.

An inquiry into the role of clients in helping workers address the challenges of dirty work stigma appears to fit well with the recent emphasis within the NHS on the importance of clinician-patient partnerships for addressing the challenges faced by the healthcare sector. As the final paragraphs of this section show, the tendency within dirty work research to neglect the role of clients fails to acknowledge the emerging importance of patient engagement for understanding stigma and its management in dirty healthcare work.

#### **1.1.2.1 Importance of worker-client relationships in wound healing**

An analysis of the possible interdependency of worker-client dynamics appears especially important in wound healing for two reasons: first, because of its patient-facing nature; and second, because patient empowerment through partnerships with professionals – a zeitgeist issue in healthcare – also concerns wound healing (Price 2011; Harding and Queen 2017b; Kapp and Santamaria 2017a). Regarding the former, as I learnt in my fieldwork, clinicians interact directly with patients, as well as their relatives, friends and carers who often accompany them to their consultations. Moreover, people with chronic and hard-to-heal wounds revisit clinics over a period

of months, years or even decades. The temporal dimension of physical wounds implies a certain durability of medical encounters. While this might be similar to the findings of other dirty work research conducted in the caring sector (Strong 1980; Shaw 2004; Sanders 2010), it is different from other studies of dirty work in which encounters with clients are presented as random and brief (Hamilton and McCabe 2016; Hamilton et al. 2017). The intensity of the interaction between patients and clinicians in wound healing means that it can be reasonably expected that patients and clinicians are, indeed, likely to encounter issues that engender stigma, but they can also find in their interactions support for managing stigma.

With respect to the issue of patient empowerment through partnerships with professionals, involving patients in wound care is viewed as important for the express reason that it can equip patients with skills for self-treatment of wounds at a historical juncture in which there are growing pressures on increasingly resource constrained healthcare systems (Price 2011; Harding and Queen 2017b; Kapp and Santamaria 2017a). Although it is undeniable that some patients with illnesses, disabilities or cognitive impairment want or need to be passively involved in their own care, there is also an emergent emphasis on the interaction between patients and health professionals being characterised by respect, empathy and patients' active participation in their own care processes (Schoeps et al. 2017). According to Corbett and Ennis' review of preferences of patients with wounds, patients increasingly seek professional relationships with clinicians that are premised not only on empathy, but, rather, also on empowering them to participate in decision-making about their care (2014, p.540). This implies a shift in wound care away from traditional ordering and compliance towards mutual agreement about patient agency.

Returning to the sociological framing of wound healing in terms of dirty work, the significance of patient involvement makes it impractical to exclude patients from the analytic process. Moreover, given that some patients already care for their own wounds, cleaning and inspecting skin tears and changing their dressings (Kapp and Santamaria 2017a), consigning them to the positional place of outsiders to the tasks involved in wound healing work is problematic at best. Interactions with patients can help clinicians better understand their clinical needs, and, in turn, inform the development of new treatments that can help improve patient health and well-being, alongside growing this under-recognised medical specialism (Harding and Queen 2017b; Queen and Harding 2017; Kapp and Santamaria 2017b). Finally, as I show

in this study, some patients are as concerned with wound stigma as clinicians, in addition to being concerned with “comfort, pain relief and life quality” (Moffatt et al. 2017, p.1311). This is because they recognise the challenges facing wound healing and the attendant negative implications for their social lives and access to care, which they seek to assuage by entering into what I refer to in this research as ‘wound healing advocacy partnerships’ with clinicians.

Therefore, overlooking the role that patients play in the dirty work of wound healing can lead to a narrow appreciation of worker-client dynamics and its potential to empower patients to help clinicians better care for them. However, extant literature on dirty work does not appear to have at its disposal the requisite tools for analysing the possible interrelatedness in worker-client relationships. This requires further consideration given the extent of client contact within certain dirty work settings. Having provided a rationale for studying worker-client relationships in the dirty work of wound healing, the next section introduces the relational sociological framework and delineates why its application in dirty work research, particularly in wound healing, has the potential to address this situation.

## **1.2 The relational subject: a route to a theoretical extension of dirty work**

The relational subject is a concept within the critical realist relational sociological perspective developed by Donati and Archer (2015), which defines human social reality as being fundamentally constituted by real relations individuals care about (Donati 2016b). Before proceeding to outline the notion of the relational subject, it is first important to emphasise how Donati and Archer (2015) stress its critical realist foundation contra constructivist perspectives<sup>2</sup>. Within the latter perspective, social relations are reduced to situational transactions, communications, subjective feelings or story-telling within groups of individuals and “are seen as subject to a

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<sup>2</sup> Ontologically, I am a realist. It is not my intention here to argue that critical realism (in itself an ongoing programme) offers the most carefully thought-out ontology for framing dirty work. I am also aware of the debates that argue that critical realism can be seen as a weak form of social constructionism (Lawson 2003a; Lawson 2003c; Al-Amoudi and Willmott 2011), rather than standing in opposition to all forms of postmodernism and poststructuralism, as Reed (2005, cited in Al-Amoudi and Willmott 2011, p.32) would argue. I do not explicitly engage with these debates in this study. However, I side with critical realism because it helps make visible how social relations in dirty work manage stigma in a way that aligns with the framework of the relational subject that I seek to defend in relation to the topic under investigation. Therefore, this study embraces critical realism empirically (albeit, not fully).

radical contingency in all their elements, i.e. their situational goals, means, rules and value-pattern” (Donati 2016a, p.155). In the context of dirty work scholarship, social constructionism has been the predominant perspective. Its dominance is due, firstly, to the strong influence of Mary Douglas’ (1966) work in the field, which portrays dirt as a ‘matter out of place’ and a ‘disorder’ within cultural and moral norms, and secondly, Ashforth and Kreiner’s (1999) subsequent practical refinements of the dirty work concept as a discursive entity (see Hughes et al. 2017 for a critique).

In contrast, the critical realist relational approach lays emphasis on the structures of social relations, which are networks of relations made up of communications and transactions, as well as “more consistent ‘stuff” (Donati 2016a, p.155). That is to say, according to Donati (2016a), firstly, people share an orientation towards caring for the relationship itself as a good, the importance of which exceeds individual preferences when agreeing on a decision that might shape the context of the relationship, whilst, secondly, Donati speaks of people physically looking at each other, talking, exchanging gestures, or holding each other in their arms (2016a, p.151). This latter point stresses the intertwining of human materiality with relational practice, which is wholly absent from social constructionist accounts that negate the physical human body and, in turn, reduce its meaning to free-flowing discourse (Marks and O’Mahoney 2014). Applying a critical realist conception of social relations to worker-client relationships in dirty work thus offers the possibility of moving beyond current theoretical doxa in this field, especially in those contexts where body work forms an important part of dirty work (Twigg 2000; Stacey 2005; Sanders 2010).

### **1.2.1 Overview of the relational subject**

The notion of the relational subject asserts that people form relations with the external world, that is, other people and the world of nature that influences them. The relational subject can thus be defined as “the human individual ‘in relation’ to others” (Donati 2016b, p.353) that “he/she cares for, that is the subject’s concerns” (Donati and Archer 2015, p.55). At the heart of the notion of the relational subject is the idea that subjects who collectively form social relations have the power to assume relational reflexive orientations towards emergent relational goods and their opposites, relational evils, that they generate together. Relational goods are a special type of common good that are produced and enjoyed reciprocally and simultaneously during social interactions. They are more than the sum of

individuals' well-being, but, rather, encompass the things that are produced via the enjoyment stemming from them sharing this relationship. Classic examples of relational goods include trust, support, collaboration and safety (Porpora 2016, p.422). These goods are formed under certain conditions, whereby individuals in interpersonal relationships reflexively diagnose their social situation, define their interests and design pertinent projects in relational feedbacks within social structures (context), as well as by taking account of their relational ties (Meliou and Edwards 2018). This relational reflexivity has consequences for the cultural and structural context of the social relation, both for the good of individuals and for the good of the members of the surrounding community. This orientation towards joint outcomes is what relational sociologists designate 'the relational emergent' (Donati and Archer 2015).

Donati and Archer (2015) assert that the validity of the relational perspective can be espied on different levels: on the micro level (for example, in the couple relation); on the meso level (civil associations and organisations); and on the macro level (for example, in citizen-state relations). The focus of this thesis is on situating the micro-level dynamics of social relations, which manifest in everyday face-to-face interactions between clinicians, patients and patients' companions during outpatient wound healing consultations, within a structural and cultural context. The next section explains the reasons for adopting this particular mode of contextualised analysis, before proceeding to explicate the value of the relational subject in the dirty work of wound healing.

### **1.3 The relational subject in the dirty work of wound healing: context**

Although relations and relationality are not taken for granted within wound healing (Price 2011; Corbett and Ennis 2014), in devising solutions to address the challenges facing this clinical specialty, much of the attention has been on technological and system level innovations (Harding and Queen 2017b), as well as classroom-type and commercial education about procedures and products (Harding and Queen 2017a). However, research into overcoming the manifold challenges in the field of wound healing "is far more likely to be effective if innovations are driven from bedside to bench" (Harding and Queen 2017b, p.5). This resonates with recent commentaries that argue that, whereas clinical knowledge about how to treat wounds may well already exist, the crux of the matter is in understanding how to

implement best practice (Today 2018) to show the accrued benefits to patients (Harding and Queen 2017a). Employing the relational subject framework can aid this analysis, because it warrants an exploration of such clinician-patient interactions in terms of their inherent relationality.

Research in wound healing that is informed by the relational subject could capitalise on the framework's legitimisation of an analytic focus on the formation of ties between clinicians and patients, their course and their effects on clinicians, patients and the social context of wound healing. Therefore, the 'social innovativeness' of this study stems from making relationality an integral part of the analytic process that seeks to understand how patients and clinicians jointly navigate the 'dirty' social context, which is made up of "what they confront – and have to grapple with" (Archer 1982, p.463), as well as their reflexive choices about things that matter to them. Under relational steering, social structures do not have to determine the subordination of patients to clinicians, but, rather, operate as barriers that can be worked through to create opportunities to shape context (see Meliou and Edwards 2018). Analysing worker-client relationships within dirty work through recourse to the relational subject perspective can analytically capture and render more explicit the otherwise "hidden, latent, unsaid" (Donati 2016a, p.151) reflexivity of workers and clients in dirty work contexts, and, in turn, encourage them to face the cultural and structural barriers they confront. These processes operating at the micro-level thus represent generative mechanisms of the relational subject in wound healing, which can provide an avenue through which to understand the cleaning up of the 'dirty' social context at the macro-level, because macro-level change comes through micro-level social relations (Donati and Archer 2015).

## **1.4 Research aim and questions**

The aim of this study is to investigate the development, nature and role of relationships between wound clinicians and patients with wounds who comprise the social context of wound healing. As the methodology and methods chapter delineates, both the dirty work and the relational subject perspectives emerged iteratively as the most expedient theories within the discipline for framing the phenomena under investigation, as my understanding developed over the course of the months spent in the field (Agee 2009). Informed by these relevant theoretical frameworks (Maxwell 2005), and after much reflection and interrogation, the overarching research question is therefore:

How is the stigma associated with wounds (re)produced or alleviated in UK wound healing clinics?

During data collection and analysis, I also developed a set of related research sub-questions, for the purposes of directing and shaping the discovery of supporting data to answer the overarching research question. These sub-questions aligned with the relational aspects of the nature of the dirty work of wound healing and wounds, that is, the ways in which clinicians, patients and patients' relatives concerned with wound healing and wounds operated together within their social context, as well as the outcomes of these interactions in terms of their effects on wound stigma. In corresponding order, these questions are:

1. What does wound stigma look like in relation to the nature and conditions of interactions between clinicians, patients and patients' relatives in wound healing clinics, and what causes it to emerge?
2. How do clinicians, patients and patients' relatives navigate the stigmatised context of wound healing?
3. What are the outcomes of these navigations for the individuals concerned and the stigmatised context they navigate?

## **1.5 Contributions of the study**

### **1.5.1 Theoretical contribution**

This thesis draws attention to how dirty work and the relational subject can theoretically inform each other. It is the first piece of research to use a critical realist conceptualisation of the relational subject to theorise the oversights and ambiguities within the dirty work literature pertaining to the place of worker-client relationships in managing stigma. The relational subject reminds us that we are inescapably involved with others, and, moreover, provides a frame and a theoretical apparatus through which to explain how various combinations of agential and structural influences induce various behaviours in clinician-patient relations. Using Donati and Archer's (2015) relational subject framework, I distinguish between three relational configurations of clinician-patient dynamics, termed: exchange relations, didactic relations and atomistic relations. I show how these relational configurations emerge from combinations of relational practices employed by clinicians and patients against the backdrop of the organisational and wider context they inhabit, as well as



their own motivations that propel “one to act towards the other” (Donati and Archer 2015, p.209). This results in distinct relational orientations, from the relational to the functional, and, finally, to the personal. Finally, I distinguish these relational configurations in terms of the manifold relational goods and evils they generate, which in themselves have emergent properties to act on wound stigma by either alleviating it or by (re)producing it.

### **1.5.2 Empirical contribution**

Through inviting the accounts of both workers and clients, I offer insights into how clients perceive and experience their interactions with workers doing dirty work. Whilst research has hitherto primarily explored how workers view their clients and how workers think clients see them and their work, there is a paucity of accounts on how clients *actually* view workers and their work, as well as how their experiences of stigma situations add to our understanding of stigma and its management. Including both groups in an analysis of managing stigma has not been attempted extensively before. Moreover, as a designation of wound healing as a form of dirty work has also not been the focus of extensive research, this study offers the first, explicit and purposeful application of the dirty work concept to wound healing work in the field of organisation studies. In so doing, this research constitutes another single occupational study to the stock of knowledge about dirty work, whilst, simultaneously, extending research on wound healing into a new body of literature.

### **1.5.3 Methodological contribution**

The third contribution centres on making a case for the further development of critical realist applications within dirty work research. Adopting a critical realist ontology as opposed to a social constructionist perspective vindicates a framework that allows researchers to go beyond analysing how workers discursively and ideologically strive to manage stigma at an intra-group occupational level. Rather, employing a realist relational sociological framework to study the worker-client relationship through a contextualised analysis reveals that stigma management also exists at the level of relations between workers and clients, their reflexive agency, materiality of the human body, and surrounding contextual factors and wider social structures. Such a multi-layered explanation of stigma management is possible through employing a retroductive analytical orientation specific to a critical realist methodology. The value of retroduction lies in its ability to go beyond the discursive

accounts of actors grappling with stigma to instead ask what the world must be like for stigma alleviation to emerge out of some relational configurations and not others. Through this, I expand the analytical repertoire that can be effectively employed in dirty work scholarship.

#### **1.5.4 Policy contribution**

Finally, the study has the potential to inform improvements in healthcare practice and delivery. It highlights that the collaboration and interactions between clinicians, patients, relatives, friends and carers are an important component of holistic care (Moffatt et al. 2017). By concentrating on clinician-patient dynamics to develop categories of clinician-patient relations and showing the positive and negative effects these relations might have on the wider social context of the medical encounter, this study offers a more comprehensive understanding of social innovation in healthcare. With respect to wound healing specifically, the study also considers exchange relations as a type of 'wound healing advocacy partnerships'. It argues that, as an extension of patient empowerment (and related concepts), they can also be considered as helping to alleviate wound stigma for patients, clinicians and future generations of patients with wounds, clinicians practicing wound care and the community that are (un)familiar with wound healing. By shedding light on advocacy partnerships, the study responds to recent programmes within healthcare development that aim to "achieve health and wellbeing with the public, patients and professionals as equal partners through co-production" (Bevan Commission 2015).

### **1.6 Structure of the dissertation**

The remainder of the thesis is structured as follows.

Chapter two reviews the dirty work literature in the field of organisation studies, and elucidates the value of the relational subject framework (Donati and Archer 2015) for redressing the neglect of worker-client relational configurations in dirty work scholarship. I look at the main theoretical resources hitherto employed in the dirty work literature, before proceeding to argue that they do not sufficiently acknowledge the importance of worker-client relations, especially with regards to managing stigma. Relatedly, I demonstrate that the dirty work literature neglects both organisational and wider contextual issues, which critical realism is ably equipped to address. The chapter concludes by putting forward the argument that the social

theory of Donati and Archer (2015) on the relational subject is an expedient framework for helping dirty work scholars understand how relations emerge, what course they take and what effects they have on stigma. The relevance of these theoretical and empirical points are appropriately mapped onto current trends within the world of wound healing. Potentially unfamiliar medical terms specific to wound healing (used in chapter two and thenceforth throughout the thesis) are defined in the glossary in Appendix 1.

Chapter three begins by outlining the principal tenets of the critical realist methodology underpinning this research. It then delineates the qualitative ethnographic nature of the present study. Specifically, the chapter describes the research sites and participants, along with the practical and ethical issues of negotiating access, and provides a summary of the data collected through observation and semi-structured interviews. Finally, it explains the retroductive technique employed to analyse data, revealing how the theoretical resources of dirty work and the relational subject were brought in as 'best fits' for explaining the occurrences in the field.

Chapter four describes the dirty work of wound healing and the stigma associated with wounds. Drawing on participants' accounts and my own fieldwork observations, I show how and why wound healing qualifies for the sociological designation of dirty work, particularly on the level of physical and emotional taints. Moreover, I highlight the current poor state of understanding and knowledge of wound healing and connect this to cultural and structural factors. Finally, I delineate the forms of social stigma experienced by patients who live with wounds by reflecting on its repercussions for patients' social lives and their access to care, as well as discussing pertinent stigma alleviating reactions from wound clinicians.

Chapter five describes how clinicians and patients navigate the social complexity inherent to wound healing consultations. Specifically, it focuses on how clinician-patient relations are organised around wound stigma through employing relational practices of communication, delegation and swapping favours. The latter practice is shown to materialise partially in an extramural space within this wound healing organisation, constituted by a nearby centre of wound healing research and expertise. Barriers to organising clinician-patient relations are also highlighted here, focusing on patients' previous negative experiences with wider healthcare, their

partial understanding of wound care matters and their inappropriate behaviour in clinics.

Chapter six discusses distinct clinician-patient relational configurations emerging out of their navigation of the socially complex environment. It characterises exchange relations in terms of acts of gratitude and reciprocity, showing how they are predicated on a shared desire to alleviate the stigmatised context of wound healing. Whilst exchanges are shown to be strengthened through patients' empathic sacrifices, such relations retain a professional character by virtue of actors' respect for their functional commitments. Exchange relations are shown to generate relational goods of 'trust between clinicians and patients', 'patient and family wound management regime' and 'collaboration in wound healing research', all of which help alleviate wound stigma. Subsequently, didactic relations are discussed. First, I acknowledge the boundaries of exchange-based relationality stemming from limitations in patients' decisional capacity. Second, I highlight how traditional patient and clinician role relations are reproduced through actors' embeddedness in their own social contexts. Didactic relations are shown to generate relational goods of 'collaboration in wound healing education', but also relational evils like 'separateness', 'dispersion of trust', 'blame' and 'accusation', which together reinforce the status quo of wound stigma. Finally, atomistic relations are explained in terms of how societal individualisation spills into wound care, the conditioning role of patients' prior experiences on their individualised behaviours, and their selective compliance with care that poses challenges to wound healing outcomes and medical and social clinician-patient relations. Atomistic relations are shown to generate the relational good of 'emergent (unintentional) concern for other patients' and relational evils like an 'inability to acknowledge needs and wants of other patients', 'reducing clinicians to roles', 'interactional strictness and sporadic allusions to discontinuing the relationship', 'overdependence on individual clinicians' and 'obstructing the provision of wound care that can improve wound outcomes'. All these relational evils risk reproducing wound stigma.

Chapter seven draws the findings together into an overarching discussion of the study's contributions. First, it advances an understanding of wound stigma. In this regard, it discusses how managing physical and emotional taints in wound healing is inherently relational. This highlights the importance of both organisational and wider aspects of wound healing that are propitious to the relational steering of stigma management, and situates the micro-analysis of stigma and its management

in the meso and macro contexts. The chapter then shows how relational configurations between clinicians and patients are paramount for managing stigma and discusses the three identified configurations through recourse to Donati and Archer's (2015) idea of relational reflexivity. Stigma alleviation in itself is presented as a special type of a relational good, which matters for clinicians, patients, patient's relatives and their surrounding community, which, moreover, helps wound healing shed the dirty work label. Finally, I discuss the empowering and emancipatory potential of the relational good of stigma alleviation by highlighting its emergent properties that propel patients to join clinicians in 'wound healing advocacy partnerships', which, in turn, support the transformation of wound healing into a focused clinical specialty of 'woundology' (Harding 2008).

Chapter eight concludes by restating the study's aim and summarising how it has been achieved. Subsequently, it reflects on the contributions and implications of this research for organisation studies, healthcare policy and the professional practice of wound healing. In contrast to the reservations expressed by Donati and Archer (2015) concerning the application of the relational subject to medical encounters, the chapter concludes that framing the clinician-patient relationship within the dirty context of wound healing as a relational subject is, in fact, wholly possible. What is more, such a framing offers novel insights into how patients and clinicians mutually cope with dirty work and wound stigma challenges that pervade the clinical practice of wound care, clinician-patient consultations at a historical juncture characterised by a drive towards patient empowerment, and the professional status of wound healing. After a discussion of the study's limitations, the chapter ends by proffering a possible agenda for future research.

## **2 Clinician-patient relations in the dirty work of wound healing: value of the relational subject**

This chapter reviews the dirty work literature and unpacks the value of the relational subject framework (Donati and Archer 2015) for enhancing our understanding of the dirty work of wound healing. The opening two sections review how the sociological concept of dirty work (Hughes 1958) has been utilised within work and organisation studies and outline the key debates. I show that, although stigma and its management are well understood from workers' perspective at an occupational level of analysis, the same cannot be said about the relational level of relationships between people who do dirty work and their clients. I suggest that further theorisation is needed to advance what appears to be a nascent appreciation of how dirty work stigma can be alleviated through nurturing collaboration between workers and their clients, both of whom are likely to be concerned with stigma. To buttress this argument, the third section reviews the main theoretical resources employed in the dirty work literature, showing that they overlook worker-client relations and neglect the wider contextual issues affecting dirty work in which these relations are formed. The chapter proceeds by reviewing the potential of alternative conceptualisations of dirty work to redress these oversights. It ends with defending the value of social theory on the relational subject (Donati and Archer 2015) for understanding how stigma management can be approached relationally from the perspective of worker-client relations in the dirty work of wound healing.

### **2.1 Dirty work: the neglect of worker-client relationships**

#### **2.1.1 Introduction to dirty work**

The sociological concept of 'dirty work' was first introduced by Everett Hughes (1958), and developed in his subsequent work (1951; 1958; 1962; 1974), as a sensitising tool for understanding those occupational worlds in which workers undertake activities that have been broadly referred to as grubby, disgusting, humiliating, undesirable, undignified, immoral, degrading, or unethical (e.g. Tyler 2011; McMurray and Ward 2014; Hamilton et al. 2017; Hughes et al. 2017). In his original conceptualisation, Hughes defined dirty work as work that:

... may be simply physically disgusting. It may be a symbol of degradation, something that wounds one's dignity. Finally, it may be dirty work in that it in some way goes counter to the more heroic of our moral conceptions (1958, pp.49–50).

He elaborated on this formulation by describing dirty work tasks as “physically, socially or morally beneath the dignity of the profession” (1958, p.122). As noted by some (e.g. Ashforth and Kreiner 1999; McMurray and Ward 2014), Hughes did not further define dirty work. However, subsequent studies by dirty work researchers resonated well with his tripartite classification, offering a further elucidation of the essence of these physical, social and moral taints and their associated “widespread (i.e. societal) social constructions” of stigma (Ashforth and Kreiner 1999, p.415) – the very concept that is believed to have marked the genesis of dirty work research (Ashforth et al. 2017).

Ashforth and Kreiner's (1999) seminal work elaborated on Hughes' model. Based on their review of extant dirty work research, the authors' first contribution was to proffer two further sub-criteria of dirty work within each form of taint (1999, p.415). In their formulation, work can thus be physically dirty through its direct association with “garbage, death, effluent”, as in the case of the work of janitors (Gold 1952) or cemetery workers (Batista and Codo 2018), or via its performance “under noxious or dangerous conditions”, such as in the example of firefighters and correctional officers (Tracy and Scott 2006). Socially tainted work includes “regular contact with people or groups that are themselves regarded as stigmatized”, like security officers (Johnston and Hodge 2014; Hansen Löffstrand et al. 2016) or AIDS workers (Snyder et al. 1999), or “adopting a servile relationship to others”, like customer clerks (Morriss 2016). Finally, moral taint transpires in work which is either “somewhat sinful or of dubious virtue”, like in the case of exotic dancers (Thompson and Harred 1992; Thompson et al. 2003) or casino dealers (Lai et al. 2013), or which requires the use of “methods which are deceptive, intrusive, confrontational” or defying “the norms of civility”, as in the case of paparazzi (see Vines and Linders 2016, p.1066). As a proviso to this typology, Ashforth and Kreiner (1999) stressed that what accords work a dirty status is not the nature of taints, but, rather, people's visceral reactions to such dirty activities, which are often communicated through debasing questions along the lines of “How can you do it?” (p.415).

Ashforth and Kreiner's (1999) second contribution involves highlighting how dirty work attributions cut across both low- and high-prestige occupations. Initially,

Hughes characterised dirty work as mean and dishonourable activities that typically fell to low-level staff, which contrasted with work that is 'clean', respectable, prestigious and professional status giving (1958; 1974). However, later it was shown that higher status occupations could also be considered dirty, by virtue of their links with people who may be perceived as socially stigmatised (McCabe and Hamilton 2015). Thus, the literature confirms that even the work of healthcare professionals can be seen as dirty via their association with socially stigmatised issues, such as alcoholism (Strong 1980), abortion (Bolton 2005), or mental illness (Emerson and Pollner 1976; Shaw 2004).

For instance, studies on nurses' work consistently frame it as dirty (Wolf 1988; Lawler 1991; Bradshaw 1998); "she [the nurse] does tasks of people below her or outside the role hierarchy of medicine. It hurts her, but she does it" (Hughes 1958, p.74). The designation of dirty here relates primarily to the material 'grunt work' of nursing, "that which involves direct contact with the body or body products" (Lawler 2006, p.50, cited in Adams and Nelson 2009, p.20), and to the physically strenuous character of such work, which can be a source of "fatigue, injured backs, and sore shoulders and hands" (Adams and Nelson 2009, p.21). Nurses' intimate contact with the human body, excreta and secretions has been described as dirty even when unfolding against the backdrop of advanced technological and scientific organisational protocols (Wolf 1988):

These are the physical tasks that, although not always requiring a great deal of formal schooling, usually elicit the response: "Oh, you must be a saint to go into nursing! I could never deal with the \_." The interlocutor might fill in the blank with a mention of blood, needles, urine, feces, *festering wounds* [emphasis added] ... or anything else that might commonly create disgust or discomfort (Adams and Nelson 2009, p.17).

Adams and Nelson drew attention to the general perception of nursing care as requiring "neither knowledge nor effort", but, rather, "a free outpouring from a feminine caring nature" (2009, p.5). According to the authors, a highly patriarchal healthcare culture prevailed at that time (Street 1992). Nurses were expected to act out a "virtue script" (Gordon and Nelson 2006) comprised of showing altruism, developing emotional connections and building relationships with patients (Adams and Nelson 2009). Therefore, in addition to being physically difficult, nursing care can also be emotionally demanding (Chiappetta-Swanson 2005).



However, for over a decade after the publication of Ashforth and Kreiner's (1999) influential model, researchers repeatedly restated the tripartite classification of dirty work as being physically, socially and morally tainted. The possibility of expanding upon these forms of taints were simply not explored. However, additional types of taints had long been signalled in studies of caring occupations, specifically with reference to the emotional work that is also required from 'dirty workers' (Bolton 2005; Chiappetta-Swanson 2005; Stacey 2005; Sanders 2010). For example, Chiappetta-Swanson (2005) invoked the concept of empathy to describe how genetic termination nurses identified with their patients' helplessness to give them a sense of emotional control. Stacey described the emotional burnout experienced by home aides from "over-investing in a client's well-being" (2005, p.844). Finally, Bolton (2005) spoke to the challenges faced by gynaecology nurses in managing emotionally charged situations.

In 2014, McMurray and Ward published their study of the work of the Samaritans as a third-party agent providing stigmatised clients with an outlet for dealing with their difficult emotions. The scholars explored "the ways in which such relational work might be considered a distinct if overlapping form of dirty work" (2014, p.1129). Therefore, they officially named working with the emotions of service users as the fourth type of dirty work. Since then, several studies have drawn on McMurray and Ward's (2014) extension of the concept of dirty work to make sense of the changing job duties across client-facing occupations (e.g. Thomas 2014; Rivera 2015; Fraher 2017; Solimeo et al. 2017; Wolfe et al. 2018). Within this body of literature, emotional taint characteristics are widely perceived as emotional performances which are complex and multi-dimensional. Rivera (2015) provides a particularly pertinent fourfold typology of emotional taint characteristics of dirty work deriving from her analysis of the emotional displays of United States border patrol agents (see p.219). First, they can be objectionable and viewed as negative, encouraging judgements of lack of care; second, they may be inappropriate to the event or circumstance; third, some are excessive by virtue of either showing too much emotion that is perceived as fake, or displaying too little emotion which is perceived as unfeeling; and fourth, emotional performances can be vulnerable, placing employees in situations where they must admit their own shortcomings or feel discomfort related to the emotion.

It is also recognised that occupations can be tainted in more than one dimension. For example, the case of 'fuzzy boundaries' (Ashforth and Kreiner 1999, p.415)

between taints can be found in the work of wound healing clinicians studied in this research. At this stage, it is important to introduce the empirical context for this study by elaborating the connections between wound healing work and dirty work. In the following sub-section, it is argued that, despite these parallels, wound healing has not been given due attention in dirty work scholarship.

#### **2.1.1.1 Wound healing in (dirty) context**

When we think of the term “dirty work,” getting our hands dirty comes to mind. For nurses, we might think of dealing with ... drainage from wounds (Thomas 2014, p.905).

Wound healing is an emergent specialist field of healthcare focused on treating wounds (Queen 2010) and, in turn, dealing with wound-related bodily issues, such as leaking blood-stained fluids, pus, inflamed excoriated skin, faecal fluid, necrotic tissue, scab, or offensive malodour (Boon et al. 2000; Bates 2006; Grocott 2007; Thomas 2014). In presenting the reality of wound healing work wound care and management literature do not commonly invoke the concept of dirty work; rather, authors refer to wound care work and patients' reported experiences of wounds as being 'dirty' in the literal sense. Viewed through the lens of dirty work, the following review of wound care and management publications suggests that the complexity of clinician-patients dynamics in wound care provision makes it a prime candidate for theoretically developing the area that epitomises the concept of dirty work.

##### *2.1.1.1.1 Wound healing in wound care and management publications*

According to Waters, “[w]ound care is messy and brings with it the messy lives of patients” (2015, p.150). Existing phenomenological studies of wound care work have implied the simultaneous entwinement (Hughes et al. 2017) of several “dirty particulars” (Ashforth and Kreiner 1999, p.421). Wilkes et al. (2003) and Lawton (2000), for example, both hinted at the co-existence of physical and emotional taints within the medical work and emotional labour of wound healing nurses, who feel “revulsion associated with gross disfigurement and uncontrolled malodorous body fluids” and experience “great stress while they try to hide their instinctive feelings” (both cited in Grocott 2007, p.57). Others (Lindahl et al. 2008; Lindahl et al. 2010) developed this consideration of mutually reinforcing properties of taints, highlighting their negative repercussions for the nurse-patient relationship. The authors argued that nurses' struggles with “[f]acing one's own defencelessness”, i.e. recognising how feeling “invaded” and “contaminated” by “disgusting” smell, which could not

“easily be washed away” (Lindahl et al. 2008, p.166) may have stood in the way of being able to “remain close to patients and ‘do good’” (Lindahl et al. 2010, p.778).

Moreover, Lindahl et al. recounted that nurses described their work as morally invasive, because dressing changes involved “revealing what is meant to be concealed” (2008, pp.165, 168) and represented an unpleasant examination of patients that went against their desire to hide their wounds. Nurses reported that close physical contact exposed them to patients’ anger, grief and fear around revealing their wound appearance and malodour. This induced in them manifold contradictory orientations. Some adopted a humanising whole-person approach, which involved them feeling compassion for patients and their relatives and choosing to look beyond the wound (Lindahl et al. 2008). Others sought to avoid compassion burnout and decided to craft their work around ulcers only, thus risking the weakening of relational ties with patients through depersonalisation (Lindahl et al. 2010).

On the topic of moral taint, Godin observed that “in health care, clean and dirty work are inextricably linked in the process of bringing about the miracle of cure that absolves health workers of any involvement with dirty work they may have been associated with, towards this end” (2000, p.1397). However, in care settings where healing is not always an option, the disassociation from dirt was hampered despite the ultimate moral imperative to cure people. This is the case in the management of chronic wounds, which frequently involves the element of palliative care (Chrisman 2010) – a form of care that has also been likened to morally dirty work (Godin 2000).

Second, phenomenological research into the impact of wounds on patients’ daily living has demonstrated the distressing physical aspects that build the situations of stigma into patients’ wound management experience. Many studies focus on the inconvenience caused by wound malodour, which patients describe as “dirty”, “unpleasant, horrible, obnoxious, rotten, terrible” (Hareendran 2005, cited in Briggs and Flemming 2007, p.323), “stench [that] was just horrendous ... like rotting flesh lingering” (Douglas 2001, cited in Briggs and Flemming 2007, p.323). Other studies emphasise the disabling impact of “uncontrolled exudate” (Grocott and Cowley 2001, p.544), or “terrible seepage” (Hyde et al. 1999, cited in Briggs and Flemming 2007, p.323) from the wounds. However, Briggs and Flemming’s (2007) review of research into patients’ experience of living with skin tears found that, surprisingly,

few studies explored its psychological impact, elsewhere acknowledged as revolving around poor body image, feelings of guilt, low self-esteem, social isolation and withdrawal from daily life (Haughton and Young 1995; Lawton 2000; Jones et al. 2008; Probst et al. 2009). According to Briggs and Flemming, some patients felt that “people needed to recognize that the wound they had was not an uncomplicated ‘scratch’ which would heal on its own” (2007, p.323). However, the opportunities to share their experiences with others have generally been limited (Lindsay 2004).

Given the salience of the notion of stigma in dirty work, what has the literature on wound healing that alludes to dirty work had to say about stigma? On the whole, it appears that, whilst some authors make explicit reference to it, this is almost always from the perspective of patients rather than clinicians:

Historically, individuals with chronic wounds were shunned from the rest of society and stigmatized for the rest of their lives. According to the Bible, these individuals symbolized sin, pain, grief, isolation and death, and were deemed to pose risks to others. So, wounds have always been associated to a process of human suffering and imbalance (Aguiar et al. 2016, p.2).

Accordingly, recent wound care and management literature has recognised the psychological needs of patients with wounds in relation to coping with stigma, understood as shame, unfavourable associations, and in terms of a lack of acceptance towards wounds in society (Augustin et al. 2012; Aguiar et al. 2016; Fitchett 2016). To the best of my knowledge, there are no wound care and management publications that directly speak about stigma towards clinicians through the lens of dirty work.

#### *2.1.1.1.2 Wound healing in organisation studies*

Despite these interesting connections and pertinent gaps, wound healing has been relatively overlooked in the organisational studies literature. This is surprising, given the rising significance of wound healing services (Today 2018). In view of the current demographic changes linked with impaired wound healing, such as an aging population and growth in the incidence of chronic diseases (Pang et al. 2017), the prevalence of patients with wounds has been growing at a pace of 10-15 percent annually (Harding and Queen 2012). Numerous studies have shown that mortality rates after the onset of ulceration are higher than those for several types of cancer, including prostate, breast and colon cancer (for a review, see Robbins et al. 2008).

Recent work by Guest et al. (2017) estimated the cost of managing patients with wounds to be £5.3 million, or four percent of the NHS expenditure in 2013. Despite a growing recognition of wound healing “as a public health concern that consumes extensive resources” (Corbett and Ennis 2014, p.537), there is still a “general lack of understanding of modern wound care theory” (Hurlow and Hensley 2015). This culminates in a poor state of wound healing education (Fletcher 2010; Queen 2017b), a lack of standardisation of care (Todd et al. 1995; Bree Williams and Waterman 1996) and unequal patient access to “the correct treatment at the right time for the right reason with the right outcome” (Harding and Queen 2017b, p.5). Moreover, “[a]s of yet, there is no formally recognized ‘woundology’” (Hurlow and Hensley 2015). Therefore, it appears timely to include wound healing in the study of work and organisations.

A careful analysis of dirty work studies reveals that scholars in the field of work and organisations may have signalled an association between the tasks of wound healing clinicians and dirty work. For example, Stacey included the description of home carers’ activities around changing bandages and cleaning wounds in her overall characterisation of carers’ work as dirty in “a broader Hughesian sense” (2005, p.849). Interestingly, although noting the dirtiness of the task both in the literal sense and in general as part of dirty caring work, she argued that changing bandages was actually perceived by carers as a skilled medical task that fell outside their direct expertise. In principle, it was avoided because it risked harming the ‘client’ and, in turn, jeopardising carers’ jobs. However, the frustration they felt at not being allowed to help clients as they mishandled the procedures would urge carers to undertake ‘safe’ dirty medical tasks, as illustrated in the extract below from one of the carers Stacey interviewed:

If they have a wound that has a band-aid or something like that, I’m going to take that off and clean it with peroxide and put it back on. But if they have a big open wound, I’m not going to do that ... I’m not going to cross the line. I’m not going to jeopardise my job to please nobody (2005, p.842).

Similarly, Tracy and Scott (2006), who used the concept of dirty work in describing the work of firefighters, alluded to wound care work being dirty. In contrast to Stacey, they argued that cleaning wounds and changing dressings were tasks that fell below the status and prestige of firefighters as “tough, knowledgeable, masculine saviours” (2005, p.20). This was the case with a homeless drug addict who received wound treatment from firefighters at the scene:

His wound was cleaned and bandaged and, after Tim [firefighter] told the man that he had “the wrong attitude,” the firefighters suggested that he walk to a special clinic designed for homeless drug addicts with chronic wounds (Tracy and Scott 2006, p.21).

In another organisational study focused on nursing practices in acute care, Lake et al. appeared to touch upon the notion of wound care being a type of dirty work. However, this was only done in passing, when referring to a nurse gathering up “*mucky* [emphasis added] discarded dressings” (2015, p.68) after seeing to a patient’s diabetic foot ulcer. The parallel becomes clear when reflecting on the use of the word ‘muck’ in dirty work scholarship. According to Dick (2005, p.1366) dealing with ‘muck’ – literal dirt – is what makes some work appear ‘dirty’ to a lay person.

In this sub-section, I have demonstrated that, despite slow but steady growth in the practical importance attributed to wound healing, research regarding wound care work in organisational studies has not kept pace. I have also substantiated the relevance of the dirty work concept for exploring “the World of wound healing” (Queen 2018, p.5). The next section continues with the critical review of dirty work scholarship as part of identifying lacunae in extant literature which serve as stepping-off points for this research.

## **2.2 Debates in dirty work**

Debates in the dirty work literature in organisation studies centre around two main themes. The first theme concerns understanding the challenging experiences involved with performing dirty work, which are invariably presented from the perspective of workers. This relates to issues such as being aware of and internalising an occupation’s dirty marks, feeling misunderstood, and receiving stigmatising reminders from the public and clients of dirty work, which has consequences for work activities, relationships with colleagues and clients, and one’s sense of self in light of the stigma (Ashforth et al. 2007; Sanders 2010; Hamilton et al. 2017; Hughes et al. 2017). The second theme concerns predominantly workers’ discursive coping strategies for alleviating the demeaning aspects of their work (Ashforth and Kreiner 1999; Kreiner et al. 2006; Ashforth et al. 2007), such as via developing “collective pretensions” and “dignifying rationalizations” (Hughes 1971, p.340) in order to “give their work, and consequently themselves, value in the eyes of each other and outsiders” (Morriss 2016, p.705). It

has been observed by some (e.g. Tracy and Scott 2006; Tyler 2011) that most of the pertinent analyses in dirty work debates have largely focused on individual work-group micro-practices. As this section shows, this may, in part, have stemmed from a failure to appreciate more relational and embodied experiences and coping strategies in dirty work.

### **2.2.1 Challenges in dirty work**

Scholars researching dirty work have generally assumed that dirty work represents symbolised degradation (Hughes 1958, p.319) because its taints are associated with the stigma that transfers onto the people who perform it, in turn, making them dirty workers (Hughes 1951; Hughes 1958; Hughes 1962; Ashforth and Kreiner 1999; Godin 2000; Bosmans et al. 2016). Although, historically, stigma had very real, bodily referents, such as scars on the flesh of slaves in ancient Greece (Scambler 2009), most accounts of stigma in dirty work studies appear to be informed by Ashforth and Kreiner's (1999) embracement of its symbolic interactionist articulation by Goffman (1963). In "Stigma: the management of spoilt identity", Goffman presented stigma as a socially constructed "attribute that is deeply discrediting", with the stigmatised person reduced "from a whole and usual person to a tainted, discounted one" (1963, p.3). Scholars who address dirty work have not interrogated Goffman's illuminations in search for an alternative conceptualisation of stigma despite their different philosophical persuasions. Thus, the notion of stigma itself is rarely questioned, but often invoked as a salient challenge for dirty workers on the grounds of its negative effects on workers' occupational and social identity (e.g. Ackroyd and Crowdy 1990; Bolton 2005; Dick 2005; Holmqvist 2009; Lai et al. 2013).

Accordingly, the literature shows that workers who conduct dirty activities are often aware of the stigma that their work attracts (Cahill 1999; Tracy 2004; Bolton 2005; Chiappetta-Swanson 2005; Dick 2005; Batista and Codo 2018). For example, Bolton (2005) showed that nurses on a gynaecology unit were conscious of the fact that their contact with failed pregnancies, vividly referred to by one nurse as "ugly dead babies" (p.178), led members of the public as well as mid-wives to perceive their work as "the dirty end of the stick" (p.177) in women's health. In addition to being mindful of receiving lower praise than the 'cleaner' branches of reproductive nursing that did not have to deal with the social and moral stains of late pregnancy terminations, they also noted their smaller financial rewards. Genetic termination

nurses in a study conducted by Chiappetta-Swanson (2005) complained about their hospital attaching a low-level of priority to the care they provided, which resulted in them reporting working under pressure and frustrating conditions of uncertainty within the structure of the hospital, as captured in accounts of them being “dumped” (p.102) on the surgical and gynaecological wards.

Research has shown that workers in other occupations within the caring sector also recognise their work as being stigmatised (Morriss 2016; Ostaszkievicz et al. 2016). For example, aides who perform the low-paid labour of home care work in the privacy of people’s houses were aware of being perceived as incompetent by members of the public, as well as sometimes feeling dehumanised by the demands of their clients. The Samaritans also derived a sense of their occupation being stigmatised from people’s reactions to them revealing they worked as Samaritans: “it killed the mood of the party – everyone went quiet and gently moved away”, said one worker (McMurray and Ward 2014, p.1135). Such remarks intimate that interpersonal reminders from the public can lead those who perform certain types of work to feel stigmatised.

Various studies have documented a common perception among workers that society misunderstood their occupation, held unjust perceptions of their job (Ashforth et al. 2007, p.156) and were sometimes disrespectful towards them (Paules 1991; Santino 1990, both cited in Ashforth and Kreiner 2013, p.137). By way of an example, Solimeo et al.’s (2017) work on patient-centred medical home clerical staff found that they felt people failed to recognise the complexity of their work that involved being part of providing care, rather than simply facilitating access to care. Research by Hansen Löfstrand et al. (2016) into the private security industry reported that workers stressed the performance of many tasks which were invisible to the public, who condescendingly reduced their work to ‘just pressing buttons’ and being called ‘a job’s worth’ (p.304). Garbage workers researched by Hamilton et al. (2017) highlighted public negativity towards their work by virtue of being called “lower than the snake’s belly” – a powerful reminder of interpersonal stigma that made its way into the title of the article. Finally, refuse collectors studied by Hughes et al. (2017) expressed that they were treated with suspicion by the public (see p.116). Consequently, dirty workers are aware of stigma towards their occupations and are sensitive to signs of disrespect in their dealings with clients (Ghidina 1992, cited in Ashforth and Kreiner 1999, p.424).



## 2.2.2 Coping strategies in dirty work

In light of their awareness of their work being perceived as dirty, and in an attempt to adjust to such stigmatising attributions, workers tend to seek ways of importing value into their work. According to Ashforth and Kreiner (1999), stigma can be countered by employing coping strategies, or defensive mechanisms, to create a positive sense of self. The word 'defensive' is crucial here, because it draws attention to a range of reactive strategies that workers undertake to alleviate the perception of stigma (Koken 2012). Given the interactional nature of the processes that reflect the perceptions of occupational stigma (Ashforth and Kreiner 1999; Makkawy and Scott 2017), it appears apt to begin the review of the literature on dirty workers' coping strategies by exploring the extent to which they may draw upon their relations and relationality to other people.

With respect to relations with clients, the literature suggests that workers "tend to be quite sensitive to signs of disrespect and thus wary in their dealings with clients" (Ashforth and Kreiner 2013, p.136). Some defensive tactics involved avoiding or confronting difficult clients, blaming them for their problems and distancing themselves from them (Santino 1990; Juhila et al. 2010; Ashforth and Kreiner 2013; Ashforth et al. 2017). In terms of how these strategies were implemented, a complex, atheoretical and anecdotal picture emerges. Here, blaming and distancing are entwined with a process of depersonalisation and disassociation from clients through the creation of an 'us-them' attitude (Tracy and Scott 2006). A small number of studies portrayed relational coping as entailing workers' more embodied interactions with human (Emerson and Pollner 1976; Stacey 2005) and non-human clients (Sanders 2010)<sup>3</sup>. For example, Stacey (2005) discussed the highly embodied relational sense of pride that home carers found in bathing clients, trimming their beards or providing bowel and bladder care. However, generally, clients' physical bodies do not feature much in the accounts of managing stigma within the dirty work literature. Indeed, the actual verbal dynamics and bodily aspects of worker-client relations often go unexplored, because dirty work studies, for the most part, empirically attend to workers' perspectives and only include clients' accounts through workers' 'second-hand' stories about their interactions.

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<sup>3</sup> By no means is this study comparing patients to non-human clients (i.e. animals). However, I believe that dirty work research on human-animal relationships (e.g. Sanders 2010; Hamilton and McCabe 2016) shows that there is an interest in exploring complex relational dynamics in dirty work, which legitimises my own research interests.

And yet, examples of distancing garnered from careful reading of the dirty work literature do cast some light on the verbal and bodily dynamics of taint neutralisation. These include: Twigg's (2000) description of how home health workers spoke of using gloves as a technique for symbolically and physically distancing themselves from clients to avoid contact with material dirt during bathing; Maticka-Tyndale et al.'s account of strippers depersonalising clients by maintaining "vigilance about boundaries with clients" (2000, cited in Tracy and Scott 2006, p.10); and Thomas et al.'s (2003) reports of exotic dancers explaining that they would not let certain racial classes of clients touch them. Within higher-status occupations, the work of blaming and distancing goes beyond taint neutralisation. Waddington (1999) described how police officers saw themselves as societal protectors and masculine heroes, whilst they engendered cynicism towards the citizens they served, viewing them as "naïve civvies" and "know nothings" (p.299), who did not understand the work they did. Deflecting blame by pinning dirtiness, taint and stigma onto those who threatened workers' preferred identity helped workers feel clean and superior to clients, who then became dirty in the process of blaming (Tracy and Scott 2006).

Moreover, employees cannot just blame any client; rather, taint is most effectively deflected by blaming those perceived as denying workers their 'status shield' (Tracey and Scott 2006, p.32). For example, Tracey and Scott described instances where firefighters showed disdain for a certain low-class of socially stigmatised and criminally inclined clients who were not appreciative of their work. Similarly, in a study of psychiatric workers in a community mental health hospital by Emerson and Pollner (1976), patients who had exhausted all their treatment options were referred to by workers as hopeless and imperfect because they often required the use of coercion and forced hospitalisation. In Strong's (1980) study of General Practitioners' (GP) care for alcohol abusing patients who denied doctors of the opportunity to use their skills, blaming and distancing meant that doctors transferred the "most irritating" (p.28) patients to another medical specialty. A similar dynamic of exclusion was described in a study by Shaw (2004), where non-compliant returning patients were disciplined through removing them from GP lists, allied with moralising and blaming. Overall, previous research has often presented workers' interactions with clients in terms of distancing dynamics.

### **2.2.3 Towards a relational turn in coping with dirty work stigma?**

However, on closer inspection, worker-client relational dynamics of distancing in dirty work can, in some cases, be understood as a more purposeful mode of emotional divestiture that was not targeted at blaming clients, but, rather, at preserving their own resources. For example, Chiappetta-Swanson's (2005) account of genetic termination nurses' attempts to cope with taints reported that they sought to develop an emotional connection with their patients whilst, simultaneously, rationalising the need for distancing as a means through which to not let any emotional over-investments get in the way of providing effective medical care. In a study of workers providing continence care by Ostaszkiwicz et al. (2016), although distancing was a pragmatic coping mechanism that helped them to avoid contact with material dirt, workers spoke of emotionally caring for their patients. Similar examples of compassionate disembodiment are found in Johnston and Hodge's (2014) study of discourses of hyper-masculinity among hospital private security officers. There, although workers were experiencing feelings of compassion, detachment from these feelings was a deliberate strategy employed to ward off physical sickness and emotional breakdowns. These studies thus suggest that some of the distancing practices evidenced in caring dirty work may have carried with them some relational loading, rather than, say, being purely about managing taints, dirt and stigma.

Going a step further, more recent work bears testament to a potential shift away from the dynamics of exclusion towards the dynamics of association. For example, Hamilton et al. (2017) observed that garbage collectors construct a sense of dignity in their work in a novel way that centres on developing discourses of paternalistic practices of care. Drawing on interviews with managers in dirty occupations, Ashforth et al. (2017) reported managers increasingly encouraging 'dirty' debt collectors to assume proactive and corrective strategies of perspective taking, empathise with clients' plights, associate with clients and put themselves in clients' shoes as reflexive defence mechanisms. Cassell and Bishop (2014) talk of taxi drivers ordering rude customers to leave their cars, albeit with respect rather than accusation. Therefore, there are notable signs that the image of clients within dirty work might be getting 'warmer', and not only across caring occupations. Indeed, it has been well-established, especially within service work, that customers can be a key source of meaning (Korczynski 2003). However, despite their importance for coping with stigma, the portrayal of worker-client relationships fails to go beyond

this. Despite signs of a relational turn in dirty work scholarship, in general, worker-client relationships are still overlooked or, at best, dichotomised into disassociation and association, with the pendulum swinging towards the former.

## **2.3 Theoretical resources in dirty work: what is known and what is missing**

### **2.3.1 Perspectives: occupational culture, social identity theory and Goffmanian stigma**

As far as relations are concerned in the dirty work literature, research has hitherto mainly focused on workers' relationships with one another on the intra-group occupational level to understand how workers who conduct dirty activities 'symbolically reposition' the negativity of dirty work (Hughes et al. 2017, p.108). Scholars have been heavily influenced by the work of Mary Douglas, specifically her notion of dirt being a 'matter out of place', a 'disorder' within cultural and moral norms and a discursive rather than absolute entity because, as she claimed, there is "no such thing as absolute dirt: it exists in the eye of the beholder" (Douglas 1966, p.2). This idea was somewhat confirmed by Ashforth et al. who found that people were "far from unanimous' in classifying various occupations as either physically, socially, or morally stigmatised", and, moreover, that there was even "less agreement about whether jobs were stigmatised at all" (2007, p.153). Accordingly, managing stigma has been conceptualised as ideological responses aimed at the neutralisation of taints via discursive strategies of reframing, recalibrating and refocusing dirty work (Dick 2005; Stacey 2005; Tracy and Scott 2006; Hamilton et al. 2017). These have been shown to be undertaken by individual workers who remain ideologically connected within occupational cultures via "values and work-group behaviours [that] emerge from collective sense-making by members of the work group" (Ackroyd and Crowdy 1990, p.4).

First, the literature has elaborated three self-serving, edifying ideological techniques of 'reframing', 'recalibrating' and 'refocusing' (Ashforth and Kreiner 1999), with the prefix 're' signifying "a cognitive shift in the positive meaning that incumbents derive from dirty work" (Ashforth and Kreiner 2013, p.130). Reframing involves changing the meaning of dirty work by infusing its means or ends with positive values via presenting it as a badge of honour, or by neutralising the negative value to make room for immediate or future infusing (Ashforth and Kreiner 2013). For example, in

the words of Makkawy and Scott, “nurses might ignore the dirty work they must complete when discussing their occupation with others (neutralizing) and claim instead that they provide invaluable services that at the end of the day play key roles in overall patient health (infusing)” (2017, p.676).

Recalibrating consists of “adjusting the implicit standards that are invoked to assess the magnitude and/or valence of a given dirty work attribute” (Ashforth and Kreiner 1999, p.422). Work is reviewed, retold or exaggerated to de-emphasise its negative components and/or transform them into positives by bringing out their value. For example, the psychiatric emergency teams in Emerson and Pollner’s (1976) study were reviewing events that required them to conduct coercive and therefore dirty activities to uncover whether aspects of these events could be classed as bearing at least some of the features of a clean therapeutic intervention.

Finally, refocusing occurs when “attention is shifted from the stigmatized features of the work to the non-stigmatized features” and the employee “actively overlooks the stigmatized properties” (Ashforth and Kreiner 1999, p.423). Refocusing imbues work with positive meaning by highlighting its intrinsic qualities, intrinsic rewards or extrinsic rewards, whilst leaving the stigma intact (Ashforth and Kreiner 2013). For example, a nurse might emphasise how caring encounters with patients undergoing pregnancy termination provide an opportunity to display the core values of nursing, or how being a forgotten group comes with the freedom to work more independently and autonomously (Chiappetta-Swanson 2005). Extant literature on taint management techniques has largely developed around these three self-serving intra-group beliefs cultivated to attend to workers’ concern with occupational self-image.

The second set of coping practices nurtured by strong occupational cultures looks beyond the immediate work-group level and takes account of dirty workers’ relationships with people outside their occupational cohort. In this regard, Ashforth and Kreiner used the “outsiders” label to refer to dirty workers’ relationships with, for example, other “organizational members, *clients* [emphasis added], family [and] neighbours” in a one-size-fits-all approach (1999, p.424). However, what such outsiders have in common appears to be their preoccupation with “stereotypes of dirt” (Ashforth and Kreiner 1999, p.424) that pose a threat to their occupational identity. Therefore, the emphasis within this second set of dirty workers’ coping practices is on the differentiation of outsiders that draws clear boundaries between

intra- and out-groups in search of social validation. Collectively known as social weighting, these practices are still fuelled by strong occupational cultures.

First, dirty workers 'condemn the condemners' (Sykes and Matza 1957). This means that they challenge and dismiss outsiders' critical and disparaging perceptions of their work in such a way that leads to disconnection from society. For example, in Ackroyd and Crowdy's (1990) study slaughterhouse workers criticised meat-eating individuals who abhorred their work as hypocritical. Second, dirty workers 'support the supporters'. According to Ashforth and Kreiner, "they come to place more credence in those outsiders (*if any*) [emphasis added] who provide a positive view of their work" (1999, p.424). This is tellingly captured in Tracy and Scott's idealistic depiction of firefighters' "customer service training where they are taught to provide the finest treatment to "Mrs. Smith," a decidedly feminine client typically portrayed as helpless, innocent, fragile, and in serious need (and therefore very much appreciative) of firefighters' expert service. However, firefighters' daily activities do not align with this ideal" (2006, p.16). As Ashforth and Kreiner (1999) observed, given the scarcity of supportive outsiders in most depictions of dirty work, workers are likely to turn for affirmation to their intra-group. In so doing, they risk further disconnection from the society who they believe hold them in contempt. Third, workers can engage in selective social comparisons with sufficiently similar, but albeit slightly inferior, outside occupational groups or sub-groups within their own occupation in so far as such social comparisons allow for flattering inferences about themselves while "hold[ing] the stigma constant" (Ashforth and Kreiner 1999, p.425).

In reviewing the scholarly applications of the concept of dirty work, Makkawy and Scott (2017) noted that the aforesaid ideological techniques and practices are inextricably bound to social identity theory (Tajfel and Turner 1985, cited in Ashforth and Mael 1989). Social identity theory holds that membership of a collective provides individuals with emotional and intrinsic values that help them develop a conception of a sense of self (Ashforth and Kreiner 1999; Baran et al. 2012; Lai et al. 2013; Bosmans et al. 2016). As observed by Baran et al. (2012), belonging to a distinct social group such as a work organisation influences who people think they are at work (i.e. their occupational identity), which, in turn, becomes part of who they think they are (i.e. their social identity). "Given that 'what I do' for workers who conduct a central dirty task is a stigmatized activity" (Baran et al. 2012, p.600), in dirty work settings individuals face the challenge of having to manage their identity

by using the above techniques and practices to foster a positive self-conception that is less tainted with stigma.

As noted in the previous section, to depict how identity is managed in dirty work, most studies draw on Goffman's account of stigma management as being grounded in social interactions. According to Scambler's (2009) review of Goffman's work (1961; 1967; 1971), Goffman offered a dramaturgical account of how people deal with stigma. Specifically, people conduct themselves in interactions with others by following ground rules, which enable them to maintain a consistent positive image of themselves and prevent 'the loss of face'. Unpunishable instances of rule breaking, justified as apposite if accompanied by apologies, requests or accounts, allow them to pursue their own goals. Therefore, Goffman reduced the structure of social interaction to the rules of impression management and argued that this structure of social interaction is what maintains social order. While not discounting Goffmanian contributions, Scambler argued that his focus on the structure of interaction overlooks the causal input of social structures, "more often theorised from outside the symbolic interactionist/dramaturgical fold" (Scambler 2009, p.444; see also Scambler 2006). Evaluations of action based on social interactions in the immediate context thus risk obscuring not only wider social structures, but also the reflexive agency of actors in relation to these wider social structures (Delbridge and Edwards 2013). These social structures are not normally considered by dirty work scholars in developing accounts of what causes stigma to emerge and how stigma can be managed.

### **2.3.2 Neglect of wider contextual issues in studies of dirty work**

The dominance of occupational culture, social identity theory and Goffmanian accounts of stigma in dirty work scholarship has resulted in wider contextual reasons being analytically side-lined, such as why stigma emerges and what it means beyond threatening workers' identity. Ackroyd and Crowdy are evidently sympathetic to this view, claiming that people "act out their work roles in a manner that is highly dependent on their customary definitions and understandings of their task and its meaning" which "are themselves embedded in quite distinctive class, regional and national cultures" (1990, p.3). Indeed, it has recently been recognised by scholars in organisational studies that the neglect of contextual factors, such as organisational context, gender, class relations, economic conditions and technological developments, may have circumscribed dirty work research (McCabe

and Hamilton 2015; Jenkins and Delbridge 2017). Just as “there can never be context-less action” (Donati and Archer 2015, p.62), “taint management does not happen in a vacuum” (Tracy and Scott 2006, p.35). However, the wider context and social structures have been neglected ever since Ashforth and Kreiner’s (1999) seminal constructionist contribution to dirty work that popularised the occupational culture perspective, social identity theory and Goffmanian conceptualisation of stigma management.

As a result, existing approaches in dirty work scholarship tend to downplay contextualised assessments of the interplay between social structures (context) and human agency in confronting stigma. To the contrary, according to the critical realist ontology underpinning this thesis, the outcomes of social scientific investigations must be analytically positioned within the specific contexts, circumstances or conditions in which they arise (Pawson and Tilley 1994). Applied to dirty work, such contextualised analyses are crucial for understanding why and in what circumstances stigma emerges, as well as why and in what circumstances it can be managed. Although it is difficult to find empirical studies that highlight the importance of organisational and wider contextual issues affecting dirty work, it is not impossible.

Beginning with organisational context as a resource for understanding the stigmatised facets of dirt, this notion was highlighted in research pre-dating Ashforth and Kreiner’s (1999) work. For example, Stannard’s (1973) analysis of work in a nursing home demonstrated how the organisation of work that reflects hierarchies, relationships of power and the well-defined division of labour can also feature in the interpretation of work as dirty. Specifically, everyday conditions of work in the nursing home physically separated nurses performing administrative and medically complex work from care aides undertaking less skilled bodily care, with a lack of direct contact between these two groups creating conditions for distrust between workers and residents.

Moving on to wider contextual issues, Ackroyd and Crowdy’s (1990) realist study of slaughterhouse workers showed that workers’ conceptions of themselves were shaped by factors external to the workplace itself, such as social values of aggressive masculinity and realism, as well as by the conditions of work that engender dirt, such as noisy machines and bodily odours from animals. Post-Ashforth and Kreiner’s (1999) seminal work, Tyler’s (2011) constructionist analysis



of the dirty work of sex shop sales assistants stressed the importance of physical place in the management of stigma. Specifically, London Soho's association with generosity, unconventionality and rebelliousness was used by workers to not only deflect the negativity of their work, but, rather, also to generate allure around its simultaneous attraction and repulsion. Adopting a critical poststructuralist approach, Tracy and Scott's (2006) study of firefighters highlighted the importance of wider organisational structures and discourses of power around masculinity and sexuality that transcend the occupational context.

Even more recently, changes to the structures and technologies of labour markets have been shown to taint new types of dirty work and 'clean' work. For example, McMurray and Ward's (2014) reflect on how a shift in occupational structures away from manufacturing towards services fuelled the identification of emotional dirty work by the Samaritans (McMurray and Ward 2014). In contrast, McCabe and Hamilton's (2015) study of modern slaughterhouse workers demonstrated how modern technological production systems served to neutralise the dirty act of killing. Moreover, individualising work dynamics in the precarious low-pay economy overrode the significance of physical taints to workers, preventing the formation of strong occupational cultures. Jenkins and Delbridge's (2017) study of call centre employees lying to their clients about the physical location of their premises showed that workers' social identities were bound up with the organisational context and values of high-quality service that legitimised and positively reinforced 'strategic deception' as a type of moral taint.

Finally, although dirty work scholarship has not engaged much with the conditioning role of prior structural and cultural contexts, Bolton's (2005) study of gynaecology nurses' dirty work recognised the role of long-standing male models of health care premised around distancing, which meant that, for example, dead babies were taken away from mothers straight after birth and their bodies were disposed of by the hospital (see p.184). Overall, the joint contribution of the studies outlined in this section is that the context of dirty work does, along with social values, aspects of work organisation, societal discourses, physical place and trends in the wider world of work, matter for understanding why, and in what circumstances, stigma is (re)produced and/or alleviated.

### **2.3.2.1 Wider contextual issues in wound healing**

It is therefore imperative to understand the contextual circumstances that sustain struggles around the meaning of 'dirt' and stigma in wound healing. Firstly, although the science of modern wound healing has developed over the past 50 years, it has not yet reached equal recognition as a specialty across different care settings and, indeed, is still predominantly undertaken by nurses in most countries (Harding 2006; Madden 2012; Harding 2015; Queen 2017b). Its common perception as 'nurses' work' reflects gendered accounts of nursing work as being sociologically dirty (see Adams and Nelson 2009). Moreover, its relatively low position within the medical hierarchy, as evidenced by wound care clinicians' sentiments that their practical expertise remains unacknowledged (Madden 2012) and that wounds might be "an irritation and inconvenience" to other healthcare professionals (Harding 2015, p.318), suggests that wound healing is generally misunderstood, which further verifies its 'dirty' designation (Ashforth et al. 2007). Amidst the numerous challenges that stand in the way of the development of a specialist status for wound healing (Harding 2006; Queen 2017b), two deserve special mention because of their relevancy for managing wound stigma, for clinicians and patients alike.

The first contextual challenge centres on the lack of recognition of clinical 'woundology' "as an important and essential component of modern health care" (Harding 2006, p.147). According to wound healing clinicians, an important step in the direction of redressing this imbalance involves encouraging public and professional support for undertaking high-quality, basic and clinical, wound healing research (Harding et al. 2002). For clinicians, research helps develop medical products and methods of practice to better meet patients' needs; for patients, participation in clinical trials offers educational value through the provision of additional information about their conditions and therapeutic value through granting them access to new types of treatment that might not yet be available (Beard 2015). Harding et al. (2013) acknowledged that research may not represent a perfect solution to raising the profile of wound healing, because it often excludes the most complex and vulnerable of patients. Nonetheless, a systematic approach to wound healing research might 'sanitise' dirty wound healing as it is believed to provide a strong opportunity for moving the 'woundology' agenda forward (Harding 2015; Queen 2017b), in turn, helping it break away from its reductive associations with 'nurses' work'.

The second contextual challenge relates to the need to develop an effective model of social innovation in wound healing by involving patients and their relatives in care to address wider pressures on healthcare staff in general, while ensuring equity of access to care for all (Harding and Queen 2017b). The wound healing area faces an increase in the number of patients with chronic wounds (Guest et al. 2017), a proportionate reduction in the number of healthcare professionals (Bloom et al. 2011) and spiralling costs of wound care (Guest et al. 2017). Therefore, “it is almost inevitable that [wound clinicians] will need to develop professional-patient partnerships, increase collaborative care and self-management education, empower people to think critically and make informed decisions in partnerships with healthcare professionals” (Price 2011, p.18).

This vision is reflected in the terminological shifts in extant wound care literature away from patient compliance (e.g. Falanga 2005), towards concordance (Moffatt et al. 2009) and adherence (e.g. Moffatt et al. 2017). Patient compliance places the emphasis on ‘submitting’ a patient to professionals’ prescriptions in a submissive way (Vermeire et al. 2001), whereas patient concordance involves patients working with clinicians to achieve the best therapeutic outcome (Pound et al. 2005). Patient adherence thus extends patient concordance to reflect the active participation of clinicians and patients in deciding on an agreed plan of management (Price 2008). This last concept resonates particularly well with the transition towards horizontal and inclusive care within wound healing. This is advocated under related concepts, such as patient empowerment, professional-patient partnership (Price 2011), person- or patient-centred care (Corbett and Ennis 2014; Schoeps et al. 2017), shared decision making (Elwyn et al. 2012; Elwyn et al. 2013), shared care models (Kapp and Santamaria 2017a), or patient enablement and self-care (Kapp and Santamaria 2017b). This signals a shift away from ‘dirty’ top-down instruction towards ‘clean’ cooperation in care (e.g. Price 2011; Elwyn et al. 2012; Elwyn et al. 2013; Corbett and Ennis 2014) capable of empowering patients to both face up to the personal burden of wounds and demand better support and care for their own, as well as others’ wounds (Queen 2017b).

Representations of patient empowerment and active involvement have given rise to vigorous debates in healthcare about the change in terminology applied to the

recipient of care, from 'patient' to 'client' (Wing 1997)<sup>4</sup>. The focus on patients as health service users (see, for example, Hardyman 2017) relates primarily to the belief that this equalises the relationship between historically active providers of care and their conventionally passive recipients (Dalrymple 2001)<sup>5</sup>. Coincidentally, 'clients' is also a term that is commonly employed in dirty work studies in relation to the recipients of dirty work services. In using the word client in reference to the under-researched worker-client (i.e. clinician-patient) relationship in the dirty work of wound healing, this study sidesteps these debates pertaining to the correct vocabulary that proper capture the nature of the relationship between healthcare professionals and people with health conditions. However, Kravitz's contention that "[h]ealth care is a service industry" (2010, p.279), allied with the prospects for potential healthcare reform in the next few years, implies that the centrality of social interactions between workers and clients for getting work done in a service society needs to be taken into consideration in medicine. According to Bell's early sociological musings on the post-industrial society, "the growth of the service sector means that "communication" and "encounter" – "the response of ego to alter and back" – is the central work relationship today" (1973, cited in Hochschild 1983, p.9). Similarly, in wound healing, good worker-client relationships, or good clinician-patient relationships, "are key for successful wound management", even though practical guidelines on how this can be achieved are scarce (Lusher et al. 2018, p.311).

### **2.3.3 Worker-client relations for managing stigma: without theorisation?**

Commenting on the state of current dirty work scholarship and the potential avenues for its conceptual progression, Makkawy and Scott observed that "scholars

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<sup>4</sup> These debates began in the morally stigmatised field of mental healthcare (see Godin 2000).

<sup>5</sup> Moreover, stripping the term 'patient' from descriptions of medical encounters may also reflect the fact that, today, medical encounters are increasingly "not about healing as such, but about the activities of normal life" (Neuberger 1999, p.1756). This resonates with trends in wound healing. At this juncture in which there is a rise in the numbers of elderly patients who have to adapt to leading lives with chronic wounds (Bester and Deventer 2015), the importance of attending to health-related quality of life has been translated into the development of various questionnaire-based instruments to investigate the effects of having a wound on daily living (Price and Harding 2004; Blome et al. 2014). However, such fixed instruments may not allow patients the freedom to talk about their own concerns. Therefore, they have been excluded from this review.

of virtually all stripes acknowledge that dirty workers use communication to redefine their work” (2017, p.675). However, their observation that dirty work is a useful lens for studying the interactive and communicative processes that depict work as necessary at a variety of levels within organisations came with a counterpoint that, thus far, the focus has been on micro-level practices of work-group members (see also Tracy and Scott 2006). Few studies have examined how dirty work and its attendant stigma shape communication and encounters in the worker-client relationship.

One possible reason for this neglect stems from the heterogeneity of clients’ involvement in the stigmatised activities of dirty work, the diversity of which challenge a straightforward theorisation of how worker-client relationships can help to manage stigma. For example, scholars have noted that clients’ involvement in dirty work can stretch over a spectrum from casual to intimate (Gold 1952). Therefore, it is reasonable to propose that the extent of clients’ contact with dirty workers and their work can differ across occupations in terms of frequency, duration, or physical proximity. In fact, some clients may not be involved at all in the performance of dirty work, as in the case of work in slaughterhouses (Ackroyd and Crowdy 1990; Hamilton and McCabe 2016). Some may be casually involved, as can be discerned in the work of garbage collectors (Hamilton et al. 2017), whilst others might be intimately involved in dirty work, with nursing being the exemplar here (Bolton 2005; Chiappetta-Swanson 2005). Overall, the activities undertaken by clients are interwoven with social expectations about the specific role relations they have with workers.

It is therefore interesting to explore the meaning of worker-client relationships for managing stigma where "dirty work may be an intimate part of the very activity which gives the occupation its charisma, as is the case with the handling of the human body by the physician" (Hughes 1971, p.344). For example, in Bolton’s (2005) study, gynaecology nurses were shown to deal with stigma by deriving a sense of satisfaction from performing highly-skilled caring tasks and from their gendered sensitivity to relate to the concerns of female patients equally positioned as mothers, daughters and wives. In Chiappetta-Swanson’s (2005) study of genetic termination nurses, the provision of emotional care was explicitly presented as one type of coping strategy guided by informal rules of care, warmth, gentleness, non-judgemental support and reassurance. Finally, in Stacey’s study (2005), home care workers spoke of feeling loyal to clients, which, in turn, motivated them to override

their contractual obligations and instead act on their clients' familial contexts to draw value from regular and often intimate interactions. Hence, it appears that relationships with clients can, indeed, play an important role as a coping strategy for 'dirty workers'.

Although empirical studies on dirty occupations have recognised that workers are likely to turn to the public for validation of the purpose and significance of their work, the general view in the literature is focused on relational negativity, which is when the public denies workers this affirmation (Ashforth and Kreiner 2013). And yet, it is possible to encounter occasional references in the literature to clients expressing gracious appreciation and gratitude to workers for the provision of care or assistance. For example, research by Solimeo et al. (2017) showed that patient-centred medical home clerks spoke of patients expressing their thankfulness for clerks' advocacy on their behalf in handling emotionally charged situations or scheduling appointments (see also Maynard-Moody and Musheno 2003; Wicklund 2007, both cited in Ashforth and Kreiner 2013, p.137). In fact, Stacey (2005) suggested that, in some dirty work contexts where care is a central activity, it is possible to speak of a bi-directional relationality between workers and their clients, with the latter, too, garnering a sense of poise from the bond they developed with workers. While this finding is acknowledged in healthcare studies, it has not been engaged with specifically within dirty work studies of caring occupations, where situations of stigma may, in fact, play a role in building relations.

Therefore, in this study I am interested in whether, and how, positive relational dynamics in worker-client interactions within a dirty work context operate as a mechanism for managing stigma. However, to conduct such an exploration it is important to broaden the analytical focus adopted in most dirty work studies from 'workers' to 'workers and clients as a whole' (Neal 2018). Neal's research is one of the first studies to advocate for a greater focus on the clients of dirty work. He suggests that, depending on whether clients are themselves considered to be tainted by society, they will variously interact with stigmatised dirty workers. As the previous section showed, patients, or clients, in wound healing, arguably, can be placed in the stigmatised category as they live with malodorous and unsightly wounds that are not generally accepted by society.

Although it is possible to talk of a relational turn in approaches to managing stigma in dirty work scholarship, this is nascent and, as such, remains relatively under-

theorised. The dominance of social identity theory has meant that the focus has primarily been on how workers cope with stigma on the individual worker level. Dirty work scholarship has not yet produced a framework for capturing the relationality of workers and clients, especially with regards to how this relationality matters for stigma alleviation as opposed to its (re)production. This neglect is an important reason for a long over-due exploration of managing taints through worker-client dynamics. One possible approach for conducting such a relational study is through framing an analysis of an under-developed area of dirty work with a theory that makes Bell's "response of ego to alter and back" (1973, cited in Hochschild 1983, p.9) the focus of scientific scrutiny in itself.

Dirty work scholarship has recognised the "all too common emergence of ... reflexive defense mechanisms" through which workers "blame ... stigmatized clients for their problems and then distance themselves from them" (Ashforth et al. 2017, p.1269). However, given this study's concern with relations and relationality, it is thus vital to examine stigma coping strategies by engaging with a notion of reflexivity that is not just personal, but, rather, pertains to "a collective (social) subject – termed Relational Reflexivity" (Donati and Archer 2015, p.59) and considers the wider context in which this relational reflexivity is historically and socially embedded. In this specific respect, the relational subject framework developed by Donati and Archer (2015) offers considerable value as one possible novel approach to dirty work, because it can be used to examine patients' personal and relational concerns vis-à-vis clinicians and their social context, and vice versa.

## **2.4 Innovative investigations of dirty work: the relational subject**

### **2.4.1 Novel approaches to dirty work**

The aforesaid description of the weaknesses of current theoretical resources deployed in the dirty work literature to understand workers' relations with clients bears witness to the need to deploy new approaches that can capture 'what is missing'. Social identity theory may have been the prevailing theoretical resource in the dirty work literature, but scholars in this tradition have been criticised for failing to recognise and address its limitations. For example, Makkawy and Scott noted that, under this theoretical steering, the techniques for recasting stigma have been portrayed in a way that shows stigma is reflected in the communication between

dirty workers and outsiders. Speaking from a critical postmodern approach, the authors thus called for greater use of more innovative discursive, rhetorical and quantitative communication techniques in dirty work studies to better explain how societal stigma is brought into effect, made real and transformed in organisational communication that “constitute organisations, societies, and the groups that comprise them” (2017, p.679).

While, more recently, there have been innovative dirty work studies that departed from a complete reliance on social identity theory, these studies have invariably conducted an occupational group level of analysis largely devoid of situational context. For example, scholars have integrated social identity theory with cognitive dissonance theories (Lai et al. 2013), conservation of resources theory (Baran et al. 2012), system justification theory (Kreiner et al. 2006), or a social stress approach (Bosmans et al. 2016). However, despite mixing interpretative qualitative approaches ordinarily associated with the deployment of social identity theory with more predictive quantitative approaches, conceptual efforts have still centred on expanding insights into how a bundle of undesirable tasks threatens individuals’ identity and how they seek to enhance their own self-image. As argued in the previous section, there is a need in dirty work research to seriously consider the influence of social values, aspects of work organisation, societal discourses, physical place and trends in the wider world of work on struggles around dirty work and its attendant taints and stigma. In the words of Makkawy and Scott, the challenge for dirty work scholarship remains to conduct more innovative “critical and postmodern investigations of dirty work”, which can “transcend the individual level of analysis and further investigate organizational and societal aspects of dirty work that intermingle with our understandings of the constructions of gender, race, and ability in relation to power differentials and hierarchy” (2017, p.677).

Therefore, with an especial focus on communication, Makkawy and Scott (2017) call for innovative research that seeks to understand how dirty work is communicatively constituted and reconstituted. However, this injunction still retains the assignment of analytical priority “to the constructive power of discourse” (Marks and O’Mahoney 2014, p.67), as per the dominant constructionist notion that dirt is a matter of ritual or cultural significance (Douglas 1966). Given my specific interest in a type of dirty work that has a highly “embodied nature” (Waters 2016, p.1) and where dirty body work (Twigg 2000; Twigg et al. 2011) takes centre stage, I am not entirely persuaded that an approach focused solely on communication can fittingly contain



the unavoidably material aspects of stigma relations in wound healing. However, at the same time as Makkawy and Scott (2017) call for critical and postmodern communicative approaches to dirty work, an ontological alternative has emerged in the writing of Hughes et al. (2017), who recognise the importance of discourse, but also seek to correct the 'symbolic slant' by stressing the material realism of work (Dant and Bowles 2003; Thiel 2007).

Realist approaches to dirty work recognise that some dirt, especially the physical kind, is likely to arouse innate and universal responses of disgust and fear (Öhman and Mineka 2001). In fact, even some constructionists have acknowledged that work that is primarily tainted in a symbolic as opposed to a physical sense, like the retail sex work described by Tyler, may have "important physical elements to the 'dirt' involved" (2011, p.1487). On the realist front, Hughes et al.'s agential realist study of refuse collectors and street cleaners showed that the penetrating smell and touch of refuse matter and "bodily fatigue can potentially undermine attempts at positive reframing" (2017, p.116). Moreover, speaking from a critical realist perspective, Ackroyd and Crowdy (1990) recognised that some work where bodily fluids are involved offers scarce opportunity to stress any cleaner or socially acceptable features:

[A]lthough it can be argued, as by Mary Douglas [1966], that dirt is always a moral as well as a physical matter, the killing of "innocent" animals certainly often evokes deep moral revulsion (Ackroyd and Crowdy 1990, p.4).

Critical realist accounts of dirty work are still uncharted territory, but critical realism is slowly making its way into dirty work scholarship. For example, although Hamilton et al. (2017) adopted a constructionist perspective to explain the discursive construction of dignity among refuse collectors, their conceptualisation of dignity married social constructionism with critical realism by drawing on work on dignity by Sayer (2011), Ackroyd (2007) and Bolton (2007). Moreover, as Bolton argued in her discussion of the dirty work of nurses:

More importantly, perhaps, these nurses are far more than representatives of a cultural construction: they also show how the category 'woman' is historically and socially embedded. These nurses cannot be reduced to discursively defined characters playing on a symbolically constructed stage. Their lives are not just made up of abstract signs but based on lived experiences. Some draw upon their understanding as mothers, some as carers of their own mothers, some on bitter memories of an impoverished

childhood. They also identify their work and their own status as healthcare professionals in relation to others in the structured divisions of health care (2005, p.183).

Here, Bolton (2005) acknowledges the specific role of contextually embedded causation in stigma and dealing with stigma. When her findings are viewed alongside Pawson and Tilley's (1994) call to place causality and change in the right conditions that are ontologically real and methodologically crucial to understanding the outcomes of social actions, it appears that critical realism could offer a way for dirty work scholarship to develop richer explanations of the drivers and effects of stigma management. Moreover, Bolton's (2005) work recognised the role of relational connections as features of the relational reflexivity of nurses constituted by their gendered selves as mothers or carers in relations with others, clinicians and patients, in the structured division of healthcare (Donati and Archer 2015; Meliou and Edwards 2018). The patient must be included when considering Bolton's (2005) "structured divisions of health care" because "he [the patient] has a part in the medical division of labour, too" (Hughes 1958, p.74). However, the field has not yet matured around a relational ontological approach that emphasises the social reality of dirty work as being shaped by those concerned with stigma, and as interdependent and premised on maintaining existing relations (Mussell 2017). Dirty work researchers are thus in need of a relational ontology and a compatible framework for providing a more nuanced theorisation of worker-client relationships in dirty work.

#### **2.4.2 A relational subject approach to dirty work**

Alongside the relational approach to managing stigma in dirty work, the framework of the relational subject (Donati and Archer 2015) appears particularly useful. The relational subject is a notion that relates to a special type of an ontologically relational social subject, which is premised on a joint commitment that connects actors to a shared enterprise worked on together for the common good. This definitional mouthful introduces many concepts which are "new and different" (Porpora 2016, p.419), which this section unpacks. By virtue of its novelty and, it must be stressed, its grounding in critical realism, the relational subject framework represents an innovative lens for dirty work scholarship that has not yet been mapped onto empirical phenomena in this field. Besides, as shown above, dirty work studies have not yet thoroughly considered the role of social relations. Rather, most discussions of relationality have oscillated around the discursive and

ideological coping strategies employed by 'dirty' workers at the intra-group level (Hughes et al. 2017). As far as worker-client relationships are concerned, extant studies have paid most attention to the dynamics of exclusion (Ashforth and Kreiner 2013; Ashforth et al. 2017). This is in stark contrast to Donati and Archer's definition of the relational subject with which I started the thesis, that argues that "our human selves *are relational through and through*, but our relationality is not confined to society's discursive order" (2015, p.80).

The relational subject framework is a product of the authors' dissatisfaction with extant schools of relational sociology (e.g. Emirbayer and Mische 1998; Powell and D  pelteau 2013) that portray social relations as random and "Goffmanesque" (Donati and Archer 2015, p.14) and encounters between self-referential individuals as being centred on either keeping these relations brief or avoiding them altogether. As Donati and Archer note:

Instead of warmth, caring and commitment, which motivate their actions ... they feature as nodes in networks of connectivity or represent its 'holes'. There is no coalescence into groups, significant to the subject involved, no social movements, committed to any cause and hostile to their opponents, no parties or interest groups with social agendas (2015, p.9).

The authors' diagnosis of "the repression of social relations" (2015, p.14) in Western society resonates with the depiction of worker-client relationships in dirty work as being premised around workers' defensive tactics pertaining to avoiding problematic encounters with clients and keeping well away from signs of disrespect from them (Ashforth and Kreiner 2013, pp.136–137). Relations between workers and clients do not appear to have their own existence. Empirically, clients are excluded from dirty work research. Readers interested in learning more about them have to resort to workers' second-hand accounts that either "blame these stigmatized clients for their problems and then distance themselves from them" (Ashforth et al. 2017, p.10) or depict clients as "behaviourally and psychologically distanced from that work and those who do it, glad that it is someone else" (Ashforth and Kreiner 1999, p.416). The part that clients could play has thus not yet been explored much in the Donatian and Archerian spirit as a form of support and a resource (2015, p.14) for managing stigma, despite traces of the aforesaid relational turn in dirty work scholarship.

However, in attempting to interpret the relational subject, Porpora (2016) stressed its foundation in the belief that people have values that can surpass self-interested

concerns (Sayer 2011). The decisions, choices and actions that actors make are not individual, but, rather, are arrived at in relation to each other and within the structural and cultural context to which they belong. Traces of such relational concern for others that acknowledge that others have needs to be met (Mussell 2017) can, in fact, be encountered through a careful reading of the dirty work literature. These arise in respect to workers' other-regarding strategies of coping with emotional taints through developing a sense of responding to the needs of vulnerable clients whose biomedical needs are not met by the current system of provision (Chiappetta-Swanson 2005; Stacey 2005; see also Mussell 2017, p.230). Coincidentally, the relational subject framework emerged at the same time as the concept of emotional dirty work (McMurray and Ward 2014; Rivera 2015) that, in part, stimulated the emerging relational turn in dirty work scholars' depiction of stigma management (Hamilton et al. 2017; Solimeo et al. 2017). Recognising the importance of social relations as real objects of consideration, the relational subject might therefore represent a missing relational ontological framework through which to articulate how stigma management can be approached relationally.

This lens appears particularly expedient when a realist critique of social constructionist depictions of relationality is mapped onto dirty work scholarship. Specifically, Donati and Archer (2015) argued that social constructionism reduces social relations to transactions, story-telling, network effects or connectivity within aggregates of individuals. Of particular value to understanding relations within the physically tainted dirty work of wound healing are Barnes and Mercer's (2010, p.68, cited in Marks and O'Mahoney 2014, p.74) and O'Mahoney's (2011) emphases on the materiality of the physical body, which they argue has been denied in social constructionist studies. Indeed, with a few exceptions (Stacey 2005; Sanders 2010), the physicality of the human body in worker-client relations, as well as how acting on it can potentially instigate change in dealing with stigma situations, has been overlooked within dirty work literature.

The distinguishing feature of Donati and Archer's (2015) critical realist conceptualisation of social relations is that, ontologically, individuals together are viewed as more than aggregates, but, rather, as having their own particular relational constitution, which functions as a new level of social reality that emerges in a specific social context. This context defines the relation that emerges from its contributory parts, whether as a simple event, like writing a medical prescription that leaves individuals unchanged (Donati 2010), as a bind to characteristics of

traditional social configurations, such as an activity-passivity model of clinician-patient interaction (Szasz and Hollender 1956), or as a bond through repetitive encounters over time, like a relation between a long-term patient and a long-term clinician (Donati and Archer 2015, p.28). This concept of emergence – “when a whole has properties or powers that are not possessed by its parts” (Elder-Vass 2005, p.316), or, in the words of Aristotle, when “the whole is greater than the sum of its parts” – is fundamental for advancing a critical realist explanation of the role of social relations in dirty work. As observed by Porpora (2016), emergence is also what gives relations their unique properties and powers to act upon those (concerned with stigma) who generated the relation.

First and foremost, social relations have the power to generate a special type of common good known as relational goods, as well as their opposites, relational evils, which are key concepts of Donati and Archer’s (2015) relational subject approach. Various scholars have contributed to how this concept is understood (Donati 1986; Nussbaum 1986; Uhlener 1989; Gui 1996). While Nussbaum (1986) argues that a relationship alone counts as a relational good, economic explanations (Uhlener 1989; Gui 1996) locate relational goods in the intangible outputs of social interactions, which are jointly produced and consumed in repetitive economic interactions. Finally, from a relational sociological perspective adopted herein in this study, relational goods designate ‘something’ that is, simultaneously, produced and enjoyed reciprocally during social interactions (such as between a doctor and a patient) by individuals who have some relation between one another and reflexively draw upon this good:

In essence, relational goods are those immaterial entities (intangible goods) that consist of social relations that emerge from subjects’ reflexivity that is oriented toward producing and enjoying together, in a shared manner, a good that they could not obtain otherwise (Donati and Archer 2015, p.213).

Examples of relational goods include friendship or family (Donati 2016a), but also trust between people, cooperation between individuals who share a problem and help each other deal with it, the feeling of safety among people belonging to a social context, collaboration in research, along with innumerable others (see Donati and Archer 2015, pp.199–200). Their distinguishing feature is that they emerge from a relation towards a common goal, rather than, say, from individuals seeking to satisfy their own interest. Relational evils are the opposites of goods, and include *inter alia* doubt, suspicion, misgiving, indifference, unimportance, insignificance,

estrangement, distancing, separation or disagreement. These relational goods and evils have effects “upon the subjects themselves and external effects upon their social environments” (Donati and Archer 2015, p.31). Emergence of relational goods and evils is central to the concept of the relational subject, because it is these goods that make the social relation a *sui generis* social reality that transcends the people who generate it.

At the heart of the relational subject lays the notion of ‘We-ness’ – a relational orientation among subjects in a relation that guides their actions in such a way that subordinates their own concerns to the concerns of the relation itself. According to the authors, ‘We-ness’ does not necessarily mean sharing beliefs, having the same thoughts, sharing a common ethos or agreement, and arriving at a joint commitment. For example, in a clinician-patient relation both groups might still seek non-relational goods, such as health or effective care. However, both actors must be oriented to sustaining their relational goods, whose pursuit enables them to feed what Donati and Archer refer to as a shared *modus vivendi* – a mode of living together. Then, the ensuing reflexive deliberations about tackling the problems actors encounter, like the situations of stigma that are the interest of this study, take on a relational, rather than personal, form. This ‘relational reflexivity’ “consists in orientating the subjects to the reality emergent from their interactions by their taking into consideration how this reality is able to feedback onto the subjects” (Donati and Archer 2015, p.153). For example, within business entrepreneurship, Meliou and Edwards (2018) drew upon relational reflexivity to explain how women, positioned as mothers, carers and spouses, confronted household instabilities through entrepreneurial responses that satisfied both their own and their family’s concerns. In this sense, relational reflexivity is what enables the development of a genuine relational subject.

The relational subject framework can thus offer nuanced insights into a variety of phenomena by engaging empirical data in innovative ways. For example, in their research in the field of entrepreneurship, Meliou and Edwards (2018) observed that female entrepreneurs engaged in intimate and embodied relationships with their children, spouses and dependents and oriented themselves towards the relational goods generated within these familial contexts. They did so in such a way that enriched their business ventures, which, in turn, informed their household dynamics. In this way, they elaborated a relational context that strengthened their *modus vivendi* as businesspersons, balancing work and family life in such a way that

transcended structural and cultural barriers to female entrepreneurship. Moreover, at the time of writing this thesis, Kakavelakis and Edwards (2018) are working on using the notion of relational reflexivity to explain leadership, in turn, signalling a departure from a leader-centric focus on top-down directives to instead propose that followers can be active co-creators of leadership, with both actors engaging in the 'we-relation' of a relational subject. Given the breadth of empirical phenomena being operationalised through recourse to the concept of the relational subject, there is evidently tremendous value in conducting an empirical study that explores worker-client relations in dirty work as constituting a relational subject, as well as how the management of stigma is an emergent product of this relation.

However, 'We-ness' is not universal to all social subjects. Rather, relations can evolve over time, with relational goods and evils either dissipating or strengthening. Accordingly, Donati and Archer (2015) present alternative potential relational tendencies of social subjects, which they refer to as 'Me-ness' and 'Thee-ness' by virtue of their unique grounding in actors' own social contexts, as well as their consequences for the relation and the social context it inhabits (see pp.68-73). First, 'Me-ness', grounded in atomistic ontology, explains the relational orientations that characterise actors' self-referential prioritisation of their own preference schedules in their social environments, seeing the concerns of others as obstacles, which, in turn, risks the relational repercussions of disagreement and dissatisfaction (see also Mussell 2017). 'Thee-ness', in contrast, captures the relations whereby subjects treat each other as 'You' when interpreting each other's concerns, thus risking fallible understandings and blaming by falling into the trap of double hermeneutics. The integration of these relational orientations within the study of worker-client relationships in dirty work can add nuance to the analysis by virtue of offering an optic for capturing and explaining the diversity of relationships in terms of their origins and outcomes for stigma, instead of 'dichotomising', as it were, between the two dominant ways of countering stigma: exclusion, and the still nascent dynamics of empathy and compassion (Ashforth et al. 2017).

Finally, the dynamics of social relations are not inconsequential for the structures and ideology that underpin these relations. According to Archer (2013), interactions from social relations can lead to a change in the structural and cultural context, producing what she calls 'morphogenesis', or a preservation of social forms, resulting in 'morphostasis'. Archer's morphogenetic approach (e.g. 1995; 2013) can offer significant insights into the mechanisms by which individuals interacting in dirty

work contexts can seek to transform existing social relations that accord them a dirty label. In conjunction with the relational subject framework, the dynamics of social relations between actors concerned with dirty work can be espied as either feeding the process of managing stigma in the direction of its alleviation through morphogenesis or reinforcing it through morphostasis. For example, Bolton (2005) recognised how gynaecological nurses' joint commitment to changing the way in which miscarriage was dealt with resulted in the endorsement of new procedures by third sector organisations and NHS hospitals. However, overall there has been little emphasis in dirty work scholarship on transforming the way in which existing institutions deal with stigma.

#### **2.4.2.1 Relational subject for managing stigma of wounds and wound healing**

Research conducted within the field of wound healing that sees it as a type of dirty work that adopts the relational subject framework could capitalise on the framework's legitimisation of an analytic focus on the formation of ties between clinicians and patients, their course and their effects on clinicians and patients and on the broader 'dirty' and stigmatised context of wound healing. It is now explicitly recognised in the wound care and management literature that treating wounds, especially chronic wounds, involves more than medical intervention alone, but, rather, requires that clinicians also build a relationship with patients (Augustin et al. 2012; Wound Care Centers 2018; Queen 2017a). While the view of success in wound healing held by many clinicians, industry and healthcare planners is still focused on key quantifiable physical aspects of wound care, such as healing rates, the importance of improved professional relationship building between clinicians and patients cannot be overstated (Corbett and Ennis 2014).

For clinicians, patient-centred care "increases the patient's willingness to share ideas with the provider and opens opportunities to collect important patient-specific information, which providers can use to guide responses to the unique challenges to that particular patient's wound care process" (Hurlow and Hensley 2015). For patients, clinicians' improved understanding of the personal burdens of wounds is an important step in dealing with their distressing symptoms; however, the literature reviewing patient preferences in wound healing suggests that "the evolution from empathy to shared wound care decision making is what patients are asking for" (Corbett and Ennis 2014, p.540). This means that in wound healing there has been a shift towards a model of clinician-patient relationships centred on patients being



the “active co-creators” (Kakavelakis and Edwards 2018) of wound care. The prevailing paternalistic structures of health care traditionally positioned patients as passive recipients of care who are acted upon by clinicians actively doing something to them (Szasz and Hollender 1956).

However, through the relational turn in wider healthcare discourse, patients can be seen as working through the structural context (Meliou and Edwards 2018) that has traditionally impeded their contributions to the care process. Thus, patients are not social dopes; rather, they are active, although to differing extents, in the way they confront social structures (Clegg 2006, cited in Meliou and Edwards 2018, p.150). By virtue of the fact that the relational subject takes account of the wider context, that is, “there is no context-less relationship” (Donati and Archer 2015, p.67), and because it recognises that people critically evaluate the context, the transition towards new models of confronting stigma that encourage patients and clinicians to jointly engage in a communicative process to work through paternalistic structures of care becomes visible. Indeed, Scambler asserts that:

[G]ood quality support in cases of dealing with stigmatised conditions is not just about informed interventions and advice, but also about the acceptance of the principle of co-participation in care, accommodating the notion of patients as decision-makers, promoting open agenda during consultations for patients to bring in matters they deem as important, holistic not biomedical approach, informing, advising, and helping (not just managing) and using counselling skills (based on the recognition of stigma (1998, p.1054).

## **2.5 Summary**

This chapter discussed the relevance of the relational subject framework for understanding the role of worker-client relations in dirty work, an area which remains under-researched in relation to managing stigma. The chapter argued that, through the philosophical dominance of social constructionism, the frequent engagement with social identity theory and Goffmanian social interactionist ideas of stigma management, dirty work studies have mostly explored how workers primarily mobilise discursive and ideological techniques for coping with stigma at the occupational work-group level, that is, arguably, detached from wider contextual issues. Until recently, clients have often been empirically excluded from offering their accounts of stigma and have generally been portrayed by workers in negative terms as a source of interpersonal stigma that led to disassociations between both

groups. Adopting a critical realist relational subject framework that views relations between individuals who share a specific social context as being central to social scientific enquiry, the chapter argued that worker-client relations represent a resource for coping with stigma as part of a shared agenda. The chapter showed that this is particularly applicable to the nascent area of wound healing work, whose organisation reflects the shift in the health economy towards patient empowerment and active patient participation in their care. This involvement makes patients, who have their own wound stigma experiences and who self-treat their wounds, insiders to the 'dirty' world of wound healing. Using the framework of the relational subject in conjunction with the dirty work lens can bring great insights to social scientific accounts of stigma and its management in the relatively under-researched world of wound healing.

### 3 Methodology and methods

... when collecting data about the world, the researcher must be reflexive, not only about the extant models, concepts, and terms which they might draw upon to better understand phenomena, but also the inherent biases and assumptions that any researcher might possess which influence both their own data collection and the future theories and models that they might develop to explain that phenomenon (O'Mahoney and Vincent 2014, p.16).

Having argued in the preceding chapter that the relational subject may provide a remedy to the incomplete understanding of worker-client relations in dirty work scholarship, especially in relation to the management of stigma, this chapter delineates the ethnographic investigation of three UK wound healing clinics that I undertook to give empirical substance to this theoretical argument. At the outset, it should be stressed that, by selecting the social theory of the relational subject developed by Donati and Archer (2015) within the critical realist paradigm, I view clinician-patient relations as having a real existence and qualities that can influence wound stigma. This ontological commitment has epistemological consequences for the employment of techniques of data collection and analysis (see O'Mahoney and Vincent 2014, p.1), which this chapter explains in the context of this study.

The chapter begins by outlining the critical realist philosophy of science, which is the foundational orientation for this study. However, critical realism “does not provide the concepts (or prescribe the methods) that are necessary for *successful* empirical research” (O'Mahoney and Vincent 2014, p.13), but, rather, acts as an ontological ‘under-labourer’ that offers resources for a social scientific enquiry (O'Mahoney 2011). Therefore, rather than “furnishing well-defined guidelines for the research process”, my focus here is more “diffuse” (Smith and Elger 2014, p.110), referring only to those aspects of critical realism that tie-in with the relational subject and are most relevant as ‘under-labourers’ to my qualitative ethnographic enquiry into how the stigma associated with wounds is (re)produced or alleviated in UK wound healing clinics. In the spirit of reflexivity, as propounded by O'Mahoney and Vincent (2014) above, I offer a candid account as to why wound healing was selected as the setting for this research and reflect on the evolving analyses of my ethnographic data to ensure the validity of my dirty work interpretations. After a rich introduction to the research sites and detailed explanations of the techniques employed to collect

and analyse the data, the chapter closes with a table summarising the most salient aspects of clinician-patient relations identified in the analysis.

### **3.1 Critical realist ontology: nature of reality**

Critical realism, associated with the work of Roy Bhaskar (1975; 1989), emerged, on the one hand, out of a critique of the positivistic search for explanations in the form of general laws derived from the analysis of observable regularities, and, on the other hand, as a refutation of the constructionist view that truth is ontologically fragile and corresponds to the outputs of the language of the other (Outhwaite 1987; Johnson and Duberley 2000). Concerning the former, critical realism postulates that the continued existence of observable ‘things’ – entities and events – does not suffice to warrant their explanation or predict that they will certainly occur in the future. With respect to the latter, while acknowledging the importance of cultural conditions for understanding phenomena, critical realism claims that “there could be a world of events without experiences” (Bhaskar 1998, p.24) which cannot be discursively described through the cultural and linguistic resources available at any given time (Johnson and Duberley 2000). As an essentially ontological position, critical realism thus presupposes that, whilst our knowledge of reality is a social and historical product (Maxwell 2012), the criterion for the existence of ‘things’ does not pertain to our identification of them, but, rather, their ability to make a difference (Fleetwood 2005).

#### **3.1.1 Stratified, deep and emergent ontology**

For CR [critical realist] researchers, reality is a stratified, open system of emergent entities (O’Mahoney and Vincent 2014, p.6).

In accordance with O’Mahoney and Vincent (2014), I begin the exposition of the above-mentioned critical realist deep objectivist ontology by explicating the idea of an ‘open system’. The term ‘open system’ refers to, for example, societies or organisations. It means that the empirical phenomena we seek to understand are influenced by a nested set of unpredictable and complex relationships among multiple related and hierarchically organised entities or ‘things that exist’ at different levels of social order within that system (Al-Amoudi 2014, p.195). These entities can be of a material, artefactual, social, ideal or other observable and non-observable nature; their properties to affect people’s actions are what make them ‘real’ in an open system (Fleetwood 2005). All these entities that make up different strata of the

system must be considered in order to explain social phenomena (O'Mahoney and Vincent 2014).

With respect to wound healing, these entities include *inter alia*: vascular ulcers (material); antimicrobial dressings (artefactual); patient empowerment initiatives (social); or societal beliefs that wound healing constitutes Hughesian dirty work (ideal). In relation to that last example, I argued in the previous chapter that many scholars who conceptualise dirty work from a social constructionist perspective would argue, firstly, that dirty work in relation to wound healing is a discursive construct known through the cultural understanding of taints and their associated stigma that threatens workers' identity, and secondly, that it can be discursively sanitised through ideological strategies that create positive self-concepts. However, assuming the absence of reality external to 'talk and text', and resting on social actors' beliefs that wounds are not to be seen or spoken of, might overlook how responsive actions by actors concerned with such ascriptions unfold within contextual conditions of possibility and impossibility for stigma and its management.

For example, in assuming an open system, critical realists are thus capable of appreciating the role of patriarchal and paternalistic care structures in contributing to the positioning of wound healing at the periphery of the medical hierarchy as 'nurses' work'. This has repercussions not only for clinicians' identity, but also for patients' access to wound care, which, in turn, extends their stigmatising wound journey on the physical level of pain, discharge or malodour and on the social level of distress and isolation. Likewise, rather than focusing only on dirty and clean narratives and stories for coping with stigma, critical realists recognise the role of external causation that complements discursive struggles, such as different empowerment and relationship-building initiatives that augur well for the future of sustainable healthcare by helping us better understand and control our health to "prevent the preventable and manage the manageable" (Pencheon 2014). This appears to resonate with the sociological demand for the re-evaluation of relations with others as an avenue for greater efficacy (Donati and Archer 2015). In this sense, congenial social relations between clinicians and patients are important sources of external causation on relational, rather than merely discursive, coping strategies.

Therefore, to explain stigmatising situations in wound healing, critical realists would seek causes at deeper levels of reality beyond discourse. Critical realism assumes

that reality comprises three nested domains: *the empirical* (sensory, measurable and sometimes recordable experiences and perceptions, signs and concepts); *the actual* (the empirical events which may be experienced as well as those which may not be perceived and can occur without being experienced); and *the real* (causal powers, structures, or generative mechanisms that trigger events). These *real* mechanisms can generate *actual* events, which may or may not be experienced in the domain of the *empirical* (see O'Mahoney and Vincent 2014, pp.9-11). According to Outhwaite (1987), for Bhaskar, many social sciences and most natural sciences, such as medicine, fall prey to epistemic fallacy by limiting explanations of 'what is' to 'what can be known about it'.

However, by adopting a critical realist stance in wound healing one may empirically witness clinicians instructing patients on wound care to involve them in their own care and patients being active in their consultations by, for example, asking clarifying questions. While it is possible that patient empowerment initiatives in the health economy are important, there might be other structures or mechanisms residing at the deeper level of *the real* that shape clinician-patient relations, such as the operating principles of the specific clinic or a shared appreciation of the socio-demographic and financial challenges health care faces. Consequently, people might engage with the discourse of patient empowerment or dirty work, but equally they might reject them as untrue. Because of the difficulty of accessing the domain of *the real*, our knowledge of reality is thus always fallible (Bygstad and Munkvold 2011), and yet, critical realist enquiries go through all these levels of stratification to arrive at the best possible approximation of what experiences and events reveal about their underlying causes (O'Mahoney and Vincent 2014). This holistic analysis of causality is grounded in the so called 'mechanisms framework' (Bygstad and Munkvold 2011).

The 'mechanism framework' is structured around the description of its three constitutive parts: mechanism, context and outcome (Pawson and Tilley 1997). According to Danermark (2002), while mechanisms cannot be observed directly, they can be indirectly experienced through the events they have the power to cause; there are micro-mechanisms of individuals and their actions, like a desire to learn or teach about wound care, and macro-mechanisms of a social nature, like the stigmatising denigration of diabetes by powerful political elites (e.g. Idlebrook 2017). Causal powers can be exercised when at least one mechanism has allowed for it, whilst they can be actualised in the absence of countervailing mechanisms within a

specific context. The outcomes of these mechanisms are therefore dependent on other mechanisms within those specific contexts which either allow or disallow the interactions between them (Bygstad and Munkvold 2011). This recognition of the contingent nature of causality invalidates predictions and instead necessitates explanations of an open system as the key aim of critical realist enquiry. In the words of Collier:

*If there were a single mechanism only, there would be a naturally closed system, and passive observation would be enough to establish laws (or the law) of nature (except that in such a world, there could be no human observers) (1994, p.46).*

Therefore, the aim of critical realist enquiry is to describe actual phenomena and to understand and explain empirical patterns with reference to underlying mechanisms, which may, or may not, be observed empirically (Bygstad and Munkvold 2011). Simply put, the aim of critical realism is to understand ‘why’ and ‘how’ things happen (Wynn and Williams 2012).

Mechanisms work through emergence, which is a fundamental concept in emergent critical realist accounts of cause (Elder-Vass 2005; Elder-Vass 2008). Emergence happens in “situations in which the conjunction of two or more features or aspects gives rise to new phenomena, which have properties that are irreducible to those of their constituents, even though the latter are necessary for their existence” (Sayer 2000, p.12). In the realm of outpatient wound healing clinics, then, it is possible to imagine that clinicians, patients and patients’ relatives working together (i.e. whole) can achieve better outcomes than each pursuing their own agenda independently of one another (i.e. parts). As observed by Donati and Archer (2015, p.14), “working in a team is more efficacious and gives more satisfaction ... family and friendship bonds are relations that, despite constituting obligations, nevertheless give meaning to one’s life”. Finally, as asserted by Harding, in wound healing “[a] shared vision is much more powerful than many individual visions” (2008, p.597). Therefore, clinician-patient relations can be perceived as entities in and of themselves. As wholes that are different from their constituent parts, they have emergent properties which are dependent upon, yet not reducible to, lower-level components of individuals (O’Mahoney and Vincent 2014).

### 3.1.2 The dualism of structure and agency

Basically conflationists reject the stratified nature of social reality by denying that independent properties and powers pertain to *both* the 'parts' of society and to the 'people' within it ... In Upwards Conflation the powers of the 'people' are held to *orchestrate* those of the 'parts'; in Downward Conflation the 'parts' *organise* the people (Archer 2000, p.5).

I now turn to the critical realist concept of analytical dualism, which aids the holistic causal explanation of phenomena through advocating "the need to maintain a separation between agency and structure in order to examine the interrelationships that mutually shape each" (Mutch 2007, p.1128). The relationship between agency ('people') and structure ('parts') was developed in Archer's (1995) morphogenetic approach. This proposes that human behaviour is shaped by living in a society and, as such, it can be partially explained via reference to socialisation within pre-existing structures, such as wider resources, conventions, and procedures (Fleetwood 2005; Hesketh and Fleetwood 2006), or generally things that "emerge from the actions of individuals and then exert a causal influence over individuals without determining individuals" (Cruickshank 2012, p.73). At the same time, individuals reflexively shape their own circumstances, as they "have to diagnose their situations, they have to identify their own interests and they must design projects they deem appropriate to attaining their ends" (Archer 2003, p.9). These interactions between agency and structure produce emergent properties, which results in the reproduction or transformation of structures, although not always intentionally and not necessarily immediately, as structural transformation occurs over long periods of time (Mutch 2010).

In discussing the morphogenetic approach, Al-Amoudi (2014) evokes Archer's (2013) more recent elaboration of social morphogenesis, where a social order at a certain point is a product of prior social relations emerging from the structural and cultural context whereby interactions between individuals and groups lead to a change or preservation in a given social order. In this sense, social relations can be understood as connectors, which mediate between agency and structure and bring about the morphogenesis of a society (Donati and Archer 2015). This is an important point, which could have given shape and direction to the findings of this study, but, ultimately, one with which my rich ethnographic enquiry into the inner lives (see Mutch 2016) of those involved in the world of wound healing could not engage. This is because the present study addresses the notion of dirty work and



stigma as elaborated through the social relational lens, whereas social morphogenesis, which occurs over long passages of time, could simply not be evidenced in the absence of a more historical analysis or biographical interviews.

However, critical realism nevertheless offers a realist way of framing social relations in dirty work by making their ontology visible in relation to social structures, which are normally overlooked in constructionist and symbolic interactionist studies. In addition, it stresses the salience of agency as the point in which structures are reproduced or transformed through the use of reflexivity, and, moreover, with a focus on memory, creativity, imagination, and, increasingly, the physicality of the human body (see O'Mahoney 2011). Social constructionists in the field of dirty work "deny the body" (Barnes and Mercer 2010, p.68, cited in Marks and O'Mahoney 2014, p.74), limiting it to its discursive representations. Phenomenologists writing on wound care (e.g. Lindahl et al. 2008; Lindahl et al. 2010; Waters 2015), in the process of celebrating embodiment, run the risk of producing trivial accounts (Moran 2001). Although the human body has hitherto also been overlooked in social theory, critical realists call for more research that explores this issue (see, for example, Sturdy 2003; O'Mahoney 2011; Porpora 2016). This study's ethnographic focus on wound healing, where the body work associated with physical taints (Twigg 2000) is central to clinician-patient interactions, may "help bring about a long over-due engagement of sociologists with ... the natural sciences" (O'Mahoney 2011, p.124) and embodied action (Porpora 2016, p.421).

### **3.1.3 The emancipatory project**

A final important implication of critical realism for the framing of clinician-patient relationships in the dirty work of wound healing is its belief in "the possibility of improving the human condition by explaining social relations and structures more adequately" (O'Mahoney and Vincent 2014, p.11). According to Sayer (2011), effective social scientific descriptions acknowledge our fundamental need to avoid suffering and to 'flourish' or develop our capacities and exercise them freely (Al-Amoudi 2014, p.200). Bhaskar suggested that realist explanations of emergent phenomena in the human sciences can produce knowledge that "may be positively applied to assist technical and medical progress" (1975; 1997, cited in Cruickshank 2012, p.71). "Emancipation depends upon explanation depends upon emergence" (Bhaskar 1986, pp.103–104). The emancipatory potential of critical realism stems from two factors. First, it draws on deep ontology to search for scientific

explanations that identify the false beliefs and unmet needs of individuals who might lack the power to change the structures that disempower them (Collier 1998). Second, it seeks to transform these structures, such as, for example, by offering explanations of “why different people in an open system [act] in different ways in different places” (Cruickshank 2012, p.74) can form the basis for coherent policy development and reforms.

For example, Cruickshank (2012) explained how critical realism can offer critical insights into evidence-based practice – still considered the gold standard in wound healing (Harding and Queen 2011) – with positive implications for nursing. Critical realism can be understood as questioning the assumption of a mechanical, regular relationship between interventions and outcomes in closed laboratory systems without any focus on the interactions with other factors within an open system. In wound healing, for example, although studies on the use of compression therapy in the treatment of venous ulcers might acknowledge co-morbidities in terms of one confounding factor, they may not take into account how patients’ previous negative experiences with this treatment might undermine even the most well-intentioned biomedical practice. Given its ethnographic nature, this study does not speak directly to morphogenesis. However, with respect to emancipation, by reflecting on the management of stigma within social structures it does consider “the means required to act on and change the world” (O’Mahoney and Vincent 2014, p.12).

### **3.2 Interpretive epistemology: the nature of evidence**

As aforesaid in the previous section, critical realists recognise that our knowledge is never absolute, but, rather, always socially constructed and, as such, fallible. However, this does not mean that all explanations of empirical phenomena constructed in the context of available evidence are equally valid (Bygstad and Munkvold 2011); the world may very well be theory-laden, but some theories do indeed offer a better way of explaining social events, activities and phenomena than others (Fletcher 2017). The purpose of critical realist enquiry, then, is to arrive at the closest possible explanation of empirical relationships between entities (Sayer 1992, pp.130–138). In practical terms, this means that, instead of recommending specific methods of investigation, critical realism allows one to draw on an array of qualitative and quantitative techniques so long as they are appropriate for researching the task-at-hand and meet the requisite standards for explanation (Sayer 2000; Bygstad and Munkvold 2011; O’Mahoney and Vincent 2014).

The qualitative approach adopted in this study reflects the causal nature of its overarching research question, which seeks to explain what (re)produces and alleviates the stigma associated with wounds in UK wound healing clinics. The lack of a satisfying answer to this question in the fields of wound care and management or dirty work literature further justified this interpretive exploration (see Shortell 1999, p.1085). I must reflexively acknowledge that this question was itself 'sculpted' by the rich ethnographic material gathered in the field, as is often the case in qualitative research (Agee 2009). However, starting this research with a broad objective to understand clinician-patient relationships in healthcare, which I became interested in after a personal event, meant that from the outset my orientation was always towards eliciting the subjective 'insider view' (Reichardt and Cook 1979) by prioritising people and the meanings they attach to the processes in their social environment (Vakkayil 2009) to understand social life in naturally occurring settings (Savage 2006). To this end, qualitative research was evidently the most valuable approach as it has "an unrivalled capacity to constitute compelling arguments about how things work in particular contexts" (Mason 2002, p.1).

### **3.2.1 The nature of evidence in healthcare: defending qualitative research**

Quantitative studies may provide the answers to questions about, for example, which drug(s) may work best for a given condition, or which proprietary dressing best promotes healing in specific types of wounds. But only qualitative studies can shed light on whether treatments add to patients' sense of wellbeing, comfort, or quality of life (Sellman 2010, p.137).

Although in the specific context of healthcare, qualitative research has long been considered to provide less credible evidence than a quantitative experimental methodology, of which randomised control trials are the benchmark (Savage 2006), since the mid-1990s the appreciation of the value of qualitative methodology has grown. As observed by several commentators (Malterud 2001; Savage 2006; Sellman 2010), the general belief has long been that only 'hard data' acquired through statistical strategies of counting, measuring, controlling and analysing relationships between biomedical variables can produce robust evidence that can be reproduced across populations. However, some nursing literature has advocated for the additional inclusion of complementary qualitative 'patterns of knowing' for interpreting the social meanings of actions in unique contexts of individual patients rather than populations (Paley 2006). Some studies even found that nurses situated

evidence from qualitative research slightly higher in their hierarchy of evidence than findings from quantitative studies (e.g. Rolfe et al. 2008). Qualitative research allows for better explorations of important experiential, interactional and emotional components in healthcare (Pope and Mays 1995; Giacomini et al. 2000; Mays and Pope 2000; Malterud 2001; Savage 2006). Hence, it is relevant to the study of clinician-patient relations.

### **3.2.1.1 Defending ethnographic studies in healthcare**

Amidst growing recognition of the value of qualitative evidence in healthcare, ethnographic methods have been gaining ground (see O’Byrne 2012, pp.860–861)<sup>6</sup>. Ethnography is often regarded as originating from the preoccupation of social and cultural anthropologists with collecting first-hand data to explore the nature of social phenomena through a detailed interpretation of human action (Atkinson and Hammersley 1994). It has come to be generally defined in the Oxford English Dictionary (2010) as “the scientific description of peoples and cultures with their customs, habits, and mutual differences”. Within the social sciences, different forms of ethnography have evolved with input from a range of research approaches from phenomenology to postmodernism (Rees and Gatenby 2014). However, in this critical realism-informed study ethnography is seen as a broader “*sociological practice*” (Rees and Gatenby 2014, p.132), which employs a suite of methods to capture symbolic forms, patterns, discourses and practices to present, explain and analyse the culture in which experiences unfold, in addition to capturing how these experiences are caused by outside structures, histories and trends (Willis and Trondman 2000, p.6).

Ethnographic methods have been shown to help understand clinician-patient relations in healthcare. For example, Allan’s (2006) feminist psychoanalytical ethnography of a fertility unit revealed how nurses’ caring and non-caring behaviours helped them manage the powerful psychological and emotional experiences involved with having contact with patients. In an institutional ethnography of paediatric intensive nursing care, McGibbon et al. (2010) discovered that, in addition to dealing with their own emotions and attending to the emotions of patients made known through the lasting relations they had with some of them, nurses were entangled in social relations of professional and institutional power

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<sup>6</sup> The number of peer-reviewed ethnographic healthcare publications, as well as the amount of funding awarded for ethnographic health studies, have been growing.

which relegated their medical authority to the background of hierarchically superior doctors. Similarly, an institutional ethnography of cancer care by Sinding (2010) revealed that bringing to light strong emotions in patients and clinicians over concerns about access to cancer care had the potential to create opportunities for more informed empathy. Another institutional ethnography identified that building relationships with doctors was an important part of medical consultation for patients living with HIV and AIDS (Bresalier et al. 2002). Therefore, healthcare ethnographies can reveal information about the effect of relations on patients' well-being, which are not available through technical-rational ways of knowing (O'Byrne 2012).

Notwithstanding the richness of the relational insights revealed in these aforesaid institutional ethnographies, their ethnomethodological focus on subjective understandings of natural settings through scrutinising social interactions overlooks the explanatory role of social structures, which, as Rees and Gatenby (2014) observed, must be better incorporated into ethnographic explanations. Critical realism can address this oversight through its recognition of the interrelationship between individuals and social structures (Porter and Ryan 1996). For example, Porter's (1993) ethnography of nurses' work recognised the causal effects of structures of racism on occupational relationships between nurses and doctors, as well as how its effects were mediated by the mechanisms of a professional ideology. Healthcare ethnographies that draw on critical realism can better appreciate how social relations operate as connectors between agency and social structures.

Despite the "trend towards increased acceptance of ethnography in healthcare" (Savage 2006, p.387), at a practical level, medical naturalism still predominates in conceptions of epistemology within many areas of healthcare. This, at least, was my impression during my early negotiations about gaining access to a healthcare setting, which consisted of consecutive approaches to named contacts provided by a university colleague and a former nurse. In retrospect, my lack of success may have been down to my inability, when asked, to specify hypotheses to be tested in an almost laboratory system in the spirit of biological reductionism. Not even a recourse to Lawson's (2003b) assertion that it is precisely the element of empirical surprise that instigates meaningful research got me over the perceived hurdle of the dominant positivist medical perspective on knowledge production (Fawcett et al. 2001; Welsh and Lyons 2001, cited in Paley 2006, p.83).

### **3.2.1.2 Wound care: nature of evidence**

As is common in doctoral training, my concerns about running out of time and not yet having a research site (see Kenny 2006), allied with empathic support from a friendly academic at Cardiff Business School (see Hardyman 2017), mediated the choice of specialist wound healing clinics as the empirical setting for my ethnography of clinician-patient relations. Waiting in the corridor of the research unit of the wound healing organisation I would soon join, I cast my eye over a research poster from a study of the concerns of patients with wounds. The word 'emotion' figured right next to a clinical photograph of a big, deep wound that stretched over an entire abdomen of a male patient. This was when I felt my qualitative research into clinician-patient relations had finally found its home. Little did I know that both the unsightliness of the wound and the affiliation of the clinics with wound healing research were going to be salient in explaining the contributions of my exploratory ethnography. In the words of Yanow (2009, p.189), although my choice of wound healing clinics for my research field did not "originate in the academic literature" nor was "selected arbitrarily", my research is "no less scientific because of this".

Importantly, given the nature of the evidence I was seeking, I learnt shortly after formalising my access that wound healing "as a speciality is in its orphan stages, and it remains important that all clinical information is recorded and evaluated, including 'real-life' experience" (Harding and Queen 2011, p.325). According to Crang and Cook (2007, p.14), the most valuable contribution of ethnography is precisely its engagement with the messiness of the 'real world'. To date, however, there have been a paucity of ethnographic studies of wound healing, possibly because of the relative novelty of the field and the rarity of specialist clinics as research sites (some exceptions include Lake et al. 2015; Waters 2015). I therefore answered the call to record 'real-life' experience in wound healing (Harding and Queen 2011). Looking back, adopting an ethnographic approach to the study of social relations between clinicians who care for wounds that attract stigma and patients who live with such wounds was particularly important, because "we have to hear from the ones who face that stigma on a daily basis. They can best inform us – from their own personal experiences and in their own words – what stigma is, what it does, and how it is conveyed" (Wahl 1999, p.468).

However, wound healing recognises the value of qualitative research for informing patient care beyond the medical intervention and considering "patients' sense of

wellbeing, comfort, or quality of life” (Sellman 2010, p.137). As Price and Harding (2004, p.11) noted, there has been some qualitative work on the impact of wounds on quality of life (e.g. Phillips et al. 1994; Charles 1995; Chase et al. 1997; Barrett and Teare 2000; Ebbeskog and Ekman 2001). To encourage their consideration of routine care, qualitative interviews with patients with wounds were collated into a generic health-related quality of life questionnaire to measure patients’ self-reported impact of wounds on their everyday living, social life and well-being, in addition to physical symptoms (Price and Harding 2004). This multi-layered understanding of wounds resonates with a critical realist stratified ontology, in that it recognises that wounds exist not merely at the molecular and biological levels, but also at the psychological, visual, olfactory, discursive and structural levels through their effects on clinicians and patients’ behaviours, experiences and care interactions. Ethnography might help further understand these strata by providing “the context for the emergence of data with regard to the cultural collision of the patient’s world and biomedicine” (Mahoney 2001, p.430).

My ethnographic immersion in this collision afforded me first-hand experience of Goffman’s (1989) ethnographic occurrence of subjecting one’s body “to the set of contingencies that play upon a set of individuals, so that you can physically and ecologically penetrate their circle of responses to their social situation, or their work situation ... or whatever” (p.125). In writing this chapter, I vividly recall the ungraceful sight-scape and foul smell-scape of the early days of my ethnography in wound healing, which, I am ashamed to admit, made me feel queasy. Outside of my fieldnotes, I tried suppressing my ‘disgust’, which according to Miller (1997) is “the most visceral of emotions” (cited in Twigg 2000, p.395). This may have been because most social sciences see emotions as antithetical to knowledge production given the long dominance of Cartesian ontology, which splits the mind from the body or the discursive from the corporeal (Gherardi et al. 2013), thus favouring a detached spectator’s view of social action to become more objective (Sayer 2011). However, in defending a realist approach to the place of emotions in research, Sturdy (2003) invokes Jaggar’s (1989) call for greater ‘emotional honesty’ as a precondition for the production of reliable knowledge. Emotion and reason are

mutually constitutive because value-laden statements can be more factually accurate, strengthening the truth status of our accounts (Sayer 2011)<sup>7</sup>.

A series of moments of serendipity amidst leaps of pragmatism helped me to make sense of the overwhelming messiness of my data, which was significantly moulded by my research objectives (Fine and Deegan 1996; Sutton 1997; Kubinyi 1999; Alvesson and Gabriel 2013). My original intention to study the social-medical world of wound healing in terms of its emotional-relational features offered little room for a reflection on my own emotional dynamics. I also experienced a moral dilemma about writing about the potentially distressing physical qualities of wounds for fear they would have negative, rather than emancipatory, effects on people and their conditions (O'Mahoney and Vincent 2014). An opportunity to share my concerns with peers came halfway through my ethnography, when I presented at a university interdisciplinary seminar. The feedback I received legitimated my silent desire to bring physical wounds to the fore by equipping me with Hughes' (1958) vocabulary of 'dirty work', which is often empirically fleshed out via the use of ethnographic methods (e.g. Emerson and Pollner 1976; Stacey 2005; Ackroyd 2009; Sanders 2010; Rivera 2015). Therefore, this research can be seen as a response to the call for reflective "theorising from bodies as well as about bodies" (Williams and Bendelew 1998, p.3, cited in Sturdy 2003, p.94).

This will become clearer in the ensuing empirical chapters, but before this chapter proceeds to introduce the study's research site and methods of data collection and analysis, I must first pre-empt potential concerns about the legitimacy, reliability and validity of my ethnographic interpretations (Yanow 2009) of wound healing as a form of dirty work. Knowing that few people like to be associated with taint and stigma, for these entities are normally avoided (McMurray and Ward 2014, p.1135), drove me to engage in member checking through informal conversations with clinicians to request their feedback on my interpretation of their work. Moreover, a series of email exchanges with a librarian at the medical school involved in the delivery of the diploma and master's programme in wound healing put me in contact with the programme director, who confirmed the practical appropriateness of the dirty work label but identified an empirical gap in the pertinent literature. Her invitation to then repeatedly present my work in the capacity of a lecturer on her programme testified

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<sup>7</sup> This also justifies the use of the personal 'I' in a critical realist study (see Sturdy 1993, p.94).



to the fact that there must have been ‘something big’ about my idea (see Delbridge 1995, p.91).

### **3.3 Introduction to the research setting: history, people and social and technical organisation**

The empirical foci for this study were three specialist outpatient wound healing clinics in the UK, all staffed by a core team of the same clinicians but run by two different units of management within the NHS. Notwithstanding some dissimilarities in the management of clinics to fit with their administrative systems, the contrast between various sites in terms of relational outcomes on the level of clinician-patient configurations was not sufficient to allow for a contrastive analysis à la Lawson (2003b), nor for according this study an increasingly popular label of a multi-sited ethnography (Leslie et al. 2014). Despite the appeal of a comparative analysis, this study is not concerned with contrasts across the clinics, but, rather, with the development, nature and role of congenial social relations between clinicians and patients, as well as the features of the wound healing organisation that are propitious to their steering, which emerged from prior social orders based on professional biographies of key individuals that conditioned the clinics’ orientating principles concerning clinician-patient interaction.

Influenced by Mutch’s praise of history in aiding critical realist explanation by offering richer guidance for understanding the empirical phenomena under consideration (2007; 2014; 2016), in this section I briefly present the history of the clinics, collectively referred to in this study as a ‘wound healing organisation’. It should be noted that, as I learnt through the process of fieldwork, this was but one (necessarily limited) element of the bigger wound healing entity, which, in addition to offering clinical care, also managed clinical, academic and commercial research, provided in-clinic education and commercial training and was involved in coordinating novel academic courses. Whilst this study does not engage with historical methods, nor does it offer a historical form of analysis implicit in Archer’s morphogenetic approach (1995; 2013), critical realism nevertheless “sensitizes one to go further back than a setting of the immediate ‘context’” (Mutch 2014, p.225). Accordingly, this section goes back in time to facilitate the identification of the most likely mechanisms that generated the relational phenomena unpacked in the ensuing findings chapters.

The origins of this wound healing organisation were entwined with the professional biography of a key personality in this study, an acclaimed consultant who, at the time of this study, run an academic department of wound healing at a UK university. This consultant, herein anonymised as 'hospital specialist', saw it as his mission to turn the novel field of wound healing into a recognised clinical specialty. His interest in wounds started in the 1970s, when a professor of surgery invited him to become involved in a wound clinic being established at a UK hospital as a space for the evaluation of medical interventions into treating post-surgical wounds. The clinic had a long gestation period, during which two to three individuals experimented with building its profile. The initially part-time provision of outpatient services was gradually combined with teaching, research and multidisciplinary collaborations to understand the microbiology of wounds. Despite high demands for clinical care, it was felt that not enough research was being done to help boost the academic credibility of wound healing. Returning from a sabbatical spent looking at wound clinics in North America, the hospital specialist became involved in setting up the world's first fully self-funded UK wound healing research group.

The motivation behind the provision of a service that, at the time of writing, remains free to patients within the NHS was a desire to show value in care for which there was an unmet need within the healthcare system. Over the years, the wound healing team grew to about 40 individuals, including doctors, podiatrists, nurses, researchers and administrators. Approximately two-thirds of them were carefully selected by the hospital specialist and employed by the university, holding honorary contracts with the NHS. The remaining staff were employed by the NHS and seconded to wound healing to increase their clinical competency. Therefore, the wound healing organisation operated within an academic context, although it 'did' a lot of the NHS' work. As one of only a few wound healing centres in the world, it offered services in research (celebrated by the 2014 launch of the world's first centre of wound healing expertise), education (the world's first diploma and master's programme in wound healing started in 1996) and clinical care (outpatient wound healing services provision in four hospitals and 10 community-based nurse-led clinics within the NHS). It is the last entity, i.e. clinical care within the NHS, that this study focuses on.

### **3.3.1 Introduction to research sites: outpatient wound healing clinics**

Specifically, this research took place in three clinics, referred to as Morgan Clinic, Davis Clinic and Bridge Clinic. The fourth clinic was not studied because it was a space for transferring patients from specialised care into community nurses' care, as well as referring patients to specialist care. Retrospectively, as a potential locus of disconnection in the relationships between specialist wound healing specialists and patients, it would have provided an interesting point of contrast for my analysis of the associative dimensions of clinician-patient relationships. However, given the study's exploratory nature, the fourth clinic was excluded from my access negotiations.

The three clinics were based in a metropolitan area formed by two adjacent UK cities. They served patients from across the UK who suffered from wounds caused by venous and arterial diseases, diabetic foot ulceration, inflammatory disorders, surgery, trauma and malignancy, as well as factitious behaviours and injection-related injuries<sup>8</sup>. In line with the local government guidelines, the waiting time for a non-urgent consultation after a referral from a GP was three months, with urgent 'cases' seen within six weeks and patients already 'on the books' consulted every four to twelve weeks. Appointments were organised by a senior clinical nurse lead, Amanda, a coordinator of all the clinics and a lecturer-practitioner in the university wound healing department. Officially, each clinic runs for two and a half to three hours, on a morning or an afternoon, seeing an average of 24 patients booked for 30-minute consultations. In practice, clinics sometimes overrun, for as many as 30 patients could attend one clinic, with some arriving without a pre-booked appointment, and with new consultations taking up to an hour.

In clinics, patients that were sat in the waiting area were subsequently invited to a consultation room, ordinarily by nurses or podiatrists. A separate room (Bridge and Davis Clinics) or an open central space (Morgan Clinic) were used by doctors as a 'base' for 'popping in and out' of individual consultation rooms to discuss treatment plans with nurses and patients (for a walk-through of a typical outpatient consultation, see Appendix 2). The clinics run a word-of-mouth 'open door policy' that, with patients' consent, granted them permission to show their work to clinicians

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<sup>8</sup> During this research, I did not meet any patients with burn wounds, as there was a separate burns unit in a nearby hospital not studied in this research.

from other fields, medical students or representatives from dressing management companies. In this study, days in which various visitors were in the clinics are broadly referred to as 'education days'.

The Morgan Clinic was established in 1991 as the world's first research unit to specialise in wound healing. Run at a teaching hospital once a week through the department of surgery, it was originally established to treat post-surgical wounds. The unexpected consequence of originally giving the clinic an all-embracing name of 'Wound Clinic' was that high numbers of patients with wounds of much wider origins sought specialist care. Over the years, the clinic established itself as a complex wound clinic. It had an official arrangement with a local department of media resources, under which two clinical photographers spent dedicated time in each clinic for routine wound photography. There were also a memorandum of understanding with a colorectal surgeon and a geriatrician who would consult individual patients. In addition, in autumn 2016, monthly visits from two lymphedema therapists were formalised in recognition of an overlap in their work with wound healing practices.

The Davis Clinic operated under a different health management board to the Morgan Clinic. Set up around 1996-1997, it had previously been managed by surgery. At the time of this research, it was managed by diabetes and endocrinology as part of dermatology. Based in the outpatient department of a community hospital, it operated as a general wound clinic one afternoon a week. The clinic had access to clinical photography, but for financial reasons photographers had to be called in from the community hospital when they were needed, as opposed to always being available on-site.

The Bridge Clinic was established shortly after the Davis Clinic and operated under the same administrative health unit. It was managed by the diabetes and endocrinology department as a multi-disciplinary diabetic foot clinic. It runs once a week, on the morning before the Davis Clinic, as a more informal site for concerned patients, with shorter waiting times of two weeks for urgent patients and six weeks for routine ones. Every clinic benefited from the presence of an orthotist and diabetic nurse, with access to clinical photography available upon request. On the first Monday of every month, the clinic operated as a combined clinic, with a vascular surgeon, a prosthetist, a diabetologist, a pain management specialist and an orthopaedic specialist present on-site to provide additional advice.

The majority of the fieldwork took place in these three outpatient clinics during patient contact hours. Therefore, study participants comprised clinical and administrative staff, patients and, as discovered shortly after joining the wound healing organisation, patients' relatives. Many of them were active participants in the consultation by, for example, taking notes, asking questions, assisting clinicians with dressing changes and, to my surprise and delight, often eagerly engaging with my ethnographic methods of enquiry.

### **3.4 Research methods**

Having defended the value of the ethnographic tradition for exploring clinician-patient relations in wound care seen as dirty work, this section considers the practical details of the techniques used to describe and explain the phenomena under study. It should be noted that by 'defending' ethnography, I do not mean to prove that this study qualifies for an ethnographic label in methodological terms. According to Yanow, researchers incorporating ethnographic methods for looking inside organisations should not feel de-legitimised as ethnographers for not coming from the anthropological 'mother' tradition (2009, p.196). Moreover, there is now great diversity of meaningful healthcare ethnographies in relation to study time frames, methods of data collection, sampling and data analysis (see Vindrola-Padros and Vindrola-Padros 2018). This study's concern with looking inside the world of wound healing and the emergent richness of insights developed about this wound healing organisation suffices to make it an organisational ethnography "at work" (Yanow 2009, p.196).

Most data were collected through the planned use of the 'tried and tested' methods of ethnography, namely observation and the writing-up of fieldnotes (Merton et al. 1957; Fox 1959; Becker et al. 2009), supplemented with qualitative interviews (Spradley 2016). Once in the field, a combination of events gave me unexpected access to 'bonus' data through my attendance at two lectures on clinical evidence in wound healing at a nearby medical school, two visits to a wound research facility with presentations on the challenges and opportunities for wound healing, and two visits to community-based wound care provision centres held in a non-medical setting, such as community clubs. Other texts (e.g. internal wound healing assessment forms, wound healing research brochures) were read but not explicitly analysed (see McMurray and Ward 2014). From a critical realist perspective, this data enabled me to place findings from observation and interviews into a broader

context (O'Mahoney and Vincent 2014). The study lasted approximately 10 months, including a six-week-long period for reflection spent away from the field two months prior to the termination of the study, when thematic saturation began to emerge. The study ran from 11<sup>th</sup> June 2016, which marked the first observation, to 3<sup>rd</sup> April 2017, which corresponded with the end date of my field access as granted by the South East Coast – Brighton & Sussex Research Ethics Committee (see Appendix 3).

### **3.4.1 Ethical considerations**

Leading on from the above reference to research ethics and given the salience of ethical conduct in studies involving vulnerable patient populations, understanding the practical aspects of my use of ethnographic methods in wound healing clinics requires a brief preamble about participant consent drawn from my ethics documentation. First, patient information sheets (separate yet similar for both healthcare management units, example in Appendix 4) were sent out to new patients along with their appointment letters ahead of their scheduled consultation. This was to ensure that patients could make an informed decision about taking part in the observational and/or interview dimension of this study in line with the 'Research Governance Framework for Health and Social Care' (Department of Health 2005). As a result, one patient emailed me to opt-out of my observation of her consultation, while another one contacted me to arrange the interview upfront.

Second, written consent was sought from clinicians to have their professional activity observed for the entire duration of the study, when introducing the study for the first time. It was often impractical to seek written consent for observation of the consultation from everyone present in the room, including wound healing clinicians, patients, their relatives and other 'accidental participants', like specialists from other units invited into individual consultations. In the presence of a consenting wound healing clinician, verbal consent was then sought from anybody who happened to be in the same room and interacting with the fully consenting health professionals (Franklin et al. 2012).

### **3.4.2 Observation**

With this process in place, I began my study with observations. As a popular element of ethnographic fieldwork, observation involves "looking at what is going on – watching and listening" (Bennet 1991, p.100), and empathic immersion in the daily life and meaning systems of those studied (Emerson et al. 2001, p.352). Given my

initial broad focus on clinician-patient relations, I found some direction for my observation in publications on care and compassion in healthcare. Accordingly, I observed what was said and how it was said (Kahn 1993), along with emotionally charged words (Black and Monrouxe 2014). While constructionist ethnographers report more on the things they hear than what they observe (Forsey 2010), crucially for critical realist researchers, some aspects of caring relations can be lost in a predominantly linguistic portrayal (Patient et al. 2003). I was therefore looking out for non-verbal behaviours and bodily communications. Many of the observations recorded in this regard corresponded with the depictions of physical and emotional strains in dirty work. These included, for example: strenuous transfers of patients with limited mobility (Stacey 2005); physical proximity to bodily issues normally kept private (Bolton 2005); and discussions of a range of stigma situations, such as self-harm, loneliness or familial concerns (McMurray and Ward 2014).

My background as a social scientist studying clinician-patient relations precluded me from sharing in dirty wound care work activities as a complete participant in field observations. However, influenced by the critical realist thinking of Archer (2000) and Sayer (2011), I felt unsatisfied with having to characterise my research role as either a non-participant, complete, or fly-on-the-wall observer that most literature on research methods offers as an alternative. In "Being human", Archer says that one's status as a researcher is intertwined with that of a participant: "we cannot shed our status as participants" (2000, p.193). Similarly, in "Why things matter to people", Sayer (2011) says that social scientists must connect with participants more, rather than assume the role of detached spectators (see also Smith 2013). I found that the best theoretical approximation of my observational position in the field was the role of 'participant-as-observer', as suggested by Junker (1952) and developed by Gold (1958), for it captured the interactional learning and the relationship I developed with participants in the field.

To begin the exposition of my 'participant-as-observer' role, I must note that both clinicians and patients knew that our relationship was predicated on research rather than care work (Gold 1958), because, in case they had misread my study information sheets, I ensured that my verbal introductions pre-empted any possible confusion about my position. Moreover, given the long duration of my presence in clinics, with time I developed both formal and informal ways of observing (Gold 1958). Given the academic character of these clinics, I observed formally on education days, joining visitors in shadowing one clinician who would 'walk, talk and

question us through' important aspects of the individual consultations we were invited to observe. I benefited greatly from this shadowing with other students. On the level of apprehending 'what was going on', I profited from a free crash course in wound healing, skipping a foundation pre-clinical medicine course. On a practical level, the presence of other students legitimated my potentially distressing writing in my field notebook. The downside of formal observations was that I never saw consultations in their entirety, because some time necessarily had to be set aside for verbal commentary outside the room.

In the absence of other students, I observed informally. I remained in one treatment room, observing consecutive consultations from start to end. The slower pace of observation and lack of educational commentary meant that I could pay attention to both verbal and non-verbal expressions of emotion (Sturdy 2003), albeit with fewer opportunities to ask questions. However, this was when I was made to feel a bigger part of the wound healing team, a colleague rather than a researcher (Gold 1958). Offering a 'free pair of hands', sometimes I would be asked to hand over boxes with dressings or patient folders. With time, the hospital specialist would even refer to me as 'one of us'. One day, he humorously diagnosed me with a 'wound bug' after I confessed to him that I had spent the previous evening watching videos on maggot therapy. Indeed, towards the end of my fieldwork, on education days, I managed to correctly diagnose hyperkeratosis and contact dermatitis. And yet, I felt unjustified in being considered 'one of them' when I got things "WRONG!!!" (hospital specialist). Indeed, one of the demands of the 'participant-as-observer' role is that "the field worker is often defined by informants as more of a colleague than he feels capable of being" (Gold 1958, p.222).

Overall, I conducted just under 120 hours of formal and informal observation, detailed in my observational field research log below (see Table 1). My handwritten jottings were transformed shortly after the observation events into electronic texts. By the time I left the field, they consisted of just over 80,000 words. Although useful in themselves, the epistemological bearing of a critical ontology is that the method of observation alone cannot reveal much about "the actor's perceptions, physical condition ... and immediate and biographical/cultural history", all of which can aid understanding of the context of the empirical phenomena under study (Sturdy 2003, p.87). Of import for a study of social relations, "*there is no context-less relationship*, and neither can the context/s be relegated to the 'Background' because they are



influential as the present as expectations, hopes or aspirations, motives, and fears” (Donati and Archer 2015, p.67).

**Table 1. Ethnographic observation log<sup>9</sup>**

| Date of observation            | Duration of observation (hours) |              |               |
|--------------------------------|---------------------------------|--------------|---------------|
|                                | Bridge Clinic                   | Davis Clinic | Morgan Clinic |
| 13 <sup>th</sup> June 2016     |                                 | 4.5          |               |
| 15 <sup>th</sup> June 2016     |                                 |              | 3             |
| 20 <sup>th</sup> June 2016     | 3                               |              |               |
| 22 <sup>nd</sup> June 2012     |                                 |              | 3             |
| 29 <sup>th</sup> June 2016     |                                 |              | 2             |
| 4 <sup>th</sup> July 2016      | 2                               | 2.5          |               |
| 18 <sup>th</sup> July 2016     | 3                               | 2            |               |
| 20 <sup>th</sup> July 2016     |                                 |              | 1.5           |
| 25 <sup>th</sup> July 2016     | 2.5                             | 3            |               |
| 27 <sup>th</sup> July 2016     |                                 |              | 2.25          |
| 10 <sup>th</sup> August 2016   |                                 |              | 3             |
| 15 <sup>th</sup> August 2016   | 2.25                            | 3            |               |
| 22 <sup>nd</sup> August 2016   | 3                               | 3.5          |               |
| 24 <sup>th</sup> August 2016   |                                 |              | 2             |
| 31 <sup>st</sup> August 2016   |                                 |              | 0.5           |
| 5 <sup>th</sup> September 2016 | 3                               | 3            |               |
| 7 <sup>th</sup> September 2016 |                                 |              | 3             |

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<sup>9</sup> The ethnographic observation log only includes days on which observations were performed. The duration of observation indicated in the table reflects the time spent observing consultations in clinics, after subtracting the time spent interviewing patients, their relatives and clinicians. The table excludes days when no observation was performed due to cancellation of clinics or prior commitments.

|                                      |       |     |       |
|--------------------------------------|-------|-----|-------|
| 12 <sup>th</sup> September 2016      | 3     | 3   |       |
| 19 <sup>th</sup> September 2016      | 2.5   | 1   |       |
| 3 <sup>rd</sup> October 2016         | 3     | 3   |       |
| 5 <sup>th</sup> October 2016         |       |     | 2.5   |
| 10 <sup>th</sup> October 2016        | 2     |     |       |
| 19 <sup>th</sup> October 2016        |       |     | 0.5   |
| 24 <sup>th</sup> October 2016        | 1     |     |       |
| 26 <sup>th</sup> October 2016        |       |     | 3     |
| 31 <sup>st</sup> October 2016        |       | 3   |       |
| 2 <sup>nd</sup> November 2016        |       |     | 0.5   |
| 7 <sup>th</sup> November 2016        | 1     |     |       |
| 21 <sup>st</sup> November 2016       | 3     | 3   |       |
| 28 <sup>th</sup> November 2016       |       | 3   |       |
| 19 <sup>th</sup> December 2016       |       | 2   |       |
| 9 <sup>th</sup> January 2017         | 3     | 3   |       |
| 16 <sup>th</sup> January 2017        | 2     |     |       |
| 15 <sup>th</sup> February 2017       |       |     | 2.5   |
| 20 <sup>th</sup> February 2017       | 2     |     |       |
| 20 <sup>th</sup> March 2017          | 3     | 2.5 |       |
| <b>Total duration of observation</b> | 44.25 | 45  | 29.25 |

### 3.4.4 Interviews

Sturdy's (2003) insights on the methodological implications of a critical realist ontology for understanding emotions can be relevant for studying social relations in dirty work in so far as "dirty work is an activity embedded with meanings that are also emotional" (Simpson et al. 2011, p.209). For example, Sanders (2005) discovered signifiers of emotional taint in veterinary dirty work via the relationships they were building with their animal patients by supplementing her field observations with interviews with veterinary technicians. Similarly, McMurray and Ward's (2014) interviews with the Samaritans alongside observations of their work revealed that the Samaritans felt stigmatised by the public via their associations with the burdensome emotions of stigmatised clients. Both studies are premised on a social constructionist belief that emotions are unobservable and can be accessed through discourse (Fineman 2006), an epistemological position shared by critical realism. But critical realism recognises that the semantic privacy of emotions does not prevent actors from describing them, at least to some extent, to one another (Scambler 2012) and that, as agents generate discursive explanations and interpretations of their emotion, they can resort to relevant extra-discursive factors (Sturdy 2003).

Therefore, to supplement the observations in this study, 51 interviews were conducted. The target sample size specified in my initial research protocol was 50, a number that Morse (2015) deemed sufficient for qualitative health research involving an analytical combination of categorical and thematic analyses. However, the number was unavoidably arbitrary, for the sampling strategy in qualitative research depends on a host of factors, including the number of participants, study design and scope, nature of the topic, quality of information gathered from the participants and number of interviews per participants (Patton 1990). All these factors jointly influence the decision about whether enough data has been collected to support the credibility of the research findings (Morse 2000; Sandelowski 2000). In this study, the *a priori* determination of the sample size before commencing the process of seeking ethical approval was additionally complicated by the fallibility of my knowledge about the sample population (May 2011). Although the study design allowed for relatives to be present in interviews, I had not appreciated their desire to provide shadowed data (Morse 2000) as they reflected on patients' experiences and on caring for them, thus doubling the number of participants in some of the interviews.

Purposive sampling was used to ensure that participants had access to the information sought in the study (May 2011, p.141). Given the exploratory orientation of the study, to cover both issues of interest to me and emerging themes of import to participants (Kakavelakis and Edwards 2012), semi-structured mode of interviewing was chosen. To reduce the likelihood of touching on sensitive subjects (Dickson-Swift et al. 2008), the patient interview guide (Appendix 5)<sup>10</sup>, as well as patient information sheet were consulted over the phone with a former health and social care nurse who, at the time of designing this study, was a wound healing clinical trial patient. The evaluation of my staff interview guide (Appendix 6) and information sheets about the study for clinicians (separate yet similar for both healthcare management units, example in Appendix 7) was performed by my supervisory panel. Clinicians who agreed to be interviewed were emailed a list of themes to give them time for reflection on questions and help them assess my intentions. All interviews were tape-recorded and transcribed verbatim.

#### **3.4.4.1 Patients and relatives**

Including patients in doctoral research is rare in the social sciences because of the time-consuming and cumbersome nature of acquiring permission from ethics committees and research and development departments of healthcare administrative units (McDermott 2016). On reflection, the cost of an eight-month-long process of access negotiation I underwent, from the day support for the study was confirmed in an email by my gate keeper to my first observational event, was far outweighed by the benefits of enriching my data with the experiences of patients and their relatives. The latter, in particular, have become increasingly appreciated as a valuable learning aid for the toolkits of resources in healthcare (Bramley and Matiti 2014; Leslie et al. 2014; Collier and Wyer 2016). It is also unusual for dirty work studies to include clients' first-hand accounts of stigma and its management (for an exception, see Neal 2018). To stress this empirical originality of my dirty work study, I therefore begin with introducing patient-participants.

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<sup>10</sup> Given the semi-structured nature of the interviews, participants were invited to cover any themes they deemed relevant. Consequently, the interview guide was amended several times.

I conducted 20 interviews with patients and/or their relatives, whose profiles are detailed in Table 2<sup>11</sup>. I issued invitations to the interviews at the end of the observed consultation, or by clinicians assisting me with patient recruitment for the study. In this way, 16 interviews took place in empty rooms in clinics. The possibility of discussing events immediately preceding this came at the cost of necessarily shorter conversations, as rooms had to be emptied and patients had other commitments. Three interviews were therefore arranged for later dates to take place in familiar cafés. Finally, thanks to my lengthy ‘participant-as-observer’ mode of observation, I built a relationship with one patient close to the point of friendship (Gold 1958), with this interview taking place at their house. The interviews lasted between 15 and 110 minutes.

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<sup>11</sup> In fast-paced and busy hospitals, it was sometimes impractical to conduct formal interviews with patients. As a result, some interviews resembled brief and ethnographic conversations recorded in codes in fieldnotes. However, they were not any less meaningful; hence, some patients who do not feature in the table feature in the ensuing empirical chapters.

**Table 2. Patients and relatives interviewed (in order of interviewing)<sup>12</sup>**

| <b>Pseudonym in study</b> | <b>Clinical profile of patient</b>                                                                                                      | <b>Presence of relative</b>                 | <b>Date, time, duration and place of interview</b>           |
|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------------------|
| Derek                     | Presented with a diabetic foot ulcer, problems for 12 months, attended Bridge Clinic every one to two weeks over a period of six months | Attended alone                              | 27 <sup>th</sup> June 2016, 10am, 31 minutes, Bridge Clinic  |
| Michael                   | Presented with two diabetic foot ulcers, problems for 12 months, attended Bridge Clinic for the first time                              | Attended with son-in-law Mark (interviewed) | 27 <sup>th</sup> June 2016, 11am, 40 minutes, Bridge Clinic  |
| Theresa                   | Presented with a leg ulcer, problems for 12 months, attended Bridge Clinic and Davis Clinic every four to eight weeks                   | Attended with husband Andy (interviewed)    | 27 <sup>th</sup> June 2016, 1.30pm, 49 minutes, Davis Clinic |
| Jack                      | Presented with a foot ulcer, problems for five months, attended Bridge Clinic once a week                                               | Attended alone                              | 4 <sup>th</sup> July 2016, 10am, 64 minutes, Bridge Clinic   |

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<sup>12</sup> Clinical profiles of patients were compiled from the information they volunteered in the interview. To facilitate the process of negotiating access, I did not seek permission to consult their medical files. As a result, the level of detail in clinical profiles might vary across participants and/or be incomplete.

|        |                                                                                                                            |                                             |                                                                    |
|--------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------------------------|
| Rachel | Presented with a toe ulcer for the first time to Bridge Clinic, diabetic for 40 years                                      | Attended alone                              | 4 <sup>th</sup> July 2016, 11.30am, 35 minutes, Bridge Clinic      |
| Elina  | Presented with a vascular ulcer, problems for seven years, attended Bridge Clinic every two weeks to three months          | Attended with husband Charles (interviewed) | 25 <sup>th</sup> July 2016, 2.30pm, Bridge Clinic                  |
| Erica  | Presented with an abscess on abdomen, problems for five months, attended Davis Clinic for the first time                   | Attended alone                              | 15 <sup>th</sup> August 2016, 2.15pm, 23 minutes, Davis Clinic     |
| Jane   | Presented with a vascular ulcer and eczema, problems for 33 years, attended Morgan Clinic every one to eight weeks         | Attended with husband Mike (interviewed)    | 10 <sup>th</sup> September 2016, 3pm, 110 minutes, patient's house |
| Malik  | Presented with a diabetic foot ulcer, problems for three months, attended Bridge Clinic for the third time                 | Attended alone                              | 19 <sup>th</sup> September 2016, 9am, 23 minutes, Bridge Clinic    |
| Tim    | Presented with blisters on feet, previously pressure ulcers, problems for 20 years, attended Davis Clinic on a needs basis | Attended alone                              | 19 <sup>th</sup> September 2016, 1.30pm, 45 minutes, Davis Clinic  |

|         |                                                                                                                                                    |                                                                            |                                                                   |
|---------|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------|
| Tony    | Presented with a diabetic foot ulcer, problems for 14 years, attended Bridge Clinic on a needs basis                                               | Attended alone                                                             | 14 <sup>th</sup> October 2016, 9am, 61 minutes, familiar café     |
| John    | Presented with a leg ulcer, problems for 32 years, attended Morgan Clinic since its beginning and on a needs basis                                 | Attended with wife Martha (interviewed)                                    | 19 <sup>th</sup> October 2016, 2.30pm, 33 minutes, Morgan Clinic  |
| Robert  | Presented with a post-surgical abdominal wound, problems five months, attended Morgan Clinic for the first time                                    | Attended with wife Joanna (interviewed)                                    | 2 <sup>nd</sup> November 2016, 2.15pm, 61 minutes, Morgan Clinic  |
| Edwina  | Wife of a patient who presented with a diabetic foot ulcer, problems for four years, attended Bridge Clinic for the first time with this new ulcer | Attended with wife Edwina (interviewed in place of her indisposed husband) | 7 <sup>th</sup> November 2016, 9.30am, 20 minutes, Bridge Clinic  |
| Rhydian | Presented with a diabetic foot ulcer, problems for one year, attended Bridge Clinic every four to eight weeks                                      | Attended alone                                                             | 7 <sup>th</sup> November 2016, 10.30am, 30 minutes, Bridge Clinic |
| Chris   | Presented with a vascular ulcer, problems for one year, attended Bridge Clinic once a month                                                        | Attended with wife Janet (interviewed)                                     | 7 <sup>th</sup> November 2016, 11.45am, 25 minutes, Bridge Clinic |



|       |                                                                                                                  |                                             |                                                                    |
|-------|------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--------------------------------------------------------------------|
| Eleri | Presented with a self-harm wound on a thigh, problems for five months, attended Morgan Clinic for the first time | Attended alone                              | 28 <sup>th</sup> November 2016, 10am, 45 minutes, familiar café    |
| Steve | Presented with a diabetic foot ulcer, problems for six years, attended Bridge Clinic every six to eight weeks    | Attended with wife Caitlin (interviewed)    | 20 <sup>th</sup> February 2017, 9.45am, 23 minutes, Bridge Clinic  |
| Rick  | Presented with a diabetic foot ulcer, problems for 10 months, attended Bridge Clinic every two weeks             | Attended alone                              | 20 <sup>th</sup> February 2017, 10.30am, 17 minutes, Bridge Clinic |
| Elsa  | Presented with a post-episiotomy wound, problems for 15 weeks, attended Morgan Clinic for the first time         | Attended with husband but interviewed alone | 24 <sup>th</sup> February 2017, 3pm, 43 minutes, familiar café     |

based wound care provision centre, whom I met during one of my 'bonus' visits to such centres, and 10 clinical photographers with support from the head of the hospital media resources. Finally, I interviewed one clinician from outside of this wound healing organisation, snowballed by a friend to whom I de-briefed about my emotional experiences of this research. Most interviews were held in quiet clinical rooms or in clinicians' university offices, with one held at my school, two over the telephone and one over Skype. As some of my interviews were curtailed by the professional commitments of wound care clinicians, which were typical of the busyness of hospital life, the interviews lasted between 14 and 92 minutes.

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<sup>13</sup> Some clinicians had left these wound healing clinics before I began arranging my interviews with clinicians. However, because I often observed their work, they feature in the empirical chapter (although they do not feature in the table listing the healthcare professionals interviewed).

**Table 3. Healthcare professionals interviewed (in order of interviewing)<sup>14</sup>**

| <b>Pseudonym in study</b> | <b>Professional profile of clinicians</b>                                                                                                                              | <b>Date, time, duration and place of interview</b>                      |
|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| Ella, podiatrist          | Research podiatrist, advanced clinical practitioner, honorary tutor and lecturer, academic journal reviewer, in wound healing organisation for approximately 18 months | 9 <sup>th</sup> September 2016, 12pm, 91 minutes, university office     |
| Phil, doctor              | Clinical research fellow, background in surgery, part-time general practitioner, in wound healing organisation for approximately one year                              | 14 <sup>th</sup> September 2016, 10am, 51 minutes, university office    |
| Amanda, nurse             | Clinical nurse, background in district nursing, lecturer-practitioner, coordinator of clinical referrals, in wound healing organisation for approximately 15 years     | 26 <sup>th</sup> September 2016, 10.30am, 71 minutes, university office |
| Eva, nurse                | Nursing training, background in acute care, in wound healing organisation for approximately 15 months                                                                  | 27 <sup>th</sup> September 2016, 9.30am, 71 minutes, university office  |

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<sup>14</sup> Professional profiles of clinicians interviewed in this study have been compiled from the information they volunteered during the interview. To protect their identity, this was done in a necessarily circumscribed way. As a result, professional profiles may be incomplete and not adequately reflect the scale of their professional accomplishments.

|                                                    |                                                                                                                                            |                                                                            |
|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Pauline, community-based wound care provision lead | District nursing background, community-based wound care provision lead for approximately 10 years                                          | 27 <sup>th</sup> September 2016, 3.30pm, 76 minutes, over telephone        |
| Alistair, clinical photographer                    | Background in photographic art                                                                                                             | 28 <sup>th</sup> September 2016, 12pm, 35 minutes, media resources unit    |
| Paula, clinical photographer                       | Worked mostly with inpatients on hospital wards and in the research facility, approximately 20 years of experience in clinical photography | 28 <sup>th</sup> September 2016, 12.30pm, 39 minutes, media resources unit |
| Roman, clinical photographer                       | Background in photographic art and experience in clinical photography in ophthalmology                                                     | 28 <sup>th</sup> September 2016, 3.30pm, 31 minutes, media resources unit  |
| Lauren, clinical photographer                      | Background in photographic art, in clinical photography training                                                                           | 28 <sup>th</sup> September 2016, 4pm, 23 minutes, media resources unit     |
| Tammy, clinical photographer                       | Training in clinical photography                                                                                                           | 28 <sup>th</sup> September 2016, 4.30pm, 24 minutes, media resources unit  |

|                                           |                                                                                                                                                                                                                                 |                                                                          |
|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| Mary, nurse                               | Background in community nursing, in wound healing organisation for approximately 20 years                                                                                                                                       | 5 <sup>th</sup> October 2016, 10am, 65 minutes, university office        |
| Christina, director of clinical education | Background in psychiatric and general nursing, worked as a link nurse with an interest in wound healing, experience in lecturing on wound care, director of clinical education for the wound healing organisation for two years | 11 <sup>th</sup> October 2016, 9.15am, 81 minutes, familiar café         |
| Emma, clinical photographer               | Background in photographic art                                                                                                                                                                                                  | 13 <sup>th</sup> October 2016, 4pm, 29 minutes, media resources unit     |
| Leighton, clinical photographer           | Photographing wounds for six years                                                                                                                                                                                              | 13 <sup>th</sup> October 2016, 4.30pm, 31 minutes, media resources unit  |
| Mats, clinical photographer               | Senior clinical photographer, background in photographic art, 10 years of experience in dental photography, 14 years total experience                                                                                           | 14 <sup>th</sup> October 2016, 12.30pm, 29 minutes, media resources unit |
| Evan, clinical photographer               | Trainee in clinical photography, one year of experience                                                                                                                                                                         | 14 <sup>th</sup> October 2016, 1.30pm, 31 minutes, media resources unit  |

|                                 |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                      |
|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| Fernando, clinical photographer | Background in medical photography, 20 years of experience, including 15 years of experience in photographing wounds                                                                                                                                                                                                                                                                  | 14 <sup>th</sup> October 2016, 2pm, 26 minutes, media resources unit |
| Claire, tissue viability nurse  | Part of the community wound healing team (nurse-led clinics), 15 years of experience in nursing, in wound healing organisation for approximately 10 years                                                                                                                                                                                                                            | 19 <sup>th</sup> October 2016, 4pm, 41 minutes, Morgan Clinic        |
| Deborah, tissue viability nurse | Background in community nursing, a tissue viability nurse with 15 years of experience and a simultaneous commercial role, prior to which she had worked as a district nurse collaborating with hospice workers, geriatricians, paediatricians, vascular surgeons, dermatologists and community healthcare professionals, in wound healing organisation for approximately three years | 31 <sup>st</sup> October 2016, 9.30am, 36 minutes, over telephone    |
| Kate, doctor                    | Wound healing clinical fellow, doctor in training, general surgical registrar background                                                                                                                                                                                                                                                                                             | 8 <sup>th</sup> November 2016, 1.30pm, 54 minutes, university office |
| Sam, podiatrist                 | Advanced podiatrist, seven years of professional experience                                                                                                                                                                                                                                                                                                                          | 19 <sup>th</sup> December 2016, 12pm, 45 minutes, Bridge Clinic      |
| Jordan, orthotist               | Qualified in orthotic and prosthetic science, in Davis Clinic for approximately                                                                                                                                                                                                                                                                                                      | 16 <sup>th</sup> January 2017, 11am, 50                              |

|                             |                                                                                                                                                                                            |                                                                                  |
|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
|                             | seven years                                                                                                                                                                                | minutes, familiar café                                                           |
| Julia, lymphedema therapist | A qualified radiographer, specialist in lymphedema, approximately 15 years of experience in lymphedema                                                                                     | 20 <sup>th</sup> February 2017, 2pm, 37 minutes, over telephone                  |
| Camilla, paediatrician      | A qualified paediatrician with specialisms in haematology and respiratory medicine, honorary research fellowship and faculty position, not affiliated with this wound healing organisation | 1 <sup>st</sup> March 2017, 2pm, 42 minutes, over Skype                          |
| Megan, research nurse       | Nursing background in surgical emergency admissions, seconded to wound healing organisation and with wound healing organisation ever since for approximately seven years                   | 15 <sup>th</sup> March 2017, 11am, 39 minutes, centre of wound healing expertise |
| Hospital specialist         | Acclaimed consultant, runs an academic department of wound healing at a UK university, orchestrator of the wound healing organisation                                                      | 21 <sup>st</sup> March 2017, 4pm, 64 minutes, Cardiff Business School            |
| Andrew, prosthetist         | Clinical lead prosthetist, in wound healing organisation through participation in combined clinic for three years                                                                          | 3 <sup>rd</sup> April 2017, 9.30am, 14 minutes, Bridge Clinic                    |

|                               |                                                                                                                                                  |                                                             |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| George, vascular surgeon      | Vascular surgeon, in wound healing organisation through participation in combined clinic for 10 years                                            | 3 <sup>rd</sup> April 2017, 10am, 23 minutes, Bridge Clinic |
| Helen, orthopaedic specialist | Podiatrist, nurse, working with foot and ankle surgeons, in wound healing organisation through participation in combined clinic for 14 years     | 3 <sup>rd</sup> April 2017, 10am, 24 minutes, Bridge Clinic |
| Catherine, diabetic nurse     | Diabetic specialist nurse in hospital housing Bridge Clinic for 20 years, in wound healing organisation through participation in combined clinic | 3 <sup>rd</sup> April 2017, 10am, 29 minutes, Bridge Clinic |



often guided by a domain-specific theoretical framework that delimits the foci of attention (O'Mahoney and Vincent 2014). However, the likely absence of conventional observable empirical tendencies within a critical realist ontology complicates the explanatory process, obfuscating the causal reasoning towards likely explanations of empirical phenomena and obscuring the selection of that with the highest explanatory power (Lawson 2003b). Therefore, a critical realist analysis “tends to be iterative and to involve a movement from consideration of the intransitive world of actual events, mechanisms, and structures to the transitive world of measures, descriptions and theories (O'Mahoney and Vincent 2014, p.11), legitimating conjecture (Bunge 2004) and abstract hypothesising about mechanisms through analogy, metaphor or luck (Lawson 2003b).

### **3.5.1 Description**

In the first step of the analysis, ethnographic data were outlined with reference to a framework offered by Spradley (1980) and subsequently expounded by Rees and Gatenby (2014), which provides an example of a toolkit for the critical realist categorisation of data into entities (i.e. wholes) and their related parts (Elder-Vass 2010). Following Rees and Gatenby (2014), attention was paid to those entities relevant to organisation studies, which is the home academic field of this research. Subject-specific entities came from my general idea of potential mechanisms active in the domain of clinician-patient relations (O'Mahoney and Vincent 2014). Table 4 below provides the final output of descriptions. The categories of data that I added to Spradley's (1980) framework are marked with an asterisk.

**Table 4. Description of data**

| <b>Data categories</b>  | <b>Entities for organisation studies</b> | <b>Subject specific entities for clinician-patient relationship in wound healing</b>                                                                                                                                                                                                                                                                                                                                                                                                         |
|-------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Space                   | Buildings and local geography            | Generic treatment room layout and equipment, consultation room capacity, waiting area, private rooms, clinicians' communication area, catchment area, community-based wound care provision centres, specially equipped centre of wound healing expertise                                                                                                                                                                                                                                     |
| People                  | Staff, patients, relatives               | Hospital specialist, podiatrists and (research) nurses with an interest in wound healing, clinical research fellows, podiatrists, clinicians on secondment, NHS nurses, geriatrician, colorectal surgeon, vascular surgeon, prosthetist, orthotist, medical students, visitors from a dressing management company and hospitals abroad, director of clinical education, clinical photographers, lymphedema therapists, physiotherapist, administrative support staff, patients and relatives |
| Activities, procedures, | Work processes and rules                 | Honorary contract with the NHS, system of seeing patients, HEIDI, TIME, delegation of care, blurring of traditional division of labour, education and teaching, recruitment into clinical trials as a basis for contracting with the NHS, use of clinical photography, admitting gaps in knowledge, team orientation, putting things into process, structured care plan with call-back                                                                                                       |

|           |                     |                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| processes |                     | provision, corporeal physicality of work, emotional strains of work                                                                                                                                                                                                                                                                                                                           |
| Objects   | Equipment           | Digital pen, paper and digital wound assessment form, camera, scalpel, dressings, creams, Doppler machine, computer records, physical records (with wound photographs), syringes, rubber gloves, swap sticks, trolley, hoist, equipment for dictation, torch, steroid creams, potassium permanganate tablets, couch, chairs, stools, apron, trolley, equipment for dictation of medical notes |
| Language  | Communication       | Face-to-face, email, letters, telephone, body language, clinical photographs, personal cards/phone calls                                                                                                                                                                                                                                                                                      |
| Events    | Meetings            | Combined clinic, patients delivered to clinics in ambulances, education days, visits to clinics, seminars, presentations                                                                                                                                                                                                                                                                      |
| Time      | Routines and cycles | Clinic duration, consultation duration, duration of wound treatment/management, duration of taking clinical photographs, respecting patients' time                                                                                                                                                                                                                                            |
| Symbols   | Signs and uniforms  | Red uniform, performances                                                                                                                                                                                                                                                                                                                                                                     |

|                                    |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Relationships                      | Line manager–employee          | Patient–clinician, relative–clinician, patient–relative, clinician–clinician (with an interest in wound healing), clinician–clinician (without an interest in wound healing and clinicians from other medical specialties)                                                                                                                                                                                                                           |
| Feelings                           | Positive and negative feelings | Patients’ feelings (acceptance, fear, regret, feeling stigmatised, vulnerability, happiness, blaming, resentment, curiosity, frustration, confusion, shame, grief, anger, depression, cynicism, despair, sense of isolation, humour, desire for independence); clinicians’ feelings (frustration, empathy, recognition of stigma, joy at healing, gratitude, lack of understanding, repulsion), relatives’ feelings (fear, relief, guilt, repulsion) |
| Goals                              | Strategies, projects, targets  | Ensuring the future of wound healing (family and patient management regime, diagnosis in a broader sense, standardisation of care across the wound healing community), improving healing rates, healing, managing pain, exudate and odour, psycho-social attention                                                                                                                                                                                   |
| History*                           | Philosophy, evolution          | Lack of specialised service provision, humble beginnings, research orientation                                                                                                                                                                                                                                                                                                                                                                       |
| Technical and social organisation* | Management, staffing           | Common philosophy of clinics, same people and different management boards, lack of recognition in healthcare system, multidisciplinary insights needed                                                                                                                                                                                                                                                                                               |

|                                       |                                              |                                                                                                                                                                                                                                       |
|---------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Sensations*                           | Smell, sight, sound, touch                   | Corporeally invasive/penetrating smell, distressing sights, expressive touch, haptic examination, auditory examination, wound visibility, bodily empathy, patients protective of their bodies                                         |
| Knowledge, understanding, perception* | Status quo of specialty and remedial actions | Wound healing education, access to funding, scientific progress, wound images and data, wound healing as a nursing issue, wound healing as a last resort, fragmentation of care, lack of interest/low priority given to wound healing |

### 3.5.2 Retrodution

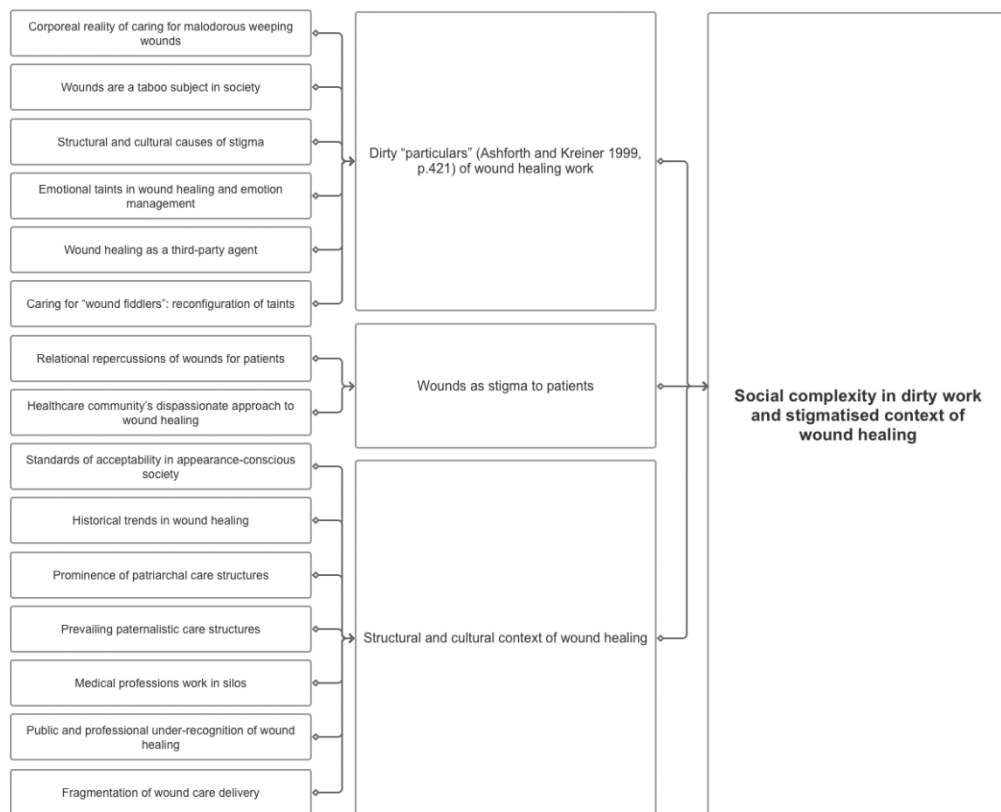
The second step of the analysis involved the theoretical construction and modelling of the mechanisms underlying the observed empirical phenomena. The explanatory logic employed for this purpose in critical realist research is known as retrodution and refers to “[m]oving from empirical findings to causal mechanisms by asking ‘what must the world be like in order for these findings to be possible?’” (Marks and O’Mahoney 2014, p.81). However, Marks and O’Mahoney (2014) recognise the practical complexity of performing retrodution, allowing for some flexibility in the way that data is analysed. Here, the process was iterative and involved repeated shifts between (re)organising data, reading the literature, comparing findings against an array of possible theoretical frameworks and discussing earlier drafts of this work. In the process, both dirty work (Hughes 1958; Ashforth and Kreiner 1999) and the relational subject (Donati and Archer 2015) were inducted as the best fit for what my data was saying. In addition to ‘stigma’ and ‘managing stigma’ which are key concepts in the dirty work literature, in continuance of my initial interest in clinician-patient relations an additional focus that oriented the ensuing analysis were ‘clients/people/outsideers’ relationships with dirty workers.

I started by manually filtering textual data from fieldnotes and interview transcripts into categories and themes. Knowing that the specific methods of data analysis used in retrodution rarely differ from those in other ontological perspectives (Marks and O’Mahoney 2014, p.81), I chose the method recommended by Gioia and colleagues as a strategy for organising my conceptual progression through the data (Gioia and Pitre 1990; Gioia and Chittipeddi 1991; Gioia et al. 1994; Gioia and Thomas 1996; Corley and Gioia 2004; Gioia et al. 2013). Although analysing data collected through a variant of triangulation presents analytical problems centred on the potential lack of coherency and corroboration (McMurray and Ward 2014), the Gioia methodology (Gioia et al. 2013) was used to aid an analysis of both observational and interview data (Gioia et al. 2010).

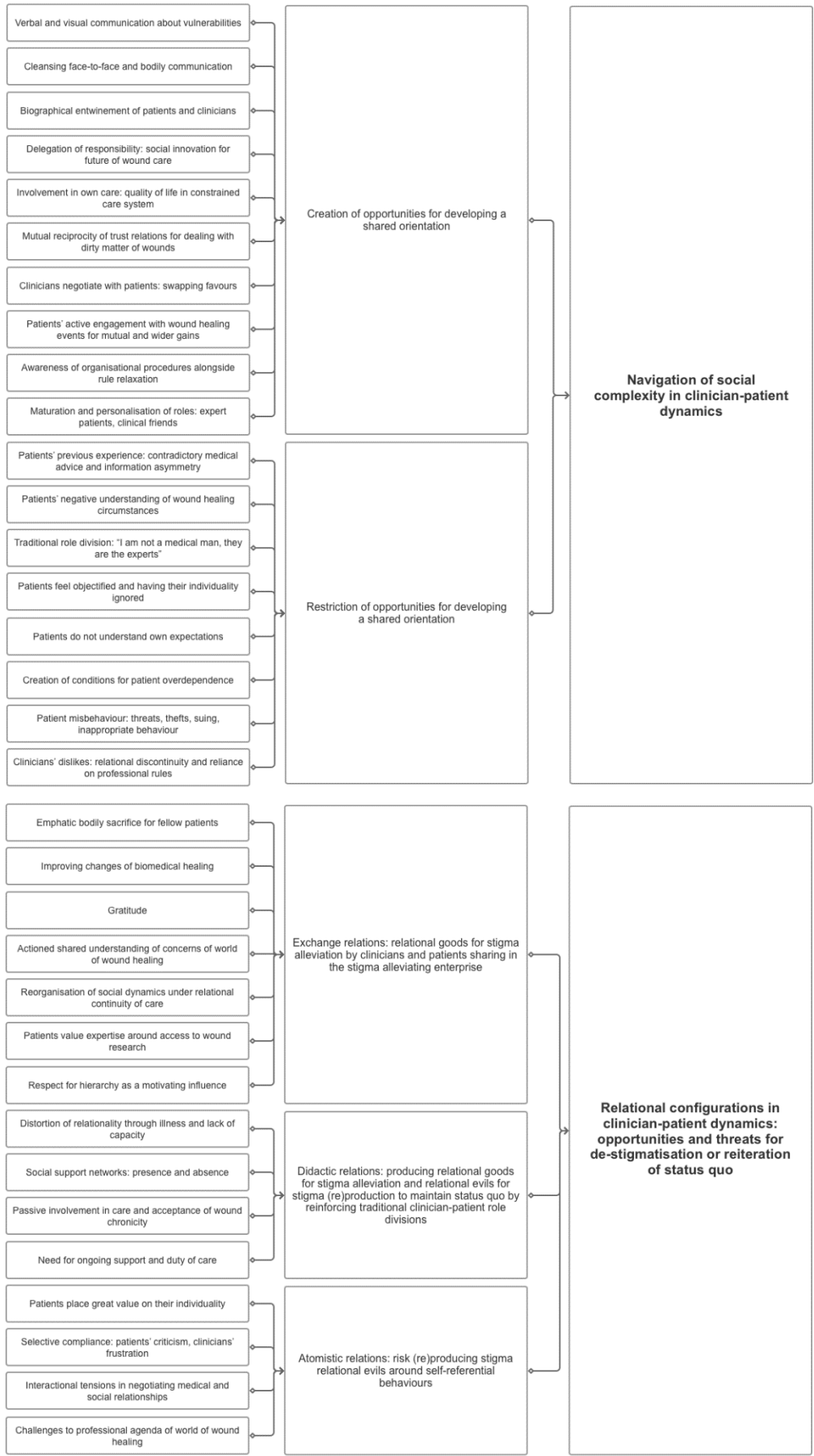
I began by identifying words or phrases which communicated meanings relevant for my data categories. I then coded them using the participants’ own words or my descriptive phrases, which generated hundreds of 1<sup>st</sup>-order concepts. Next, I searched for similarities and differences among the codes to reduce their number by grouping them into themes derived from my reading of the data and from existing literature in the fields of dirty work and relational sociology. Although the dirty work

literature was my initial source theory, emerging themes around clinician-patient relationships did not have adequate theoretical referents. Therefore, these concepts were theoretically populated with relational sociology as a supplementary theory later in the theorisation process. In the spirit of inclusivity that characterises critical realist analysis, data coding incorporated actors' discourses and theoretically deduced categories as contextual and structural determinants of these discourses (Rees and Gatenby 2014). Finally, I distilled the emergent 2<sup>nd</sup>-order themes further into 2<sup>nd</sup>-order aggregate dimensions. Figure 1 below provides my final data structure.

**Figure 1. Data structure for 'Managing stigma in UK wound healing clinics'**<sup>15</sup>



<sup>15</sup> See Appendix 8 for samples of additional 1<sup>st</sup>-order interview extracts and fieldnotes in support of the 2<sup>nd</sup>-order themes.





Finally, I must disclose the practical reasons behind the choice of the Gioia methodology against an understanding of its limitations in supporting retroduction. This choice was fuelled by the esteem in which I hold the work of my supervisor, who first introduced me to the method and subsequently published work with it (Meliou and Edwards 2018). Moreover, my doctoral training was generously supported by Cardiff Business School who funded my attendance at the alluringly named 'Doctoral Sweatshop' at the London School of Economics, where the Gioia methodology formed an important part of the curriculum. I agree with Al-Amoudi that the Gioia methodology may hide "under the carpet all the inconvenient facts that, nonetheless, are the gold dust from which truly novel research is forged" (2018c). This 'gold dust' is addressed when considering recommendations for future research in the concluding chapter. However, within the time frame of my doctoral research the Gioia methodology offered a neat and pragmatic way of dealing with my data.

### **3.6 Summary**

This chapter shed explanatory light on the methodological thread running through this exploratory, emergent and iterative study of clinician-patient relations developing in the context of stigmatised wounds and dirty wound healing work. This chapter itself has been iterative. It has explained how critical realism, which has not yet been given much explicit attention in dirty work scholarship, sits in the methodology employed to bring to light neglected issues of emergence and 'realness' of dirty work and the social relations within it. However, it has also explained how I have jettisoned certain aspects of critical realism, such as the historical morphogenetic approach, in my selective adherence to a strict critical realist framework. The presentation of the critical realist ontology was therefore crafted onto how I deal with 'parts' in this study – from qualitative ethnography in healthcare through wound healing, dirty work, social relations, observational and interview methods, patients, their relatives, and clinicians. The chapter ended with a figure detailing the structure of my data that was arrived at with guidance from critical realist conceptions of the world and knowledge discovery. The relations between 1<sup>st</sup>-order concepts or between 2<sup>nd</sup>-order themes, which explain how combinations of entities could potentially lead to the transformation or preservation of the wound healing context, are delineated in the following empirical chapters, which follow the order outlined in the figure above.

## 4 Dirty work of wound healing and the stigma of wounds

You wouldn't get excited about scabby feet, would you? It's a tough job, but somebody's got to do it (hospital specialist, fieldnotes, Davis Clinic, October 2016).

In order to appreciate the social complexity around how and why wound clinicians and patients with wounds come to build relationships, this chapter offers a “bitterly frank” (Hughes 1958, p.51) description of real-life experiences of clinicians caring for wounds and of patients living with wounds. First, the chapter shows that the nature and conditions of social interactions between clinicians and patients in an outpatient consultation means that wound healing can be categorised as a form of dirty work. The issues, unpacked using participants' discourses, put the physicality and emotionality of the dirty work taints at the fore of the wound healing practice<sup>16</sup>. Then, the chapter examines patients' perceptions and experiences of living with wounds and how they negotiate their care on a daily basis outside of the outpatient clinics. The integration of patients' perspectives contributes to an understanding of the taints of the dirty work of wound healing and wider wound stigma. Throughout the chapter, the explanation of wound stigma is linked with discursive and structural contextual conditions under which wound healing operates in the UK. This chapter is guided by a research sub-question:

What does wound stigma look like in relation to the nature and conditions of interactions between clinicians, patients and patients' relatives in wound healing clinics, and what causes it to emerge?

### 4.1 “Here, you just have to get in and do the dirty work”

The designation of wound healing as dirty work, unambiguously articulated in the section heading above which is taken from the interview with podiatrist Sam,

---

<sup>16</sup> Because “the wound care community is very small – everybody knows everybody in wound care” (Christina, director of clinical education), some of the evocative descriptions hinting at judgement or disgust experienced at work are not assigned to the individuals who voiced them. Nonetheless, these descriptions must be included in the dissertation because their concealment would give “a false notion of the problems which have to be faced”, thus risking the masking of “the possible psychological and social by-products of the solutions that are developed for the problem of disgust” (Hughes 1958, p.51).

obliquely permeated the discourses, and manifested in the actions, of wound clinicians, patients and patients' relatives who often accompanied them to consultations, and, as such, represented important actors in the consultation dynamics. Below, a vignette of a patient with gritty malodorous weeping wounds on her feet opens with an account of the dirty work of wound healing. The selection of unsightly wound appearance and malodour as the points of departure for evidencing the dirty designation of wound healing work, should come as little surprise given their coverage in chapter two that reviewed outsiders' perceptions of this work. Correspondingly, the evocative fieldnote below, collected on one of my first visits to Bridge Clinic, confirms this perception by showing how my own introduction to the clinical practice of wound healing was heavily mediated by my embodied novice exposure to raw cuts in the human body that seeped thick drainage and emanated foul odours:

A patient in a wheelchair is brought into the clinical room by a man who, as I soon learn, is her brother. The patient appears aloof; with heavy dressings on both her legs, she is unable to transfer onto the bed on her own, so her brother and nurse Eva help her. As doctor Carrie takes the bandages off, she comments on how 'nasty' the patient's legs are looking; she should not have allowed for the mud to get into the dressings. Am I detecting a sense of irritation in Carrie's voice? With the dressings off, a pungent smell attacks my nostrils. I feel a lump forming in my throat and try stifling a cough as I notice the patient's heel is black – necrotic, dead. The room starts filling with more clinicians. I now have an excuse to move away from the source of the smell of rotten flesh that is slicing through the air. The hospital specialist lifts the patient's leg as Carrie begins removing the necrosis with a scalpel. Blood is dripping onto the bed and a ball of dead tissue comes out, leaving a hole in the heel. Although, at first, Carrie seems unaffected, I spot her wince whenever she looks away from the patient – a natural sign of a visceral repugnance ... The smell is lingering after the patient has left the room (fieldnotes, Bridge Clinic, July 2016).

On the outside, wound healing work has many material and corporeal facets that can cause strong visceral repugnance. Wound clinicians routinely perform body care activities in intense proximity to purulent ulcers, fetid infections or putrid gangrene. Judging by my own instinctual reactions, individuals unfamiliar with wound healing work can find it revolting, intrusive and intolerable. In the vignette above, 'dirt' is also 'literal' – caused by mud from the ground that got into the patient's dressings that were supposed to keep the wounds clean. Here, the physically dirty overtones of wound care appears symbolically enlarged by the

common location of wounds on the lower leg or foot – “the lowest and maybe weakest part of [the] body”, as patient Jane pointed out, and a body part which in many cultures has historically been seen as taboo due to it being considered the most inferior and dirty part of the human body (see Douglas 1966)<sup>17</sup>. In addition to physically affecting some of the clinicians, the practices involved in caring for wounds on patients’ lower extremities, which were often swollen from the build-up of fluids, put a further strain on clinicians’ bodies. “You need to be nice and fit”, joked clinical photographer Roman, before explaining the effort involved in finding the correct position to establish the best viewing angle for capturing wounds. Despite the availability of a small number of adjustable beds and occasional usage of patient handling hoists, nurses unequivocally blamed “bone-breaking” (Trina, district nurse) “bending with the ulcer care” (Claire, tissue viability nurse) for pain in their back, neck, shoulders and knees:

A lot of the couches don’t go up and down. That’s not acceptable. We should have the right equipment to be able to do the care. But you tend to accept and just get on with it (Christina, director of clinical education).

The above introduction briefly introduces some of the material and corporeal associations of the wound healing specialty with physically dirty work. In so doing, it sets the scene for the following section. In what follows, I delve deeper into the stigmatising perceptions of wound healing work, in terms of their hidden contextual causes and consequences, and further emotional taints revealed by broadening the dirty work analytical lens from ‘clinicians only’ to ‘the patient–clinician relationship’ as a whole.

#### **4.1.1 How can you do it?**

It’s such a visual thing, wounds (Emma, clinical photographer).

There was an explicit agreement amongst wound clinicians, patients and their relatives that wounds were not nice to look at. In both the interviews I conducted with clinicians and in the professional presentations I attended, wounds were described as ugly, slimy, horrific, deforming, or mutilating. This depiction appeared to be shared by distressed patients and their relatives who showed their awareness of the ungraceful smell and appearance of wounds, by scornfully and self-

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<sup>17</sup> See, also: <http://www.traveltaboo.com/feet-taboo/>.

deprecatingly referring to them as stinky, mucky, messy, gooey or 'slothy' [sic]<sup>18</sup>. "Welcome to the horror show", was one mordant greeting used by a patient in Bridge Clinic when I entered his consultation room (fieldnotes, February 2016). "This would have made me scream in the past", I overheard another patient say to a nurse who was taking the dressing off his healing foot ulcer (fieldnotes, Morgan Clinic, January 2017). The associations of wound healing with that from which people would look away in displeasure highlighted a connection with the classic understanding of dirty work from Ashforth and Kreiner's (1999) article "How can you do it? ...". Presented below are pertinent examples of reactions from other healthcare professionals, clinicians' family members, friends and even patients themselves, respectively, as reported by clinicians:

There seems to be an aversion to feet, so when you say you work with feet, and then you add on the bit, 'I work with diabetes, and we deal a lot with gangrene, dead tissue and debridement of ulcers', and that really then does turn their stomach (Sam, podiatrist).

I was trying to explain what I did and what my job was ... and they said, 'Oh my God! I don't know how you can do that, it's absolutely disgusting! Doesn't that turn your stomach doing it?' (Ella, podiatrist)

'Why do you want to do that?' Ha-ha! They do think I'm a bit nuts wanting to deal with wounds, day in and day out. They are like, 'Surely, there is a better part of nursing to do than looking at that every day?' ... I don't think they quite like the conversation about it. And it's like, 'Oh no, that's too much information'. So, I just tend to not really say a lot (Megan, research nurse).

How do you think patients feel when they have photographs taken of their wounds? (Anna, researcher)

They think you're crazy. As in, 'Why would we want to be doing this?' (Lauren, clinical photographer)

The routine practices in wound clinics unfolded against the background of unpleasant sights and odours; angry weeping skin tears emanating sweet aromas of almonds through chemical smells of ammonia to putrid stench of rotten, decomposing flesh. Reverberating throughout the clinics were patients' own angry utterances of displeasure at wound malodour, with various levels of emotive undercurrents; from nervous and self-conscious questions, along the lines of "is it

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<sup>18</sup> "Patients used the word 'sloth' a lot. They never say 'slough', they say 'sloth'" (Mary, nurse).

smelling?” (fieldnotes, Bridge Clinic, August 2016), through to relatively objective and dispassionate symptom descriptors, such as “the smell is quite strong” (fieldnotes, Morgan Clinic, August 2016), to reproachful and angry grumbles, for example “it stinks, everything stinks!” (fieldnotes, Bridge Clinic, October 2016). Some smells were physically intrusive, with professionals whose involvement in wound clinics was recent or interspersed with duties in other medical areas noting the olfactory visibility of wounds at work and their lingering presence outside of work:

You need to go home and have a shower. But especially with some of the acute diabetic wounds we see, because some of them are, can be very, very smelly ... Even when you wash your hands, it's still just there (clinician, anonymised).

I think the smell of the wound is very much like rotting meat and we associate that as badness and illness (Paula, clinical photographer).

In contrast, specialist clinicians with many years of devoted experience noted that they no longer noticed some of the odours. As explained by the hospital specialist, his nose got used to smells over the years, so if he could smell the wound, then he knew it was “bad” (fieldnotes, Davis Clinic, June 2016). As found in many dirty work studies, and wound healing, too, the long-term experience of unpleasant tasks necessarily led to a degree of de-sensitisation and normalisation of the dirty matter, insofar as it aided the medical diagnosis. For example, I saw nurse Eva help herself to a sweet brought to the clinic by a patient, then lean over the patient's ulcerated foot to inform him dispassionately that the wound was “a bit smelly” (fieldnotes, Davis Clinic, August 2016). On another occasion, I watched nurse Susana bring a heavily soiled dressing close to her nose and then tell the patient that it smelt “a little bit, not too bad” (fieldnotes, Bridge Clinic, August 2016). However, even veterans in wound healing recognised that their closeness to “smelly wounds” or “scabby feet” (hospital specialist) rendered their work a taboo subject in society.

#### **4.1.2 Wound care and wounds as taboo subjects**

Gosh, where do you start really? The thing is ... I think [the hospital specialist] will probably agree that wound care is such a taboo subject in society! The [hospital specialist] will agree. It's not there in the media ... you don't get to see a lot of the wounds when you are in a really bad state ... there is not a lot about foot ulcers or gangrene (Ella, podiatrist).

At a historical juncture in which “external appearance is much more important than ever before” (Kate, doctor), images of yellow pus oozing painfully from a purulent sore on the sole of a purplish swollen foot can offend the tastes of the public and are therefore kept away from their gaze. Culturally invisible, hidden under dressings to prevent infections, and too “yucky and horrific” (receptionist, fieldnotes, Bridge Clinic, April 2017) to be shown on television, clinicians agreed that wounding is a low-profile and unappreciated medical issue – “almost like the kind of disease [the public] don’t talk about” (Ella, podiatrist):

‘You can talk about it, but don’t show us the wounds. We don’t want to see them. They are disgusting, they’re ugly, they are smelly’ (hospital specialist).

We need to talk about wound healing and to raise its profile (Ella, podiatrist).

Aware of the low-profile of wound healing, patients complained about public ignorance and false beliefs about wounds, which manifested in an unconcerned misunderstanding of this important medical problem:

As for wounds, I don’t think you see anything, do you? ... if you just see a cut, it’s a cut, innit [*sic*]? People don’t know what goes on internally ... you see a blister on a foot or a graze, you just put a plaster on it. It’s what people think (Rick, patient).

As explained by clinicians, the majority of the scarce media coverage of wounds centres on their traumatic or acute nature. Wounds feature on television in medical shows to add drama to car accidents or surgical procedures. Chronic wounds, like venous, arterial or diabetic foot ulcers of the kind that many of the patients I met during my research suffered from, are less ‘popular’:

They do get on TV series, but it’s the casualties, it’s the car crash, so I think the chronicity of wounds ... there is a programme I haven’t seen myself. It’s called ‘Embarrassing Bodies’. They have hard wounds on there and skin conditions on there. But straight away it’s putting a negative play onto that (Christina, director of clinical education).

The mass media in general appeared to provoke the denigration of patients suffering from chronic wounds:

I know it sounds a bit drastic, but I feel like I’m rotting away. I know that might seem a little bit over the top, but I read somewhere years ago that people with diabetes they ... they, rot from the inside (Jack, patient).

The tellingly titled television programme and reading materials projected an insensitive narrative around wounds and wound care. In addition, one nurse recounted her offence at being approached by a television crew looking to recruit patients with wounds for a dating show about people whose medical conditions might stand in the way of their quest to find love. Thus, the attitude in the mass media towards wounds might pre-condition the public to perceive patients with wounds as being identifiably different from healthy people.

#### **4.1.3 Acknowledgement, explanation and attempts at alleviating stigma**

Wound healing clinicians did not negate, but, rather, accepted, pronounced and skilfully manoeuvred the tabooed perception of wounds in society to dispel any misconceptions about the nature of wound healing work. The association with physical taints was routinely openly spoken of in front of anyone interested in wound healing. “You need an afternoon off after seeing wounds all week, you will need to hide in a dark room and cry”, joked the hospital specialist to medical students visiting Davis Clinic at the end of one education day (fieldnotes, October 2016). Clinicians felt that the physically off-putting nature of their work accounted for a reasonable proportion of why, in general, wound healing was not seen by other doctors as a popular area of medical interest. This suspicion was soon confirmed in my research conversations in and outside of my fieldwork:

The wounds do have an element of ... they are unsightly, they are smelly. So, for me, I would not enjoy clinical practice dealing with those wounds every day. It would put me off (clinician, anonymised).

Within the first week of my fieldwork, still shaken by the unfamiliar severity of diabetic foot complications, I offload to my close friend, who is a medical student. I begin fervently praising the clinicians who seem professionally unaffected by the sights and smells, which they come into intimate contact with on a daily basis, and which I still cannot quite get out of my ‘sensorial system’. ‘Looking after diabetic feet? Well, what a career choice!’ my friend comments degradingly (fieldnotes, June 2016).

Returning to the aforesaid educational day in Davis Clinic, the hospital specialist ended his explanation of a very complex wound condition by saying to his students, “You wouldn’t get excited about scabby feet, would you? It’s a tough job, but somebody’s got to do it.” This quote lends support to the argument that what makes other healthcare professionals say, “I would not enjoy clinical practice dealing with



those wounds” might, in fact, be repugnance at the physically dirty work required by wound healing clinicians. However, it also suggests that wound healing clinicians drew a sense of satisfaction from doing this kind of dirty work. To them, the physical taints offered scope for crafting a sense of potential satisfaction over other healthcare professionals in the medical community, stemming from being able to perform work which, although it is necessary, many people do not want to do.

In addition to their awareness of the potentially off-putting physical aspects of wound healing work, clinicians expressed concern that the general contextual conditions around them were contributing towards wound healing not being deemed a high-priority. Starting with the local level of the NHS organisations with which they contracted, clinicians felt the position of their clinics within the hospitals in which they operated were unclear. The annoyance at feeling different and unwelcome was unconcealed:

It doesn't fit. We've been squeezed in like the cuckoo in the nest ... the number of times I've tried to get adequate and appropriate funding for the service, and I've been told by the NHS managers, 'Oh, I've never done this before, this is too complicated, this is too difficult, just carry on and we'll forget about you'. We are very much cuckoos in nests (hospital specialist).

Commenting, more generally, on the perception of wound healing within healthcare, clinicians further observed that it did not yet exist as a recognised scientific specialism:

I still think we are on the periphery. I think we're seen as a nice extra. But we are not seen as a priority enough to have a specialism of wound healing, to have standardised training, to have a medical career pathway (Christina, director of clinical education).

If you've got a problem with your heart or your guts [you go and see a] cardiologist, gastroenterologist ... Who do you go and see if you have a problem with a wound? It could be anybody ... if you have a problem with a wound, you should go and see a 'woundologist' (hospital specialist).

Even when I speak to people and they say, 'What are you doing?' You say, 'I'm a research nurse in wound healing'. They are like, 'What can you research to do with wounds? It's quite straightforward, isn't it?' And we're like, 'No' (Megan, nurse).

Firstly, clinicians identified the lack of education about wound healing as a barrier to overcoming the undervalued perception of their work as “a nice extra”. Christina continued:

We’re starting in work, trying to find out what is taught in the medical nursing curriculum of the undergraduates in relation to wound care. There is very little. And there is no consistency across the universities. And quite often it is taught by people who are not practising clinicians.

Although two clinicians recruited by the hospital specialist wrote their dissertations on wound healing, most did not have an official wound healing qualification, but, rather, learnt to care for wounds in their experience as either district nurses, in secondments, or in research posts in the wound healing clinic. This shows that the understanding of the theory of healing wounds and the knowledge of practical skills, such as bandaging, has not been given strong emphasis in healthcare training. This was seen as a barrier that wound clinicians were trying to overcome by reaching out to other disciplines and involving them in wound care:

I think it’s historical. It’s barriers that we are slowly breaking down to actually get them to understand really what we do. Years ago, a podiatrist used to be known as chiropody. And chiropodists were well-known for just cutting toe nails and debriding hard skin. There was no real link with wound care. So, now, cause the role has changed, we are now podiatrists, we all have degrees in podiatry, then I don’t think their education is not realising how our role and how our job has actually developed ... so we’re providing education sessions at the moment to GP surgeries, to practice nurses, to nurses here, to nurses on the wards (Sam, podiatrist).

Secondly, the disinterest shown by other disciplines within medicine towards wound healing was a product of long-standing patriarchal structures of care. As stressed by nurse Amanda, most of wound care today still remains within the domain of nurses’ work; it is estimated that between 60 and 70 percent of wound care is delivered by district nurses and practice nurses. Therefore, almost unavoidably, wound healing still maintains its traditional association with the “‘feminine’ profession such as nursing” (Lorentzon, 1990; Witz, 1994, cited in Bolton 2005, p.170) and its qualities of kindness, tenderness and caring for people, as opposed to the medical skills of diagnosis and prescription.

Only recently have people recognised that, because wound healing developed many years ago and it developed with dressings, and it was very much seen as a nursing issue. And then it’s only now we are catching up with the scientific knowledge

because the dressings, you know, doctors are like, 'Oh, we don't do wounds, that's the nurses' job' (Amanda, nurse).

My conversation with paediatrician Camilla, who was uninvolved in the running of these particular clinics, led me to wonder whether the perception of wound healing as a nursing issue might be eroding the significance of wound healing as a specialty. Below, the paediatrician strongly questioned whether wound healing clinicians made any difference at all to patient care:

I do think it's an area where the nurses play the most important part, personally. I think it should be integral to nurse training and good nursing skills. Do I believe there is a need for a specialist wound healing service? I don't know. I have been involved in consulting them, but did it add to the cases? I'm not sure. I'm not sure this has added more than expert nursing added.

Thirdly, most scientific progress in wound care noted by Christina has been masked by the industry developing new and improved dressings. Clinicians felt this might not be helping the true science of the subject area:

People focus on the dressing, and the dressing is the least important factor in the whole process. It's understanding what's going on. And when the patient isn't healing, people try and change the dressing. Whereas, in fact, they need to go back and look at the individual to say why they are not healing? Are they malnourished? Have they got a low white blood cell count? Have they got the diagnosis in the first place? But it does not happen consistently across the whole of [the UK]. I think the nursing, podiatry and medicine. Again, it's because [wound healing] is not a specialism, in cardiology they are told about the cardiology system, or they are taught about the respiratory system, neurology system. But they will not be taught necessarily about wound healing (Christina, the director of clinical education).

As a result, many people held a simplistic and faulty association of wound care with merely changing dressings. This served as an obstacle to patients' recovery, not least because dressings were but one, and perhaps the most passive, approach to wound healing – with progressively more active approaches utilising devices, drugs, surgery, and biological agents such as stem cells (Queen 2018). Moreover, combined with the constraints of the cost of dressings and the siloed approach to budgeting, this obstacle further challenged the credibility of the wound healing specialty. For example, in the UK there is a government-approved list of dressings that can be prescribed, and the hospital then chooses which ones can be used. Here, silver dressings could not be used in Bridge Clinic because of their high-cost,

requiring clinicians to make do with what they had (fieldnotes, Bridge Clinic, September 2016):

Because of the way in which the budget is sort of siloed, I can put a cheap dressing on and save money, but that cheap dressing has to be changed every day as compared to an expensive dressing, which needs to be changed every three days. And the increased cost of the dressing releases far more savings than saving the cost of the dressing where I've got to go three times to do it, whereas I might have done it once with something else (hospital specialist).

Having been out to see a number of different GP, ECGs (electrocardiograms), community practitioners, the focus is very much on prevention, disease prevention, wound management but not necessarily for wound healing. It tends to be, rather, other chronic disease management ... Wound healing is not a priority. It is when it comes to cost and the cost of wound care product, but it isn't in terms of the overall management, the time, and just people's attitude towards managing chronic wounds in the community (Deborah, tissue viability nurse).

Consequently, according to Deborah, outsiders to wound healing failed to fully understand the complexity of wound healing in terms of the knowledge, skills and attitudes required to medically heal a wound, not to mention the emotional difficulty that patients with wounds go through.

#### **4.1.4 Emotional taint characteristics in handling physical taints in wound healing**

Aversion to the sight, smell and drainage from wounds can mean that patients with wounds might have nowhere to turn and feel alone. This requires an occupational response from wound healing clinicians in which they must combine genuine clinical interest in competently treating wounds with empathetic interactions with patients. Clinicians from this particular wound healing organisation along with clinicians running community-based wound care provision initiatives both recognised the negative emotional implications of living with a condition that "nobody wants to see":

The main thing is compassion ... you need to really be interested in people with wounds, because there is [I'm not sure] how far it's true, but people say that, with wounds, nobody wants to see them (Phil, doctor).

I felt it was a 'Cinderella service'. That it caused people a lot of problems, a lot of pain, anxiety, embarrassment and it stopped them going out. Because they had nobody, really, who was

interested in their problems in the medical profession (Pauline, community-based wound care provision lead).

Clinicians recognised that many patients were only coming to the wound clinics out of desperation. They have often failed to access a service nearer to home that might be able to help them because “nobody’s interested in them” (hospital specialist). Therefore, Doctor Phil’s above succinct encapsulation of the importance of emotional experiences and displays by wound healing clinicians for reassuring recognition of wound stigma invites a consideration of the emotional taint characteristics involved in doing the dirty work of wound healing. In the words of prosthetist Andrew:

There are people for whom, the emotions of going through wound healing, that’s not healing, or going through the process of applying dressings, being treated with no progress in sight, you do see people get very emotional and can get very down at the position that they are in.

When asked what the most demanding aspect of wound healing work was, podiatrist Ella explained:

I think emotionally it does impact you. I don’t think you would be a human being if it didn’t.

Empathetic recognition that patients were often feeling low, vulnerable, embarrassed, angry, dependent on others, depressed, and, in the most difficult cases, even suicidal (e.g. patient Theresa in the past), was vital for how the delivery of very physical wound care activities incorporated emotional considerations. Required to directly handle inelegant physical facets of wounds whilst being sensitive to patients’ emotional reactions, raised a tension between instinctual responses to visual and olfactory dirty matter on the one hand, and, on the other, the requirement for professional honesty towards the patient and emotional management of these responses to save the patient further upset:

I always try to remain professional, because the patients are always upset about it, and say, ‘Oh, it’s awful’ and you say, ‘Oh, it’s not that bad, we get a lot worse than this son don’t worry. Whatever your leg is like, I can guarantee that I have seen worse and smelt worse’. And you just try and reassure them, and sometimes it is the worst I’ve ever seen, ha-ha, but I don’t want them to know that. It’s a real challenge (Ella, podiatrist).

People can come in with necrosed dead toes, which actually drop-off during the examination process. But because I’m from a nursing background, from day one I’ve been exposed to wounds

and wound care. So, for me, I see it as part of my role, it's been normalised over the years. Sometimes a wound will be undressed downstairs and it's quite striking and you've got to stop yourself gasping when you see some of the wounds. And sometimes the smell is pungent. But over the years you've learned to become a good actress, I suppose, and just keep calm on the outside and be non-judgemental. Because, as bad as it is for you, it's 10 times worse for that person living with it 24 hours a day. The only saving thing, we do a lot of diabetic wounds, when you look at them and you see them and they are quite horrific, worse than anything you would see on a film or in television programmes like 'Casualty', they can never really do mock-up dress to real wounds. The only saving grace for the patient is that sometimes they have quite significant nerve damage, they can't feel it (Catherine, diabetic nurse).

Wound clinicians' professional demeanour disguised the careful management of bodily limits to some material 'dirt'. Although, reservedly, clinicians would sometimes give accounts of feeling "physically sick", "gagging", or having their "stomach flipping". One horror story that was shared with me in Bridge Clinic involved a patient turning up to his appointment with maggots coming out of his leg from a fly that laid its eggs in the wound after the patient had fallen asleep in the garden. "Not the medicinal maggots that come in little teabags", I was told. "The nurse nearly fainted". It is, perhaps, inevitable that clinicians, being human, would experience similar physical reactions to wound smell and appearance. This has a scientific justification as a natural bodily reaction to the threat of contamination. However, the moral order of the clinics that underpinned medical encounters was to "just swallow it" (Eva, nurse) and reassure the patient that they have seen or smelt worse, even if that was not necessarily the case. Aware of "the emotional aspects of having a stinky, smelly horrible wound" (Helen, orthopaedic specialist), clinicians would generally sidestep their visceral reactions to avoid uncaringly further upsetting the patient. Therefore, they would not give the ungraceful aspects of wounds any more attention than they deserved, be it to aid the diagnosis of an infection, or to empathically alleviate patient distress with assurances of the commonality of smells for various infections and the ability of the right treatment to address patients' concerns.

From the day you start training you should never show when something is awful. You just make your excuses. If it's a really smelly wound you just say, 'I'm just going to go get some dressing' and then you come out, get a breath of fresh air and go back in. You would never show to the patient that you were distraught. Because that's just not nice for somebody to think (Amanda, nurse).

Different types of smells tell you different types of infections that are present ... So, whether it makes you feel right or not it doesn't matter, because all that is telling you is extra information that you've got of the wound to choose treatment (Sam, podiatrist).

A patient says she is 'desperate' to get their legs healed. She then asks the nurse, 'How do you know that it's infected? What are my legs telling you?' The nurse replies that she can 'tell by the smell of the wound' (and the surface of the wound bed, which seems elevated) (fieldnotes, Morgan Clinic August 2016).

Finally, there was the emotional cost stemming from getting to know the patient over the years and watching them decline as an individual and eventually pass away. This required clinicians to develop their own emotional coping strategies to manage the effects of emotional taints, centred on their inability to help patients, to protect their own emotional well-being:

We often talk to each other because we often all know the patient ... This particular gentleman, this particular lunchtime, another nurse and myself, we sat down and talked about it and it was just really nice to kind of, almost have this non-formal clinical supervision if you like, but being able to talk about how you were feeling and just saying ... You know, it was sad but we knew we did everything we could and we couldn't change the outcome (Ella, podiatrist).

## **4.2 Wound healing as a third-party agent of dirty work**

Having considered the emotional taint characteristics of wound healing work, this sub-section returns to the lack of interest in patients with wounds in the healthcare community. My research suggests that the lack of willingness of other clinicians to come into contact with the dirty matter of wounds, as well as the resulting difficult and challenging emotional reactions of patients, creates a need for a third-party agent (Hughes 1962; McMurray and Ward 2014) who can face these taints. As considered below, by assuming this noble role wound healing clinicians run the risk of being further stigmatised.

### **4.2.1 "Somebody's got to take ownership"**

Although some wounds that patients presented with were described by clinicians as "nice'n'easy", generally speaking, in wound healing clinics it was regularly stressed that clinicians took 'all-comers', who were not always straightforward cases. As doctors Kate and Phil explained, patients with wounds suffered from a wide umbrella of sometimes related and other times completely unrelated bio-, psycho-

and social issues, ranging from cardiovascular disease and diabetes, through to substance abuse, mental health and self-harm problems to loneliness and isolation, which presented as the one wound. From the viewpoint of the clinicians whom I interviewed, in light of this complexity many patients reported to wound clinics as a last resort. Having exhausted their local treatment options from individual specialists that tend to focus on single areas, they found themselves 'out of place'. By contrast, as doctor Phil explained, the underlying philosophy of these clinics that prided themselves on expertise in healing wounds was generalist, starting with a highly-complex exploration of "each and every thing" that could cause the wound, before proceeding to work from bedside to bench. In the words of doctor Kate:

The human body should heal, a wound should heal, there shouldn't be a wound on a human unless there's a reason why that person can't heal it. This is why [the hospital specialist] is constantly harping on about how this is not a dressings clinic, this is a wound healing clinic.

Given the cross-specialism approach facilitated by access to the multidisciplinary team in wound healing, some of these factors were correctable, thus making it possible to arrive at the "perfect solution" (hospital specialist) of healing followed by a patient's discharge from the clinic. Others required clinicians to settle for a "better outcome" (hospital specialist), with clinicians finding themselves in the emotionally difficult situation of having to admit that there was nothing else they could do other than to manage the wound. This was the case with the three patients described below:

The next patient is a man with an aortic valve, who was operated on in 1997. The wound on his chest used to be open, but since he started seeing the wound care clinicians for six-weekly appointments, it's closed further. 'They can't fix my wound, but they are helping me', says the patient (fieldnotes, Morgan Clinic, July 2016).

I meet a patient with a complex, chronic incisional hernia who 13 years ago underwent an emergency operation. 'For patients like him, often there is no right or wrong answer. How do you measure success in wound healing? He's not healing, we haven't given him his tummy back, but the clinical photographs we have taken are evidence that we are making some difference', explains the hospital specialist (fieldnotes, Morgan Clinic, November 2016).

The hospital specialist explains that he does not want to discharge a wheelchair-bound patient with an unusual pilonidal sinus disease, but keeps him on the books so that his mother, when concerned, can call in to be invited to the next clinic. 'The softie bit



of medicine that many doctors don't get', he explains, telling me later that the patient's sister who suffered from the same condition had an infection from a pressure ulcer and passed away (fieldnotes, Morgan Clinic, December 2016).

Patients with non-healing wounds were discussed by the hospital specialist as being challenging from the perspective of governmental figures. As he explained, he felt that when doctors exhausted their treatment options for patients whose wounds did not heal, they referred them to other clinicians to protect their statistics of success. This is where the specialist tertiary service of wound healing appeared to step in. Their occupational response was to adopt an overall generalist responsibility for the orchestration of care for such patients while retaining an inclusive orientation, inviting the expertise of "friendly specialists in [other] disciplines" (hospital specialist) into the consultations through a memorandum of understanding and formal combined clinics:

My philosophy is, which again is slightly unusual ... I will take charge of that patient, I will work that patient up to the best of my ability. And if I need a colorectal, a dermatology, a diabetology or a vascular surgeon or whatever, I'll go and ask for that opinion. And I'm asking, 'Can you do something, yes or no? If you can do it, do it and give it back. If you can't do it, still give it back to me so that I will still sit in the middle' (hospital specialist).

This sense of self-assumed responsibility for the coordination of care for patients referred to in the wound healing clinics can be seen to connect with a 'mantra' which was 'chanted' by the hospital specialist to patients in consultations and to visitors to the clinics: "I can't guarantee I'll heal you overnight, but what I can guarantee is that I won't lose interest". 'Not losing interest' was part of the compassionate appreciation that many patients who eventually came into wound healing "have been in the system and the system has played with them, and when they've got bored of playing with them they've thrown them out again" (hospital specialist). Therefore, wound healing clinicians admitted taking a pragmatic approach to treating patients to prevent inefficiencies and reduce the unnecessary interventions by other clinicians, such as general practitioners or practice nurses. When it came down to the wound clinics' organising practices, this translated into never discharging patients from the clinics:

We can never ever discard them because, more often than not, somebody's got to take ownership (Claire, tissue viability nurse).

The consultation was often used as a space for discussing difficult issues indirectly related to treating the wound itself, as well as those for which clinicians were not trained, be it diet, work patterns or housing arrangements. This shows how clinicians absorbed the responsibility for caring for patients' other concerns, undertaking tasks that fell outside of their direct medical expertise, to the extent that they did this kind of work safely and did not jeopardise the patient's health (e.g. they listened and asked questions about the diet, but responded by recommending referrals to nutrition experts). This was because they saw the wound as a manifestation of all these problems.

By nonetheless taking over the responsibility, wound healing represented a third-party agent of dirty work that ran the risk of having difficulty in justifying its credibility and success as a medical specialty, thus reinforcing its under-appreciation in medicine. Finally, the practical approach of keeping patients on the books to prevent continual investigations ran a further emotionally tainted risk:

The only thing I would say is sometimes in the clinic we see patients who have long waiting lists. And we have patients that still keep coming back. And I do wonder sometimes, if we keep people on our books too long and there is other people that we could help ... I do wonder sometimes about the decision there when there are people on the waiting list (Christina, director of clinical education).

Christina felt that knowing there was nothing more clinicians could do for the patient "must be awful" for the patient and the clinicians alike. From this perspective, keeping patients coming back was the morally right thing to do. However, she wondered about the ethical implications of this decision. In this sense, the noble philosophy of 'not losing interest' placed some clinicians between the hammer and the anvil.

#### **4.2.2 "The wound is their way of crying, asking for help"**

Returning to the clinics' founding principle of taking 'all-comers', I expected that clinicians' interactions with patients with wounds caused by stigmatised psychosocial issues, such as mental health issues or substance abuse, would reveal a social taint of wound healing. "Wound fiddlers" was a term in the wound clinicians' vocabulary that referred to patients with factitious wounds who, consciously or otherwise, self-inflicted their skin tears or prevented them from healing. For example, one education day in Davis Clinic, having joined a team of medical

students, I briefly observed a consultation with a young female patient with irregular wounds on the front of her calf. The hospital specialist skilfully used this consultation to demonstrate the potential of a new camera device to detect and create images of various bacterial infections, which would signal an improvement on performing wound swabs. It was only after we had left the room that the clinician told us that the patient had admitted to creating the wound with the use of an aerosol spray and a lighter.

Seemingly, in addition to being physically tainted, the wound could also be associated with moral and social 'dirt'. It spoke to moral taint through its association with patients' deviant behaviour, and it spoke to social taint in so far as it attracted the self-harm umbrella and often received unsympathetic derogatory treatment from others. Another patient with a self-harm wound on her thigh, Eleri, recounted how she met with negative perceptions of self-harm wounds from the Accidents and Emergencies (A&E) clinicians. She evaluated it as being in stark contrast with the approach from wound clinicians:

I had had some negative responses from doctors when I'd gone into hospitals for other things. They see the scars and link the two together ... I think the guys in the wound clinic, they were understanding, they understood that they're from an illness rather than anything else. I have experienced some negative reactions regarding A&E ... It's self-inflicted, you've put yourself here and once you've been treated they sort of just want you in and out ... It's that label ... it's hard to get past it (Eleri, patient).

However, wound healing clinicians made no such judgements. Instead, they stressed that patients' openness about self-harm facilitated referrals to specialist services. In this sense, self-harming patients were not seen as 'out of place', because they cooperated with clinicians whose philosophy it was to orchestrate patients' referrals to other specialist services.

In so far as caring for "wound fiddlers" was seen as dirty work, it was with regards to the emotional rather than social taint. First, the emotional taint stemming from clinicians feeling vulnerable at connecting with patients and having to admit shortcomings in their knowledge, or at feeling "heart-broken" when faced with the moral, social and emotional dirt of the feelings and behaviours of self-harming patients:

That is a minefield. I don't understand that at all. And I do ... I wouldn't say I struggle, but I do find self-harmers difficult to deal

with. Probably because I don't have the knowledge of being a psychiatric nurse (Mary, nurse).

The evidence of self-harm was just when I saw her arms. It's heart-breaking, that she has gone through that ... But it is so sad, so sad that somebody would do that and leave permanent scarring that is so obvious that they would see day in day out everybody else can see. Because you couldn't mistake that for anything else because it's so obvious. It's heart-breaking, heart-breaking, that's she's gone through that. And we've got to appreciate that some patients' lives are hard ... Dreadful. They've gone through so much and we've got to appreciate that. And just be kind, be kind and patient. As much as sometimes you want to bang your head on a brick wall, [they] just want to be the listened to (Amanda, nurse).

The majority of cases of self-harm were hard to prove, with the diagnosis often being made by a process of exclusion. Podiatrist Sam described a patient who was pouring nail varnish over her wound. At first, clinicians could not figure out why the wound was constantly deteriorating. It was only after a hospital admission when the wound had healed that "the penny dropped". The patient described by Sam was an example of patients who would harm themselves in response to their experience of social isolation and no longer having around them a circle of close family, friends or neighbours. In such cases, wound healing clinicians suspected that patients' wounds were used as a way of maintaining some kind of relational continuity in their otherwise lonely lives. This was their way of saying, "I want contact, I want human contact" (Amanda, nurse). Aware of that need, wound healing clinicians saw themselves as 'outsourcers' of the management of these emotional needs, giving "wound fiddlers" a place in wound clinics as an outlet:

I think [hospital specialist's] take on it is that they will continue to be, to kind of have that role, adopt that role and use services and in some cases, you know, if they go from clinician-to-clinician-to-clinician they will get continually investigated, whereas at least if you keep them in the one clinic and you have investigated everything else and you are, as sure as you can be, that that is the problem, then at least it prevents them becoming further medicalised by having other kind of fruitless investigations elsewhere ... it's difficult to know if the approach of just managing the wound and giving them our place as an outlet for it is beneficial or not (Kate, doctor).

Of course, equal kindness and patience was not felt at all times and by all clinicians in relation to all the patients who 'fiddled' with their wounds. The overlaps with the conventional social taint of wound healing work were perhaps most visible in the case of some wound healing clinicians in relation to wounds linked with ongoing

substance abuse. The hospital specialist suggested that some “wound fiddlers” suffered from a factitious psychological disorder under which they were producing their own wounds to get the drugs they wanted:

A patient with a lot of wounds and a stoma on his abdomen, which started with gallstones and a bowel disease. He is lying on the bed and sucking on a lollipop, his wife in a chair next to him, reading a newspaper, completely uninvolved in the consultation. ‘Are the painkiller lollipops helping?’, asks the nurse. ‘No, they are not, even though I’ve got 12 of them a day’, the patient angrily snorts back ... As I later learnt, the patient used to poke a stick into his wound and watch faeces come out, as the clinicians learnt from his wife (fieldnotes, Morgan Clinic, December 2016).

Such consultations were frustrating. Whilst the wound healing clinicians would listen and empathise with the pain, they would not provide patients with prescriptions for the heavy pain medication they demanded. On other occasions, they would simply conceal their anger at their inability to understand the motives of stigmatised populations such as drug users.

You’ve then got another bracket of junkies and all. That’s sort of soul-destroying, especially the ones who come in with relatives. You just think they need somebody to approach them. They are a bit of a pain in the neck and you think, ‘Oh, here we go again’. Somebody’s got to be there, even if it’s just to help the relatives. We have a – I don’t know if you’ve met her – a parent in Davis Clinic, her son is a junkie, he looks like he is a hippie, tattoos and long hair. And she said, ‘I’m the parent, if I don’t bother about him, nobody will bother about him’. And you think, she needs support as much as he needs support. There is nothing wrong with her, but her son is falling apart (clinician, anonymised).

As shown in the extract above, instead of staging an emotional performance they might find difficult to get into, the clinician redirected their attention onto more genuine emotions around caring for the patient’s mother. As expressed above, there is a sense of having to be there for the family, because if clinicians are not there for them, no one else will be. This reinforces the role of wound healing clinicians as a third-party agent, not only in the medical sphere, but also in the wider community of patients’ familial and social networks.

## **4.3 Wound stigma: patients' stories and clinicians' responses**

Until now, I have focused on wound stigma principally in connection with clinicians' dirty work of caring for wounds on patients' bodies and having to deal with the potential causes and consequences of these wounds concerned with patients' lives beyond their corporeality. However, of equal if not more importance is the shame, the lack of societal acceptance and unfavourable associations with having "smelly" and "horrific" wounds, as experienced by patients themselves. Although, unlike clinicians, patients did not explicitly employ the concepts of stigma and taboo in their wound stories, their specific experiences and general impressions of dealing with the physical challenges of skin tears in social interactions with family, the wider community and healthcare professionals were suggestive of the existence of the social stigma of wounds.

### **4.3.1 Relational repercussions of wounds for patients**

Early in my fieldwork, it became apparent that, in addition to the physical concerns around wounds, such as pain, infection or exudate, which patients resented, they were also very distressed by the social correlates of wounds. In particular, wound malodour and appearance were frequently highlighted as having relational repercussions through their connotations in a society with that which is deemed to be not acceptable. The following excerpt from an interview with Christina, the director of clinical education, sets the scene for this section's focus on wounds as stigmatising to patients:

I think it's to do with body image, isn't it? I don't think smell is acceptable in our culture anyway. You don't sit next to someone on a train or a plane and if they smell you don't go, 'Oh, I hope I'm going to sit next to them again'. You don't want to, it's not something that we accept. And I think body image is, our skin is intact. So, a break in our skin is alien to us.

Christina's view of the socially stigmatising correlates of wounds had parallels with patients' accounts of people's reactions to their wound malodour and unsightly appearance. For example, patients' wound stories spoke to a very powerful negative interpersonal impact of wounds on their social relations within the community:

I had a Somali lady who used to come and see me and she had a terrible problem with an ulcer at the back of her foot. And it was building up an awful lot of callus. And I said to her, 'Realistically, unless we try and get you in an offloading shoe or an orthotic to keep pressure on this area, this is unlikely to heal'. One of the pressures she had is that she is Muslim. So she had to wear sandals. Part of her religion is that there is an etiquette of how they dress. And when she goes to pray or to the mosque, sometimes she would go four times a day. And part of the ritual when she goes is to take her sandals off, wash her feet in communal water and then go to pray. And it was so difficult because she felt the compromise of her changing her footwear and having all these bandages on her feet was a big issue, because she feared she would be rejected by the community and she felt that she wasn't able to be a good Muslim. And it was very sad. As a Christian, I really related to her. It was quite nice because I had a chance to say to her that I go to church and we talked a bit about that. And it was trying to look at ways of making sure she could feel she belonged in the community and was a good Muslim (Ella, podiatrist).

Moreover, patients highlighted the power of wounds to bring about social avoidance behaviours within the confines of family life, for example. A male patient revealed that his wife would sometimes sleep in a separate bedroom because she found the smell intolerable (fieldnotes, Morgan Clinic, June 2016). Another male patient, Jamie, admitted that he did not want his partner to join him in the clinics, nor change his dressings, because she was "squeamish" and "could not do wounds" (fieldnotes, Morgan Clinic, February 2017). Relatives' disgust, which was unavoidably hurtful, was articulated and acted out. For example, one patient's children refused to help her with changing her dressings because they saw her feet as "horrible" (fieldnotes, Morgan Clinic, September 2016). Another distressed elderly female patient complained that her daughter and grandchildren no longer visited her as often as they used to because they could not "stand the smell" from her wound (fieldnotes, Morgan Clinic, July 2016). Finally, one patient's daughter frantically shook her hands off after being asked by a nurse to help her lift her mother's ulcerated legs (fieldnotes, Davis Clinic, August 2016). These experiences demonstrate how wounds can put a strain on romantic relationships, maternal bonds and grandparent-grandchild closeness, in turn, risking the weakening of private interpersonal bonds.

Similarly, negative responses to upsetting bodily qualities of wounds were presented as deriving from the public domain. As explained by nurse Amanda, uncaring reactions of the public towards the unknown smells from the wounds

played an integral role in why clinicians aimed to handle patients' disclosures of their stigmatising experiences with non-judgemental professionalism and empathy:

I think, generally, out and about, people can be very rude. And very unfeeling. Just the odd comment, 'Oh, what's that horrible smell?' is enough to make somebody stay in forever and never go back out again. I mean, there was a little old man the other day, he'd come in to the clinic on the bus, and his legs were quite smelly. And he said to me, 'Amanda, are these smelling?' And I said, 'Oh, a little bit'. He said, 'Oh', he said, 'there was a little boy on the bus and he was staring at me'. And I thought, 'Isn't that just dreadful?' He said, 'I don't think I will go on the bus again'.

Finally, hurtful comments also came from some clinicians outside of the wound healing community. For example, orthopaedic specialist Helen recalled how her colleagues who were unaffiliated with the wound clinics made unsympathetic requests to quickly admit patients with malodorous wounds, which were making the waiting area "stink". Therefore, other clinicians may also indirectly contribute to the isolation of patients with wounds:

Where I work ... I'm always getting complaints about the smell of my patients. Because the other doctors and nurses, they know what I do, it's frequently made reference to. Or sometimes if somebody's wound smells very bad and they are in the waiting room, somebody will come and they will ask, 'Please, can you get this patient in? It's stinking in the waiting room. We need to get them out of the waiting room'.

Of course, the relationship between wound malodour and disassociation from the family and wider community was by no means deterministic. Nor for that matter was the stigma encountered by patients direct or targeted at them per se; family members, the general community and healthcare professionals from other areas did not look down on the individual who had the wound, rather any hurtful reactions were focused on the olfactory or visual dimension of the wound itself. In many cases, the strength of family ties meant that many relatives would overcome their initial visceral displeasure and undertake the role of a primary carer for their wounded family members. For example, patient Jane's husband featured as a veteran in stories of family wound management regimes shared by clinicians. Below, Jane recalls the beginnings of Mike's long-term involvement in changing her purulent soiled dressings, which used to make him physically sick:

In the beginning, he couldn't even, like, the look of the dressings, he couldn't look at them, he still doesn't like the look of them. He's



dressing them, and he is going, 'Oh, God, this is disgusting'. He's not saying I'm disgusting, he is just saying this should be.

This 'disgusting' physicality of wounds appeared to operate as a bi-directional mechanism of disassociation. Not only was it causing other people to create a distance from patients, it also caused patients to distance themselves from other people. In the words of nurse Megan, patients "don't go into public places because they are frightened that other people are going to smell it". Indeed, during my data collection I heard a story about one elderly lady who had stayed indoors for four years because of feeling embarrassed at wound malodour (fieldnotes, community-based clinic, September 2016). In another story, a woman heavily reliant on a wheelchair was too ashamed of the smell to get into a taxi to go food shopping (fieldnotes, Davis Clinic, July 2016). Fretfully confiding in clinicians their distress at feeling "smelly" and "dirty" (Claire, tissue viability nurse), patients would often stay at home drained with exhaustion, or withdraw from social life due to embarrassment and social anxiety:

It's a big burden on, you know, you can't go places because you don't know when this is gonna fall off, because that's what happens to it. Gets so wet it just comes away (Elina, patient).

I don't know whether you noticed but I was standing [in the corridor]. I couldn't sit in the waiting room and see all that ... I ... umm ... got a fear of it and I think, I can't look. I know they are all covered up but I just, I couldn't sit down and have it all around me, you know, it's my worst nightmare (Rachel, patient).

Although patients covered wounds with dressings to prevent infections, they saw bulky bandages as a barrier to reaching a societal ideal of body image:

Do you think there is such a thing as stigma? (Anna, researcher)

Yes, definitely, especially for patients with leg ulcers because with the foot ulcers, in podiatry, we can kind of hide them ... But I think it's the patients who end up with large leg dressings, that's who will have the issues (Sam, podiatrist).

Similarly, some patients had 'issues' with other aspects of wound treatment. There was resistance on patients' part to wear specialist footwear, compression hosiery and use walking aides, such as walking sticks or wheelchairs, to travel longer distances. For example, on one occasion in the clinic a patient emphasised to the doctor that he did not want to go down the route of wearing specialist footwear three times during one consultation (fieldnotes, Morgan Clinic, October 2016). Their

explanatory accounts, acknowledged by the clinicians, pointed towards the stigma and vulnerability around wound treatment:

You feel a bit disabled. Cause you walk up the hill and you're sort of hobbling, you know (Jack, patient).

I don't think he likes me pushing him in a wheelchair and he can't walk (Caitlin, Steve's wife).

A few patients have told me they don't want to go down the route of specialist footwear. Do you think there is a stigma of wearing specialist footwear? (Anna, researcher)

Definitely! (Jordan, orthotist)

As patient Rick explained, "nobody wants to show people that you might have a problem because everybody wants to be fit and healthy". According to clinical photographer Alistair, the imagery of the human body that the public are exposed to daily through advertising is free from any physical imperfections:

I don't want to blame it on advertising but you understand what I mean. Generally, what people see every day is free from any sort of imperfections. People hide those things away and they get very embarrassed of them. So, wounds are covered up and hidden away.

Even when they are dressed, wounds made patients "stand out from the crowd" and "feel insecure", which echoed stigma, as confirmed by podiatrist Sam and orthotist Jordan. Patients would deliberately guard their wound problems from other people. One 16-year old patient whom I met in Morgan Clinic only let me into her consultation after the dressing change. "I don't mind talking about it, but I don't like people looking at it", she said. Patient Jane recalled the steps she took to mask wound malodour from fellow holidaymakers on a cruise:

I took my own nappy sacks so that we could put the dressings in the nappy sacks. To hide them there, and then put them in the bin. My reasoning behind it was it was safer in nappy sacks and it was fragrance-free, so it wasn't smelly. It was just a personal thing. I didn't want people thinking, 'What kind of a smelly woman is in there?' If those bags are ok for nappies, they've got to be okay for dressings.

We might explain these secretive behaviours as being underpinned by a fear of being marginalised due to a lack of societal acceptance of wounds, whose appearance and smell might seem misplaced. They are misplaced because it is not normal to smell wounds in a non-specialised wound clinic, such as in a taxi, a

supermarket, on a bus or on a boat and because the smell is unfamiliar to patients without wounds, such as the driver, shoppers, commuters on the bus or holiday makers on a cruise. Patients are deliberately concealing olfactory and visual taboos so as not to expose themselves to hurtful public reactions, which jeopardises a sense of cleanliness in the wider community. Therefore, we might view sensitive clinicians' reactions of 'Oh, a little bit' when asked if the wounds are smelly as a strategy for handling hurt in the emotionally tainted work they undertake, when they find themselves having to fill-in as a third-party agent. In so doing, they are converting wound clinics into friendly communities for the dissipation of wound concerns grounded in a different degree of intentionality than family, the general community or even other healthcare professionals. This represents a small step in encouraging organisational forms that foster stigma alleviation.

#### **4.3.2 Nonchalant treatment of wounds and wound healing**

Moreover, the patients I interviewed expressed frustration over what they saw as other clinical specialties that they had sought input from holding debasing perceptions of the wound healing specialty. These perceptions were manifested in a range of attitudes from lack of knowledge about wound clinics through to a misunderstanding of standards of wound care to scepticism about its value, which exacerbated patients' feelings of being rejected and ignored. Some patients told me that they had encountered ignorance and/or disinterest around referrals to the wound healing specialty.

In the room, the patient and his wife complained about a surgeon who 'made the wound, but did not heal it', and who did not show sufficient interest in the patient for about one year. When the patient told the surgeon that he was going to attend Morgan Clinic, he said that the surgeon's eyes 'lit up' and he seemed relieved to finally be 'getting rid of him' (fieldnotes, Morgan Clinic, June 2016).

Patient Robert, with a post-surgical wound on his abdomen, and his wife Joanna complained about feeling angry and frustrated at detecting indifference "everywhere we go" (Joanna) – from the colorectal surgeon and the nurse assigned to Robert at the hospital, from district nurses, and from the local health centre:

I can imagine a situation where some poor soul, eight-nine months on, is having this process of packing, dressing, with no end result. Nobody would be saying, 'Oh hang on, this is not right ... there is something wrong with you'. I did – I wasn't aware of [hospital

specialist] at the time – but I did talk about seeing a wound specialist, but I was told it would be months and months before I could get an appointment (Robert, patient).

He [colorectal surgeon] kept saying to us, 'You've got a localised wound, um, there is nothing much to worry about. You're perfectly well in yourself. It is a nuisance, it is a hindrance to your everyday life, but don't worry because eventually, it may take a long time, but it will heal' (Joanna, Robert's wife).

Thus, it would appear that Robert and Joanna felt that the surgical team, as well as community health professionals, were reluctant to involve the wound healing clinicians in Robert's care. Seeking clarification, I asked vascular surgeon George, himself affiliated with the wound healing organisation through his involvement in the combined Bridge Clinic, about the perception of wound healing amongst other clinical specialties. He gave an evasive answer, which nonetheless confirmed Robert and Joanna's suspicion that surgeons were not interested in wound healing:

I think wound healing is seen as an area in which results are seen reasonably slowly. So, for many surgeons who are used to a quick win, it's very often not an area where ... the majority of patients have chronic problems.

This was indicative of a siloed approach, a topical criticism of many medical professions (Barry 2017) encroaching on wound healing. Indirectly, it also perpetuated wound stigma through dismissing wound healing as a route that patients 'didn't need to go down' (Joanna, Robert's wife) unless all else had failed. Therefore, collaboration across clinical specialties was crucial for it could shorten the wound process and actually bring to bear best practice at a much earlier date:

In terms of the interrelationship between the surgery and the wound, it is by definition, intrinsic. You cannot have a wound without the initial surgery, it would seem that, at present, the wound healing process is very much an 'after the event' process. Therefore, each discipline must agree to communicate more with each other and exchange information. To what extent do the surgeons know of the types of surgery (in detail) that produces the most problems afterwards? Is there a common factor(s) in these cases? What are the common factors (if any) in slow healing wounds? How much information of the actual surgery does the wound specialist have? (Robert, patient)

Other patients also described their own long and windy referrals to wound healing. However, they framed the reported lack of clarity in terms of a suspected ignorance about the clinics and standards of care. For example, for patient Elsa, who had a post-episiotomy wound, her journey to Morgan Clinic consisted of 'pit stops' via

multiple approaches, including mid-wives to hospital physiotherapists, who, according to Elsa, may not have known that the wound clinics existed. A recurring complaint from patients about the care they received prior to contacting specialised wound care clinicians was that their wound treatment often came down to simple dressing changes with no end in sight:

Before that, it was more of going to my local doctors and getting the nurses to dress it for me and keep an eye on me for it sort of thing (Rick, patient).

They had me in mid-2003 for [toes] numbers two and three off ... and, in fact, said, 'You'll be absolutely fine! You won't play for Arsenal football club'. Ha-Ha... [sarcastically] (Tony, patient)

At the doctor's, they just say, 'Oh, everything is looking ok, change the dressing, carry on, bye-bye'. So, what's the point? (Derek, patient)

As I said in the beginning, I was just going and going and going and I wish I had been referred earlier so that's a bit of a ... not really a condemnation but it's a bit of statement for the community. I was getting nowhere, and I was having no referral (Rhydian, patient).

Rhydian's take on the "statement for the community" also concentrated on other specialties reducing wound care to merely simple dressing changes – his doctor "was as useful as a chocolate tea pot!" As discussed above, this sour sentiment resonated with wound healing clinicians' recognition of the common reduction of wound healing to dressing changes by other medical disciplines. Their accounts further pointed to other clinicians assuming a blinkered attitude towards wound healing, in some cases taking a paternalistic approach to caring for patients and actively refusing a more inclusive collaboration:

This morning, I've had the nurses on the ward say they won't come over. But I've said I will go over because I know there is a patient on the ward who needs it. But they are blinkered to say, like, they haven't asked me to go over (Sam, podiatrist).

In addition to being looked down at, wound care as a specialty was fragmented, under-appreciated and misunderstood. For patients, this was a source of apathy, disillusionment, and even anger. For clinicians, this blinkered attitude restricted the opportunities to grow wound healing as an independent clinical specialty. Overall, the social terrain of wound healing in the UK was complex, stigmatised and sociologically dirty.

## 4.4 Summary

This chapter described and explained stigma in relation to wounds and wound healing being dirty work. The above accounts largely pointed toward indirect stigma through being shunned or avoided, rather than being directly discriminated against. Nonetheless, they are indicative of some of the mechanisms responsible for (re)producing stigma in the work of wound healing clinicians and in the lives of patients, showing that the effects of stigma, even if socially constructed, are nonetheless real. Moreover, patients' awareness of the contextual constraints impacting on their negotiation of their own wound care suggested that stigma is more complex than merely having a physical wound, but, rather can be explained with reference to contextual factors of constraint. In recognising them, this chapter delineated the 'dirty' and stigmatising contextual conditions of living with wounds and of wound healing. Considering both dimensions together provides a fuller account of the social complexity of wound stigma. Ascertaining who the social groups concerned with stigma are, as well as the effect it has on them, is a prerequisite for explaining how affected actors navigate this social complexity. The next chapter turns to precisely this.

## **5 Navigating social complexity in wound healing consultations**

Chapter four explained the social complexity of the sociologically dirty and stigmatised context of wound healing consultations in outpatient clinics. This chapter explains how clinicians and patients plan and direct the course of their activities within this context. Thus far, there is a paucity of knowledge about how individuals who perform and receive services dubbed as dirty jointly negotiate this context. Specifically, this chapter examines how clinicians and patients relate to this social context and how they act with reference to this context. As the chapter shows, by integrating patients' accounts, sometimes this manoeuvring generated a shared orientation among patients and clinicians to alleviate stigma and dirty designations of wound healing through seeking to increase the profile of wound healing. At other times, the social dynamics of consultations restricted the shaping of shared orientations, thus reproducing stigmatising and dirty entities. The mechanisms that led to both the creation and restriction of opportunities for a joint orientation are explained in relation to clinicians and patients' cognitive understandings of the wound healing environment, their feelings and beliefs about wounds and wound healing, and their social positioning in and outside of the outpatient consultation. This chapter is guided by a research sub-question:

How do clinicians, patients and patients' relatives navigate the stigmatised context of wound healing?

### **5.1 Organising clinician-patient relations around wound stigma**

The social organisation of wound healing clinicians' work was guided by relational considerations that extended beyond the immediate context of the outpatient clinic. This meant that the way in which clinicians related to patients' concerns (and vice versa) took account of the wider environment of wound healing, including the pertinent repercussions of its dirty work designations and wound-related social stigma (chapter four). This section describes some of these relational activities, which were organised around the recognition of stigma related to wounds and wound healing. In particular, it shows how the relational activities of

'communication', 'delegation' and 'swapping favours' that emerged as relevant were organised around an aspiration to alleviate the negative effects of wound stigma.

### 5.1.1 Communication

As shown in chapter four, in the wound clinics the topics of medical communication were physically and socially tainted and generally unmentionable in the broader social context. Logistically, the specialised medical environment dedicated to treating 'disgusting' wounds was a space in which their dirty matter was not only directly spoken about, but also physically unveiled through the covering of dressings and often clinically photographed to leave a permanent trace in patients' medical records. Given the wound healing clinicians' heroic moral endeavour to "make a difference to a patient's life" through "interest, focus and expertise" (hospital specialist, fieldnotes, Morgan Clinic, December 2016), acknowledged within patients' accounts of clinicians as being "angels of mercy" (fieldnotes, Davis Clinic, November 2016) or "a mentor" (Tony, patient), little moral ambiguity inhered within wound healing work. However, by virtue of legitimately concentrating on fully exposing wounds normally kept private and concealed from the public, wound healing could be seen by others as bearing traces of moral taint, particularly through their close connection with clinical photography. Christina, the director of clinical education, told me that patients who had photographs taken of their wounds "might feel like it's a 'freak show'" (fieldnotes, Bridge Clinic, September 2016):

You're never going to get away from the fact that medical photography is an undignified profession. You're doing an undignified thing to a person cause you're photographing sick people. And they don't want to be photographed (Alistair, clinical photographer).

It's a little bit invasive as well what we do. Someone taking the photograph of parts of your body, sometimes it can be quite intimate parts of your body (Mats, clinical photographer).

Certainly, when we go onto a ward where the nurses aren't used to us being there they sometimes introduce us as paparazzi, which instantly puts a patient on a negative footing with us. Um, so you go in and you have to undo everything that they've already told the patient by telling them that we are paparazzi. Cause we're definitely not (Paula, clinical photographer).

Last week, one of the girls came in to take the photographs. Mike is going, 'Smile, you are on candid camera!' I looked at him and he said, 'I'm not talking to you, I'm talking to the foot'. Because otherwise, 'Oh, here they go again, and there is another



photograph, and what are they going to do with this?' (Jane, patient)

Healthcare professionals in these clinics recognised the risks that casting the clinical spotlight on wounds held for patients' emotional states in terms of making them feel vulnerable. A particularly emotive example came from a lymphedema therapist who recalled one of her own patients bursting into tears when she started feeling his legs. "Nobody ever touched my feet when I was in hospital", he reportedly said (fieldnotes, Morgan Clinic, September 2017). The empathic appreciation of patients' upset at their bodily isolation shone through the ways in which non-verbal communication with patients was organised to help alleviate their experience of wound stigma by gently touching the unsightly, weeping and foul-smelling body parts:

'Touch doesn't happen a lot when you have a wound that's smelly', explained Christina, the director of clinical education, after we watched the hospital specialist resting his palm against the red, swollen and 'raw-looking' foot of a patient with an amputated toe throughout the education session. 'That's why you will notice that he touches patients a lot', she explained (fieldnotes, Bridge Clinic, October 2016).

There was something intriguing about touch within wound healing. On the one hand, touch was an expected part of the medical investigation, and appreciated by some patients as humanising the interaction:

I am sat in the consultation room, awaiting the arrival of the next patient. An elderly man enters the room. He points at his right leg and mutters, 'This lady's swelling up a lot'. The nurse places her bare palm on the patient's lower leg, the sock still on, and confirms that 'it is hot' (fieldnotes, Bridge Clinic, August 2016).

I think it makes the patient feel like you are human ... it really humanises situations, helps them connect with you and feel like you care about them, and they care as well (Erica, patient).

On the other hand, in a culture that advises clinicians "to err on the side of caution and keep physical contact to the minimum necessary" (MDU 2018), wound healing clinicians can find themselves cornered in a dilemma. Moreover, not all staff were at ease with comforting patients through touch. There was a role to be played in terms of patients' recognition of the esteemed professional trajectory of the founder of the clinics, who had explained to me before I started this research that he was comfortable with appropriate touch:

And I think that the patients all do love him and he, kind of ... 'gets away with it' is totally the wrong phrase but ... because they know that he's got that many years of experience behind him, they know he's eminent (Kate, doctor).

However, the value of touch in reconciling negative stigmatising perceptions of wounds was also recognised by even those junior colleagues who did not have it "in their character" to hug patients, like doctor Kate who entered wound healing from what she said was a "less relaxed environment" of surgery:

[Touch] shows that whatever they may or may not think about themselves, you definitely don't think they are 'disgusting' or that they shouldn't be touched or that their wound shouldn't be touched.

Providing patients with a sense of them not being dirty, but, rather, creating in them a feeling of being 'clean', underpinned both non-verbal and verbal communication in the clinics. On the physical level, the essential act of cleaning the wound was narrated in a way that aimed to provide patients with a sense of emotional reassurance if they were concerned with the wound smell:

'It is a bit mucky, but we'll give it a wash and it will probably smell better once we've given it a wash' (Eva, nurse).

Likewise, clinical photographers would only photograph patients after the nurse had done the "dirty work when it comes to cleaning people" (Alistair, clinical photographer). Whilst, undeniably, cleaning the wound was a technical requirement to ensure the standardised exposure of the wound bed and tissue, clinical photographers also saw it as humanising:

If it is more sensitive areas, then we make sure that patients are clean. So, then, if they were to see their photographs they wouldn't be almost embarrassed (Tammy, clinical photographer).

There was a strongly held conviction within the wound clinics that patients should be spared very negative descriptions of their wounds. Clinicians treaded carefully, avoiding negative words as these "stick in a patient's mind" (Amanda, nurse). However, they also felt that patients "should be told the truth" (Mary, nurse), and that patients wanted to be told the truth:

If you're honest with them and you say, 'today it is smelling, but don't worry we'll see whether it's infected and if we can treat it, or if we can use a charcoal dressing to sort of get rid of the smell'. It often opens up a conversation into, sometimes, 'Oh yes, I didn't do this because of how smelly it was, and it wasn't like that last

week and now it is'. So, you do get more ... if you're open with them, they're often open with you (Megan, nurse).

[Hospital specialist] tells you how it is. Some people do not tell you how things are, he does, he is very straightforward (Theresa, patient).

Such “dead honest” (Chris, patient) conversations about embarrassing wound concerns normally fell silent during communication with a wider community which often tabooed wounds. Moreover, as Megan’s quote confirms, there was value in having clinically clean conversations about wound symptoms. Knowing if the wound was deteriorating or healing, what changes to wound size or discharge to expect, what cream to put on, or whom to call when the wound looked odd or smelt funny increased the limited awareness of wounds, treatment techniques and of the complexity of the system of care around it. In the previous chapter, I spoke about the strong conviction within the wound clinics about the need to be empathically honest with the patient as a way of building an emotional connection. Here, I offer a different perspective on honest clinician-patient communication as a way of empowering the patient to take steps in the direction of reducing stigma through opening about the stigmatising aspects of wounds. This can be viewed as a small step in encouraging organisational forms that foster stigma alleviation. The more clinicians talked to patients and their relatives about wounds, the easier it was for them to take a more proactive attitude to navigating their own care by starting conversations about their wounds through various channels that the clinicians made available to them:

They gave us a number to phone if we were very worried about anything, and that has helped (Janet, Chris’s wife).

We've got a couple of young female patients who particularly I have spent a lot of time talking to them about. And they have access to my email, so we email other. They emailed me quite intimate photographs of wounds (Amanda, nurse).

Amanda stressed the unique bond she formed with these patients, whose wounds could be considered to be further stigmatised through their connection with sexual health. Although not qualified to provide mental health advice, Amanda took pride in knowing that patients trusted her enough to offload to her on very intimate topics. This example of sensitive and visual communication highlights the bi-directional relationality that emerged between patients and clinicians in wound healing clinics,

from holding clinically clean conversations about otherwise 'dirty' topics normally shrouded in secrecy around embarrassment and fear of the unknown.

### **5.1.2 Delegation**

An important aspect of communication in wound clinics was getting patients more engaged in terms of understanding that they can take a more hands-on and empowered approach to navigating their own wound care. This led to the emergence of another mode of organising clinician-patient relations described by the hospital specialist as delegation. Delegation can be defined as getting patients, as well as their relatives, more involved in their care. Therefore, delegation surpassed communication because it shifted some of the control over wound care into the hands of patients and their relatives once trust in their clinical competence had been established.

Beginning with the involvement of patients, one example given by the hospital specialist centred on a three-layered compression bandage used to mimic graduated compression. This was based on an empathic recognition that many patients had previously had a bad experience with reportedly painful compression therapy. In an effort to gradually encourage patients to have "some squeeze" on their legs for better managing wounds, while giving them control over the amount of experienced tightness, the hospital specialist decided to offer patients freedom over how many layers of bandage they would wear:

A large number of patients who, once we'd given them the freedom and independence to care for themselves, didn't wanna go back to the dependency or the district nurses coming to visit them or going to a clinic. 'I've got freedom, yes, I've got this thing, yes, it's got to be changed, but I can manage the cream or the dressing and I can pull the compression on like socks, so why would I then give up that freedom and independence to go back to waiting in a clinic for half an hour for my appointment?'

Events like this, although by no means observed in the case of all patients, were recorded frequently. Patients spoke of changing their dressings alone, assessing the level of swelling, or applying dressings with disinfectants to prevent infections. This suggested that a large proportion of patients were ready to accept part of the care responsibility. On an individual level, it positively influenced patients' practical quality of life by making them more knowledgeable and less dependent on the often-inconsistent community care:

Any conception of best practice for treating the wound was really down to the individual experience of the nurses. The nurse actually packing your wound would not necessarily have previous wound treatment experience. I mean, I was able to satisfactorily undertake the packing and dressing of the wound itself after a short time (Robert, patient).

Delegation gave patients autonomy and a sense of building scientific skills, which has been shown in the dirty work literature to provide those involved in the delivery of dirty work with a sense of dignity that is threatened by dirty work stigma. Patients became participants in their own care and, effectively, they became the providers of dirty wound care work. Delegation, to some extent, reduced the effects of dirty work stigma for wound healing clinicians, because turning patients into the providers of wound care increased wound healing knowledge and skills across the population.

However, there was also a relational component to patients' uptake of delegation. There was mutuality of help between delegators and 'delegates', as based on an anticipation of future interactions, patients adhered to treatment plans so as not to disappoint the clinicians who had trusted them. This was a way of accumulating credit for cooperation, whilst, simultaneously, fuelling clinicians' satisfaction in their work.

There is a sensibility that because of the relationship you form with the team, you don't want to let them down either. So, there is that common sense of your own care before you come back and see them and show them how you've done it. Get your brownie points. You're ticking the box (Rhydian, patient).

In terms of also delegating parts of care to the patients' relatives, this first came into focus through observing the involvement of patients' relatives in wound healing consultations. Specifically, whenever a patient travelled from afar they often came with a relative, who would take notes in the consultation. Intrigued, clinicians had approached the relatives to find out the reason why they were taking notes:

They said, 'It was such an effort to get here, doctor, that I want to make sure that I've written down exactly what you want done, because I know from my previous experience that different people have different ideas, and nobody actually seems to be consistent' (hospital specialist).

The lack of standardisation and consistency in wound care across the UK healthcare community was referred to in the previous chapter as one factor that explained the designation of wound healing work as dirty. Based on the data

gathered for this study, it is difficult to argue that delegation alone can contribute to reducing the fragmentation of wound care in the wider community. But the de-stigmatising and cleansing value of delegation lay in its power to build a regime of effective patient and family wound management, which was considered as a crucial element of a much needed culture shift away from passive reliance on healthcare provision towards active involvement in one's own care. The hospital specialist argued that this was important to the long-term survival of the NHS, as well as the wound healing specialty, specifically. If patients and their family members were thus taught to perform simple tasks around wounds themselves, then healthcare professionals' resources may be allocated to developing complex wound healing technologies.

Of course, patients' involvement in their care was not without its limits. The system of delegation did not rely on the complete absorption of care responsibilities by patients and their relatives. When their wounds needed more than what they could do with it, or, in the words of patient Tim, needed "the work of a proper wound nurse", there needed to be a lifeline for patients to contact healthcare professionals. Therefore, for the system of delegation to work, clinicians realised there was a need for an element of mutuality and reciprocity of trust relations for dealing with the dirty matter of wounds:

If I'm delegating responsibility, 'You look after yourself. You manage this thing and if you're worried, give me a shout or come and see me. And I'm happy to see you without an appointment ... Ring this number if it looks funny, feels funny, smells funny or whatever you're concerned about'. So at least you're not, 'You're all on your own now, go, don't pester me again'. It's, 'You're on your own, but you've got a way back in if you're at all concerned' (hospital specialist).

When patients engaged with delegation, what emerged in the realm of the clinician-patient relationship was greater flexibility in terms of departing from, or slightly bending, the technical rules of the clinics. With both sides to the relationship finding themselves mutually reliable, there was a promise and trust that both sides would not abuse the flexibility.

I suppose because we've done our own dressing, medication, over the years they know if I am calling, there's something wrong, whereas maybe somebody who doesn't do that will be a little bit more anxious. I know exactly when I've got anything wrong with me, as I say (John, patient).

Therefore, patients who earned some “brownie points” (Rhydian, patient) through their successful engagement with delegation would later be rewarded in some other form, such as being able to be seen in the clinics without an appointment when they were concerned. This was because they were trusted to adhere to the plan of care and use their knowledge to reasonably judge when clinical assistance was needed. Thus, it could be argued that delegation involved an element of negotiation and development of informal contracts between clinicians and patients, centred on building up credit that could later be claimed back or paid back, thus resembling the swapping of favours.

### **5.1.3 Swapping favours**

Swapping favours stood alongside delegation as a subtle relational activity that served to get patients more involved in their own care in such a way that went beyond what was expected within the institutional bounds of an outpatient consultation. In general, the working of favours resembled the Oxford English Dictionary’s (2010) definition of the word as “an act of kindness beyond what is due or usual”. However, in these wound clinics the interpretation of the concept of favours as it was invoked in clinicians’ discourses appeared reserved for the sphere of what I refer to as ‘wound healing engagement and impact events’, which stemmed from the academic context of this particular wound healing organisation. This included: clinical trials, wound research seminars, industry events, medical students’ examinations and even this study, which were all concerned with raising the profile of wound healing to create clinical systems where there are enough competent clinicians to see the patients who need them:

What I need is a system where the right patient is fitted in at the right level in the system (hospital specialist).

One important aspect of the ‘wound healing system project’ was the academic context of the clinics and their affiliation with a nearby centre of wound healing expertise, of which I became aware during my data collection. My exploration of the research component of the clinics served to shed light on the swapping favours mechanism. A recurrent example of how the mechanism of swapping favours worked involved recruiting patients to take part in wound healing research. The extract from my fieldnotes below highlights the assistance I received from wound healing clinicians in soliciting patients’ input into my own ethnographic study:

The hospital specialist asks me to follow him so that he can introduce me to a patient who is 'complex' and 'articulate'. As always, I stand in the doorway, waiting for the patient's permission to enter the room. I overhear the usual, 'You know how you keep coming here, and we are kind to you, would you be kind to us ...', this time ended with, 'and help my friend Anna, who is a PhD student and looks at how we communicate with patients with chronic conditions?' He agrees (fieldnotes, Bridge Clinic, November 2016).

An important feature of this recruitment was the symbolic accentuation of the two-sidedness of the act of kindness, of the kinship, friendship and informal partnership maintained through the continuity and repetitiveness of the medical encounters between the patients and the clinicians. This patient, Tony, had been attending the clinics every two, three or six months since 2002, or in his words, whenever there was 'an event'. He proceeded to explain that if he suddenly grew concerned about his wound, he "would have been guaranteed an appointment" almost immediately. Although Tony thought this privilege was unfair on other patients waiting to be seen on the day, he felt it was a privilege well earned through his respect for the professional clinical advice, which he obediently followed:

If you respect the professional, they can get away with anything and you pay more attention to what they are saying, and you are more likely to carry it out. It takes two to tango. He has done things for me in the past and he's given me hope. 'If there is anything wrong at all, you must turn up'. Which some clinics wouldn't do ... That's just human nature. Like I said, it takes two to tango. He does things for me, so I do things for him.

These 'things' included taking an active interest in the state of "wound care biz", as Tony described it. Tony was familiar with the professional biography of the hospital specialist and his efforts to grow the profile of this nascent clinical specialty. In addition to asking questions about the field of wound healing, he would agree to take part in clinical trials. Of course, agreeing to support wound research did not mechanistically lead to the privilege of being seen when the patients felt they needed it, but when it coexisted with absorbing part of the care responsibility, clinicians appeared to distinguish these patients and acknowledge their support through relaxing the formal rules of the outpatient appointment system. In a sense, there was a natural symmetry in the swapping of favours with some patients.

Swapping favours between patients and clinicians was thus an important component of coping with wound stigma. Many patients and their companions, some of whom actively contributed to patients' accounts, were very "happy to help"



(Martha, John's wife) professionals with an interest in wounds with their research, because they wanted to express gratitude for the care they received over the years and saw it as their way of "giving something back", as patient Jamie said. Jamie, who had long suffered from a rare type of venous disease that mostly affects men in wheelchairs, did not mind 'modelling' in student seminars as "an interesting case" because he understood the need for clinicians in training to increase their scientific knowledge of his condition. Similarly, patient John – the Morgan Clinic veteran of 32 years – regularly contributed to the promotion of wound healing by modelling in medical education, as well as taking part in industry videos about wound dressings and clinical trials for new wound dressings:

It's hospital doctors, GPs, and they just look at your leg, and then ... it's like a time thing, they ring a bell and they come and they are told by the two examiners, which is normally a man and a woman, I don't know what they mean in medical terms ... But they are the examiners and they say ... [medical term, inaudible], and they've only got two minutes to actually look at your leg and come to a diagnosis, and then they have to tell these people and then again ask questions.

I had to go in for the film crew and talk about it and they photographed the whole time while I was doing it. And I sort of, a silly film [was] made.

As a new treatment was brought out, we'd always try it with the [hospital specialist] ... new dressings were being brought out and you trialled them for them.

Tim and Jane spoke of their similar contributions through agreeing to have the photographs of their wounds shared with people interested in wound healing:

The photographs he's taken of the wounds I've had, they've gone around the world. They've gone to China, they've gone to Australia, they've got to everywhere that he's been at the time I was in that mess (Tim, patient).

As far as I'm concerned, they can publish [photographs of my wounds] in the News of the World, I don't care, as long as it helps to sort it out. I don't care what happens ... If it helps somebody else (Jane, patient).

Of course, it was clear that participation in clinical trials was especially highly-beneficial for the patients concerned. Vital in this regard was the nature of care that patients would receive in clinical trials as compared with care in the community. The patient who would come into the trial would receive between four and sixteen weeks of specialist, standardised and very frequent care which was not always available

on the NHS. Therefore, healing their own wounds was often a silent aspiration underpinning participation in a clinical trial, in addition to the desire to express gratitude to clinicians or help sufferers in the wider community. “I keep thinking that the next trial is going to cure it”, said John’s wife.

It is important to stress the relational weight of these acts of swapping favours. Those patients who shared with me stories of participating in wound healing events for engagement and impact, simultaneously, spoke about having a special and unique relationship with clinicians. For example, they likened the connection they had with them as being akin to friendship or family:

I’m staging my performance. Questions and answers. Because they’re all looking at the same thing as you, yourself. Looking at wound healing and that sort of thing. So, it’s easy for me because I’ve had wounds, I’ve had chronic wounds. And I’ve made friends. The people are absolutely, they are all lovely people and we have a relationship (Tim, patient).

Mary has always said she’s my second wife, because she nags me like my first wife. And then Amanda says, ‘I am the third wife’. If they ring me, if they say, ‘It’s your first or your second wife calling on the phone’ so I know exactly what they want – they want to me to trial something for them (John, patient).

Effectively, such patients positioned themselves as “part of the big family” (Martha, John’s wife). This was undeniably due, in part, to the high frequency of clinical appointments over the years. As explained by patient Tony, “the first meeting with a medic is entirely professional; as time goes on it is likely to move more and more towards lay”. With over 20 years as an outpatient in Morgan Clinic, Jane joked that “marriages don’t last that long”, adding that “given the length of this connection, it is impossible not to develop a relationship, good or bad”. Indeed, there was some evidence of blurring the boundary between personal-life outside of the clinics and professional relationships within the clinics. Sometimes this led to the emergence of a shared orientation among patients and clinicians towards the wound process. As explained by Tim, a patient not willing to work with clinicians was “making things awkward for themselves”. In contrast, patients who generally were prepared to “go with them” earned the status of ‘important people’, who could later claim back the credit earned by aligning their attitude to their wound care with clinicians’ attitude:

It seems to work because they will then come to me and say, ‘We have a study going on, Tim, and would you like to come and be part of it?’ And I’ve not turned down any yet (Tim, patient).

The hospital specialist knocks on the door and walks into the treatment room in which I am interviewing Tim. 'If I'd known you had an important person in here like Tim, I wouldn't have bothered coming in', he says, and then leaves the room (hospital specialist).

Yeah, I came home last Tuesday and saw Marianne last Wednesday, so you can't complain, can you? And this is a clinic with a waiting list. So, perhaps I shouldn't have said that" (Tim, patient).

In this sense, the relationship of clinicians towards the patients also became 'lay'. As patient Tony explained:

As time goes on [the relationship] is likely to move more and more towards lay ... So, consequently, when I see a nurse in three months' time, I will be saying, 'How is your family?', rather than 'How are you doing?'

Jovially, John and Tim revisited demonstrations of their 'lay' relationship with clinicians. John confessed that he used to have the nickname "the broom patient", that stemmed from him frequenting the clinics in their humble beginnings in a cleaned-up broom cupboard in the hospital. "I have to put up with his cheek", John added. "He's cheeky. You wind him up. But he loves me", Martha added. The following fieldnote reveals more about such 'cheeky' interactions:

'You're a [expletive]', the hospital specialist joked when Tim came to the clinic for an emergency appointment after slightly carelessly hurting himself on holiday (fieldnotes, Davis Clinic, September 2016).

He called me many other names, which I will not say with the recorder on (Tim, patient).

Of course, despite inevitably developing a connection with patients and their families and, in turn, blurring of the boundaries between the personal and the professional, there were nevertheless organisational limits to what clinicians could do for their patients. For example, clinicians did not attend weddings, anniversary celebrations or other personal events in patients' lives; invitations were politely declined, albeit followed up with a courtesy card or a phone call. Even attendance at funerals was deemed to be unprofessional, although staff at the clinics admitted "shedding a few tears" (receptionist, fieldnotes, Bridge Clinic, April 2017) over losing patients they had developed an attachment to over the years.

On the topic of organisational rules, another crucial element of the context of these wound healing clinics that connects to swapping favours and, as such, must be

acknowledged, was the financial motivation on the part of clinicians to involve patients in wound research trails. To reiterate, the clinics were not run by the NHS. Instead, the majority of staff were employed by the university or by the nearby centre of wound healing expertise. The basis of providing the service on NHS premises was that clinicians would look for patients they could recruit into clinical trials from these clinics.

So, every patient I can take into a clinical trial, we're earning money of it. Once, probably the best percentage that we have had is probably 25 percent of patients we were seeing in the clinic we can take into a clinical trial, it was brought down to as low as 12 percent. Because the argument is that these patients need to be seen whether they fit into a clinical trial or not (hospital specialist).

Although, at first glance, this rule would appear to imply a materialistic take on these relationships, some patients recognised the necessity of looking for funds to keep the clinics in operation. Patient Jane commented:

[Hospital specialist] founded it and he flies all over the world, spreading the word, teaching and looking for funds. It was only a couple of years ago that he didn't know whether he had money for the next year. Because the NHS don't give him one penny. And yet, he has patients from every single department of the NHS. That includes operations, wounds, anything. They will refer their patients to him.

This element of negotiating and contracting, as was the case with delegation, did not shift these relations into the sphere of pure transactions, but, rather, kept them within the domain of reciprocal action. Clinicians were professionally caring for 'all-comers', who became 'important people' for whom they were willing to risk working around the formal rules, whilst patients were befriending 'cheeky' clinicians while going the extra mile in their wound journey to give themselves, and the wider community of patients with wounds, a higher chance of healing. Therefore, this reciprocation of favours can be regarded as a catalyst for the cementing, or deepening, of clinician-patient relationships.

## **5.2 Barriers to organising clinician-patient relations**

Communication between clinicians, patients and their relatives in wound clinics did not mechanically lead to delegation and swapping favours that helped support the 'wound healing system project'. Collaboration on some aspects of care co-existed with tensions, disagreements and criticism about others. Clinicians expertly cared

for patients who were actively involved in their care, as well as for those who, due to an array of possible factors, took a more passive attitude to their care. Specifically, patients' previous negative experiences with health care, their incomplete understanding of wound care matters and instances of inappropriate behaviour, as revealed in the data collected for this study, encumbered relational progress. In other words, these factors represented impediments to steering clinician-patient relationships in such a way that could alleviate stigma. In some cases, clinician-patient interactions appeared to stall at the level of the conventional clinical encounter, premised on the medical model and imbued with clear role division between patients and clinicians, which, in turn, reduces the scope of opportunities for advancing the field of wound healing and increasing societal acceptance of wounds.

### **5.2.1 Previous negative experiences with healthcare**

The most recurrent theme in patients' accounts of their negative experiences with healthcare centred on various forms of failed communication with healthcare professionals. Structuring clinician-patient communication was described in the foregoing section as an indirect enabler of tightening relational ties. Here, however, I draw attention to countervailing events of various forms of communication breakdown, brought to light by patients reporting feeling uninvolved in communication with clinicians, as well as feeling deserted, objectified and having the support they had provided discounted.

For the most part, patients' accounts of broken communication reported in the interviews in the specialised wound healing clinic context centred on prior experiences with healthcare they had received in the community or in non-specialised hospital care. Three corresponding examples of patients' reported exclusion from communication with the providers of wound care outside of this study's focal wound clinics, two interactions with district nurses in the community and one in the hospital, are captured in the extracts below:

[Patient Michael] should be showering but then they said he can't shower with the dressings. Other people have said, 'We'll put something around his feet so that he can shower'. The carer said he 'needs to shower every other day'. But then someone else said he can't shower so he has kind of a bed bath. It's a lack of communication between the carers and the district nurses. They don't tell everybody what to do. It's been a bit up in the air. So, it's trying to get everybody to communicate ... They don't seem to tell

you a lot about it. And then you have one person saying, 'I want to put this on', then another person saying, 'I'll put something different on'. They don't really allow information to us. They say, 'Bandage it up, but we'll look after it' (Mark, Michaels' son-in-law).

That's the impression that, you know, some of them, not all of them, but some of them, they don't say it, but they come across as, 'I'm the nurse, I've done the training, I know. And I woke up this morning with great big holes in my feet, never had them before'. Most of the people that come here, they were in nappies when I started having these things (Jane, patient).

They put two families of maggots on my foot. The first lot didn't work, the second lot, it did work and ... on a Monday, the registrar came around and there was no talk of me going home. And then, somewhere like three o'clock, the Tuesday afternoon the day after, 'Oh, you can go!' (Derek, patient).

Provision of contradictory medical advice in the community reinforced the information asymmetry between patients and healthcare professionals, whilst the withholding of information on treatment progress and follow-up care translated into patients feeling frustrated and rushed through the system, as well as having their concerns ignored and their expertise dismissed. Consequently, some patients and their companions felt that, even if they wanted to become more involved in their own care, these efforts were stifled, which, in turn, resigned patients to enact the patient role. For example, companion Mark continued to describe how frustrated he felt with wanting to do more for his father-in-law, but not receiving clear inclusive information to competently and confidently carry it through:

So, I did it myself in the end. I, obviously, I don't know what I'm doing. So, I just do what's best, I took it off, put a new one on. But if there was a bit more information, then if something did go wrong, like if he has a shower: he needs to shower certain days, so we can change the bandage. But we could help him with the shower. Re-bandage it ourselves, rather than waiting for [district nurses].

Similarly, Derek continued to describe how "unimpressed" he felt with his quick discharge, further referencing an unstructured care plan whose delivery failed. Moreover, he highlighted an array of negative experiences throughout the interview, including those outside of specific aspects of his wound care. These involved being left waiting in a cold corridor for his eye appointment, being returned to the wrong ward by the hospital porter, hospital clinicians not knowing what foot they were supposed to look at, as well as medical letters not explaining what antibiotic he was on. As a result, he felt confused about whose advice to trust. "If you tell me

something – they are the experts, I expect it to happen”, he said, reinforcing his enactment of the patient role.

Derek appeared paralysed with the challenges he had experienced prior to entering the clinic. This meant that clinicians in wound clinics were faced with a doubly complex task of having to rebuild the lost trust before they could seek to establish a trust-based relationship. To start with, the embodied ‘dirty’ nature of wound care constituted the very mechanism through which trust could be re-established:

When I go to [Bridge Clinic] and they start trimming away, ‘Oh, that’s not looking good’, or what, there are two different levels of communication. Now I’ve got to be honest, I’ve got more confidence in the people here because they are actually trimming away to see what it’s like underneath (Derek, patient).

However, the task of re-establishing lost confidence appeared more difficult in light of the fact that negative experiences had sensitised patients, who the system had played with, to become defensive and vigilant about any breakdowns in communication, including those related to the non-NHS nature of the clinics’ operations:

Most of the things that have happened to me they have been very good, but there are areas where there certainly is a lack of communication. I had an appointment to see [hospital specialist]. Turned up. ‘Oh, he’s not here, he’s in Australia’. So, why make an appointment to see me if he’s not going to be there? ... There was some other guy who didn’t do anything or say anything, he just came in, had a look and walked off (Derek, patient).

Within the outpatient wound clinics, Derek’s criticisms centred on the absence of expected expertise in his outpatient appointment and lack of conversational interactions in the clinics. He directed some of his criticism at the social context of consultations; however, his willingness to be part of the social context was unclear. Derek did not know the names of the clinicians who looked after him. He did not know the names of the clinicians he was seeing at Bridge Clinic, the podiatrist’s name, nor the name of ‘some other guy’ who on one occasion replaced the hospital specialist with whom Derek had an appointment, whilst he was displeased at his involvement in educational sessions where clinicians were talking to each other about his body:

When you’re lying on the bed ... They are talking about you to one another and they don’t always include you in the conversation, which I think is wrong as it’s my body at the end of the day.

It is important to stress that clinicians empathetically reported their difficulty in accepting what they perceived as morally dubious methods of disseminating knowledge about wound healing. For example, an orthopaedic specialist explained how she found traces of moral taints in patients' suffering would be presented to the interested visitors in clinics as if the patient was not there:

It's not deceptive, but it's very difficult for them. You're discussing it ... sometimes it's something interesting, you've got a student with you, and you can have a really, really, nasty wound. But, of course, from an educational point of view it's awful. It's terrible for the patient, but actually it can be very professionally interesting (Helen, orthopaedic specialist).

However, this moral taint appeared to be cleansed through clinicians' focus on the value of educational sessions for creating new generations of wound healing specialists:

I could go much faster if I didn't have the visitors or the students there all the time. But I would argue that I'm missing opportunities to sell wounds. The important thing is not to sell me, because it isn't about me, it's about the patient, it's about the problem of wound healing. And if there are clinicians around the world who are interested or potentially interested, and they are struggling to get access to a wound clinic, why on earth wouldn't they come to this thing and see 50-60 patients in the day? (hospital specialist)

Most patients understood the "problem of wound healing" and appreciated the professional biography of wound healing clinicians, as well as the need for more 'woundologists':

If a normal period for a wound to heal is, say, eight weeks? If the period to get an appointment is four months, then you're never going to see a specialist within a normal procedure. If, however, that eight weeks turns into twelve weeks, or fifteen weeks, or sixteen weeks, and suddenly it starts to be appreciated as a problem, you still have four months or five months afterwards. So, the early availability of specialists like [hospital specialist] is vital (Robert, patient).

Moreover, most patients altruistically endorsed the 'wound healing system project' research and education, due to the academic profile of the clinics. Institutional buffers against these associations with moral taint were in place. For example, clinicians sought patients' consent to have visitors present at their consultation by informing them of the academic character of the clinics in their appointment letters before again requesting their permission in-person in clinics, whilst clinical



photographers ensured that patients understood the nature of consenting to have photographs of their wounds taken for their medical records, education and/or publications:

I always ask them. Never assume (hospital specialist).

When we are called to photograph a patient in a wound clinic, first of all ... we obtain consent from the patient. And the consent is separated in three levels. So, we have Level 0, which is: the photograph only can be taken for the patient's notes. For the patient's case. Level 1, which is: we can use the picture for the patient's notes, but also for teaching purposes as well. And level 2, which is: to use the pictures for the patient's notes, teaching purposes and possible publication, which means that consultants that want to have a publication of something, or if they want to publicise those pictures for any reason, then they can do that after obtaining new consent from the patient (Roman, clinical photographer).

### **5.2.2 Incomplete understanding of wound care matters**

In general, most patients neutralised the potential moral taints of clinicians' implementation of the 'wound healing system project' in treatment rooms with altruistic assertions along the lines of "they've got to learn somehow" and "if they can't help me, maybe they can help someone else in the future" (patients, various). However, a further barrier to organising clinician-patient relations stemmed from the understanding of some patients of the importance of the 'wound healing system project' for alleviating the stigma concerned with wounds and wound work. Patients who did not grasp what the hospital specialist referred to as "the problem of wound healing" were often acting in a way that showed a resigned acceptance of wounds, in addition to a lack of a sense of direction for their wound journey:

What were your expectations for this appointment? (Anna, researcher)

Well, I don't know, but they didn't accomplish anything (Derek, patient).

During my research, I met many patients like Derek who shared his resigned acceptance of wounds and lack of understanding of his own concerns. However, they were often not approachable for an interview. Those who did agree to speak to me stated that they had no expectations at all:

To be perfectly honest I have no expectations and I'm like that anyway. It didn't bother me, it really didn't bother me. Whatever

they were gonna do, they do, so that's the kind of character I am, I'm not bothered about a lot of things (Michael, patient).

It is important to acknowledge that both Derek and Michael were relatively new to the wound clinics. Derek had been attending for six months, whereas Michael was interviewed after his first ever appointment. It is possible that this temporal element partially explained their disinterest in wound care matters. In settling for accepting whatever course of action clinicians would put in place, these patients thus positioned clinicians as experts and reinforced their role as patients. For them, passive receipt of instructions was sufficient. They seemed to appreciate the delegation of complete responsibility for designing treatment plans and, largely, for the implementation of the treatment to clinicians. In addition to going to his GP's surgery, Derek would report to Bridge Clinic every two weeks for a check and a dressing change. In between, the only thing he would do was rest his foot. "That's all I can do", he explained, adding that he was the patient and clinicians were the experts in making decisions about his care. In fact, he ignored or resisted clinicians' attempts to involve him in his own care. However, he did not seem to seek to react to his negative experience in a proactive way, but, rather, stopped himself from voicing his experiences of difficult emotions.

As much as Derek wanted to be involved in the communication about his care, his willingness to become involved in his care was less pronounced:

Another lady came I was seeing morning. I had a lot of dead skin, from where it's been. She gave me a [expletive] for not applying cream. I said, 'You are telling me now I've got to go to the doctor's, or here five times a week to have my cream rubbed on me as well?' 'What do you mean?' I said, 'I cannot dress my foot'. And it took quite a lot of time before it registered, that. Now it's not for me to tell the nurse, 'Oh, you've got to rub cream in it'.

Derek felt that his individual physical impediments were not acknowledged in the demands that were placed upon him. Instead, he seemed content to uncritically accept those aspects of his treatment plan, which were done to him and did not require any input from him. From the perspective of clinicians, patients like Derek represented a group of patients who are passively involved in their own care; they could not be encouraged to manage their own wounds and expected somebody else to "fix them" (hospital specialist, fieldnotes, Bridge Clinic, June 2016). Engagement, involvement and empowerment did not work with such patients. During the research period, I heard clinicians refer to these patients in a number of

ways. In a relatively objective way. They were referred to as “typical ... patients”, in the sense that they refused to take on board the need to help clinicians manage their own condition given the severity of their wounds. They were humorously designated as “Mr Grumpy”, in the sense that the patient always complained. Finally, slightly more vociferously, other clinicians remarked on the challenges posed by such patients as part of a broader cultural problem in the UK:

We as patients are passively involved in our own healthcare. ‘I’m a lump of meat. Somebody comes and does something to me, because I’ve got a problem with my lump of meat’ (hospital specialist).

Although clinicians understood the anxiety that such patients were experiencing in relation to their health, they nevertheless saw their expectations as unrealistic. This made them feel frustrated. They tried explaining to the patients that the clinics were not run by the NHS every day, and, as such, there were time constraints from only having a few afternoons a week to see all the patients. The rest of clinicians’ time was spent doing research, teaching and completing other academic commitments as part of their job. Although Derek did not recognise the professional trajectory of the hospital specialist and his role in disseminating knowledge and improving the standards of care globally, he seemed to have some awareness of the problem of wound healing. He appreciated that wound healing was closely connected with performing the bodily care activities, such as “trimming away”, or “doing the dirty work”, as podiatrist Sam said. This was a component of wound care that Derek had not received in non-specialist medical settings. It is precisely through exploring patients’ complaints about the care they had received in the community that it becomes possible to paint a fuller picture of the effects of wound stigma. For example, patients’ complaints about incorrect diagnosis and treatment received in the community, as well as the fact that most of their prior wound treatment had been reduced to merely changing dressings, pointed towards misinformation about wound healing in the wider area of medicine outside the wound healing clinics:

When I started, it was with dermatology and nobody seemed to know what it was. They were all treating it for something different (Elina, patient).

Before that, it was more of going to my local doctors and getting the nurses to dress it for me and keep an eye on me for it sort of thing ... they weren’t doing what the podiatrists do, i.e. measure the wounds (Rick, patient).

Likewise, both the provision of contradictory medical advice and the withholding of information pointed to an unstructured service delivery in the community, which perpetuated the dominance of medical models of care with a clear role division between patients and clinicians, rather than a socially innovative model of patient involvement.

### **5.2.3 Inappropriate behaviour**

While clinicians in these wound clinics sought to build flatter, more horizontal trust-based relationships with all patients, they recognised the risk of their relational activities tipping over board and generating conditions for patient overdependence on the wound healing clinics. This overdependence manifested itself in various alarming forms, including trying to book appointments all the time or repeatedly coming in to see specific clinicians. From the perspective of clinicians, overdependence emerges as a product of over-enactment of the patient and clinician roles that stretched beyond the normalised sphere of providing health service and responding to service provision. It was designated as servile, rather than shared, wound care and linked with the displacement of the delegation of some care responsibilities and their preservation on the part of the clinician. In this sense, although reflective of patients' strong associative links with clinicians, overdependence meant that patients' use of wound healing services was excessive, which was "weighing" upon wound healing clinicians (Christina, director of clinical education). It jeopardised the formation of a clinician-patient partnership capable of alleviating stigma, instead fostering servitude amongst wound healing clinicians and further disempowering already stigmatised patients. As doctor Phil commented:

We're there to help once, not to control their health, [if] you know what I mean. We can give you some advice, but we can't control what you want to do. As long as they have got the mental capacity, they've got their own capacity to make their decisions, then I think we should give some control back to them and try and help them with ... it's working in a partnership with a patient, rather than working for the patient, making them dependent.

It was in relation to 'making patients dependent' that a possible, counterintuitive, contribution of clinicians themselves to reproducing stigma was identified. Specifically, this concerned clinicians' humane reluctance to deny patients access to physical or emotional care resources. A further issue stemming from clinicians empathetically recognising the unpredictability of patients' wound journeys arose when the very source of their satisfaction and pride in (emotionally dirty) work –

helping patients with wounds – fostered overdependence, which created scope for the care delegation for empowerment and stigma alleviation to become overpopulated with preserving the biomedical cultural roles of patients and clinicians:

I know it's difficult, isn't it? Because no one wants their clinician to say no, and a patient's journey changes, they can get well, but then they are back again. I think it changes with the stages of their illness. I think as healthcare professionals sometimes we foster overdependence, because we get something from that as well. We feel good by helping, so we keep that going, I think (Christina, director of clinical education).

It was suggested that clinicians' awareness of wound stigma was also a formative aspect in terms of fostering the conditions that led to patient overdependence on wound healing clinicians. Given that wound healing was not viewed as an area of medical interest, not to mention the fact that these specific clinics saw themselves as a third-party agent satisfying unmet demands, some patients came to clinics for the comfort of this safety net, this exclusive shelter, rather than for more open conversations and inclusive activities. In the words of Christina, the clinics were their "last chance to lose". As she commented:

I don't know if it's overdependent, or just dependent, I think. Because especially when they have seen everyone else, and everyone else has given up on them.

The interview with the hospital specialist offered additional insights into understanding the mechanisms that fostered patient overdependence. Continuing with Christina's systemic justification of the conditions 'nurturing' overdependence in wound healing, he highlighted the enablers of this overdependence as being within the wider health service that is free at the point of delivery. According to him, the lack of a financial exchange means that some patients might not see the value of the service they were receiving, which risks them misusing the care resources:

In our healthcare system, we don't provide healthcare service, we provide illness service. We manage illness, we don't manage health. And somehow or other we've got to turn society around, get them more involved in their own care and lifestyle choices that means that ... if you want to have McDonald's and chips every night, sorry, you're gonna have to pay a little more towards your healthcare because you've inflicted this a little bit on yourself. I know it's difficult, I know it's addictive, I know it's all sorts of other things. But it's not fair if somebody's over here, eating sensibly, exercising, keeping their weight under control and doing the things

we know they are supposed to be doing, somebody else says, '[expletive] that, I'm gonna do what I fancy doing and sit in front of the TV and eat chips all night and not engage, somehow or other'. We shouldn't be penalised, but it's to say that there is a responsibility for you, Mr Citizen, to contribute to the consequences of that. Whereas if you do get ill and you've done everything you could, it's just bad luck. We will look after you and we're not asking you to contribute.

The above account helped develop a well-rounded, balanced picture of the mechanisms that engender patient overdependence. This can be seen as stemming from a number of mechanisms, including: clinicians' enactment of their role and finding dignity in dirty work; the local context of wound healing that created the conditions for being (over)dependent; and the wider system that encouraged the misuse of resources; however, it is deemed to reside in the individual responsibility of patients, who are not cultural dopes, but, rather, have the capacity to either engage with or disengage from their own care.

There were many instances of other inappropriate behaviours observed in the clinics that were reported by clinicians. These ranged from addressing clinicians in overfamiliar ways that they found patronising, through to inappropriate touching and threats, thefts and legal lawsuits:

It's also important to make sure you've got that line, so that the patients don't feel overfamiliar with you as well. Because sometimes they can feel that your relationship maybe sometimes goes past that of nurse-patient (Eva, nurse).

He was a tetraplegic gentleman, so he was paralysed from the waist up. And he always managed to get his hand up my back side, always. When we were getting him on the bed. And he would say, 'Oh, sorry Amanda, it's a spasm'. He would smile at me, always! And it was just one of those things, you would say, 'I'm watching you!' You would not encourage that (Amanda, nurse).

Amanda also recalled a patient obtaining the hospital specialist's address and threatening to wait outside his house, blaming him for not getting any better. Finally, I heard stories about a patient stealing objects from a research centre after being recruited into a clinical trial, and another who sued clinicians and provided a false account of his experience (fieldnotes, Bridge Clinic, November 2016). Clinicians were not immune to such misbehaviour. Occasionally, they let their frustration slip out in informal corridor conversations, whilst at other times they explained their frustration in interviews:

Sometimes I don't like patients. I don't like them as individuals. I don't like the way they speak to me, I don't like their approach. I don't like, perhaps, the way they speak to their carers or their loved ones, or their ... sometimes, you call that an inappropriate relationship, because I don't like them and I'm sure there are patients who don't like me.

Castling light on all these types of inappropriate behaviour is important, because it adds further depth to the complexity of the social context that patients and clinicians navigated in the wound clinic. In extreme situations, declining treatment to the patient would go against the code of professional ethics. Therefore, professional duty of care stood in for communication, delegation and swapping favours. When faced with a lack of collaboration, the best course of action was to adopt a more formal attitude – the opposite of rule relaxation. To reinforce this conclusion, this section ends with a comment from Christina, the director of clinical education:

Um, and sometimes you have to be professional, but you don't have to like everybody either. And I don't have to like you and you just have to acknowledge that and make sure it's not clouding your judgement. Sometimes you just don't like people. You're being professional.

### **5.3 Summary**

This chapter showed that not all patients linearly engaged with communication, delegation and swapping favours in support of the 'wound healing system project'. Rather, some patients were seen to be confused, scared and reliant, whilst also, at times, being impolite and offensive. These attitudes are, of course, part of being human. However, their elucidation in this study is important. Firstly, they corroborate the clinics' organisational rule of taking "all-comers", regardless of whether they qualify for a clinical trial or not. Secondly, they shed further light on the challenges that clinicians face when engaged in the dirty work of wound healing, particularly when seeking to involve the patients themselves in this work and, in turn, dilute the 'dirt' that accrues to them. The elucidation of the rules of, and barriers to, organising clinician-patient relationships undertaken in this chapter, adds depth to extant understanding of aspects of the relations associated with stigma alleviation and (re)production by illuminating why clinicians might find it difficult to build relationships with certain patients. The next chapter continues this story of the social complexity pertaining to how and why wound clinicians and patients come to build relationships by reflecting on the various relational clinician-patient configurations.

## 6 Clinician-patient relational configurations

Now, another patient might see it as the individual against the system, where the system dictates what's happening. 'You will come in then and you will take these pills. You will go to your GP surgery to get that foot dressed'. That kind of didactic relationship as opposed to an exchange relationship (Tony, patient).

The presentation of findings on the relational aspects of the nature of dirty work of wound healing and wounds (chapter four), as well as on the ways in which clinicians, patients and relatives concerned with wound healing and wounds operate together through their social context (chapter five), affords a final empirical reflection on how actors' negotiations of their relations can be represented as heterogeneous 'relational configurations'. In this chapter, I identify three relational configurations emerging from the clinicians, patients and patients' relatives' various engagements with the relational dynamics of communication, delegation and swapping favours in light of their previous experiences with wounds and wound care, in addition to their understanding of the dirty wound healing context and their considerations of their own concerns in relation to the social context of wound healing clinics. I examine the distinguishing dimensions of the configurations that characterise the distinct ways in which actors consider their personal and relational commitments. I also show how their different forms of deliberation are mediated through their orientations towards their perceived relational goods and/or evils (Donati and Archer 2015), which can either threaten, sustain or develop relationships amongst actors confronted with stigma. Attention to the relational goods in worker-client relationships within dirty work underlines relational positivity, which has hitherto been overlooked in the literature, while recognition of relational evils corresponds with extant studies' documentation of relational negativity. This chapter is guided by the following research sub-question:

What are the outcomes of these navigations for the individuals concerned and the stigmatised context they navigate?

### 6.1 Exchange relations

I begin by discussing a type of clinician-patient relation that can alleviate wound stigma, through recourse to patient Tony's succinct encapsulation of the spectrum of clinician-patient relational dynamics in wound clinics. Quoted in the opening of



this chapter, it offers a taxonomic starting point for naming the first relational configuration as exchange relations. As this section shows, exchange relations were characterised by strong relational, as opposed to personal, deliberations among patients, their relatives and clinicians towards one another in a dirty wound healing context.

### **6.1.1 Gratitude and reciprocity**

Crucial to the relational deliberations underpinning exchange relations was the rule of reciprocity. This was evident in how actors enacted their feelings of gratitude, which generated a relational good of 'trust between clinicians and patients'. First, patients and their relatives were grateful to clinicians for the clarity and continuity of their treatment plans. For greater resonance, they sometimes contrasted it with the ambiguity and disruption of wound care they had experienced prior to entering the specialised wound clinics:

If this treatment doesn't work, then we know you'll probably have to have another procedure again. At least you're prepared for that. You know what's coming. Whereas, up until now, we're sort of in limbo, we don't know what's coming. We don't know what's ahead (Joanna, Robert's wife).

In clinics, doctors and nurses used empathic verbal and bodily communication to educate patients and their relatives on wound care. Patients trusted that the instructions delegated to them by clinicians were right for them:

They tell you what you can do and what you can't do, so things you can't do you don't do them (Tim, patient).

'Don't get it wet', and so on ... and 'put the patches on the antiseptic dressing', and 'don't go around without it'. So, [I] follow the instructions (Rhydian, patient).

Through this, clinicians sought to delegate part of their care responsibilities to empower patients and, simultaneously, address the constraints of a predicted proportionate reduction in the number of skilled clinicians in the healthcare arena. In turn, they were grateful to patients for their responsible engagement with care delegation, such as by ensuring they had their dressings with them on holiday, for example. They reciprocated by trusting that their reasons for requesting to be seen without an appointment were justified. If delegation worked, clinicians were likely to relax the rules of appointments by providing patients with a lifeline of prompt support whenever their wound 'looked funny', 'smelt funny', or induced emotional concern.

Against the backdrop of enjoying a safe channel through which to seek expert care when required, patients and relatives were able to play an active role in coordinating the frequency and timings of appointments. In these wound healing clinics, delegation led to a reduction in clinicians' professional dominance and signalled a move towards the exchange of 'equals':

When I was on holiday, I had these blisters and I thought, 'Well, I've got so many dressings with me, I can use those until I get home' ... And I knew as soon as I was home, I got home on the Tuesday and on the Wednesday, I was there in the clinic seeing Marianne. So, straight away, I get the ball rolling and see what they can do for me. Things are getting better already. And that's the value of having a relationship. If these people weren't fussy about seeing me, they wouldn't see me. But they made space (Tim, patient).

Patients explained how they approached their care relationship in a bi-directional manner grounded in a shared sense of mutuality of obligations, rather than seeing it in terms of their subordination to clinicians' projections of top-down instructions. Their motivation to contribute towards the effectiveness of wound care through their adherence was tantamount to cultivating a social relation with clinicians over and above looking after their malodorous, unsightly wounds. This reordering of personal and relational concerns that pushed the latter to the fore is best illustrated through Tony's aforesaid description of his relationship with clinicians that 'it takes two to tango', as well as Rhydian's account of the social currency of 'brownie points' that was noted in chapter five's discussion of 'delegation' and 'swapping favours'. Moreover, Tim voiced a vociferous relational understanding of wound care, equating divergence from medical instruction with getting yourself in 'social' trouble:

If the patient isn't working with the doctor, then it's not gonna work. It'll not be there. Like, I've got with these people. Because I've seen people here who are not happy with what's going on. And they just make fools of themselves as far as I am concerned ... If you've got something about you and they can see that you need help or want help, then they will [help you], but if you're having help but are not worried about what you've got then what can they do? They can't put you right if you don't want to be put right.

Social relations with clinicians were central to patients' accounts of exchange relations. Patients appreciated how clinicians got to know them better through repeated consultations, coming to understand not only their wounds, but also how they acted and behaved:

'I know you're not well, because you're not joking today', says the hospital specialist to patient Rhydian (fieldnotes, Bridge Clinic, November 2016).

However, patients also got to know clinicians better. More specifically, a degree of personal disclosure from clinicians acting as relational beings rather than singular selves provided patients with a sense of safety about their treatment prospects:

The nurses are quite open here, they speak about their family, I talk about mine, they talk about theirs, we talk about life in general which is nice, it helps. It helps to know where you're going, they can look after you ... especially a hand on your shoulder or your arm and then they tell you, 'I promise you, Tim', that did it for me, that was it. And it's this closeness I suppose, isn't it? It's friendliness and niceness (Tim, patient).

Patients reciprocated this closeness in their responses to medical communication. The following vignette illustrates how Tony's special bond with clinicians and the trust he bestowed in their judgement informed his deliberations about how to re-organise his own concerns:

You met Amanda? She was my saving grace. I've seen her now for ... 10 years. And we can always have an amusing chat, 'What you've been doing?' and so and so and so, and there is that level of empathy, so, consequently ... when she was ringing the alarm bells herself on Tuesday – she didn't actually say, 'You must come in, you must do this', but because you've sort of known someone a little bit, then you can relate to their concerns and that's basically just, you know, people's inflection, mannerisms, things like that. So, you develop more of a relationship in that respect and because of that ... I think if it had been another person from the wound clinic, I might have said I would come in on Wednesday. But the thing is, because of, because ... Amanda had picked up a vibe if you like from me, I then took the [inaudible] myself to say, 'Right, I'll come in tomorrow'.

### **6.1.2 Shared understanding of wound healing context**

As the foregoing examples show, exchange relations were mediated through the relational good of 'trust between clinicians and patients' produced by the underpinning values of gratitude and reciprocity. This section extends this consideration of relational deliberations in exchange configurations by drawing attention to how the enactment of gratitude and reciprocity by patients was demonstrative of their awareness of the circumstances of wound healing, as well as their motivation to work through the contextual barriers that constrained their

treatment options. This produced further relational goods related to 'patient and family wound management regime' and 'collaboration in wound healing research'.

The former was a product of patients' and their relatives' realisations that, not only were they able to, but sometimes they had no other choice but to undertake some wound care at home. As they interacted with staff in wound clinics, they were cognisant of the scarcity of specialised wound care. This was addressed in chapter five's presentation of delegation with an especial reference to patients' relatives taking notes to inform at-home treatment under the 'patient and family wound management regime', which provided patients with a sense of dignity that was threatened in situations of dirty work and stigma. Continuing with this theme, this chapter proposes that this regime in and of itself is a relational good. An orientation of patients, their relatives and clinicians towards it was visible in their actions towards its production, such as in clinicians involving relatives in consultations, and patients and relatives taking notes and observing, safe in the knowledge that they had a lifeline to a healthcare professional if required. This contributed to them working together in the wider patchy setting of wound care provision. Indirectly, it helped alleviate the effects of stigma by contributing to the diffusion of knowledge on wounds and wound healing:

I think that the relatives or friends or carers that come with the patient are an important part of the consultation because they obviously care about the patient, otherwise they wouldn't be there. And nine times out of ten, they are probably the people who will remember what was said more than the patient. Sometimes the patient doesn't know what you're saying. Or they might be the actual person who will be doing the dressing. It is as important to keep them involved as the patients (Eva, nurse).

So, you've ended up doing your wound yourself, on a number of occasions. You had to do your wound yourself, because no one would see it. They did show us how to do it. 'Oh, you can do this yourself' (Joanna, Robert's wife).

Just as delegation could potentially lead to the generation of the relational good of 'patient and family management regime', the aforesaid discussed practice of swapping favours has the potential to reveal another relational good inherent to exchange relations, which is 'collaboration in wound healing research'. To reinforce the importance of the findings outlined in chapter five, patients in exchange relations eagerly spoke of supporting wound healing research by stressing its value for

helping to advance wound healing, while clinicians explicitly appreciated patients' support:

There are other things that happened ... they were doing a certain test, they asked me if I would like to be part of it. So, that, that was quite interesting ... after that I would sign up to anything, you know, because if it helps, it's worth doing (Rhydian, patient).

'Dave has helped us a lot with our wound research', says Ella to the students as she debrides Dave's ulcer (fieldnotes, Bridge Clinic, July 2016).

'Collaboration in wound healing research' was considered to be a special relational good, in that clinicians and patients, based on their shared concern about the deficient condition of wider wound care provision, combined forces to develop the field of wound healing, and, in turn, address the needs of other people affected by it that lay outside the immediate exchange relation. Taking the example of clinical trials, participation certainly gave patients a greater chance of healing, whilst running trials surely increased the scope for clinicians to raise the profile of their specialty. However, this also produced the intangible positive side-effect of enhancing the potential scope of treatment for other patients, both in the present and in the future. Unpacking this final effect of wound healing research centred on other patients who are facing similar constraints in wound care delivery can shed even more light upon the production of this special relational good.

### **6.1.3 Patients' empathic sacrifice**

The focus on the plight of fellow patients when choosing to collaborate in research was acknowledged in John's compassionate reflection on the severity of wounds and the anguish they brought to others. Over the course of the 32 years since the hospital specialist first took him "under his wings", John had participated in a lot of wound healing research. This equipped him with a very empathic appreciation of the diversity of the population of patients who have wounds:

Everyone is different because without being rude, everyone is all different shapes and sizes, so obviously legs use ... a very big... bandage. And you really feel for them because you know they must be really struggling ... My philosophy is, having come to the wound clinic all these years and visiting the hospital, you can always see people ten times worse than yourself ... There used to be a photograph on the wall on the ward, pictures of wounds, in the research unit, have you ever seen those? Some of ladies' breasts by here and lumps and wounds that won't heal, so that

must be really uncomfortable and, um, I also remember when we started [in Morgan Clinic], there was a little boy who would come from away. He had ingrown hair in his bottom, and that's one of the worst things you can have. He's not been to school and when he went home he had to lay flat looking at the television or reading, they weren't allowed to put him on his bottom. And they brought him from away, the hospital specialist looked after him. His mum said that's all he does. The ambulance men brought him in on a stretcher. But when you see these really elderly people in the wheelchairs with the legs bandaged, I mean that must be no sort of life whatsoever. So, everyone's different.

Denoted by Christina, the director of clinical education, as a “catch-22 in wound care”, the heterogeneity of the patient population meant that it was difficult to recruit sufficiently homogeneous groups of patients to run randomised controlled trials which are the gold standard for advancing medical knowledge. Unsurprisingly, this represented a significant barrier to further developing the science of wound healing. The gratitude that John and his wife Martha felt to wound healing clinicians for the care John had received, and their empathic appreciation of other patients facing the same problem, motivated them to offer their time and John's wound to extramural wound healing engagement and impact events and wound healing education within clinics. This sacrifice appeared compassionate and altruistic in light of his ongoing wound problem, which wore him down over the years:

He is much slower than he used to be ... I can see a tremendous difference in the last two years, not to mention the pain, it does wear you down. He's great, he keeps cheering and you see somebody else worse off ... Although it's not healed up, I think if we hadn't found the hospital specialist in the first place, I think he would have lost his leg because he was so bad before he took over ... The care he's had over the years! That's why we're always happy to help anybody, really, with their research because they have been second to none haven't they? (Martha, John's wife)

We had the other young doctor, didn't we, but he was a bit too rough and went in a bit too deep, it took six weeks before his leg healed up enough for him to come back! But you know everybody's got to learn (Martha, John's wife).

As an example of this help, John recalled trialling a new type of bandage in front of a film crew who turned the video and audio footage of his experience into a programme about wound products. Like John, Tim also contributed to the generation of video resources that added to the scientific repertoire of wound healing.

They had cameras in, there was a drug company involved, hospital specialist was involved with ... And they were just, they were using their dressings. And they sent us a camera team down to the hospital. And I went down, cause they were gonna put this dressing on my foot or on my leg. And Amanda was doing it, we were all ... camera is rolling, they give me a microphone and Amanda's doing the dressing. And I was there on the bed. And as soon as she came by me, when she touched my leg I said, 'Oh, Amanda!' Girls burst out laughing. Amanda looked and just burst out laughing. And they said, 'Cut! Cut! Cut!' And we set up again. And I was like, 'Are you alright, Amanda?', 'I'm alright'. As soon as she put her hand on my leg, 'Oh, Amanda!' And that was it, she just couldn't do it. Every time I looked she would start laughing. And, you know, I was just fooling around. I just thought I'd wind her up. Just, for the fun of it. And it was all filmed as well ... we had yards of laughs, just for laughs, that was all. I was bored. And, just for a laugh. But, yeah, I mean, you just watch them when they are doing dressings, things like this, it's not something that you wanna be looking at. Sometimes, you don't want to see it.

#### **6.1.4 Preservation of functional commitments**

With help from John and Tim's 'bodily sacrifices' for the advancement of wound healing, "the knowledge has increased scientifically quite dramatically", said Christina, the director of clinical education. At the same time, John and Tim made no bones about the value to them individually of participating in wound healing research. Tim's story also revealed an example of a re-organisation of a professional event to maintain a sense of joviality and amusement, for the purposes of brightening up what Tim himself saw as the otherwise grim reality of wounds and wound care. For Tim personally, participation in the dressings video provided a way of coping with the challenges around living with wounds that he vividly described as "messy" and "disgusting". Moreover, access to innovative treatment through research unexpectedly helped Tim clear his physically "mucky" wound:

There was a laser pen they had, and they were trying to heal up a wound on the side of my foot. By burning dead flesh and muck out to get rid of it. And they tried a few times and it didn't seem to be doing a lot at all. So, we stopped the study. I stopped the study. I didn't get any more of the laser treatment. But we went back to the treatment I was using before we went onto the laser. And it suddenly cleared up, healed up, sorted itself out. It's just little things like that. But I'd had the sore for a long time, I'd had the wound for a long time. And then, using the laser cleared out what needed to be cleared out. And then the dressing did the rest. And the simple dressings we were using that didn't work.

Similarly, John explained how participation in trials helped him work around the lack of regular and straightforward access to standardised wound care in the wider healthcare environment:

If you go to the research unit, you can go there on a Tuesday, you could be back there on a Thursday because they want to see how the dressing has reacted to your leg. And it's the same with all the dressing over the years. They give you 100 percent care. And if anything's wrong, you just have to ring and tell them if you think, you know, if certain things aren't right. And they will come and see you.

Finally, despite much being said about the emotional connection and warmth of the very human interactions, the influence of hierarchies on the clinician-patient relation persisted even within exchange configurations. Indeed, on one level, there was familiarity, a chance to have a smile and a laugh and develop an overall amusing relationship that made everything flow better. However, there was also a deeper, altogether more serious level, where patients related to clinicians' instructions with a greater degree of respect for medical advice by virtue of their social positionality as experts. For example, Tony revealed that the re-organisation of his personal concerns in responding to medical communication was influenced by this position:

In general terms, if the hospital specialist at that tier says something I'll do it.

Similarly, when I asked patient Tim what made his relationship with clinicians special, he immediately stressed the specialist expertise of "proper wound nurses" who "know what they are doing". Finally, although John and Martha addressed the hospital specialist by his first name in the treatment room, in the interview they highlighted their awareness of his professional progression. Therefore, reciprocity, gratitude, shared understanding of wound healing and patients' empathic bodily sacrifices under exchange relations did not mitigate the hierarchy of power.

## **6.2 Didactic relations**

Thus far, the chapter has focused on how the negotiation of relations among clinicians, patients and relatives in a dirty wound healing context centred on endorsing the concerns of the exchange relation, such that actors recognised the importance of ameliorating the context of wound healing. However, some outcomes of clinician-patient relational dynamics were such that actors did not relate to this shared venture in the same way. As patient Tony informatively noted in the quote



that opened this chapter, some negotiations resulted in relations based more on top-down didacticism. In contrast to exchange relations, in which clinicians, patients and relatives participated on a level that surpassed that of a professional consultation, the distinguishing feature of didactic relations was that they retained a functional character associated with the traditional roles of 'clinicians' and 'patients'. Such didactic relational configurations are illustrated in this section by elaborating two sub-types that were apparent during the fieldwork.

### **6.2.1 Boundaries to relationality due to lack of decisional capacity**

It is important to begin by acknowledging, albeit briefly, that not all patients were able to be involved in their own care. For some of the most vulnerable patients with serious physical or mental impairments, didactic clinician-patient relations around passive involvement in care were not only desired but also desperately needed. From an empirical angle, such consultations often took place behind the closed doors of treatment rooms. As per the conditions of access granted by the research and development departments of the healthcare organisations participating in this research and the remit of the NHS ethics committee, such patients were not recruited into this study. Nonetheless, on rare occasions I was able to grasp some of the dynamics of such consultations via fly-on-the-wall observation, ordinarily when I shadowed the hospital specialist along with visiting medical students:

I follow the hospital specialist guiding the medical students into a quiet room, in which he talks us through the consultation we just observed. The female patient was 'toxic' – in his words. She had sepsis. She was aloof. She came to the clinic with her two daughters, who had told the hospital specialist their Mum was confused and wasn't being herself on that day. We are told, based on this particular consultation, that it was not the patient who was the unit of consultation; instead, it was the patient's daughters who spoke for their mother (fieldnotes, Davis Clinic, September 2016).

Could such patients be discussed as forming relationships with clinicians that can help to alleviate wound stigma or are they nothing more than simple medical interactions focused on the wound? The answer is affirmative when such consultations are viewed through the contextual lens of the academic character of the clinics. In the example above, the patient did participate in medical education. With permission from the patient's social and familial network, she contributed to spreading wound healing knowledge. Consequently, I would argue that, although the patient did not appear to have the decisional capacity to actively contribute to

the agenda of growing the wound healing specialty, the example still illustrates how her consultation transcended the purely medical interactional level. Through her familial network, the patient participated in the generation of a relational good of 'collaboration in wound healing education', which is one channel for advancing wound healing knowledge.

### **6.2.2 Reproduction of traditional role relations**

The second sub-category of didactic relations comprised patients who exercised their capacity to assess their social position in relation to clinicians and the context of wound healing and decided not to commit to a wider 'wound healing project'. Instead, they appeared content with adhering to the roles assumed at their initial encounter with clinicians whom they confined strictly to their functions. Such patients expected the dynamics with clinicians to follow predictable rules in a regular order. Indeed, interviews with such patients revealed very little in terms of their human relationship with clinicians. Instead, by way of examples, patients Elina, Chris and Steve spoke entirely about their clinical treatment, stressing their satisfaction with the care they were receiving, whilst uncritically accepting their sick role. They did not mention anything that would suggest that the relationship could go beyond traditional role relations. There was evidence that such patients, and the clinicians they interacted with, saw a clear line between the responsibilities of both parties. For example, podiatrist Ella noted that some patients delegated the physically tainted task of dressing often heavy legs to her, without accommodating into their interactions a consideration of the strenuous effect this had on her body. In my fieldwork, I occasionally observed instances of patients' similarly self-referential behaviours:

There have been times where I feel like a patient potentially could have helped me more and have refused to do it. 'No, I'm not lifting my legs, that's your job' (Ella, podiatrist).

Tissue viability nurse Claire is sitting at the bottom of the bed, facing the patient. Claire puts compression dressings on the patient's leg. She bends down, then forcefully pulls the tight dressing up the patient's calf. The first layer of compression dressing is on. Claire repeats the process with the second layer and then the third. The patient keeps still. It looks exhausting to me! 'I woke up with a strange pain in my back', says Claire. 'Tell me about back pain!', the patient replies, as if she has not sensed the hint (fieldnotes, August 2016, Morgan Clinic).

Commitment to the traditional role division was also voiced directly by patients themselves in stressing their 'separateness' from clinicians as a form of relational evil. Clearly, there was patients' acceptance of a paternalistic care arrangement under which they were ready to do what they were told and their welcoming a patriarchal organisation of treatment delivery. For example, Derek kept repeating his passive subjugation to clinicians' expertise, Jack highlighted his felt lack of appropriate motivation to step out of the role of a sick patient, and Michael and Eleri reiterated their disinterest in holding any serious conversations with clinicians about where their interaction might take them:

You're the expert not me when I come here (Derek, patient).

I know I just don't have the motivation ... I'm getting into this sort of the sick role. Do you know what I mean? It's not like coming here, and a few times I've been discharged. It seems to be, like, an ongoing down and it will be now (Jack, patient).

Really, I haven't got any concerns. I just hope they sort it out, that's all (Eleri, patient).

Conversely, clinicians would always try to break down these functional barriers by seeking to hold serious conversations geared towards understanding patients' own social contexts. In so doing, they tried to narrow the gap between 'professionals in white coats', which they were worried they were being perceived as, and the 'empathetic human beings' they wanted to be seen as.

And then once they see that you're a human being and you're quite empathetic, but also you're just a normal person, you're not somebody in the white coat or I would be in a red uniform, just like a little clone there to tell them, 'Do this, do that'. When they start to see that you are a normal person, sometimes they start to talk more about their lifestyle, what their home is like ... what the challenges are. They start to trust you (Ella, podiatrist).

You might have doctors who – not in our unit – but there may be some doctors who will say, 'This is what you do'. You don't speak to them. 'No, you've got to do this, go away, take this, go' (Phil, doctor).

I think that you can build a relationship quite quickly if you just speak to somebody on their level rather than, 'This is a professional-patient consultation', you know – 'I'm here to help you. Tell me what we need to know and then we can try and make things better for you' (Eva, nurse).

These efforts to build relations that went beyond functional attachments were recognised by patients themselves. For example, Michael praised the clinician who

cared for his ulcer in the consultation, noting that 'she didn't project herself onto him'. Therefore, Michael's observation shows that some patients understood that clinicians were trying to build a relation beyond the delivery of biomedical care. However, sometimes the incongruities between what patients and clinicians sought from their relations resulted in settling for the retention of traditional roles qua 'patients' and 'clinicians':

There are some patients that you just wouldn't go there with. There are some that do not want to talk, they are quite closed down and you tried and still are not getting anywhere. You accept that this is what the relationship is going to be. But this is the patient's choice, it's not you not being prepared to give the best, really, to the patient. Always a challenge (Ella, podiatrist).

### **6.2.3 Embeddedness in social context**

Patients' commitment to a relational orientation in relation to 'I, the patient' and 'You, the expert' can be partially explained via their negative experiences in their own social contexts prior to attending the specialised wound clinics. The role division that was ingrained in them through prior interactions with other healthcare professionals skewed them towards expecting relational evils. For example, Michael's son-in-law, Mark recounted their previous interactions with district nurses:

You ask them a question, it's almost as if you shouldn't be asking the question, it's almost like, 'We know what we're doing, just let us do it'.

Such experiences conditioned patients to await similar disappointments, sensitising them towards negativity in their interactions with wound healing clinicians. For example, in the early days of Derek's attendance at the wound healing clinics, a glitch in communication across different hospitals involved in Derek's wound care led him to experience anger and distrust that he then translated onto his interactions with wound healing clinicians. Frustration and anger generated a relational evil of the 'dispersion of trust':

They couldn't find on their records what antibiotics I've been given and in the end the doctor rang the surgery and asked the receptionist in the surgery to let her know what antibiotics I was on ... The left hand doesn't know what the right hand is doing, and I think it's disgusting! To be honest, I worked in heavy industry and I was a team leader, I had to do things very, very quickly for those who worked in a steel works, they are no longer there. And I think if my departments had been run like some of the things here it would have been absolute murder.

The strong attachment to his social context influenced Derek's interpretation of the relational dynamics in clinics. Through his own professional biography, in which he valued accuracy, speed and a sense of responsibility towards others, Derek was expecting the same point-by-point way of dealing with things and was thus disappointed when this did not happen. Similarly, Jack was expressive of his commitment to his previous career as a mental health nurse and observed that he may have been occupying a different position relation to what he sensed was, at times, the impersonal way that clinicians spoke about him in the treatment room:

And one thing I find, I don't think it's intentional, but occasionally people talk over you. As a mental health nurse, the first thing we were always told is, the central theme through it is personal communication. Sometimes they sort of, you know, 'he needs this', 'he needs that ...'

In presenting the didactic relations, thus far I have focused on the interactions within the scope of clinical consultation. However, a similar role of prior conditioning was visible in the relational practices between clinicians and patients pertaining to the research aspect of wound healing work. This can be illustrated further by continuing with Derek's vignette. In general, Derek's orientation towards supporting wound healing through participation in clinical trials was altruistic, in that he acknowledged the suffering of fellow patients and expressed a wish to help them to the best of his ability as a patient:

If it doesn't help me, it could help someone in the future.

However, the following extract in which Derek recalls his involvement in clinical research sheds some light on the potential mechanism responsible for breaking this altruistic orientation. When recalling a specific attempt to recruit him into a trial, he expressed his anger towards clinicians' lack of recognition of his previous support:

When I came to see [the hospital specialist] the one time, one of the ladies who walks around here in like an orange-y colour top, she came in and said, 'Oh, will you do us a favour?' and I said, 'What's that?' 'We'd like to put you in a trial' she said. Yeah, like I said, you can ask me to do anything and I'll do it, cause if it doesn't help me it could help someone in the future. So, she brought me like a photograph. I said, 'I've already been on that'. And she said, 'What do you mean?' It was nowhere on the record and I said, 'Doesn't anybody read the bloody record around here?' See? As far as I am concerned, this shouldn't have happened ...

Again, Derek showed how his attachment to his own understanding of standards impacted on his valuation of clinical dynamics. The relational evils of 'blame' and 'accusation' emerged, which he demonstrated through the use of expletive laden language. In this case, it was possible that clinicians' attachment to their own academic context may have also influenced how they approached Derek in the clinical context of the consultation. As a result of this discrepancy in their respective perspectives, Derek withdrew his support from taking part in further clinical trials. Based on the above extract, it became apparent that the symmetry in swapping favours discussed in chapter five was not automatic. Rather, patients were only willing to continually support clinicians' efforts at growing the wound healing specialty if they felt that clinicians paid attention to their individual profiles, grounded in their unique problems and history of interaction. If, however, they felt that clinicians failed to distinguish between individual patients who provided support, how they did it and when, this bilateral support was broken. Lack of recognition of the individual profiles of patients was a crucial mechanism in the failure of communication, delegation and swapping favours. Because of a divergence between clinicians and patients' concerns, delegation became an unreasonable demand, whilst a request for a favour became focused on clinicians' own professional agenda.

### **6.3 Atomistic relations**

In contrast to the exchange and didactic relations referenced verbatim in an interview with Tony, naming the final relational configuration observed in the field required some work. I repetitively iterated between the data and extant literature to better capture what exactly characterised this specific clinician-patient social formation. My consecutive readings of the configuration recurrently pointed to the distinguishing feature of patients' sense of individuality. Given the lack of fit of the grounded data categories I had previously experimented with to convey it, I found that relational sociologists like Mussell (2017) and Donati and Archer (2015) better approximated it in their presentation of atomistic social ontology. Below, the atomistic configuration is discussed through recourse to the relations in which patients' actions were perceptibly indicative of an individual orientation towards their own preference.

### 6.3.1 Societal individualisation in wound care

The existence of atomistic relations was brought to my attention by the first clinician I interviewed. Having observed the strain that wound care work puts on clinicians' bodies, I asked podiatrist Ella whether she felt that patients were aware of this physical taint associated with her work. She acknowledged that some patients would attempt to discursively dilute the taint by voicing concern over the weight of their legs. However, she also reflected on patients' frequent self-referential behaviours. The entire account is presented below because it skilfully diagnoses the distinguishing characteristics of atomistic relations:

I think society in general has become very needs driven, and that their needs supersede everybody else's. For example, we may have had patients that you had a good relationship with that you have been seeing for a long time. And maybe they have come to the clinic, but the clinic is very, very busy. Maybe they have turned up an hour earlier for their appointment, and they keep coming and knocking on your doors, saying, 'Well, where am I on the list, when are you going to see me?' Because they expect you to put them to the front of the list, despite the fact that they can see the clinic is very busy. And you are like, 'Oh, take a seat, the clinic is very busy, but I can't guarantee what time because we've got lots of rooms running at the same time'. And because they don't get what they want, they will then knock on another door and try it again. And in the end, they will start saying, 'Oh, I'm not waiting today if I cannot be seen straight away'. And I'm like, 'Okay, that's fine just go to the desk and ask for another appointment to be made'. Because it's not fair. You've got lots of patients to look after and everybody has to be looked after in the same way. And if somebody in the waiting room is physically unwell, a septic infection in their body, they have to be admitted and you are not going to keep them waiting in the waiting room for two hours, they need to be seen and get medical attention straight away. But it's really surprising sometimes that when it's happened, then other patients in the waiting area will complain. And they say, 'Oh, I arrived before that patient, how come they've taken her in straight away, and I've been sat here waiting'. 'Oh, I'm sorry, that lady is very unwell, we are gonna have to call an ambulance and get her admitted'. They are still like, 'When am I gonna be seen?' Honestly! 'But what about me?' 'I demand this', you know (Ella, podiatrist).

This example testifies to the fact that some clinician-patient relations were not characterised by an equal appreciation of the social nature of human individuality, such as was the case in exchange relations. Rather, atomistic relations are characterised by patients acting in an individualistic manner. What is particularly striking in the extract above is patients' 'imperfect ability to acknowledge the needs

and rights of other patients in relation to one another'. 'Atomistically-inclined' patients could come to the clinic at a time that helped them fulfil their own agenda to be seen as quickly as possible. Therefore, they often arrived early expecting to jump into another patient's appointment slot. If they succeeded, this meant that other patients, who suffered from the same medical condition, might have had to wait longer. The shared dimension of wounds was not clearly acknowledged in such scenarios and there may also have been little comparison of one's own situation with others' suffering and needs. Moreover, other patients might have felt it was unfair on them, which, in turn, produced relationally negative consequences of complaining. From this perspective, some consultations in wound clinics could be seen as self-regarding acts that risked alienating other patients.

In light of this observation, some patients did, indeed, reveal their clear attachment to their personal agenda in their interactions with clinicians. Differences between the treatments that patients requested and those that clinicians were prepared to offer in their position as experts revealed interpersonal tensions that threatened their involvement with each other and, in turn, risked the reproduction of wound stigma. In the example below, a worried patient requested a magnetic resonance imaging (MRI) scan for a bone infection. Clinicians, however, discounted this request as unnecessary.

I think they think I worry too much. They haven't said that but I ... I'm always asking for an X-ray or even a CT scan – I don't know if I can have one of them or not – but I did say, 'Can I have an MRI scan?'. They said, 'No, there's not really much point really' (Rachel, patient).

It is important to stress that, at the time of this study, the waiting time for an MRI scan was four months. Despite its value in detecting bone infections, clinicians made careful decisions about using this scarce resource, regardless of whether patients were aware of its scarcity or not. Other requests from patients risked 'reducing clinicians to the part they were supposed to play in the consultation associated with their role'. As a relational evil, this had the unexpected effect of reproducing specific aspects of dirty work relations, pushing clinicians into positions of having to sustain the strain on their bodies or of having to negotiate their way out of positions of servitude (chapter four):

Patients can be quite selfish. Which ... they're only there about themselves, rightly so, we're probably all the same. But some



patients, you know, they are quite large, and they don't make no effort to help you. Which can be quite back-breaking (Eva, nurse).

We have patients who say, 'No, you've got to do this dressing and I know because I have got this wound for more time than you've been a doctor', so this is what's got to be done. Again, it's finding that balance ... for example, you have the patient's agenda, you have your own agenda ... That's not the right attitude to do everything what the patient says, but maybe share trying to find the right balance (Phil, doctor).

### **6.3.2 The conditioning role of patients' prior experiences**

Given doctor Phil's observation about the duration of wound condition for some patients, patients' sense of individuality appeared to have some grounding in the early onset of their wound journey. For example, for patient Jane, it started 15 years prior to the establishment of the Morgan Clinic. A confrontation with the cool, impersonal and objectifying attitude of a clinician at the diagnostic, and hence relatively formative, stage, left her feeling estranged and forced her to manage the wound on her own to the best of her ability:

The very first guy I saw that diagnosed me with an ulcer, he breezed in, great big strapping guy, I was 31. I was lying on the bed. I was in absolute agony. He breezed in and he had a big pen. The nurses had unbandaged the leg. He came in, he looked at me, and then he said, he was looking at my foot, and asked, 'How long have you had this wound?' I said, 'About a year'. It wasn't that particularly big. He had this big pen in his hand – I'll never forget it – and he was bouncing this pen on my wound and he said, 'Well'. And he's not even looking at me; he's looking at my foot. He said, 'How old are you?' I said, 'I'm 31'. 'You're a 31-year-old woman with a leg of a 70-year-old. Go home and live with it'.

The lack of concern and detachment on the part of the clinician in this encounter was emblematic of the blaming and distancing depicted in dirty work scholarship's dominant portrayal of workers' relations towards their clients. In the example above, in place of empathy towards the patient's upset at an alien bodily oddity, there was only depersonalisation and objectification, with the pen operating as a physical barrier which potentially exacerbated a pre-existing sense of human isolation. In place of delegation via a lifeline of support, there was only separation via the injunction to accept the wound, bringing to mind the concepts of unimportance, insignificance, estrangement, disaffection and distancing that occur prior to Jane and the clinician even getting to the stage of being able to generate such evils. Left

to her own devices, Jane took pride in her independence, self-reliance, courage to speak up, as well as the creativity she displayed in her own self-treatment:

As Amanda kneels down to take the bandage off Jane's leg, I start chatting to her about her daily routine. She tells me she reads a lot. She doesn't do any housework anymore, although she was 'proud' last week when, still sat on a chair, she used a long brush to sweep off the dust. It took her 15 minutes, stretching her arm out, but she did it 'herself'. I nod, whilst in the corner of my eye I catch Amanda cutting off what looks to me like sanitary towels stuck to the bandages ... and I am not mistaken, as I soon find out when Jane explains that this was the only solution she could come up with to absorb the exudate (fieldnotes, Morgan Clinic, August 2016).

It was only about 20 years ago that I met the hospital specialist, and when I first met him, we used to clash. We used to have flipping murders. He kept saying, 'You need compression bandages'. And I kept saying, 'It's not vascular ulcers', and he was saying, 'But it is vascular ulcers' (Jane, patient).

The nurse who is new and here on a secondment, and thus unfamiliar with Jane, asks why she is not in compression. Jane replies that she has recently given a talk at an event saying that compression and elevation do not work. 'I've been elevating my legs for 40 years and this has had no effect on me' (fieldnotes, Morgan Clinic, December 2016).

### **6.3.3 Selective compliance and challenges to dirty wound healing work**

The above data extracts are demonstrative of the ways in which Jane placed value on her individuality and how this subsequently informed her interactions with clinicians, sometimes positively, whilst at other times, in relationally negative ways. For example, Jane was praised for her diligence in performing potassium soaks, but she refused to wear compression because of the pain it gave her. Clinicians' frustration at Jane's selective cooperation generated a relational evil of 'interactional strictness and sporadic allusions to discontinuing the relationship'.

It's all well and good telling people, 'This should be in a compression bandage', but when it's causing people more pain than what you're already in, forget it, it ain't gonna happen. If my legs are going to heal, which they won't (Jane, patient).

We know what therapy she needs. But she won't have it. Absolutely refuses. Absolutely refuses. Says it causes the wounds. And yet without it, the wounds aren't getting better. And we know if we could only get her in, but you know that with certain

personalities, it's like butting your head on a brick wall. So, we just keep seeing her, respond to what we are seeing and hope that one day, one day, you might be able to influence her ... And, as you know, the hospital specialist is very strict with her. But it is difficult, it is very difficult. And you want to say to her, 'Why do you come?' She criticises everything you do, doesn't follow the plan and the wound is getting worse and worse and worse and at times she's in tears because they are so much worse (clinician, anonymised).

The above quotes suggest that Jane was making her own decisions about compression therapy which the clinicians may have interpreted as being based on her personal opinions. However, as observed by nurse Eva, such selectivity in certain patients' compliance was not entirely selfish, but, in fact, sometimes stemmed from the stigma of vulnerability around wound treatment. This was a challenging terrain for clinicians to navigate, because, while compliance with some treatments conferred stigma on patients, their non-compliance produced low-outcomes and challenged the credibility of wound healing:

There are patients that you see that don't take your advice and it does seem that they don't want to get better ... We have a lot of patients who suffer with pressure areas and battling that is quite hard, because some of these patients are young and wheelchair-bound and they don't want to use an air mattress, or they don't want to sit on an air cushion, because it doesn't look particularly great. Or they don't want to wear the correct shoes. So, trying to make them understand that their wound isn't going to heal unless we change things can be quite hard (Eva, nurse).

Jane was also eager to take part in clinical trials. "As long as they do not chop my leg off", she muttered while signing a consent form (fieldnotes, Morgan Clinic, August 2016). "If it helps somebody else ... if they can stop somebody from doing that, I'm all well and good", she said in an interview, hinting at an opposite-to-atomistic, unselfish concern for others through empathetic bodily sacrifice. The concern for others was an emergent, albeit unintentional, product of her concern for herself. This suggested that, despite her strong sense of individuality, she performed some relational deliberations, thus signalling the relational good of 'emergent (unintentional) concern for other patients'. This was also visible in the accounts of other patients who made comparisons with fellow sufferers, even if they placed themselves at the centre of such comparisons.

People don't understand, really, and you try and explain, and they try to understand, but unless they're in your shoes they don't, they don't get it, so I wouldn't wish that on my worst enemy (Rachel, patient).

Today, they see, like, 25-30 patients, so it's, like, 25-30 people like myself here, so they've got to balance all different people for all different reasons (Malik, patient).

However, Jane's participation in other extramural wound healing engagement and impact events accorded with her sense of self-interest. In the extract above, she devalued compression therapy based on her own experience with it, thus questioning best practice and challenging the uptake of this therapeutic intervention. Moreover, she prided herself on having knowledge of the non-NHS and self-funded nature of the clinics. In the quote below, she explains how she acquired this knowledge, not so much through a relational interest in the "wound care biz" (like patient Tony), but, rather, in an attempt to work around the constraints that stood in the way of her satisfying her own concerns:

[The hospital specialist] founded it and he flies all over the world, spreading the word, teaching and looking for funds. It was only a couple of years ago that he didn't know whether he had money for the next year ... I want to know what's going on, basically. And I found out [that the clinics are self-funded] because he told me when I needed it ... there was this treatment, it's registered for arthritic patients, but it wasn't registered for the pyoderma. My theory was, I've had this pyoderma forever. It only takes seven years to register the drug for any particular condition. Bloody start registering it now and in seven years' time I will have a cure. It was quite logical as far as I was concerned (Jane, patient).

Therefore, Jane's involvement in her own care showed a careful personal deliberation about what mattered to her. Concerning her relationship with clinicians, those mattered to her, too. However, her relational devotion showed a peculiar mix of egoism alongside concern for others:

As Jane awaits her appointment, I join her in the waiting area for a chat about her relationship with clinicians. Jane recalls the time when the hospital specialist was unwell, when she told him, 'You look like crap, you need to sort yourself out. If you leave now, I don't know what we would all do without you'. She admits that while she recognises that this was a 'selfish reaction', she also admits that she was 'genuinely concerned about him' but 'if he finished work tomorrow, a new clinician would have to go through thick folders full of medical notes about me to understand the amount of suffering I have been under. This might be a selfish point of view and, if so, then it is what it is', but she also 'genuinely likes the guy' (fieldnotes, Morgan Clinic, August 2016).

### 6.3.4 Tensions in negotiating medical and social relationships

Jane's above account illustrates how, for some patients, relational concern for others related not so much to the social situation that they found themselves in, but, rather, the extent to which their personal concerns underwrote it. "If it wasn't for [hospital specialist], I wouldn't bother", Jane added. Similarly, another patient admitted during a corridor chat we had that one of her concerns was being told her wound had healed enough for her not to have to come back to 'see the team' (fieldnotes, Morgan Clinic, September 2016). Whereas for Jane, a sense of this continuity represented an emotional safety net, it may have prevented her from developing the forms of relational concern shown within exchange relations. In its place, there were individually focused relations she felt she had with specific clinicians, which signalled her 'overdependence on individual clinicians'. The extract below reflected the mind-set of this group of patients:

Sometimes, one of the issues will be, 'Where is [the hospital specialist] today, why is he not here, I've come to see him, I don't want to see anybody else'. And we're like, 'Oh, it's okay, his doctors are here'. If there is an issue they need to discuss with the professor, they can speak to him, but he is overseas at the moment, and you explain the part ... No man is an island. And he's wonderful, but he's always accessible to his doctors, and he is always of great support, but I think patients demand that they have this one-on-one contact with him every single time they come to the clinic and it's not realistic (Ella, podiatrist).

When I returned to the common area after observing one of Jane's consultations and chatted about it to a nurse, she commented that Jane was "hard work", which helped me get a handle on this particular type of relational evil. She then continued, "Some patients enjoy their illness, sad as it sounds, and these patients always have the same outcomes, which is a lack of improvement" (fieldnotes, Morgan Clinic, August 2016). Given her lack of improvement, clinicians simply carried on in their role of providing the same care with little outcomes. These inert attitudes fed relational evils centred on 'obstructing the provision of medical care that could bring healing outcomes'. Moreover, when confronted with such relational atomism, clinicians then had to negotiate two sets of interactions with patients like Jane: first, a medical relationship to negotiate care, despite potential disagreements over expert treatment; and second, a social relationship to respond to the patient's sense of individuality. Not only did the latter aspect problematise their medical authority

through disagreement about diagnosis and treatment, but it also risked a misuse of their resources through the encouragement of overdependence:

And you try to explain to them that it's what they are doing that's making it worse and if they only followed our plan for a little while ... they can't see it. And, so, you have this really difficult consultation. And in your mind, you say to them, 'Why do you bother coming, why do you come to the clinic if you don't follow our advice?' You criticise everything, and yet you still want to come to clinic. And that's very difficult, and [the hospital specialist], all he says is, 'Just keep chipping away, keep chipping away'. What you find with these patients is if you discharge them they will only pop up somewhere else, and someone else will think, 'God, isn't this terrible?' And they will start the whole investigation again, they will take the blood, the scans, the X-rays, the history ... everything that we have done, and it will all come back normal or whatever. And so how costly is that to the NHS? So, these patients we never actually discharge them, because they would only go and see somebody else. We keep seeing them and just hopefully keep chipping away and just hopefully try and persuade them, but it's probably one of the most difficult consultations (Amanda, nurse).

The transition in Amanda's account from reflecting on the challenges of atomistic relations towards explaining the clinics' organisational 'rules of action' to never discharge such patients to protect other specialties from similar challenges connects with the idea of wound healing as a third-party agent (chapter four). Here, they took on the difficult task of managing the care of strongly independent patients whose selective uptake of care may have reduced their chances of healing, thus keeping the cost of wound healing care high, whilst, simultaneously, saving other specialties from incurring similar costs. Although such relational configurations helped patients deal with wound stigma by immediately pleasing the patients, they challenged the overall scientific progress of wound healing.

## **6.4 Summary**

The issue of worker-client relationships in dirty work has hitherto been either overlooked or viewed simplistically in largely antagonistic terms. This chapter advanced on this one-sided understanding by offering a detailed presentation of the relational configurations between clinicians, patients and patients' relatives in the dirty and stigmatised wound healing context. The data presented here highlighted that worker-client relationships represent heterogeneous and meaningful spaces of positive associations that can help alleviate wound 'dirt' and stigma, rather than

representing only contingent connections and negative disassociations that serve to (re)produce dirt and stigma. The three relational configurations identified in the analysis of the data are necessarily arbitrary simplifications of the richness of social relations evidenced in wound healing, which defy clear-cut categorisation. However, to appreciate their nature and to capture how they differed, this chapter focused on how they underpinned personal and relational considerations, along with producing manifold relational goods and evils. It also connected these configurations together with findings from chapters four and five, which examined the ways in which clinicians, patients and patients' relatives concerned with wound healing and wounds operated together in a dirty context. To conclude the empirical reflections in this study, Table 5 below summarises the clinician-patient relational configurations in the dirty and stigmatised context of wound healing.

**Table 5. Summary of key findings of the study**

| <b>Relational configuration</b> | <b>Outcomes of relational dynamics</b>                                                                                                         | <b>Personal versus relational commitments</b>                                              | <b>Generation of relational goods and evils</b>                                                                                                                                                    | <b>Alleviation and/or (re)production of wound stigma</b> |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| Exchange relations              | Gratitude and reciprocity; Shared understanding of wound healing context; Patients' empathic sacrifice; Preservation of functional commitments | Relational deliberations in approaching care                                               | <p>Relational goods: 'trust between clinicians and patients', 'patient and family wound management regime', 'collaboration in wound healing research'</p> <p>Relational evils: none identified</p> | Alleviation                                              |
| Didactic relations              | Boundaries to relationality due to lack of decisional capacity; Reproduction of traditional role relations; Embeddedness in social context     | Commitment to functional roles within the relation: 'I, the patient' and 'You, the expert' | <p>Relational goods: 'collaboration in wound healing education'</p> <p>Relational evils: 'separateness', 'dispersion of trust', 'blame', 'accusation'</p>                                          | Some alleviation, some (re)production                    |



|                            |                                                                                                                                                                                                                                |                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                              |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| <p>Atomistic relations</p> | <p>Societal individualisation of wound care; The conditioning role of prior patient experiences; Selective compliance and challenges to dirty wound healing work; Tensions in negotiating medical and social relationships</p> | <p>Prioritisation of personal satisfaction with one's own position in social relations</p> | <p>Relational goods: 'emergent (unintentional) concern for other patients'</p> <p>Relational evils: 'inability to acknowledge needs and wants of other patients', 'reducing clinicians to their traditional roles', 'interactional strictness and sporadic allusions to discontinuing the relationship', 'overdependence on individual clinicians', 'obstructing the provision of wound care that can improve wound outcomes'</p> | <p>Some alleviation, more (re)production</p> |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|

## 7 Stigma alleviation as a relational good: towards ‘clinician-patient advocacy partnerships’ in support of ‘woundology’

Relational goods are emergent, being generated and sustained by the subjects constituting them, and possess their own properties and powers: to motivate, to facilitate, and to constrain the parties involved in them and to affect matters beyond them (Donati and Archer 2015, p.62).

The aim of this study is to explain the development, nature and role of clinician-patient relationships by drawing on an ethnography of three specialised outpatient wound healing clinics in the UK. Current demographic and social trends signal an increase in the number of patients with chronic and hard-to-heal wounds (Guest et al. 2017), allied with a proportionate reduction in the availability of clinicians able to care for such patients (Bloom et al. 2011). Against this backdrop, wound care professionals have to seek ways of “working with patients to maximise their outcomes and their ability to carry on leading their lives as independently as possible. There is very little doubt that [clinicians] will need to work in partnership [with patients]” (Price 2011, p.18). To date, efforts to build such partnerships have developed under the conditions of wound stigma. In general, wound healing has received “limited and patchy academic and clinical interest” (Harding 2015, p.318). More specifically, publications in wound care management (Bates 2006; Lindahl et al. 2008; Lindahl et al. 2010; Lake et al. 2015) and organisation studies (Stacey 2005; Tracy and Scott 2006) have noted that wound healing bears resemblance to Hughes’ (1958) notion of dirty work, because of workers’ proximity to patients’ foul and otherwise stigmatising wounds.

My iterative data analysis has demonstrated that wound healing, indeed, qualifies as dirty work (Hughes 1958; Ashforth and Kreiner 1999; Thomas 2014). I observed various situations of wound stigma in which clinicians were stigmatised for their dirty work, whilst patients were stigmatised for their ‘dirty’ wounds. Moreover, I observed that both groups were not merely interacting, but, rather, were *relating* to each other in a way that recognised the need to act beyond their immediate concerns and to improve the current state of knowledge and understanding of wounds and wound healing more broadly (Harding 2015, p.318). However, theoretical resources within extant dirty work literature do not afford a rich conceptualisation of clinician-patient

relations, which means that the role of worker-client relations in dirty work is both under-researched and theoretically under-developed, especially in relation to the management of stigma. It was this which warranted the integration of the relational subject framework (Donati and Archer 2015) into the analysis. Specifically, through its focus on relational goods and evils, the framework afforded an exploration of the relations, and aspects of these relations, which enabled the alleviation of stigma, as well as the relations, or aspects of these relations, which (re)produced stigma (Al-Amoudi 2018a). Therefore, this study has asked the following question:

How is the stigma associated with wounds (re)produced or alleviated in UK wound healing clinics?

This chapter develops an answer to this question by situating the study's empirical findings in relation to extant literatures on dirty work, the relational subject and wound healing, respectively.

I begin with a reflection on the unique taints of wound healing as a type of dirty work, the role of organisational and wider contextual issues in (re)producing and alleviating stigma, and locate these aforesaid micro-level issues within the meso and macro context. I then show how the relational configurations identified in this study differ in terms of both the relational orientations employed and their effects on relationships and stigma. Finally, I present stigma alleviation as a unique type of relational good that has value for clinicians, patients, the wider community and in terms of its de-stigmatising potential for wound healing, before moving onto frame its value in wound care and health policy in terms of 'advocacy partnerships' and 'woundology'. I conclude the chapter with outlining this study's contribution to the field.

## **7.1 Advancing understanding of stigma in relation to wounds and wound healing**

This study has endeavoured to go beyond social constructionist doxa in dirty work scholarship to emphasise the existence and management of stigma and 'dirt' at the levels of discourse, ideology and occupational culture (e.g. Thompson 1983; Ashforth and Kreiner 1999; Ashforth et al. 2007). In line with a critical realist relational sociological approach, below I offer a situated, contextual discussion of a grounded framing of wound stigma and its management that explains the connections between its internalities (Edwards and Meliou 2015). Specifically, I

discuss clinicians, patients and patients' relatives' relational responses to stigma, their material and corporeal practices (O'Mahoney 2011) around the ungraceful features of wounds and the attendant difficult emotions they produce, as well as the informative potential of the organisational context and the external conditions in the health economy (see Delbridge and Edwards 2013; Jenkins and Delbridge 2013; Edwards and Meliou 2015; Jenkins and Delbridge 2017).

### **7.1.1 Relationality in managing aspects of wound stigma**

As one of the first explicit dirty work analyses of wound healing focused specifically on clinician-patient relations, this study has foregrounded the salience of the physical and emotional aspects of wound stigma. The primacy of physical and emotional taints in dirty wound healing work resonates with other dirty work studies of physically tainted caring occupations, which McMurray and Ward observed had "read into" (2014, p.1138) emotional taints before they themselves explicitly coined the term 'emotional dirty work' (e.g. Bolton 2005; Chiappetta-Swanson 2005; Sanders 2010). However, this study has gone beyond merely unpacking physical and emotional taints as descriptors of the "orphan" specialty of wound healing (Harding and Queen 2011, p.325). Rather, it highlights the under-appreciated entwinement of these taints (Hughes et al. 2017), specifically how their handling in consultations informs the provision of physical and emotional support in the immediate context of the actors concerned.

Thus, for example, the 'messy' debridement of dead skin – one common therapeutic intervention that underscores the 'material dynamics of dirt' (Hughes et al. 2017) in wound healing – is negotiated in a way that employs the countervailing discourse of purity. Simultaneously, it is buttressed with embodied clinical practices that literally clean the wound of 'muck' and 'stink', whilst strengthening clinician-patient relations through building trust in the effectiveness of the treatment (Lusher et al. 2018). Moreover, the role of social touch in corporeal communication, under threat in a non-touching culture (Bolton 2005; Coccozza 2018), embodies wound stigma alleviation through nurturing humane relations in empathic recognition of the relational repercussions of living with malodorous unsightly skin tears in a body-conscious society (e.g. Body confidence campaign 2015). Finally, empowering patients to self-care and co-coordinate their appointments through the process of delegation, equips them with an ideological sense of control and improves their capacity to perform at least some of the 'dirt' removal.

This study's portrayal of managing stigma through mobilising embodied strategies that produce clinician-patient relational emergent signals a departure from social constructionist dirty work studies. If such work considers worker-client relations at all, they mostly limit their focus to negativity between both groups, or in the rare cases when positivity is discussed, to narrations of care. In these studies, discourses of paternalistic care are employed largely on an occupational level in relation to workers expressing a sense of improving people's lives (Hamilton et al. 2017), or, alternatively, satisfying their drive to care for people through drawing on the ideologies of nursing (Bolton 2005; Chiappetta-Swanson 2005). When the relational level is considered, as is the case in Stacey's (2005) study of home carers, attention is placed on them valuing the time spent with clients, rather than the physical taint associated with body care. This study has advanced an understanding of managing stigma as a relational, discursive and physical practice, through examples of patients absorbing part of the dirty tasks as opposed to passively delegating them to clinicians (Ashforth and Kreiner 1999) and clinicians disguising their visceral reactions to material contamination (Twigg 2000), partly through normalisation after repeated exposure to taints that are simply part of the job (Hughes et al. 2017), as well as in consideration of patients' emotional states (Rivera 2015).

Therefore, founded in the relational thinking of critical realist social theorists (Donati 2010; Donati 2016a; Donati 2016b; Donati and Archer 2015), this study has depicted clinician-patient relations in physically and emotionally tainted wound healing work as more than contingent communications and feelings. As Archer, when citing Donati (2010), points out, "the relation 'is not merely the product of perceptions, sentiments and inter-subjective mental states of empathy, but is both a *symbolic* fact, ("a reference to") and a *structural* fact ("a link between"). As such, *it cannot be reduced to the subjects even though it can only "come alive" through these subjects*" (2010, p.202). Here, clinician-patient interactions were guided not only by the cultural expectation of non-judgemental reactions to the visceral proximity of wound 'dirt' in a dedicated clinical region, but also via an emotional bond that fostered an emergent relational mode of being.

### **7.1.2 Organisational and wider context of dirty work**

Moreover, there are some parallels between this study and the few dirty work studies which argue that organisational and wider contextual issues should feature in accounts of dirty work (Stannard 1973; Tyler 2011; McCabe and Hamilton 2015;

Jenkins and Delbridge 2017). Of particular import for explaining the aspects of clinician-patient relations associated with wound stigma alleviation and (re)production were: the academic context of this wound healing organisation; demographic and social changes in the UK that have led to the rise in the number of patients with chronic wounds (Guest et al. 2017); and the related guidelines in the health economy promoting patients and their caregivers' empowerment in wound care (Lusher et al. 2018).

Research, education and industry events in wound healing, as well as clinicians and patients' appreciation of their potential to help "wounds and wound healing receive the attention they need" (Harding 2015, p.319), were important features of the interpretation of aspects of clinician-patient relations associated with wound stigma alleviation. For example, affiliation with wound research was a strong aspect of professional biographies for some clinicians. For example, Nurse Megan saw the "research side" of her job as the most satisfying because of the "phenomenal" difference that standardisation of treatment and regularity of contact made to patient care. Therefore, proximity to research neutralised stigma for these clinicians, because of its 'scientification' of wound healing. Moreover, patients' enjoyment of their "collaboration in a scientific research team" was a textbook example of a relational good (see Donati and Archer 2015, p.199). Not only did participation in extramural wound healing engagement and impact events transform clinician-patient relations onto an emergent level of familial and friendly networks by fostering entitativity, i.e. "a perception among individuals that they are grouplike" and under the threat of stigma (Kreiner et al. 2006, p.626), as well as helping to improve recognition of wound healing as a specialty (Madden 2012).

As for wider contextual counterpoints, the study has shown that calls for patients and their caregivers to participate in self-treatment in response to growing care demands and shrinking resources (Bloom et al. 2011; Price 2011; Guest et al. 2017; Lusher et al. 2018) are commensurate with alleviating stigma by blurring the dirty worker – clean client divide. Most social constructionist dirty work studies that take occupational groups as their main unit of analysis (Jenkins and Delbridge 2017) focus on work groups forming strong, unifying occupational cultures as the foundation for stigma management (Thompson 1983; Ackroyd and Crowdy 1990; Ashforth and Kreiner 1999). In contrast, this study has shown that the drive towards increased patient involvement can facilitate greater inclusiveness in wound care, by turning outsiders – patients – into insiders within dirty work. This, in turn, can offer

patients a valued sense of worth (Hughes et al. 2017), while, simultaneously, diluting the breadth and depth of physical dirtiness of work activities for nurses in clinics (Kreiner et al. 2006).

This is not to say that organisational culture does not matter. For example, it was visible in the organising principles of taking 'all-comers', getting to know patients' social worlds and never discharging patients with forever healing wounds (Augustin et al. 2012). Assuming the role of a third-party agent 'cleaned' some of wound stigma for patients through offering them a care outlet that was safe, easy to access and responsive to their individual needs (Augustin et al. 2012), but it also had a perverse effect of reinforcing the dirty work imagery of wound healing through undermining healing statistics. More importantly, though, it also suggested that the cultivation of human relations with patients who the system had messed around with was more compensatory for clinicians building 'positive self-definitions' (Ashforth and Kreiner 1999, p.419) than in terms of improving governmental figures. No action is context-less (Donati and Archer 2015, p.62); therefore, the lack of standardised wound care provision outside the wound clinics may have prompted corresponding relational workgroup dynamics in clinics. By extending social constructionist studies that overlook these contextual issues, this study has underscored how organisational and wider counterpoints (McCabe and Hamilton 2015) are paramount in alleviating or (re)producing stigma in clinician-patient relations.

### **7.1.3 Nested framing of stigma of wounds and wound healing**

Having highlighted the salience of actors' relational deliberations and the importance of organisational and wider contextual issues in managing stigma, the study now turns to explaining the connections between these stigma relations (Scambler 2011) to offer a post-Goffmanian, stratified view of wound stigma. Dirty work scholarship has hitherto tended to focus mostly on exploring the discursive struggles around stigma (re)production and alleviation. This study contests this reductionist view. Instead, it explains the management of stigma associated with the dirty work of wound healing and wounds as being a product of connections between dirty and clean discourses, the social relations between relationally reflexive actors that exist at functional, professional, familial and community levels, and features of organisations that influence their relational steering, such as the academic context and the wider health economy (Mutch et al. 2006; Delbridge and Edwards 2013; Edwards and Meliou 2015). In accordance with Edwards and Meliou's (2015) preoccupation with complex social orders, organisations and human action that

helps to explain leadership in family firms as being more than simply an outcome of family governance and administrative settings, but, rather, as a nested set of relationships, this study argues for stigma in dirty work to be framed in a similar, nested way.

It is important to stress that, although the study has explored the meaning of the stigma associated with living with wounds and working with wounds, the composite of wound stigma was not shared equally between clinicians and patients (Al-Amoudi 2018b). Rather, patients understood their place in the “World of wound healing” (Queen 2018, p.5) in different ways; in fact, they had a different grasp of the problem of wound healing itself, diverse experiences with healthcare, and different levels of appreciation of clinicians’ professional biographies. Some felt motivated to become more intimately involved in the dirty work of wound healing as insiders, and, as such, attached worth to building new relations with clinicians through a corporeal engagement with the ‘wound healing system project’, thus improving the state of wound healing. Others chose to preserve the patient role and prioritised their own interests, in turn, retaining the status quo of wound healing. The connections between wound stigma situations experienced personally and professionally lay in the practices of communication, delegation and swapping favours, that is, when patients’ awareness of and willingness to act on the problem of wound healing met with clinicians’ exercise of the power of their professional biography (Scambler 2011) under the ‘wound healing system project’.

The outcome was conceived of in a relationally reflexive way through relational processes nested within actors’ relational deliberations and the organisational and wider contexts that generated stigma alleviation or (re)produced it. People make choices about actions around stigma in relation to what they consider to be worthy (Al-Amoudi 2014). They have concerns about stigma through their cognition, beliefs and social positions. Negotiating these concerns in relation to context can materialise in various relational configurations that have different properties for alleviating or (re)producing wound stigma at the level of wider social transformation (Scambler 2009). By looking at stigma management through recourse to a realist relational sociological approach (Archer 2003; Delbridge and Edwards 2013; Jenkins and Delbridge 2013) and a nested framing, this study expands upon the constructionist framing of stigma and dealing with stigmatising situations.



## **7.2 Relational configurations matter for managing stigma**

Therefore, this study of clinician-patient relationships in wound healing has broadened the analytical focus of most dirty work research from ‘workers’ (e.g. Strong 1980; Bolton 2005; Tracy and Scott 2006) to ‘the worker-client relationship’ as a whole (Neal 2018) and found that such relations matter for managing wound stigma. As demonstrated in chapter six, they matter insofar as they produce relational goods, or evils, with properties that can either alleviate stigma or, in the case of evils, (re)produce stigma. Following critical realist social theory, below I interpret these goods generating relations as ‘generative organisations’ (Al-Amoudi 2014, pp.201-202). More specifically, I discuss their structures in terms of a networks of relationships between their constitutive elements (Donati 2006; Donati and Archer 2015; Donati 2016a) that include clinicians, patients and patients’ relatives reflexively drawing on their memory, creativity, interests and imagination in undertaking activities in and outside wound healing clinics, performing their roles, displaying their social positions and using discourses and identifying social rules, norms and issues of worth (Al-Amoudi 2014). The emergent (Elder-Vass 2005; Elder-Vass 2008) products of various combinations of these entities were three relational configurations introduced in chapter six. This chapter distinguishes between them in a relational mode, by retroductively hypothesising relational reflexivity as a key distinguishing trait. Insights into the relational tendencies of ‘We-ness’, ‘Thee-ness’ and ‘Me-ness’ (Donati and Archer 2015) are integrated into a causal explanation of why some clinician-patient relational configurations help to alleviate wound stigma, whereas others risk stigma (re)production. Finally, the properties of these relational configurations in terms of their relational goods and evils for wound stigma are discussed.

### **7.2.1 Exchange relations: ‘We-ness’**

Mobilising Donati and Archer’s (2015) work on relational reflexivity revealed parallels between exchange relations and the relational orientations of ‘We-ness’. Of particular import to the ensuing discussion is that, according to Donati and Archer (2015), ‘We-ness’ depends on relational goods which are referents of relational reflexivity and it develops through the generation of further relational goods (p.73). Moreover, ‘We’ must be recognised as a commitment that binds people together around jointly performing tasks that are seen as common (p.190). Chapter six offered a detailed elaboration of the relational good of trust between clinicians and

patients, which they enjoyed amongst themselves both in and outside of clinics. In this chapter, I focus on the relational goods emergent in trust relations and enjoyed extramurally on a higher social level (Elder-Vass 2005), which allows for an elaboration of the foregoing conception of 'We-ness' in relation to the common concern of alleviating wound stigma as a common good.

Outside of the clinics, one emergent effect of delegation was the relational good of 'patient and family wound management regimes'. Those who showed an interest in the acquisition of wound healing knowledge could perform some skilled wound care tasks on their own. This changed actors' positionality, discursively signalled by clinicians describing patients as 'important people' or 'experts', and by patients describing clinicians as 'mentors' or 'teachers'. The creation of 'woundologists' through the sharing of wound care skills with interested patients who wanted to get involved in wound care (Harding 2006) contrasts with most dirty work literature that stresses that workers possess inscrutable skills that distinguish them as 'special' (Bolton 2005). Moreover, such repositioning went even further; its emergence resonated with the archetypal relational subject of the family (Donati 2016a). The bi-directionality of family references was most visible on the research side of the wound healing organisation as an emergent effect of swapping favours. Here, clinicians acted as researchers seeking to fill gaps in their knowledge, whilst patients became triallists offering clues for improved therapies (Szasz and Hollender 1956). By activating the resources that each group has, yet cannot use alone, the relational good of 'collaboration in wound healing in research' helped to progress the science of wound healing.

A higher-level product of the relational good of 'collaboration in wound healing research' was that patients showed relational reflexivity towards the wider wound healing community. Naturally, taking part in wound research expanded their own chances of seeking the non-relational good of health (Donati and Archer 2015), which could imply the kind of individualisation normally associated with relational evils (Donati 2016a). However, exposure to the heterogeneity of the patient population, such as, for example, through clinical photographs in the research unit, made the wider physical distress painfully visible. This experience induced feelings of empathy and a desire to help wound healing clinicians to help others. After becoming more aware of fellow sufferers, patients came to appreciate their positions as agents who had the freedom and physical ability to enact a sense of responsibility towards others associated with wound stigma (Mussell 2017).

Consequently, the opportunity for patients to literally cast their gaze over the taints of wound healing work can help to generate a sense of unity with other patients, which then guides their conduct in and outside of clinics in a relational manner.

However, even within exchange relations, there were constraints on the boundless development of relationality into a full personal relationship. The works of Lawson (2012) on normativity and social rules and Reed (2001) on trust and control, help explain the preservation of functional commitments as morphostatic causes that kept exchange configurations at the professional level of clinician-patient relation. Starting with rules and norms, if a concerned patient wanted their wounds to be promptly seen by a 'proper wound nurse', the accepted way of ensuring this was to adhere to the norms of the clinic. Firstly, they had to want to heal the wound; and secondly, they had to generally concord with clinicians' advice. The sense of worth (Al-Amoudi 2014) that patients felt for the privilege of being seen on short-notice facilitated rule relaxation. Nonetheless, patients pronounced their respect for the clinicians' venerated professional biographies and merited academic ranks. As Reed (2001, p.206) points out, there is an irreducible element of control in all trust relationships. However, rather than trust masking hierarchy, as Reed (2001) suggests, in accordance with Jenkins and Delbridge (2013) I found that patients were cognisant of the fact that participative consensual relations retained elements of power that clinicians had over patients, and, as such, clinicians did not interact with patients in a "power vacuum" (Godin 2000, p.1402). It was this reflexive mediation of constraints, typical of a 'We-ness' orientation (Donati and Archer 2015, p.70), that was responsible for stabilising exchange relations as an emergent entity from its constituent parts (Elder-Vass 2005), specifically through communication, delegation, swapping favours, of which rule relaxation was seemingly a 'main bargaining chip'.

### **7.2.2 Didactic relations: 'Thee-ness'**

A differently configured emergent set of internalities (O'Mahoney 2011) by which clinicians, patients and their relatives engaged with the stigmatised wound setting helped elaborate the second type of relational configuration. In their characterising of didactic relations, chapters five and six demonstrated the persistence of barriers to building clinician-patient relations around shared concerns. The distinguishing feature of didactic relationships was their embeddedness in the historical model of clinician-patient relations, which was predicated on the division of roles between active clinicians and passive patients (Szasz and Hollender 1956). However, rather

than settling for explaining didactic relations via a deterministic perspective that emphasises paternalistic structures of care, my analysis suggests that patients in didactic relations with clinicians showed a preference for cultivating the relational tendencies of 'Thee-ness'. This was premised on the reciprocal treatment of each other in relation as a 'You', as well as in terms of a lack of convergence between their concerns around wound stigma.

On account of 'Thee-ness', the aspirations of patients and clinicians differed owing to their various interpretations of their positions in the dirty "World of wound healing" (Queen 2018, p.5). Patients may be paralysed by their prior experiences with healthcare that preconditioned them to be on the defensive lookout for discounting behaviours from wound healing clinicians, which meant that they then entered into their relations with clinicians with already dispersed trust resources. They may be attached to their own social context too strongly to step out of their own way of apprehending the world and into a relational *modus vivendi* that encapsulated a shared sense of value around the common concern of wound stigma (Donati and Archer 2015). They may protectively give in to the structures of power embedded in clinicians' historical dominance that reinforces role division and, in turn, generates the relational evil of separateness. As a result, joint-ness of aspirations concerning the dirty 'World of wound healing' are entirely absent. In its place, there is the reiteration of the knowledge asymmetry stressed in extant dirty work literature, whereby workers are in a position of superiority to their clients due to them being able to do work that no one else can (Ashforth and Kreiner 1999).

This is important from the perspective of the dirty work literature. Although clients' negativity towards workers has been extensively documented in the dirty work literature, most studies do not seek explanations of clients' behaviours in terms of their agency, reflexivity, memories, emotions or interests (O'Mahoney 2011). Rather, many studies assume *a priori* that clients are aware of the "dirty particulars" (Ashforth and Kreiner 1999, p.421) of specific jobs and their association with stigma in various occupational groupings (Hamilton et al. 2017; Hughes et al. 2017). My analysis of didactic relations departed from this view by showing that some patients might not be fully aware of the problem of wound healing and of the salience of the 'wound healing system project', because "they cannot avoid the double hermeneutic" (Donati and Archer 2015, p.69). For example, clinicians' request for a favour, that is, for a patient to take part in a clinical trial, was interpreted by some patients as clinicians showing disregard for their individual clinical profile, rather

than as an attempt to help the science of wound healing and alleviate wound stigma. As a consequence, didactic patients' understanding of the stigmatised social context of wound healing might be fallible. Unless serious conversations are held to align the concerns of both parties to this relation, then the relational evils of blaming and accusation will invariably arise. This confirms the dominant depiction of worker-client relationships in dirty work as being based around blaming and distancing (Ashforth et al. 2017), which does not alleviate wound stigma, but, rather, leaves it intact.

Although the lack of common commitment towards, and activities dedicated to, alleviating wound stigma may have precluded the development of a relational subject that was witnessed in exchange relations, this did not mean that no relational goods whatsoever were generated in didactic relations. Given the academic context of this wound healing organisation, the relational good of 'collaboration in wound healing education' indicated the existence of some relational reflexivity, which served to confirm that the relationality between actors can be minimal, impeded or distorted (Donati and Archer 2015, p.29). Therefore, patients in didactic relations showed some solidarity with clinicians, even if this solidarity was not entirely relational, but, rather, was functional and influenced by the institution of medical education through shadowing (Stoeckle et al. 1993; Bing-You et al. 2014). Besides, just as Donati and Archer (2015) recognised that relations evolve over time and the relational subject can disappear and weaken (p.190), the existence of the relational good of 'collaboration in wound healing education' within didactic relations suggests that the relational subject could appear and strengthen over time as short-term patients become long-term patients.

### **7.2.3 Atomistic relations: 'Me-ness'**

Finally, in interpreting clinician-patient relations as atomistic, I focused on how the configurations of their internalities were indicative of the presence of a 'Me-ness' orientation, based on the primary agency of the 'Me' (Donati and Archer 2015), that is, of an individualistic and self-interested moral agent that can be represented outside of the relational system (Mussell 2017). With respect to the account of Jane, her prior experiences may have pre-conditioned her to become reclusively "self-sufficient" (Donati and Archer 2015, p.69) and tackle any wound stigma situations self-referentially. This depiction of her autonomy as pushing her to override clinical advice and challenge the de-stigmatising 'scientification' of wound healing, evokes the notion of the individualisation of the self that Donati (2016a) associates with the

generation of relational evils. Such selective compliance affected the relationship, and had repercussions for wound stigma itself.

First, the practices enacted by patients were indicative of the embracement of individualisation that degenerates the relational subject (Donati and Archer 2015). Jane appeared to adopt the role of an expert by virtue of having to find a way to cope after the previously experienced conditions of estrangement. This socialised her into exercising personal reflexivity, rather than relational reflexivity being regarded as 'We-ness' within the wound healing family. Where familial discourses and practices transpired in patients' talk, this was in so far as it allowed for the maintenance of an emotional attachment to individual clinicians, which produced the relational evil of overdependence on individual clinicians. This over-attachment was further evidenced via invitations being issued to personal engagements through which patients sought to transform the rule noted by Eva, according to which clinicians and patients should not become overfamiliar with each other. Concerning the relational evil of 'obstructing the provision of wound care that can improve wound outcomes', atomistic relations appeared to connect to the disruption of norms around conventional medical practice that "patients are only too willing to cooperate" (Strong 1980, p.38; see also Shaw 2004) by seeking help from those in positions of power (Szasz and Hollender 1956).

Second, clinicians' responses to conflicts with patients exemplified a morphostatic property of reinforcing the stigmatised status quo of wound healing. Research suggests that mutual dissatisfaction around the lack of patient cooperation with clinicians and clinicians' lack of understanding of patients' individual needs, ultimately, leads to relational discontinuity between clinicians and patients (Szasz and Hollender 1956). However, this study has found that, despite interactional rigidity and clinicians' sporadic allusions to discontinuing relations with patients, in practice clinicians 'accommodated' very difficult consultations as opposed to discharging patients (Strong 1980), thus assuming the role of a third-party agent that risked further stigmatisation (McMurray and Ward 2014). The unavailability of wound healing expertise elsewhere meant that clinicians kept 'chipping away', hoping they would 'persuade' patients to change their attitudes from being individualistic to more relational. Clinicians were faced with defending their medical expertise while 'serving' misbehaving patients (see Santino 1990). Therefore, in managing stigma they had to continually work on the relationships they had with such patients, striking a balance between feeling good for helping them and feeling

bad for fostering patients' overdependence, whilst preserving traditional care models in misalignment with the shift towards increased patient empowerment and self-care (Price 2011; Corbett and Ennis 2014; Kapp and Santamaria 2017a; Schoeps et al. 2017; Lusher et al. 2018).

Donati and Archer conclude their account of 'Me-ness' by asserting that self-interest and the perception of social bonds as constraints to maximising one's own 'preference schedule' (2015, p.68), precludes the relational subject from developing. However, I have identified that even atomistic clinician-patient relations in wound healing showed some emergent engagement with the personal and professional concerns of other patients and familiar clinicians. Jane had her own preferences concerning her treatment, which, also in line with Donati and Archer's (2015) reading of atomistic social ontology, were not simply "selfish", but, rather, left her at an advantage in her "preferred terms" (p.68). In weighing up her chances of healing through withstanding discomfort in treatment against living with the wound as she did for years, she performed a careful self-interested calculation which offered her the greatest personal utility (Donati and Archer 2015; Mussell 2017). However, this is not to say that individualism permeated the atomistic relational configuration and that there was no deontic relationality. Rather, a sense of taking personal responsibility for her own care to 'do clinicians proud' showed some development of the relationship over time. Moreover, I would argue that 'collaboration in wound healing research' showed that even atomistic relations that generate relational evils can provide some support for stigma alleviation. This testifies to the existence of a form of emergent relationality which serves as a prelude to potentially more relationally reflexive conditions geared towards greater common goods.

### **7.3 Stigma alleviation as a relational good**

The above discussion of clinician-patient relational configurations as generative organisations has delineated how exchange, didactic and atomistic relations generated relational goods and evils, which had consequences for the management of wound stigma. This section follows on from this discussion to, more specifically, explain the way in which relational goods that speak to collaboration in wound healing research and education, as well as to concern for other patients, have important properties for alleviating wound stigma. Stigma alleviation as an entity alludes to the common concerns of clinicians and patients who generate it through their lower-order relational goods. As an emergent higher-order entity, stigma

alleviation is of benefit to patients who are psychologically distressed by wound pain, odour, itching, leakage and infections (Briggs and Flemming 2007), clinicians who feel undervalued and seek to have their practical expertise recognised (Madden 2012), and the wider societal community of the ever-growing population of patients with chronic wounds (Posnett and Franks 2008). In this sense, stigma alleviation can be recognised as a special type of a relational good in its own right. This section offers a conceptual clarification of this proposition by unpacking it in line with Donati and Archer's point that relational goods affect "the parties involved in them" and "matters beyond them" (2015, p.62), in addition to reflecting on the implications of wound healing being designated as dirty work.

### **7.3.1 Parties involved: patients, relatives and wound healing clinicians**

To understand the relational good of stigma alleviation, one must reflect on the generative organisation that produced it. Here, stigma alleviation was most visible in exchange relations characterised by a temporal history that showed the operation of relational reflexivity and represented the 'We-ness' orientation of the relational subject, thus "emphasising a social reality of inter-dependence, one where the moral agent acknowledges and seeks to maintain existing relations" (Mussell 2017, p.223). With respect to the motivations of actors concerned with alleviating wound stigma, this meant that patients wanted to maintain the relationships they had developed with clinicians and that they reordered their own concerns to fit in with this primary concern (Donati and Archer 2015). For example, John and Martha did not prioritise a self-referential concern in light of the unfavourable effects that their collaboration in wound healing research and education had thus far had on John. When Martha discussed the bodily sacrifice that came with John's support for the 'wound healing system project', it was clear that she had evaluated the fitness of the sacrifice in relation to the gratitude they had for clinicians, thus allowing for the subordination of her own concerns to that of instigating a change in the future state of wound healing knowledge and understanding. There was thus a strong reflection upon the relationship itself, rather than on the I/Me (Donati 2016a). Being able to contribute to these exchanges created a fertile ground for relations to grow as an consequence of inter-dependency in a connected, emergent social system (Mussell 2017). Therefore, it is reasonable to postulate that showing benevolence towards all stakeholders in the wound healing community was a manifestation of interdependence within the relational subject and a mechanism through which to maintain a relation that emerges through mutually beneficial exchanges.



Whereas stigma alleviation was most visible in those exchange relations with a historical-relational and temporal register (Donati and Archer 2015, p.212), which were mostly found on the research side of this organisation, it also developed in collaboration with short-term, new patients and those who did not qualify for clinical trials or chose to opt out of them. For example, to help patients overcome the relational repercussions associated with the wound stigma they experienced, in the provision of dirty work clinicians used micro-level bodily and verbal communications in treatment rooms that stressed the clean and fresh appearance of patients (Stacey 2005), the rhetoric of a family bond (Hondagneu-Sotelo 2007), familiarity with patients' social worlds (Solimeo et al. 2017), emotionally dirty pastoral care for 'all-comers' (McMurray and Ward 2014), empathy (Chiappetta-Swanson 2005) and compassion (Rivera 2015). To help clinicians deal with dirty work stigma, patients supported wound healing education. Familiar with the established educational practice of shadowing the doctor, they rarely refused the presence of visitors. Patients with self-harm wounds were positively involved by clinicians in the generation of stigma alleviation through, for example, being presented as models for demonstrating infection-tracking technologies.

Therefore, stigma alleviation was generated, less or more willingly (Donati 2016a), by all patients in relation with clinicians through clean means of cooperation and gentle mediatory input from individual clinicians and institutions of medical education. Willing patients developed a strong sense of moral commitment to the wound community and sought to act upon this. Those patients who appeared less willing were still positively involved by clinicians, who helped them recast their own stigma in such a way that did not involve coercive means of ensuring compliance (Godin 2000), but, rather, oriented them towards stigma alleviation. Although Donati and Archer (2015) argue that the relational subject orients their actions to the relational goods or evils as opposed to interpersonally or institutionally, they do not explicitly rule out the possibility of mediation from the latter two orientations (see p.50). In this regard, almost all the patients contributed towards increasing scientific knowledge about wound healing.

### **7.3.2 Matters beyond: surrounding community**

Through the theoretical lens of relational goods, it is possible to see how stigma alleviation also represents a common good for the surrounding wound care community. In this study, it appeared most visibly via 'collaboration in wound healing research' through which actors jointly assumed responsibility towards the

community. An invitation to wound research itself set in motion a relationally reflexive mode of thinking, such as: “If it doesn't help me, it could help someone in the future” (Derek, patient in a didactic relation); “If it helps somebody else ... if they can stop somebody from doing that, I'm all well and good” (Jane, patient in an atomistic relation) and “We're always happy to help anybody, really, with their research” (Martha, relative in an exchange relation). At least in theory – because not all invitations to research were accepted – the academic character of this wound healing organisation supported the development of a socially responsible orientation towards the increased generalised flourishing of the surrounding community through identifying, meeting and alleviating its needs (Mussell 2017, p.223).

At the very least, patients in exchange relations, as well as the clinicians, were cognisant of the current state of knowledge and understanding of wounds and wound healing when interacting in clinics and extramural wound healing events. In this study, Robert drew attention to the lack of communication in dirty work among the various interfaces of the distinct clinical specialties, while Tony recalled the ‘blasé’ treatment of his diabetic amputation 13 years earlier. Jamie had accepted his wounds would never heal and was coming to clinics for ‘some banter’, whereas Martha and John hoped that each new trial would ‘heal it’. Megan found seeing the fundamental difference that treatment under clinical trial made to patients’ care to be the most satisfying aspect of her work, while the hospital specialist stressed the financial gains to be made from clinical trial recruitment that ensured the ongoing operation of the clinics. Although actors’ personal concerns were slightly different, there was some collective reflexivity that made actors hold back on their concerns at times and orientate their actions towards contributing to, albeit slowly but surely, increasing the knowledge capital in the wound care community for the development of clinical systems. Under these systems, all patients would be seen by competent and experienced clinicians, as well as benefitting from research-led therapeutic advancements (Harding 2015).

Stigma alleviation through wound research can be recognised as a relational good, because it is borne out of the differences between patients and clinicians, which are nonetheless compatible (Donati 2016a). This means that clinicians could not do wound research without wounds to do research on, whereas patients could not do wound research without the expertise and support of clinicians (“Because they're all looking at ... wound healing and that sort of thing. So, it's easy for me because I've had wounds” (Tim, patient)). However, they converged on the need to find ways to

heal wounds better, and thus attempted to do this together in reciprocal gratitude. There was a connection between their differences (Donati 2016a). In the dirty work literature, there has hitherto been scarce focus on any such connection, other than a cursory mention that clients are grateful to workers for doing the dirty job (Ashforth and Kreiner 1999). However, the gratitude has not been portrayed as reciprocal. Here, founded in a relational sociological framework, the swapping of favours testifies to the fact that stigma alleviation emerges out of full reciprocity between clinicians, patients and patients' relatives.

### **7.3.3 Wound healing getting cleaner?**

It is tempting to equate the relational good of stigma alleviation with the dirty work of wound healing 'getting cleaner' (Godin 2000). However, as has been the case in most ethnographic studies of dirty work (Tyler 2011; Hamilton and McCabe 2016), the reality of managing wound stigma has proven to be far more complex than this. This study showed the co-existence of relational evils in didactic and atomistic clinician-patient relations that impeded actors' engagement in relational reflexivity, and which was mediated through reference to the relational good of stigma alleviation. Their emergent effects, such as reinforcing the historical activity-passivity models of clinician-patient relationships (Szasz and Hollender 1956), the potential overuse of clinicians' resources leading to patient overdependence (Hardyman 2017), or obstructing the scientific progress of wound healing, can preserve the status quo of wound healing. Therefore, stigma alleviation should better be viewed as a product of the interaction of some actors' agency with the social and cultural environment of wound healing. That is to say, it is a morphogenetic mechanism that can lead to either the sanitisation or transformation of the dirty work of wound healing, while the co-existence of counter-mechanisms in the form of relational evils can serve to maintain its current form.

More importantly, morphogenetic development represents a future change in action that happens over time (Donati and Archer 2015). Integrating history into the analysis can thus add depth to the focus of the study (Mutch 2007; Mutch 2014; Mutch 2016) by helping to trace the historical evolution of a dirty occupation becoming cleaner (see Godin 2000, pp. 1398–1399). However, although I designed my study about the obscure world of wound healing at an opportune time in which governments around the world were slowly beginning to take an interest in wounds, engage with professional groups and empower patients – as evidenced by 2014 unassumingly being marked as the year of the wound (Queen and Harding 2014) – I

nevertheless limited myself to ethnographic and ahistorical evidence (Mutch 2016). Undoubtedly, stigma alleviation has a long history, has adopted a certain course and may have profound outcomes for wound healing for years to come (Donati and Archer 2015). However, it was simply not feasible to analyse all of this within the scope of this study. However, whilst endeavouring to not tear stigma alleviation out of the broader ideas and resources in the dirty wound healing context that shape its form (Mutch 2016), the study has uncovered more connections between managing wound stigma and the wider context than extant dirty work literature would suggest.

Seminal studies asserted that dirty work occupations were stigmatised because of their association with difficult physical, social, moral and/or emotional issues (Hughes 1951; Hughes 1958; Ashforth and Kreiner 1999; Ashforth and Kreiner 2014; McMurray and Ward 2014). Therefore, managing stigma has mostly been documented in terms of processes of ideological disassociation from dirty issues (Ashforth and Kreiner 1999; Tracy and Scott 2006; Ashforth et al. 2007). In contrast, this study has proposed that it is possible to think about managing stigma in terms of the re-association of wound care clinicians with taints in extramural regions of their organisation to change the general perception of wounds from “an irritation and inconvenience” (Harding 2015, p.318) to a subject of scientific interest. Moreover, this re-association involved lay actors, which reflected how broader contextual influences (Mutch 2016) on the wound care discourse promoted patient involvement through a sense of ‘sharedness’ (Kapp and Santamaria 2017a). It comprises a collective response of those concerned with and affected by it to recognise the structural and cultural constraints and, accordingly, to bring together the necessary resources to work through and/or seek to lessen these constraints. Therefore, stigma alleviation as a relational good can contribute towards wound healing becoming cleaner through its own empowering and emancipatory properties (Mussell 2017).

## **7.4 Towards empowerment and emancipation in wound healing**

Finally, this study has shown that the relational good of stigma alleviation can have practical implications for the area of wound healing. In response to Mutch’s (2016) call to ensure the connectedness of research to the social context, this section situates the empirical findings and the theoretical discussion in the wider context of wound healing to illustrate the empowering and emancipatory properties of stigma

alleviation, which contingently affects dirty structural and cultural constraints in the wound healing environment (Mussell 2017). Here, the concept of emergence is once again expedient. According to Al-Amoudi (2014), there is no limit to emergence. Specifically, when the relational good of stigma alleviation within clinician-patient relations is considered against the backdrop of the drive in wider healthcare towards patient empowerment and wound healing, as well as clinicians' drive towards turning the clinical field of wound healing into an individual, focused, evidence-based clinical specialty, then what emerges are 'clinician-patient partnerships for wound healing advocacy' that support the development of 'woundology'. Therefore, in accordance with Meliou and Edwards (2018), this study underscores how the relational good of stigma alleviation can 'talk back' to the same environmental trends and constraints under which it was relationally generated.

#### **7.4.1 'Clinician-patient partnerships for wound healing advocacy'**

Recognising stigma alleviation as a relational good with empowering and emancipatory emergent properties represents another significant step forwards for understanding how it can be operationalised on a more practical level. In particular, the commitment of clinicians, patients and patients' relatives to a common goal of sanitising wounds and wound healing by improving extant knowledge and understanding in this area can be viewed as forms of 'lay' collective organisations (Al-Amoudi 2014, p.202). For the sake of the consistency of argument, I call them 'clinician-patient partnerships for wound healing advocacy'. They arise when clinicians, patients and patients' relatives, who, respectively, care for wounds, live with wounds, or care for and live with someone with wounds, come together "to take actions of *advocacy*" (Donati and Archer 2015, p.204). In this study, these actions ground their participation in 'wound healing engagement and impact events'. Through their related goals of aiding wound diagnosis and treatment, facilitating therapeutic advancements and fostering the development of clinical systems to ensure that patients with wounds are seen and treated by experienced and competent clinicians (Harding 2015, p.318), 'wound healing advocacy partnerships' are relevant to actors immediately concerned with the relation, as well as to present and future generations of patients and clinicians in the wider wound care community.

When placed side-by-side with current trends in wound care, especially the much-advocated need for patients and their relatives, friends, carers or other caregivers to engage in self-care (Price 2011; Corbett and Ennis 2014; Kapp and Santamaria

2017a; Schoeps et al. 2017; Kapp and Santamaria 2017b), 'clinician-patient partnerships for wound healing advocacy' can be seen as one socially innovative model through which they can be empowered to do precisely this (Harding and Queen 2017b; Lusher et al. 2018). It should be noted that such partnerships represent a higher-order level of patient empowerment, due, in part, to the fact that they involve more than simply encouraging patients to play a proactive role in self-treatment by, for example, changing dressings and compression bandages (Franks et al. 2016), but, rather, require successful communication and delegation. Scholars from the wound care and management fields (e.g. Grocott et al. 2007) reiterate the importance of involving 'lay' societal members (Mutch 2016) in preventing inefficiencies in clinical development. Therefore, through the swapping of favours as a mechanism that facilitates the integration of patients into wound healing research and other engagement and impact events, patients are also empowered to play a proactive role in promoting wound healing as an important component of healthcare (Harding 2006).

Moreover, there is further potential for empowering patients and clinicians through 'partnerships for wound healing advocacy' to directly confront stigma. It has been suggested in the wider healthcare arena (Wahl 1999) that patient involvement in the organised effort to educate the public and other healthcare professionals about stigmatised conditions can be empowering, self-enhancing and enable patients to move beyond the negative label. In addition to giving patients the opportunity and power to speak out in such a way that supplants their vulnerability on an individual level, the emergence of 'wound healing advocacy partnerships' resonates with Scambler's (1998) structural focus on changing paradigms of stigma and disease under the full acceptance of the principle of co-participation. In addition to highlighting the relational dimension of the very term 'partnership itself', attention should also be drawn to the stigma alleviating use of active language such as 'wound healing', in contrast to the passive language of 'wound care' that suggests that "symptoms [are] to be managed by a third-party rather than empowering the patient to self-care" (Lusher et al. 2018, p.311). Given that the 'delegation' of distasteful, disgusting, polluting, but yet necessary tasks to someone else (Ashforth and Kreiner 1999, p.426) is one of the denominators of work being dirty (Rainwater 1967; Birnbaum and Somers 1986; Dick 2005), in this study the dynamics are changed to focus on actors coming together and collaborating to obtain advocacy for wound healing.

Advocacy as a mechanism of stigma alleviation has not been considered extensively in the dirty work literature beyond incidental allusions to advocacy in discussions of reframing (Koken 2012), seeking social buffers as a safeguard against identity threats from the stigmatising attitudes of outsiders (Bosmans et al. 2016), or joining organisations comprised individuals with the same occupation to seek legal advocacy (Cohen 1991). The de-stigmatising and empowering property of advocacy groups has been touched upon mostly on an occupational level in dirty work studies that make reference to the work of janitors (Ashforth and Kreiner 2014), animal shelter workers (Schabram and Maitlis 2017) and nurses (Adams and Nelson 2009). There are some exceptions that do come closer to a level that involves clients, such as a study of community mental health nurses employing clean methods of advocacy to patients as a cleaner type of work (Godin 2000), as well as a study of how medical clerks derived fulfilment from advocating on patients' behalf in appointment scheduling, which was deemed to be a form of emotionally dirty work (Solimeo et al. 2017). This study takes this view of advocacy even further by stressing its bi-directional nature, showing that patients can step out of the sick role and become experts in their own wound care, speakers for the wound healing community and members of the wound healing family. Empowered by their new positions, they publicly support the professional and emancipatory (Mussell 2017) agenda of developing wound healing as a clinical specialty.

#### **7.4.2 'Woundology'**

Following on from the previous section, I conclude the discussion of my findings by engaging with the terminology of emancipation, as elaborated by Mussell (2017) to show how the relational goods of stigma alleviation that generate 'advocacy partnerships' have emancipatory properties for the clinical specialty of wound healing. Specifically, emancipation in wound healing can be linked to clinician-patient partnerships, because the actions of advocacy can raise the low-level of awareness of wounds and wound healing. In this context, emancipation is achieved through the potential of 'wound healing advocacy partnerships' to support the development of 'woundology' – an imaginary term for a new focused evidence-driven clinical specialty that guarantees that the right patient is seen by the right clinician for the right reason at the right time (Harding and Queen 2017b, p.5).

In explaining 'clinician-patient partnerships for wound healing advocacy' in this specific setting, I have extended the arguments made in extant wound care and management literature about the need for significant research investment to both

increase research capacity and improve clinical practice and care delivery in wound healing (Harding and Queen 2012). It should also be noted that, in addition to capitalising on partnerships with patients, clinicians also built partnerships with other medical specialties. The poor state of current knowledge and understanding of wounds and wound healing in the medical community was evident in both the lack of interest and involvement of other doctors. To raise the profile of wound healing, clinicians did not claim to possess special skills that were unavailable to others in the wider healthcare community, as is sometimes the case in other dirty work contexts (Bolton 2005). Neither were there blatant manifestations of self-praise. Rather, clinicians drew on the expertise of colleagues in related healthcare arenas, including dermatology, angiology, diabetology, colorectal surgery, gerontology, orthopaedics, physiotherapy, podiatry, prosthetics, orthotics and lymphedema, among others. Some of these relationships were formalised within regular diagnoses and treatment in outpatient clinics, while others were organised on a more *ad hoc* basis. However, all supported “a combined goal – that of ‘Woundology’ with equal recognition to other clinical specialties such as oncology and cardiology” (Wound Diagnostics 2010, p.207). Following Al-Amoudi’s helpful neologism, it is possible to argue that the relational good of stigma alleviation had a ‘concurrent’ morphonegetic consequence, consisting of “the multiplication of concurrent institutions, without necessarily entailing the disappearance of earlier ones” (2014, p.198). If achieved, neither the well-being of sufferers with other conditions nor the professional well-being of other clinicians would be discounted.

The results of such ‘woundology’ initiatives are already beginning to transpire. Indeed, the overall coverage of wounding in the general culture is still scarce and selective in comparison to other health conditions. For example, diabetes has a huge presence within the British media. It is commonly known that diabetes is “a leading cause of amputation”, but this is invariably graphically illustrated by a photo of a clean prosthetic leg next to a strong and muscly-leg. Not much is said of the wound side of diabetes, other than it being “linked with neuropathy and poor circulation” (Diabetes UK 2018). Images of yellow pus oozing painfully from a purulent sore on the sole of a purplish swollen foot evidently still offend the tastes of the public and news media, which continues to limit discussion of the wound stage of diabetes to ‘issues with the feet’ (Thomas and Carson 2018). However, discourse is beginning to change, as some news media are no longer skipping the ‘wound stage’ of diabetes (O’Neill 2018), whilst wound healing has become part of breakfast debates on the radio (Today 2018). These developments are just some of the most



recent confirmations of Queen and Harding's observation that "the change has begun, and some would suggest that this is probably a very necessary step in the evolution of our clinical specialty" (2014, p.1).

However, four years later, when speaking on behalf of the "World of wound healing", Queen asserted that "we should ask ourselves have we made as much progress as we should" (2018, p.5). Calling for a comparison of wound healing advances with the progress made by other clinical specialties, he noted that there is still a long way to go in fostering the interest of other clinicians and health planners in the field of wound care. Moreover, he advocates the need for greater steps towards the creation of interdisciplinary teams through which wound care can be best provided to patients with wounds. A relational desire to integrate the insights from other specialties in interdisciplinary collaborations confirms the concurrent morphogenesis, as well as the fact that the intended emergence of 'woundology' would not reduce the significance of other extant specialties. Overall, then, wound healing emancipation, through the intended development of 'woundology', is an ongoing process whose completion cannot be fully ascertained at the time of completing this study. However, the potential of 'partnerships for wound healing advocacy' to provide fresh impetus for a new generation of wound clinicians as an emergent effect of the relational good of stigma alleviation can be linked with empowerment. This, in turn, can be reasonably assumed to be a 'transitional' (Mussell 2017, p.235) part of this process.

## **7.5 Contributions to dirty work and social theory from the relational subject**

I conclude by combining my findings and discussion into a framework (Figure 2) that emerged out of my retroductive analysis (adapted from Gatenby 2008, cited in Rees and Gatenby 2014, p.142). The framework summarises the evolution of clinician-patient relationships in stigmatised wound care work, from social interactions in outpatient consultations (see Appendix 2) to social relations in the "World of wound healing" (Queen 2018, p.5). It shows the retroductive reasoning used to explicate how various combinations of causal mechanisms, entities and parts can, in fact, generate a relational subject with the potential to produce a unique type of common good of stigma alleviation, which, in turn, leads to 'advocacy partnerships' in support of 'woundology'. These 'partnerships for wound advocacy' are emergent relational

coping strategies, which help to achieve and sustain relational goods generated within delimited relationships set up in the spatial context of the clinic.

First, it presents contextual influences (chapters four and five) which frame the nested view of wound stigma affected by the wound healing organisation, as well as the wider social context it inhabits. These forces either facilitate or challenge the development of clinician-patient relations as a relational subject (Donati and Archer 2015). Heterogeneous structures of internal relations between them generated three clinician-patient relational configurations, whose emergent properties can be represented as relational goods and/or evils (chapter six). These configurations are further distinguished by the dominant relational tendencies assumed by the actors that constitute the relation. Although all the configurations contributed towards alleviating wound stigma to various extents, only exchange relations represented a relational subject with empowering and emancipatory properties that further united actors into 'partnerships for wound healing advocacy' that most strongly and visibly supported the development of the clinical specialty of 'woundology'.

The main theoretical contribution of this thesis is that delimited interactions within social relations whose internal structure and dynamics are circumscribed by the context of the medical encounter can constitute a relational subject, which, in turn, can produce relational goods and/or relational evils. Even though clinicians and patients cannot form conventional familial or friendly ties, chronic conditions, like wounds, open up space for wound healing to occupy in socially innovative relational ways. Here, patients and clinicians jointly re-organised their relationship to orient themselves towards alleviating the stigma of wounds and wound healing. Such a formulation extends Donati and Archer's proposition that the "doctor-patient relationship does not constitute a relational subject because this relation does not enter into two actors' personal identities but remains external to them" (2015, p.58).

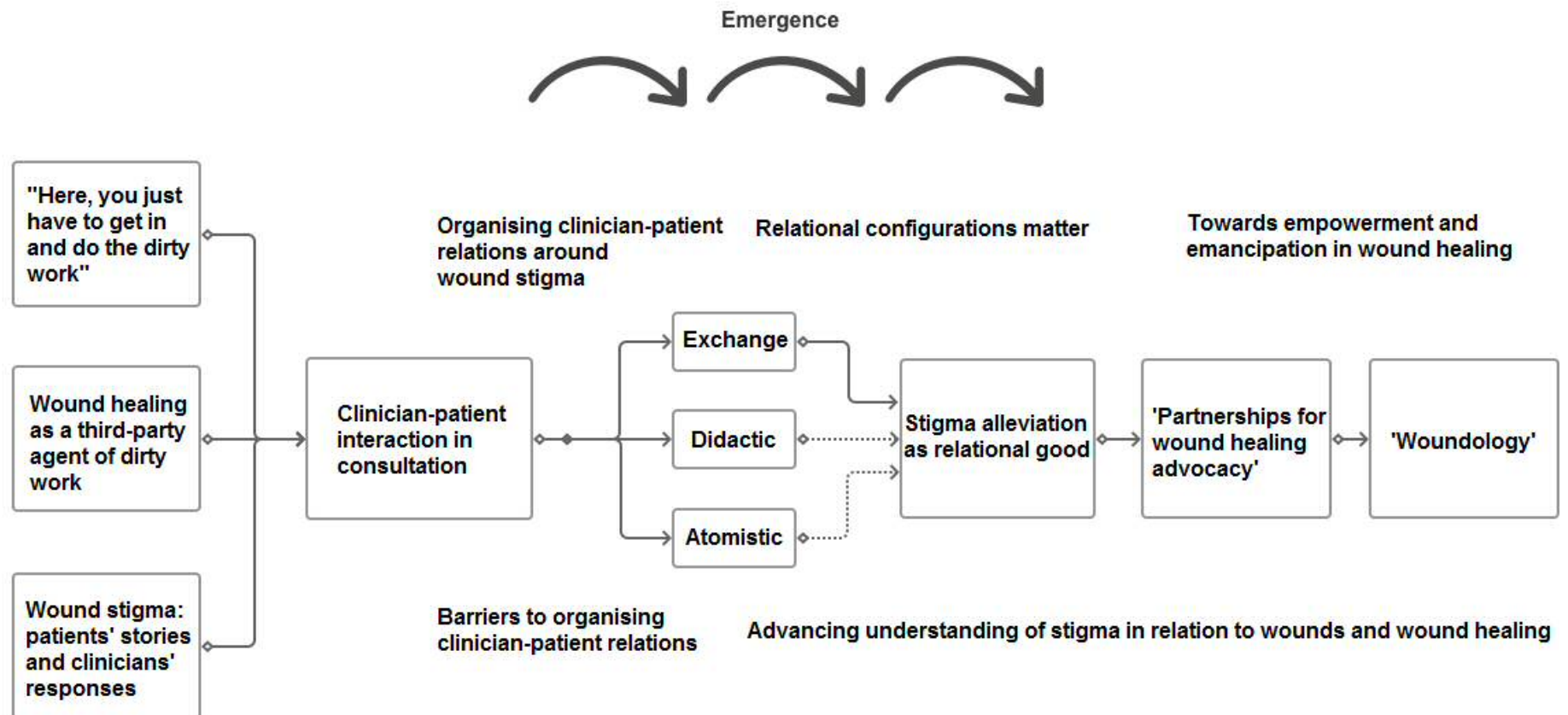
The empirical and methodological contributions of this study stem from its utilisation of a critical realist relational sociology to study the concept of dirty work, hitherto colonised by social constructionism, to show that overcoming dirty work stigma presupposes the production of relational goods. Using a critical realist lens, which targets the relationship between workers (clinicians) and their clients (patients), may prove interesting to scholars who feel unsatisfied with the under-theorised, anecdotal and disembodied accounts of worker-client relationships in extant dirty work scholarship. Critical realist relational sociology allows for a stratified focus on a nested framing of stigma as comprising more than ideology and discourse, but,

rather, also agential material activities in physical performative interactions, embodiment in physical persons, and material and relational resources in the organisational and wider social context (Marks and O'Mahoney 2014). By exploring dirty work from the perspective of both workers and clients, I provide long-overdue insight into this relationship as a whole (Neal 2018). Moreover, the focus on wound healing in this study marks another contribution to single occupational studies in dirty work literature.

Finally, on the policy level, the idea of an 'advocacy relationship' in healthcare could offer guidance into potential ways of involving patients in their own care. At the very least, it can promote focusing on the process of care as opposed to the outcome, in turn, bringing to the fore the importance of the quality of the interactions and relationship building to the effectiveness of care (Hardyman 2017). It also extends current understanding of the possible ways to "achieve health and wellbeing with the public, patients and professionals as equal partners through co-production", as laid out by the Bevan Commission (2015) in their programme for healthcare development.

This chapter closes with a summary table, which presents the central arguments developed in this study (Table 6). The table has been adapted from Hardy and Thomas (2014) and Thomas (2018), as well as being developed with guidance from Jenkins and Delbridge (2017). First, it identifies research problems from relevant literature reviewed in chapter two. Then, it introduces the theoretical approach adopted to solve these problems. Next, it offers summaries of the key findings from chapters four, five and six. Finally, these findings buttress the relevant contributions developed in chapter seven. Unlike the previous chapters, the discussion chapter does not end with a summary section. The arguments that have arisen in the discussion chapter are restated in terms of the significance of this study in the conclusion.

Figure 2. Managing stigma in UK wound healing clinics



**Table 6. Summary of key contributions of the study**

| Literature and problem                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Core concepts                                                                                                                                                                                                                                                                  | Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Contributions                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Most dirty work studies have focused on how workers mobilise primarily discursive and ideological resources to cope with the challenges that the stigma of dirty work poses to their identity. Clients are presented as a source of negativity. Theorising draws mostly from social identity theory, paradoxically neglecting the social dimension of dirty work, especially in terms of how relations with clients can represent a supportive resource for coping with stigma situations.</p> | <p>The study draws on Donati and Archer's (2015) relational subject framework to show how delimited relations among clinicians, patients and patients' relatives in a dirty wound healing context can produce a special type of relational good called stigma alleviation.</p> | <p>Three relational configurations between clinicians, patients and relatives in dirty work. These social relations differ in terms of their dynamics, commitments and outcomes. Exchange relations involve a relationally reflexive social subject, whilst in didactic and atomistic relations the relational social subject is not 'genuine' (Donati and Archer 2015, p.190). In the two latter relations, the commitment to the alleviation of stigma does not appear to bind patients and clinicians together. Solidarity and reflexivity of a relational type only emerges in</p> | <p>Rich structures of worker-client relationships beyond random service encounters have material and embodied dimensions that are emergent from a combination of internalities, as well as involving reflexive agency on the behalf of the actors in the interactions.</p> |

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|                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | exchange relations. Clients can be a source of positivity.                                                                                                               |                                                                                                                                                                                              |
| <p>Research has shown how stigma is experienced by workers in dirty occupations, mostly in relation to the taints of dirty work. The experiences of clients concerned with the stigmatised dirty work context have been overlooked, because clients have been largely empirically excluded from most dirty work studies. The role of the organisational and wider contexts in shaping stigmatising situations has also been neglected. We need to</p> |  | <p>Meaningful situations of stigma for both workers and clients. Organisational and wider context both affects experiences of stigma and shapes responses to stigma.</p> | <p>Nested framing of stigma as involving interactions between stigmatised actors' agency, as well as the social relations and organisational and wider social context that they inhabit.</p> |

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| <p>understand how stigma is experienced by clients concerned with dirty work and how the context shapes the experiences of and reactions to stigma, because it can add depth to our understanding of stigma and coping with stigma in dirty work contexts.</p>                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                             |
| <p>Work in critical realist relational sociology has shown how relational dynamics among people concerned with a shared enterprise can generate positive outcomes for the benefit of those directly concerned in the dynamics and those outside of it. Applying this lens of relational thinking in a study of dirty work, we therefore need to understand whether and how relational dynamics</p> |  | <p>Stigma alleviation as a common good. It has the emergent effect of helping to clean up stigma for patients, clinicians and the wider wound healing community. Empowerment and emancipation through 'wound healing advocacy partnerships' support the development of 'woundology', which emerges from the relational good of</p> | <p>Introduction of the concept of the relational subject to the theoretical repertoire of dirty work to address shortcomings in theorising worker-client relationships. Alleviation of stigma presupposes the generation of relational goods among workers and clients.</p> |

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| <p>between workers and clients in a 'dirty' context can reflect a shared enterprise around stigma, as well as considering what effects it might have on those directly concerned with the dynamics and those outside of it.</p> |  | <p>stigma alleviation.</p> |  |
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## 8 Conclusion

The aim of this study was to explain the development, nature and role of clinician-patient relationships by conducting an ethnography of three specialised outpatient wound healing clinics in the UK. This concluding chapter refers back to this aim by offering a holistic overview of the significance of what I have found in this study. Having finished the study, I consider the material presented in support of answering the overarching research question:

How is the stigma associated with wounds (re)produced or alleviated in UK wound healing clinics?

I begin with sketching a brief picture of how the aim has been achieved and then re-examine some of the material presented in this thesis to reacquaint the reader with the study's key findings and arguments. Subsequent to this, I consider the contributions of this study and its implications for social theory, healthcare policy and the professional practice of wound healing. Next, I comment on the limitations of the study. The chapter closes by providing directions for future research, which arise from the study's limitations and research themes that emerged during the early stages of data analysis, but which had to be dropped during the iterative process of teasing out the study's 'big idea'.

This ethnographic study of UK specialist outpatient wound healing clinics has argued that congenial clinician-patient relations developed against the backdrop of organisational features that encourage their steering can generate unique outcomes in the form of relational goods and evils. Relational goods and evils have the power to not only alleviate and/or reinforce the stigma associated with the dirty work of wound healing for clinicians, but also the social stigma associated with having wounds for patients. By mobilising the relational subject (Donati and Archer 2015) as an optic through which to study the hitherto overlooked social relations between people who perform dirty work and their clients, I have offered a critical realist take on what these relations are, how they matter in terms of what stigma means to all those concerned with it, and how stigma can be jointly managed by them. In the context of the clinical specialty of wound healing (Harding and Queen 2011), in

which clinicians and patients develop a joint orientation towards the relational good of wound stigma alleviation, an emergent outcome is the further reshaping of their relations towards 'wound healing advocacy partnerships', which can empower patients to confront stigma, while, simultaneously, supporting clinicians in their professional agenda of developing wound healing into the focused specialty of 'woundology' (Harding 2008).

To make this argument, the study has taken five steps structured within the relatively conventional framework of what is expected from a doctoral dissertation in the social sciences. Firstly, the introduction explained the central orientating puzzle to guide and be solved in the main body of the thesis by engaging with the key themes of interest, namely: wound healing in the UK, the sociological concept of dirty work and the social theory of relational sociology, as developed by Donati and Archer (2015). Secondly, the theoretical chapter reviewed the scarce literature on dirty work and argued that it provided a largely anecdotal, disembodied and atheoretical depiction of worker-client relationships. This literature is primarily focused on the contingent dynamics of blaming and distancing to counter the social constructionist view of stigma which fails to take into account the wider, relational turn in sociological thought that views people's relations with others as a real support for human flourishing (Donati and Archer 2015), or a resource for alleviating stigma. The latter conceptualisation was shown to be of import for the nascent field of wound care, which is characterised by patients' intimate involvement in the dirty work of wound healing and the presence of patient empowerment initiatives in the wider healthcare arena.

Thirdly, I introduced the details of the empirical project undertaken to understand what might cause worker-client relations in dirty work to take specific forms, as well as what this means for stigma and its alleviation. I turned to a critical realist ontology to buttress my starting assumption that such relations in dirty work can have a real existence and de-stigmatising qualities that merit their scrutiny as objects of study. I showed how the critical realist conception of reality as stratified and emergent, as well as the idea of agency and structure being mutually influential in putting in place conditions for an emancipatory change in the stigmatised social order, offered a particular way of framing relations in dirty work that has not yet been explored in largely social constructionist and Goffmanian dirty work scholarship. A qualitative

ethnography of specialist outpatient wound healing clinics was presented as offering an expedient empirical avenue for fleshing these themes out, as it would enable me to directly engage with dirty workers (clinicians) and their clients (patients) to understand their relations and the organisational conditions propitious to their steering.

Fourthly, the study's empirical chapters highlighted three important sets of findings in this regard. Chapter four described the socially complex, dirty and stigmatised environment that wound healing clinics inhabit. In addition to highlighting how wound healing can be considered as tainted primarily in relation to physical and emotional 'dirt', it also explained stigma with reference to the wider contributory role of social structures, such as patriarchal, paternalistic and siloed systems of healthcare, along with the denigration of certain vulnerable social groups. The chapter further expanded the meaning of stigma in the dirty work context to include pertinent experiences of patients living with 'disgusting' and otherwise stigmatising wounds. In so doing, it gave voice to the normally silenced clients of dirty work and aided understanding of the motivations behind their actions towards dirty workers.

Chapter five elaborated worker-client relational dynamics in a way that went far beyond the dynamics of exclusion proposed in extant dirty work literature. Social relations between clinicians and patients were shown to be carefully navigated within the specific conditions of this wound healing organisation, which has also previously been overlooked in dirty work literature. The organisational conditions that steer these relations made it possible to not only communicate about care, but also delegate care responsibilities and swap favours outside of the immediate context of clinical care in support of the professional agenda to grow wound healing as a clinical specialty. The chapter also highlighted the barriers to this navigation, specifically locating them in patients' own biographies, which explain why in some situations some patients interacting with clinicians will form different relations aimed in different directions.

Chapter six focused on the outcomes of this relational steering, offering three clinician-patient configurations as emergent products of combinations of relational practices within the complex stigmatised context. The relational configurations were distinguished in terms of the relational goods and evils that they produced. Exchange relations were thus shown to generate relational goods for stigma

alleviation via both clinicians and patients sharing in the wound stigma alleviating enterprise. Didactic relations were depicted as those that maintained the status quo of wound stigma by producing some relational goods for stigma alleviation, but also some countervailing relational evils for stigma reproduction through reinforcing traditional clinician-patient role divisions. Finally, atomistic relations were considered as risking the reproduction of stigma by generating relational evils via the housing of self-referential behaviours. The chapter showed that, although some worker-client relations can bear relationally negative qualities, as depicted in dirty work literature, others can provide a resource and support for stigma alleviation.

Lastly, the discussion chapter more abstractly situated the study's findings in relation to existing literature on dirty work, whilst, simultaneously, framing them around the notion of the relational subject (Donati and Archer 2015) and drawing on my critical realist orientation to develop contextualised emergent explanations. I started by offering a nuanced understanding of wound stigma as experienced by both clinicians and patients, allied with the stigma management nested in their agency and their relational bodily practices that were afforded by the organisational and wider wound healing context. I stressed the material dynamics of 'dirt' as being entwined with its emotional management by clinicians, such as through empathising with and empowering patients to become insiders to the dirty work of wound healing. This mutualised the efforts to alleviate wound stigma, despite differences in concern between patients and clinicians. Through recourse to relational reflexivity, I distinguished between how these differences materialised through three relational configurations, which were premised on the orientations of 'We-ness' (exchange relations), 'Thee-ness' (didactic relations) and 'Me-ness' (atomistic relations). I concluded that exchange relations came closest to the archetypal relational subject (Donati and Archer 2015).

Stigma alleviation, which was most starkly visible in exchange relations, was in and of itself considered to be a higher-order emergent relational good. It was shown to empower patients and to mediate their relations with clinicians in a way that transitioned away from traditional role division towards 'partnerships for wound healing advocacy'. In addition to helping patients deal with stigma, these lay organisations (Al-Amoudi 2014) had the power to support the emancipation of wound healing because they represented a way of speaking about wound healing

that 'sanitised' it. This is a novel way of looking at dirty work. In particular, the realist treatment of worker-client relations as 'wholes' composed of combinations of internalities allows for the development of a causal explanation of their emergence, as well as their emergent effects being products of actors' diagnosis of what is possible given their own projects, which based on the stories of patients interviewed for this study, could be variously approached from relational, personal or functional angles. This serves to open the 'black box' of worker-client relations in dirty work, presenting them as nuanced entities with properties to alleviate and (re)produce stigma.

## **8.1 Contributions and implications**

The main contribution of this thesis to social theory is its contention that circumscribed interactions within social relations whose internal structure and dynamics are delimited by the professional rules of the context can constitute a relational subject, which can produce either relational goods or relational evils. According to Donati and Archer (2015), the emergence of relational goods and the reflexivity of them coming together to form social relations under certain conditions, and with certain consequences, can be analytically captured through the concept of the relational subject (Donati and Archer 2015). Correspondingly, this study documents clinicians, patients and patients' relatives using their agency to strengthen their relationships through bodily practices enabled by the academic context of the clinics, which, in turn, form exchange relations which help to alleviate wound stigma by contributing to advocacy initiatives that support the growth of wound healing as a clinical specialty. Therefore, the relational subject can be invoked to frame the actions of clinicians and patients in the dirty wound healing context. This contribution contradicts Donati and Archer's assertion that the doctor-patient relation "does not constitute a relational subject because this relation does not enter into two actors' personal identities but remains external to them" (2015, p.58). In contrast, this study shows that in specific contexts, such as wound healing, the doctor-patient relation *can* constitute a relational subject through a blurring of the ascriptive role identities under a shared agenda to alleviate stigma.

This encourages the pursuit of social scientific research focused on understanding the development, nature and role of clinician-patient relations across the spectrum

of healthcare specialties. Although the context of the medical encounter has been historically dominated by the concept of detached concern for the majority of the 20<sup>th</sup> century, even though clinicians and patients today still cannot form conventional familial or friendly ties, chronic disease, which is increasingly part of the health and illness process in the 21<sup>st</sup> century, creates space for medicine to occupy in innovative relational ways. In this space, patients and clinicians can jointly re-organise their relationship to orient themselves towards working through structural and cultural barriers to produce collective outcomes to the shared concerns facing a specialty.

What this means for the dirty work field is that it is important to focus more on the emergence, nature and effects of organised relations between workers and clients. In many areas of work that attract the dirty work label, clients can be intimately involved in the performance of dirty work, and, as such, can be affected by stigma in different yet related ways to how stigma impacts upon workers. This study has uncovered the potential of such relationships to not only broaden our understanding of stigma, but also to recast it when workers and clients come together and orientate themselves around a shared aspiration to alleviate stigma. It has thus portrayed these relationships in terms of triumphs, rather than in terms of setbacks. The stigma alleviating value of worker-client, or clinician-patient, relationships in a dirty wound healing context represents a novel insight to the dirty work literature, which merits further attention. Moreover, the idea that the alleviation of stigma presupposes the generation of relational goods by dirty workers and their clients requires further study by both relational sociologists and dirty work scholars.

By exploring worker-client relationships in dirty work from the perspective of both workers and clients, I offer insights into how clients see workers. The literature so far has mostly focused on how workers see their clients and on how workers feel clients see them and their work (through anecdotal descriptions and re-quoting), but there has been a dearth of research into how clients actually see workers and their work. Including both clients and workers in an analysis of the overcoming of stigma and dirt is not something that has been done before, but given the findings of this study, offers an avenue for novel insights.

Moreover, by situating wound healing in the dirty work literature, I contribute another single occupation study to the wider body of dirty work research. Until now, wound

care and wound management publications have alluded to the concept of dirty work, and, in fact, practitioners in wound healing would say that this is what they do (Holloway 2017), but the dirty work concept has not yet been used explicitly in these publications. Through undertaking this work, this study offers the first, explicit extension of current empirical knowledge regarding how the dirty work concept can be applied to wound healing. Moreover, dirty work scholarship could use the dirty work lens to explore the inner worlds of related areas of healthcare affiliated with wound healing, such as clinical photography, which appears to bear moral taints.

Beyond the relatively small field of dirty work, this study offers implications for the wider healthcare community about improving patient treatment by steering the relations between participants and encouraging organisational structures that enable such steering. More specifically, the idea of creating conditions for developing 'advocacy relationships' in healthcare can be seen as an extension of the concepts of patient empowerment, patient-focused care and patient involvement. It overcomes the traditional role division in which patients are seen as the less powerful part of the relationship. Patients and clinicians can, in fact, be active contributors to the same project by virtue of their social positionality. That is to say, they contribute from different perspectives, but the value of the contributions are of equal importance as stigma affects them both in a related way. This could extend current understanding of how to "achieve health and wellbeing with the public, patients and professionals as equal partners through co-production", as set out by the Bevan Commission in a programme for healthcare development (Bevan Commission 2015).

This study of clinician-patient relations is also significant for our understanding of the processes by which patients decide whether to enter into clinical trials. The study suggests that this decision may be a relational activity. This means that in making the decision, patients' considerations go beyond the individual benefits to be gained from accessing innovative treatments to instead include reflections on their relationship with clinicians. Thus, an established clinician-patient relationship might be an important prerequisite for patients' consideration of participation in clinical trials. Because decisions on participation in clinical trials are not only a matter of an objective assessment of the trial itself, it might be difficult for clinicians, and for patients alike, to draw clear boundaries between clinical trials as scientific

enterprises and as relational activities. Therefore, unexpectedly, this study has offered an optic for better understanding the dynamics of clinical trials as interplays between scientific concerns on the one hand, and relational and personal concerns on the other.

Finally, an important implication of this study for wound healing practice is that the absence of medical outcomes does not necessarily constitute ineffective medical care. Indeed, patients who could not be healed evaluated the care they received as effective. This suggests that wound care can be deemed as effective when the focus is not solely on its medical outcomes, but, rather, on the process of wound care and the quality of interactions and relationship building (Hardyman 2017). Harding and Queen (2017b) believe that capturing relevant data related to current service provision in wound healing is important for persuading politicians and health service planners that the clinical care of patients with wounds is a common and important issue. This study's findings on why the lack of medical outcome does not necessarily equate with perceptions of ineffective medical care thus has important implications, which can help to vindicate the power and legitimacy of wound healing against the trend to focus on healing rates as the governmental measure of success.

## **8.2 Limitations**

It is important to critically consider the importance of factors that may have had a potential impact on the interpretation of the study's findings in relation to the above research question. Limitations to the empirical study are acknowledged on the theoretical level with respect to engagement with the theory, on the personal level with respect to the researcher's bias and on the practical level of conducting the research.

The first limitation pertains to the extent to which my data allowed me to address the notion of relational reflexivity. Relational reflexivity is a key component of critical realist relational sociology in the style of Donati and Archer (2015), which this study sought to defend as an overlooked ontological framework for understanding worker-client, or clinician-patient, relations in dirty work. Archer's original conceptualisation of (personal) reflexivity was based on qualitative research conducted using biographical interviews, with her subsequent work reflecting the importance of social



contexts in moulding human biographical pathways and therefore their reflexivity (2003; 2007). However, this ethnographic study focused more on the daily practices of clinicians and patients, along with any biographical and historical data volunteered as being important by the participants themselves.

This empirical discrepancy may have potentially prevented me from creatively speaking to Archer's work, such as, for example, by developing sets of categories for the types of 'relational reflexives' (see Archer 2003) for each of the configurations. Instead, I framed my findings within the secure space of distinguishing relational configurations within existing knowledge on the relational tendencies of 'We-ness', 'Thee-ness' and 'Me-ness', for the purposes of presenting a reasonable consideration of what established relational tendencies can bring to our understanding of clinician-patient, or worker-client, relationships in dirty work. However, my lack of critical engagement with Donati and Archer's (2015) work does not disqualify my findings entirely, as according to Sayer (2009; 2010) cited in Caetano's (2015, p.10) critique of Archer's work, social actors could simply not be competent if their actions were not based on practical reason. Therefore, although I have not fully elaborated Donati and Archer's (2015) framework, I have shown in greater detail what relational reflexivity really looks like in a specific social context of the dirty work of wound healing, as well as delineating what difference it can make to this context through the specific relational goods and evils that it can help generate.

The second limitation stems from a personal bias in my engagement with Donati and Archer's (2015) framework. From my early days as a postgraduate researcher at Cardiff Business School, I found myself unexpectedly taking part in various intellectual rendezvous with the literary output of Margaret Archer and Pierpaolo Donati, often set up by my supervisors' cultivation of their rich professional networks of expertise in social theory. In addition to their pointers to her published work and meeting Margaret Archer in person on a few occasions, the idea of stigma alleviation as a relational good was presented by one of my supervisors to Pierpaolo Donati himself. His affirmation may have potentially further contributed to clouding my ability to more critically reflect on the framework. As Porpora asserts in reviewing "The relational subject", the book is "clearly written but not easy" (2016, p.419). Although he notes that "Donati and Archer themselves become the very kind

of collective relational subject of which they speak”, my reading of their works, produced both separately and together, pointed to inconsistencies in their definitions of social relations.

For example, while Donati and Archer (2015) state that “[n]either ‘connectivity’ (in networks) nor ‘transactions’ (between people) *necessarily* entail social relations” (p.20), I found the position of the said transactions in social relations unclear. In an essay following the publication of the book, Donati himself asserted that “the relationship networks which form the families are born by flows of communications and transactions, but they emerge as a reality which goes well beyond the contents of the explicit communications and transactions” (2016, p.155). While this contradiction might have been lost in translation from the Italian, in which Donati works, of particular import was Porpora’s ‘quibble’ with the denial of transactions:

“How can network connections or interpersonal transactions not entail or even be social relations?” (2016, p.422)

Recognising that “we can become too precious about the purity of an argument” (Edwards 2018), I identified the swapping of favours that carries transactional connotations as being crucial to converting clinician-patient interactions into exchange relations, albeit based on symbolic, i.e. non-economic exchanges. This, I felt, revealed the nuances of the nature of these relations and allowed me to show a different side to the relational subject in the healthcare context.

Finally, there are practical limitations that stem from choosing this particular wound healing organisation as a research setting. The close affiliation of this wound healing organisation with world-class wound healing research may not be a common aspect of all wound healing clinics, with some patients in other geographical locations lacking the possibility to become advocates for wound healing through pursuing the research pathway. Moreover, my collaboration with a key nationally renowned orchestrator of the wound healing project points to the strong role that the personal and institutional biography had in framing my findings. In many countries, including my home country of Poland, wound healing is still very new, with the Polish Wound Management Association only being set up in 2004 (Polskie Towarzystwo Leczenia Ran 2018). This limits the transferability of the study’s findings from the perspective of healthcare policy.

Furthermore, the business of these particular clinics, with several consultations unfolding at the same time, meant that I could easily miss some of the more regular patients, not to mention that I only interviewed patients once. This may have prevented me from tracing their wound journeys and developing biographical patient vignettes which, in turn, could have let me speak more directly to the idea of relational reflexivity. Moreover, as pointed out by the hospital specialist himself, the study did not compare the accounts of outpatients in these particular specialist clinics with patients from other localities, whilst the clinicians from other specialties that I interviewed about their perceptions of wound healing were mostly already “infected with a wound bug” (hospital specialist), which risked biased accounts. Further bias in my findings may have stemmed from clinicians’ assistance with patient recruitment, as it is likely that they nominated the most articulate individuals capable of reproducing the dominant wound healing discourse, while more vulnerable patients would not be interviewed.

### **8.3 Recommendations for further research**

The aforesaid limitations of this study represent noteworthy points of departure for future research. For example, organisational scholars interested specifically in clinician-patient relations in wound healing could elaborate upon my findings on clinician-patient configurations by increasing the number of patients in each relational category. While a moderate cohort of 20 patients was sufficient for this exploratory study’s search for the ‘big idea’, a more comparative analysis could seek to involve more patients to go into greater detail about the differences across relational configurations and their various outcomes. Alternatively, future research could focus intensely on a small number of patients and trace their wound journeys by conducting repeated observations and interviews over time to construct sophisticated patient vignettes. This would address the lack of understanding in social theory of “the morphogenesis of how relations begin, the course they take, and the effects of the outcomes to which they give rise” (Donati and Archer 2015, p.30).

In relation to this, the latter strategy could also offer scope for conducting biographical interviews through the adoption of a life-history methodology. In entrepreneurship research, biographical interviews have been used to present the

processes of starting a business under different circumstances as deliberate and relationally reflexive (see Meliou and Edwards 2018). Within healthcare, this method of research has been shown to connect people's ideas about their health, illness and the healthcare system with the familial, educational or professional contexts from which they emerge and which are deemed to be important to them (Cornwall and Gearing 1989). Therefore, it can reveal the deliberate capacities of patients, as well as clinicians, in different contexts, in turn, helping scholars forge reflexive links between agency and structure (Archer 2003). In this sense, biographical interviewing could be used to explain clinician-patient relations in the dirty wound healing context in a way that speaks to the concept of relational reflexivity more directly than the present study.

Similarly, this study's interest in the physicality of the human body and agency as per a critical realist ontology, partially realised herein within the scope of the available evidence, has revealed new avenues for scholars to explore within the context of the so-called 'bodily turn' in social theory. Future studies could focus on the formation of social relationships in wound care as an embodied process, and in terms of being embedded in (inter)corporeal experiences and in (inter)corporeal emotions. For example, this study recognised the importance of haptic dexterity in wound healing practices which are firm enough to gather diagnostic knowledge from the biological responses of the patient's body, yet also delicate enough to build trust-based relationships in a non-touching culture (Bolton 2005). Therefore, one possible research pathway could centre on understanding the connection between the ideas that wound healing clinicians use, the sensi-motor capacities that embody the professional medical knowledge used to conduct their work (Gherardi et al. 2013; Parolin and Mattozzi 2014) and the procedural corporeal practices professionally inscribed into wound care that carry elements which are 'expressive' (Cocksedge et al. 2013) and designed to convey gentleness, care or compassion.

Whilst it could be argued that 'bodily enactments of wound care' is an area ripe for development, especially for phenomenological scholars, Porpora notes that in critical realism Archer "consistently aligns with Merleau-Ponty in attending to the ways in which we deploy our bodies to relate to ... reality, from purely physical manoeuvres to patting reassuringly each other's shoulders" (2016, p.421). Moreover, Al-Amoudi (2016) posits that phenomenological description is often the

first step towards a critical realist explanation of embodied action. Finally, from a dirty work framing, such descriptions offer the potential to demystify the poorly understood realm of wound healing without resorting to the use of visually upsetting images. Therefore, they could offer a form of stigma preview, which Ashforth et al. (2017) conceptualise as a technique for newcomers to adjust to stigma that acquaints them with a realistic view of the job at both the cognitive and emotional levels. The authors note that 'stigma preview' might not apply to higher-status occupations, which presuppose exposure to job taints in formal education, such as medicine. However, as wound healing is still developing as a specialty, phenomenological descriptions could aid clinicians' attempts to seek legitimacy for their work through evocatively yet 'tastefully' engrossing newcomers in the wound healing specialty.

Future research could also study how patients understand, perceive and experience their own bodies and how this influences the way in which they negotiate their relationships with clinicians. Two potential research ideas could relate to agential (dis)embodiment and physical illness as a locus of relational security. Firstly, the data gathered for this study captured some patients speaking of the wounded parts of their bodies as separate beings, and as personifying their legs. Such descriptions might be indicative of patients seeking to create a distinction between their continuing sense of self and their conceptions of how the experience of leg ulceration might have challenged this ongoing sense of self through its effects on their daily-life over time. Interestingly, the detachment from the diseased body parts appeared to be performed in a manner that showed respect for these bodily changes. That is to say, the legs were almost given their own agency inasmuch as they could communicate with wound care clinicians and had their own emotional life. They were brought into the outpatient consultation to join in the conversation with medical expertise. The idea that body parts might have agency is a potentially interesting one for scholars intrigued by the intransitivity of the physical body within a critical realist ontology.

Secondly, the relational evil that speaks to patients' overdependence on clinicians captured in this study could spur research into how chronic wounds become the loci of patients' emotional lives in a potentially dangerous way. As long as the body remains sufficiently ill, there is a higher chance of receiving ongoing clinical

attention from doctors and nurses with whom a patient has developed a connection. Simply put, it gives patients a reason to come back. The emotional significance of maintaining 'just enough illness' can be implicated in patients' fear of physiological improvement putting an end to the regularity of medical encounters with familiar doctors and nurses, which itself constitutes a way of dealing with stigma. This relationship between patients' social bonding with clinicians and their physiological health/illness is a complex one, and not alien to health services research (see Hardyman 2017). However, it affords an interesting point of departure for further analysis in the critical realism of the (ill) body.

Finally, in addition to expanding upon the issues that proved impractical to elaborate herein, I have identified interesting research ideas that could have implications for the professional practice of present and future 'woundologists'. Firstly, significant insights could be drawn from conducting a genealogy of the wound healing specialty. This could be done through analysing the literature and documents from the wound healing curricula, as well as through performing biographical interviews with clinicians who have been with wound healing since its inception. Bringing history into the scientific explanation of wound healing could help identify both the challenges to, and strategies for growing, a specialty that reflects its broader contextual influences. Alternatively, future studies could pick up where this study empirically left off and examine the work of nurses in community-based nurse-led clinics that receive patients from and refer them to specialist outpatient services. With wound care generally still reduced to the work done by nurses who are associated with "the powerless and subordinate" (Bolton 2005, p.170), such research could counter this perception by exploring the professionalisation of wound nurses, which would indirectly support the wider project of emancipating wound healing. Both research endeavours could contribute towards the expansion of knowledge about this novel medical field, which, in turn, can help its solidification as 'woundology'.

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## Appendices

### Appendix 1. Glossary of medical terms<sup>19</sup>

Abscess – a collection of pus, or liquid, sometimes caused by a bacterial infection and treated with antibiotics. Abscesses can develop on various parts of the body, including on hips and chest, toes or on lower legs.

Ankle brachial pressure index (ABPI) – the ratio of blood pressure in the arms and blood pressure in the ankles. The measure obtained is often taken as a cut-off point for high compression bandaging.

Antimicrobial dressing – a dressing which can help reduce the level of bacteria in the wound. Some antimicrobials include honey, iodine or silver.

Aortic valve replacement – a kind of surgery performed on an open heart to replace its aortic valve.

Charcoal dressing – a type of dressing which can help control wound malodour.

Charcot – a muscular weakness or paralysis that makes it difficult to lift the front part of your foot and toes.

Co-morbidity – the presence of an additional medical condition alongside the main medical condition.

Compression therapy – therapy aimed at reducing the swelling of lower legs through applying pressure to improve blood circulation, such as through wearing stockings.

Contact dermatitis – a type of eczema caused by a reaction to a particular type of dressing.

Crohn's disease – a lifelong condition in which parts of the digestive system become inflamed.

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<sup>19</sup> Prepared with reference to the NHS Choices website (NHS 2018).

CT scan – a computerised tomography scan, which provides a way of looking inside the body.

Debridement – the removal of dead tissue and debris, most often performed through the use of a scalpel. The removal of too much tissue can result in overexposure of the wound which hinders the healing process; when not enough skin is removed, ulcers hiding underneath which require treatment might not be exposed.

Diabetic foot ulceration – a skin tear on the lower leg or feet associated with inappropriate blood sugar levels, which prevents the tear from healing; is sometimes associated with nerve damage.

Doppler assessment – a test used to measure APBI, performed with the use of a hand-held device or an automatic device ideally once every six months; for patients suffering from diabetes, a pressure reading should be taken from toes not ankles as diabetes produces calcification of some arteries, which can give a falsely elevated reading on a Doppler assessment.

Deep vein thrombosis (DVT) – a blood clot within a vein in the body, usually in the leg.

Electrocardiogram (ECG) – a test for a heart's rhythm and electrical activity.

Eczema – a skin condition in which the skin becomes itchy, red, dry and cracked.

Episiotomy – a procedure involving making a cut in the area between the vagina and anus during childbirth to allow the baby to come through it more easily.

Eschar – slough or piece of dead tissue.

Factitious wound – a wound produced or interfered with by the patient, either wilfully or unconsciously, normally due to underlying psychological conditions.

Hernia – a condition when an internal part of the body pushes through the muscle, appearing as a swelling or a lump.

Hypergranulation – overproduction of granulation tissues in the process of wound healing.

Hyperkeratosis – a skin condition in which the skin appears covered with dry scales.

Inflammatory disorders – a condition in which the body's immune system attacks the body's own cell.

Lymphedema – a condition associated with poor lymph flow that causes swelling, usually in the legs.

Maggot therapy – the use of specially grown medicalised live fly larvae to clean up dead tissue within a wound.

Magnetic resonance imaging (MRI) scan – a non-invasive procedure for looking inside the body; in wound healing, it is useful for diagnosing bone infections.

Necrosis – cell death.

Pilonidal sinus disease – an opening in the skin at the top of the buttocks, which can cause an abscess.

Potassium permanganate tablets – a medication used for cleaning wounds that involves soaking wounded body parts in water with dissolved tablets. It normally causes staining of the nails.

Pressure ulcers – skin tears which are normally a product of pressure or friction, and more commonly known as bed sores.

Pus – a liquid formed during an infection.

Pyoderma – a skin condition in which small red blood blisters or bumps are formed.

Slough – a yellow, creamy or greyish tissue around a wound.

Vascular ulcer – a long-lasting skin tear which normally develops on the inside of the leg, just above the ankle.

## **Appendix 2. Walk-through of an outpatient consultation**

Consultations followed a model of holistic wound assessment referred to by the oft-repeated mnemonic of H.E.I.D.I, where H stood for history, E for examination, I for investigations, D for diagnosis and I for intervention with indicators, or a plan of medical care.

### **H for history**

The first important part of the consultation was the medical interview, which was underpinned by the whole person approach. Clinicians asked patients two groups of questions. They would start by enquiring whether they suffered from any underlying conditions, such as diabetes, cardiovascular disease, rheumatoid arthritis or inappropriate pressure, which could inhibit the natural process of wound healing. Other questions centred around the patients' history of surgeries, medications, including painkillers, their eating and sleeping habits, smoking, hygiene, stress levels, living arrangements, the nature of their work and whether or not they had any social support from family or friends. Attention was also paid to any past amputations, which from a clinician's perspective indicates whether the condition that caused the amputation might be ongoing. The second group of questions focused on the wound itself: how and when it had begun, what had been done before, and whether the patient had any wounds in the past.

### **E for examination**

The next crucial component of the consultation was examination. Again, this was underpinned by the whole person approach. The clinicians would repeatedly recite the mantra that "It's the whole of the patient, not the hole in the patient". Therefore, the clinicians spoke of the importance of using all their senses (apart from the sense of taste) to examine the patient. They would touch the skin around the wound to feel the temperature or assess the pulses. "Over the years I have developed the ability to feel the feet. It's a skill and an art", said the hospital specialist on my first day of observation in Davis Clinic when he was talking me through a typical consultation. "Just eyeballing the wound is never good enough", he said on another occasion. A tool for clinical assessment used by the clinicians was abbreviated to TIME: Tissue (nonviable or deficient); Infection/inflammation; Moisture (imbalance); and Edge

(non-advancing or undermined) (see Schultz et al. 2004). First, clinicians looked at Tissue to assess whether it was healthy or not. "Offensive black necrotic eschar", "beefy red", "granulation" or "hyper-granulation" were the terms most often used. Then, they searched for evidence of inflammation or infection, along with the causes of the latter. Infected wounds often emanated unpleasant smells or produced purulent discharge, which was noted on the wound assessment form. Next, clinicians would evaluate the moisture balance. Finally, the edge of the wound was examined to see if the edges were rolled or raised, as this could indicate the presence of cancerous cells.

### **I for investigation**

Having examined the patient, clinicians proceeded to investigate the wound by choosing from a range of complex techniques that required special training. The one most commonly observed involved the use of a hand-held Doppler machine to perform an ultrasound to measure a patient's ABPI: the ratio of arm pressure to ankle pressure. Any broken areas on the skin were covered with foil. A small amount of gel was then applied in two places on the patient's foot, and a probe attached to the Doppler machine was gently pressed against these areas to amplify the sound of blood flow. The machine would then beat out a rhythm, which only an experienced clinician could assess. The reading of the test helped the clinicians decide whether to recommend the use of compression dressings. Some patients, such as those with diabetic foot ulcers, would sometimes require tests for bone infections. Here, three investigative techniques were available to the clinicians. MRI was one of them, but was very rarely used because of long waiting lists of around four months. Bone x-rays were also seldom used, because, although helpful in diagnosing chronic bone infections, the clinicians stressed that in acute cases bone changes lag behind infection by a few weeks. In addition to these imaging techniques, blood tests were sometimes performed with a focus on white blood cell count. Finally, the probe to bone test was sometimes used. On occasion, the clinical appearance of the wound itself was sufficient for diagnosing a bone infection. Sometimes doctors would take a tissue biopsy to check for the presence of cancerous cells if the wound was not healing, or when it looked unusual. A local anaesthetic would be applied around the wound, a biopsy sample would be taken and then placed in a special container. The area would normally bleed and require

the use of cotton pads to be pressed against the area of the wound to absorb the bleeding.

### **D for diagnosis**

Based on the result of the examination, the clinicians would then make their diagnosis. The diagnosis referred to the identification of the cause of the wound and any underlying condition; the wound itself was never a diagnosis. Moreover, the right diagnosis was more than just symptom control. Rather, it involved designing the appropriate treatment plan. Such diagnosis, in the broader sense, was an important aspect of wound healing.

### **I for intervention with indicators**

The last part of the consultation comprised creating a plan for intervention with indicators, which would allow for the assessment of the success of the treatment. Interventions were sophisticated. One type of intervention performed in the clinics was debridement. This referred to the removal of the build-up of dead tissue and debris, such as yellow slough or black necrotic tissue. This created conditions for the growth of bacteria that slowed down the wound healing process. Although there are various methods of debridement, in these outpatient clinics debridement was most often performed with the use of a sharp scalpel. Debridement thus required a great amount of care; clinicians held the patient's leg or foot with one hand and gently removed the tissue with the scalpel held in the other hand. This task was therefore entrusted to podiatrists or specially trained nurses. It was the hospital specialist who told the nurses to debride.

## Appendix 3. Ethical approval



### Health Research Authority

South East Coast – Brighton & Sussex Research Ethics Committee

Research Ethics Committee (REC) London Centre

Ground Floor, Skipton House

80 London Road

London

SE1 6LH

Telephone: 020 7972 2491

27 March 2016

Dear

**Study title:** The ontology of compassion: An exploration of reflexive medical practice

**REC reference:**

**Protocol number:**

**IRAS project ID:**

The Proportionate Review Sub-Committee of the South East Coast - Brighton & Sussex Research Ethics Committee reviewed the above application in correspondence.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Assistant NRESCCommittee.SECOast-BrightonandSussex@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

#### **Ethical opinion**

On behalf of the Committee, the Sub-Committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

#### **Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).*

*Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, [www.hra.nhs.uk](http://www.hra.nhs.uk) or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of management permissions from host organisations.*

#### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra\\_studyregistration@nhs.net](mailto:hra_studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### **Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion").

#### **Summary of discussion at the meeting**

The PR Sub-Committee agreed that this was a well presented study with no material ethical issues



### Approved documents

The documents reviewed and approved were:

| <i>Document</i>                                                                                                                | <i>Version</i> | <i>Date</i>      |
|--------------------------------------------------------------------------------------------------------------------------------|----------------|------------------|
| Covering letter on headed paper [Covering letter]                                                                              | 1              | 10 March 2016    |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of sponsor insurance Version 1 27th January 2016] | 1              | 27 January 2016  |
| IRAS Checklist XML [Checklist_10032016]                                                                                        |                | 10 March 2016    |
| Letter from sponsor [Confirmation of Sponsorship from Cardiff University Version 1 27th January 2016]                          | 1              | 27 January 2016  |
| Participant consent form [Patient consent form Version 3 27th January 2016 ]                                                   | 3              | 27 January 2016  |
| Participant consent form [Patient consent form Version 3 27th January 2016 ]                                                   | 3              | 27 January 2016  |
| Participant consent form [Staff consent form Version 3 27th January 2016 ]                                                     | 3              | 27 January 2016  |
| Participant consent form [Staff consent form Version 3 27th January 2016 ]                                                     | 3              | 27 January 2016  |
| Participant information sheet (PIS) [Patient Information Sheet Version 3 27th January 2016]                                    | 3              | 27 January 2016  |
| Participant information sheet (PIS) [Information about the research for staff Version 3 27th January 2016]                     | 3              | 27 January 2016  |
| Participant information sheet (PIS) [Patient Information Sheet Version 3 27th January 2016]                                    | 3              | 27 January 2016  |
| Participant information sheet (PIS) [Information about the research for staff Version 3 27th January 2016]                     | 3              | 27 January 2016  |
| REC Application Form [REC_Form_10032016]                                                                                       |                | 10 March 2016    |
| Referee's report or other scientific critique report [Scientific review letter PhD Anna Galazka Version 1 16th December 2015]  | 1              | 16 December 2015 |
| Research protocol or project proposal [Research protocol Version 3 27th January 2016]                                          | 3              | 27 January 2016  |
| Summary CV for Chief Investigator (CI) [ 2 page CV Version 1 8th March 2016 ]                                                  | 1              | 08 March 2016    |
| Summary CV for student [CV of doctoral student Version 1 11th February 2016]                                                   | 1              | 11 February 2016 |
| Summary CV for supervisor (student research) [Supervisors' CVs Version 1 12th February 2016]                                   | 1              | 12 February 2016 |

### Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### **After ethical review**

#### Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

#### **User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

#### **HRA Training**

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

|                                                       |
|-------------------------------------------------------|
| <b>Please quote this number on all correspondence</b> |
|-------------------------------------------------------|

Yours sincerely,

#### **Chair of PR Sub-Committee**

Email: [NRESCommittee.SECOast-BrightonandSussex@nhs.net](mailto:NRESCommittee.SECOast-BrightonandSussex@nhs.net)

*Enclosures: List of names and professions of members who took part in the review*

*"After ethical review – guidance for researchers"*

*Copy to:*

**South East Coast - Brighton & Sussex Research Ethics Committee**  
**Attendance at PRS Sub-Committee of the REC meeting in correspondence**

**Committee Members:**

| <i>Name</i> | <i>Profession</i>                            | <i>Present</i> | <i>Notes</i>              |
|-------------|----------------------------------------------|----------------|---------------------------|
|             | Consultant Psychiatrist                      | Yes            |                           |
|             | Retired Civil Servant                        | Yes            |                           |
|             | Consultant in Anaesthesia and Intensive Care | Yes            | Chair of PR Sub-Committee |

**Also in attendance:**

| <i>Name</i> | <i>Position (or reason for attending)</i> |
|-------------|-------------------------------------------|
|             | REC Assistant                             |

## Appendix 4. Patient information sheet



### **Patient Information Sheet (Version 3: 27/01/2016)**

#### Study title: Effective medical care in wound healing

I would like to invite you to take part in my doctoral study on effective medical care in wound healing which has been set up at Cardiff Business School. My main aim is to explore what effective wound care means to healthcare professionals and patients in practice to help build understanding of medical practice that might inform medical care and education. Joining the study is entirely up to you. Before you decide, I would like you to understand why I am doing it and what it would involve for you. Please read this leaflet carefully and discuss it with others if you wish. If you have any questions about this study, you can contact me  
or my supervisor

#### **Why is the study needed?**

Wound healing is an important new medical specialty. Because it is new, we still need to understand better what people with wound problems see as effective medical care. This is why I would like to recruit about 30 users of the services of wound care centres across            and speak to them about their experiences with medical wound care. At the end of the study, I will compare these stories to report to clinicians on what you understand as effective wound care.

#### **What does taking part in the study involve?**

You have been chosen as a potential participant in this study because you have been referred to the

I would like to observe the

way in which clinicians talk to you during your visit and talk to you for 30 to 60 minutes, depending on you, about what effective wound care means to you. I would like to audio-record our conversation with your permission. I would like to have this conversation at the end of your visit if you feel comfortable to do so. But you do not have to make an immediate decision. If you decide to talk to me, we can arrange our conversation at any time between April 2016 and March 2017, which is the period the study will run for. There will be a quiet room available for us at the clinic but you can suggest another place at the clinic where you would feel more comfortable. If you take part in my study you will not be asked to undergo any additional medical treatment or change your usual activities. There are no factors which can exclude you from participation. The decisions about your treatment will still be made by your usual doctor.

**Will the study benefit me or future patients with the same condition?**

There will be no immediate direct benefit to you but the results of the study could potentially inform medical care and medical education in the future.

**Confidentiality and patients' rights**

You will be asked to sign and date a consent form to confirm that you have agreed to speak to me. You will also receive a copy. My copy of the form will be kept secure and protected from unauthorised access in a locked cabinet at Cardiff University. After the study has ended, it will be kept secure in line with Cardiff University archiving policy. The transcript of our conversation will be anonymised. This means that your name will be replaced with a sequenced number (e.g. Patient 1, Patient 2) and the data will only contain your gender, as well as your age and your description of your wound, if you decide to share this

with me. I will not seek any access to your medical notes. Audio-recordings of our conversation will be securely destroyed once our conversation has been transcribed. Electronic copies of your data will be kept secure on a password-protected computer at Cardiff University under its IT security policy. Any copies stored on a USB and an external hard-drive will be encrypted. These devices, as well as paper copies of anonymised transcripts, will be kept secure and protected from unauthorised access in a locked cabinet at the University.

Your data will be analysed to support my doctoral research. To make maximum use of the data and to avoid wasting other patients' time in the future, your data may also be used to support future research which could involve collaboration with other researchers and institutions. However, they would only see anonymised data and would not be able to track them back to you.

**To obtain further information...**

You are free to ask questions before, during or after the study. The results will be described in my doctoral dissertation expected to be submitted in March 2019 at the latest. It will be available from Cardiff University, potentially published as academic articles in peer-reviewed journals, at conferences, as a policy brief, or as summary reports if the asks for them. If you would like to see the results, too, please contact me on

**What if there is a problem?**

If you are not happy with the general care and treatment you receive during the study, please speak first to me, the researcher,  
or to my academic supervisor,

who will try to resolve the problem.

**Do I have to take part?**

Your participation in the study is entirely voluntary and completely up to you. You can refuse to take part now but you can change your mind later. You can give me permission to observe your consultation but refuse to talk to me – or the other way round. You can also withdraw from the study at any time without giving a reason and request that the information you provided be destroyed prior to project completion and not be used in research, refuse to answer questions which you find uncomfortable or ask me to switch off the voice recorder at any time. This will not affect your relationship with the staff looking after you and you will still receive the treatment your doctor thinks is right for you. If you decide to take part all you need to do is come to your appointment. I will be there and you will be free to ask any further questions. Thank you for taking the time to read this information.

## Appendix 5. Patient interview guide

### INTERVIEW GUIDE: Patients. Version 2. 15/01/2016

Preface: Welcome the participant and thank them for their time; introduce yourself and present a proof of identity (Cardiff University ID card); offer them a drink (if location permits); briefly outline the purpose of research and clarify interview aims; explain outcomes to researcher and benefits to participants; request that participants sign an informed consent form; ask for permission to audiotape the interview.

Patients bring their (1) physical concerns (biomedical; disease) and (2) psychosocial concerns (existential; health related quality of life <HRQoL> (Price and Harding 2004); illness) into the consultation. Elicit information on both by (1) reconstructing patient's history around visiting the wound clinic and (2) building an account of the relation of / patient's management of their home life and their clinical treatment. Make sure you are: leaning slightly toward the patient, nodding, making eye contact, and using facilitative hums and murmurs, using patients' names (depending on how they introduce themselves) and showing concern for their comfort and privacy (asking if they are comfortable in the study / interview room, closing the door before the interview starts). Start with one question and wait for the answer (may be sufficient according to Platt et al. 2001):

#### *Asking about 'the person'*

1. Please tell me about your visit(s) to the wound healing clinic. *N.B. Returning patient:* What's new in your life lately? Any changes in your life since your last visit here? Or refer to any events in their life they mentioned in the previous interview...

Establishing who the patient is, what it is that matters to them the most; an invitation to tell their own story might produce an account which will allow me to understand the reasons for their visit(s), the frequency of the visits, the profiles of clinicians they see, their perceptions of their wound (e.g. healed, not healed, healing), their experiences with the wound, their feelings about the wound, their relationships with family and friends, their daily interests, their values and fears. Depending on the richness of the account:



*Patients' expectations*

What are you hoping for in a relationship with a doctor and a nurse?

What were you most hoping to accomplish here today? What do you hope to accomplish here in the long run?

Do you always understand what the doctor tells you and do you feel able to ask questions if you are not sure?

*Patient's experience of the wound*

What has having this wound been like for you? Can you tell me about that?

Probe for...

Its effects on daily functioning: Since you have had this problem, are there any things you can no longer do which you were able to do before?

Social life: How is your family / how are your friends dealing with it?

*Patient's ideas about handling the condition*

You have probably got some ideas on what you can do yourself to manage the wound. Can you tell me what they are? And how do you do that?

*Patient's main feelings about the wound to elicit emotions and personal reactions to the wound*

How does the wound make you feel? What is your personal reaction, what emotions does it produce?

Look for signs of...

Fear?

Distrust?

Anger?

Sadness?

Ambivalence?

Other?

If the patient refuses to talk about emotions, say, e.g. *I understand you might not want to talk about this. Of course, you don't have to tell me anything that is too uncomfortable to talk about. But I am just trying to understand fully what you see as effective relationship with a doctor here in wound healing and I want to understand your view as fully as I can.* Do not prompt further!

*Closing remarks:* Ask if the participant would like to add any further comments; offer them a chance to check interview transcripts and to read a draft version / summary of main findings (indicate a timescale); thank them for their time and insights.

## **Appendix 6. Staff interview guide**

INTERVIEW GUIDE: Staff. Version 2. 15/01/216

Preface: Welcome the participant and thank them for their time; introduce yourself and present a proof of identity (Cardiff University ID card); offer them a drink (if location permits); briefly outline the purpose of research and clarify interview aims; explain outcomes to researcher and benefits to participants; request that participants sign an informed consent form; ask for permission to audiotape the interview.

Section 1: Career and work experience

Background data about staff members' work and work experiences

What motivated you to enter the medical profession? (Probes: You mentioned previously something about X, would you please try and say more about that? (Kvale 1996), critically follow up the answers, ask for specifics, test the strength of the participant's belief by doubting it (Kvale 1996)

Why this particular speciality?

How long have you been in your current job?

Work description: clinical work, role within a care team, management of junior staff, training others, involvement in research?

What/where did you train?

Looking back into your training, were you taught about the importance of compassionate practice? Were you taught to be compassionate? Do you think compassion can be taught?

For experienced practitioners: Do you think there has been a change in the way compassion is taught nowadays?

What are the core values the public expects you to adhere to?

What are your organisation's values?

How do the behaviours of staff relate to these values?

How explicit is the expectation that organisational values and behaviours should be related?

How are the interrelationship between behaviours and values evaluated?

What performance drivers do you feel you are operating under?

How do you stay focused on the quality of patient care against these performance drivers?

## Section 2: Meaning of compassionate medical practice

How would you describe the nature of medical care?

What are the behaviours and feelings associated with providing medical care?

What techniques, if any, do you use to maintain yourself in the present moment?

What do caring doctor-patient relationships ideally look like? What do they really look like?

What do caring relationships between medical staff ideally look like? What do they really look like?

What characteristics do you consider typical of a medical practitioner? What (1) skills, (2) qualities and (3) knowledge are needed by medical professionals today to be compassionate?

Look out for: emotional intelligence, listening, trust, authenticity, openness, caring, reflection, commitment, genuineness, empathy, resilience, courage, respect, motivation, lack of judgement, kindness, responsiveness and the like.

Thinking of your current job title and responsibilities, how would you describe medical practice?

Based on your experience, can you describe an example of:

(a) Appropriate display of positive emotions?

What made it appropriate?

What personal satisfiers did you experience?

How can you build them into your practice in the future?

(b) Inappropriate display of positive emotions?

What made it inappropriate?

What personal stressors did you experience?

How did you process your personal emotions?

What can you do to prevent them in the future?

(c) Appropriate displays of negative emotions?

What made it appropriate?

(d) Inappropriate displays of negative emotions?

What made it inappropriate?

How did you process your personal emotions?

(e) Displaying emotions other than the ones experienced?

For each one, describe the participants in the events, events leading to the emotion felt, felt emotion, expressed emotion, reasons for considering it appropriate or inappropriate, any impact on themselves? On other medical professionals? On patients? (Kramer and Hess 2002).

Section 3: Meaning of reflexivity

When does your work feel meaningful to you?

What aspects of your job give you satisfaction and joy?

What motivates you the most?

What rewards mean to you the most?

When does your work feel less meaningful?

What demotivates you?

Do you change/make adjustments to the way you work when you feel demotivated?

What is your understanding of an integrated/holistic appreciation of the patient's condition?

How do you develop an integrated/holistic picture of the patient's care?

How do you strike an appropriate emotional balance in interacting with the patients?

What is appropriate emotional balance for you in the first place?

What is your understanding of reflection in action? Have you ever been in a situation which caused you to reflect in action? Please describe it.

*Closing remarks:* Ask if the participant would like to add any further comments; offer them a chance to check interview transcripts and to read a draft version / summary of main findings (indicate a timescale); thank them for their time and insights.

## Appendix 7. Information sheet about research for staff



### Information about the research for staff (Version 3: 27/01/2016)

#### Study title: Effective medical care in wound healing

I would like to invite you to take part in my doctoral study to better understand the role and nature of medical care in wound healing. My main aim is to explore what effective compassionate wound care means to healthcare professionals and patients in practice to help build understanding of medical practice that will inform consideration of existing protocols, conventions and training. Joining the study is entirely up to you. I hope that the information provided in this leaflet will help you decide if you would like to accept my invitation. However, should you have any further questions, please ask me during a briefing session or contact me  
or my supervisor

#### ***What is the purpose of the study?***

The purpose of this project is to explore the meaning of effective medical care in wound healing. Because of an often long road to recovery, patient care in wound healing may be more than simply a medical intervention. It may incorporate relationships, too. This might reveal a compassionate element, among others, and its emergence shape and place in current treatment of patients with wounds can be further explored.

#### ***Who will be undertaking it?***

The study will be undertaken by Anna Galazka, a doctoral researcher at Cardiff Business School funded by the Economic and Social Research Council and Cardiff Business School.

#### ***What will be expected of me if I agree to participate?***

I would like to observe your interactions with patients with wounds during consultations over a period of 10 to 12 months starting in April 2016 and talk to you about your approach to treatment of patients with wounds. Participation would not require any preparation on your part. Such conversations are expected to last approximately 30 to 60 minutes, but can be longer or shorter depending on you, and would be arranged at a place and time which is most suitable for you. With your permission, I would like to audio record them.

***Is my participation voluntary?***

Your participation is entirely voluntary and you have the right to withdraw from research at any time without giving a reason. However, as your insights are valuable to me, should you have any second thoughts or questions about your participation, I would greatly encourage you to seek assurances from me or from my supervisor prior to your definite withdrawal.

***What will happen to data?***

You will be asked to sign and date a consent form to confirm that you have agreed to speak to me. You will also receive a copy. My copy of the form will be kept secure and protected from unauthorised access in a locked cabinet at Cardiff University. After the study has ended, it will be kept secure in line with Cardiff University archiving policy. The transcript of our conversation will be anonymised such that your name will be replaced with a sequenced number (e.g. Doctor 1, Nurse 1) and the data will only contain your gender and medical specialty and age, if you decide to share it with me. Audio-recordings of our conversation will be securely destroyed once our conversation has been transcribed. Electronic copies of your data will be kept secure on a password-protected computer at my research organisation under its IT security policy. Any copies stored on a USB and an external hard-drive will be encrypted. These devices, along with paper copies of anonymised data, will be kept secure and protected from unauthorised access in a locked cabinet at the University. Your data will be analysed to support my doctoral research. To make maximum use of the data and to avoid wasting other healthcare professionals' time in the future, your data may also be used to support future research which could involve collaboration with other researchers and institutions. However, they would only see anonymised data and would not be able to track them back to you. If you withdraw from research, you can request that the information you provided be destroyed prior to project completion and not be used in research.

***How will I benefit from participation?***

I hope you might find that by participating in this study you will actively contribute towards the creation of a culture of continuous improvement in the NHS. Moreover, reading about the outcomes of the study could be an opportunity to compare your experiences with those of your colleagues.





***How will the results of the project be disseminated?***

The results of the project will be reported in my doctoral dissertation, with final submission due on 29<sup>th</sup> March 2019. It will become a public document stored in the Cardiff University repository. All efforts will be made to ensure the highest quality of work, with an eventual aim of publishing the results as a peer-reviewed journal article, a conference paper, a poster or a policy brief. A summary report will be provided if your institution requests it. Should you wish to obtain a copy of the dissertation, or a summary of findings, please contact me on

Thank you for taking the time to read this information

## Appendix 8. Sample of additional 1<sup>st</sup>-order interview quotes and fieldnotes in support of 2<sup>nd</sup>-order themes

| Social complexity in dirty work and the stigmatised context of wound healing        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| <p>Dirty “particulars” (Ashforth and Kreiner 1999, p.421) of wound healing work</p> | <p>I remember other photographers coming back from that clinic and saying, ‘Oh, you know, they think she is making it worse on purpose’. And that stuck out because we’ve had instances like that where patients either hurt themselves intentionally and try and aggravate the wound or they don’t take the doctor’s advice, because they know if [inaudible] it’s going to get worse. And that sticks out because obviously there are other issues going on there. I always feel quite sympathetic towards them, because obviously they need support. They need help, but it might not necessarily be from the wound team (Leighton, clinical photographer).</p> <p>They’ve got all sorts of horror stories about dressings coming off and patients not being able to bend down and do it them themselves, so they’ve been walking around on a dirty floor, for four or five days before they come back here ... and cat hair stuck in it and all sorts of debris stuck in it (Catherine, diabetic nurse).</p> <p>I think where people see the wounds, they are horrified, horrified, but they have no</p> |

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|                                     | <p>idea. And I think a lot of the wounds are in intimate areas, they are quite smelly, they look horrible, they are wet. I mean you must admit some of the wounds are awful (clinician, anonymised).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <p>Wounds as stigma to patients</p> | <p>I think that clinical staff do try to make an effort to make it private, and on the wards when the curtain is pulled around they put a note around saying, 'Do not disturb, dressing in progress'. But patients around listen, and the nurses will say, 'Oh, it looks a little worse today', or 'It is a little more smelly today' (Helen, orthopaedic specialist).</p> <p>I think because despite what, even if we can't heal a wound, we will keep trying, we won't just say, 'Right, we can't heal you, so off you go' and discharge you. We will keep seeing patients, we will manage all the symptoms with a wound and we will try our best to get it to a point that's easier for a patient to live with it. And the hospital specialist always says, 'We will keep trying. We will never give up on you' (Megan, nurse).</p> <p>We've had one girl who had Charcot. We tried to do events when we have groups of young people together to talk about topics such as going to university, drinking, travelling. She won't come because she is wearing an air cast. So, she feels stigmatised by having a wound on the foot. For an outsider who didn't know that she had diabetes, that could be a simple fracture where she'd been playing sport. But</p> |

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|                                                  | <p>she's really embarrassed by her foot. She sees it as a big social stigma to be walking with a big air cast, cause she sees it as stigma and all the reconstructive surgery that she has had (Catherine, diabetic nurse).</p> <p>You are wandering around in this boot and the people are seeing you wandering around in this boot. And you just try and be normal ... some people didn't like me sit in the boot because they felt sorry for me. Sometimes (Rhydian, patient).</p>                                                                                                                                                                                                                                                                                                                                             |
| Structural and cultural context of wound healing | <p>We often have patients who have come from out of area, and they've exhausted all their local resources and they have not got anywhere (Amanda, nurse).</p> <p>Because all these people get wounds, so then they come into us (Mary, nurse).</p> <p>It really is a multidisciplinary team in wound healing and I think that, yeah, as you say, they take all-comers and I think it allows them to focus on the wound particularly, and their approach is cross-specialties and they don't mind getting involved in diabetes or getting involved in something else (Kate, doctor).</p> <p>I think there is just a massive lack of training in wound healing. It's just not something that seems to be an area that they plough a lot of training into when you're doing your degree. This is a shame, really (Megan, nurse).</p> |

## Navigation of social complexity in clinician-patient dynamics

Creation of opportunities for developing a shared orientation

'Hang on Jane, I'll see what I can do about it'. Even though that's not what he said, it is what he said through body language and body tones (Jane, patient).

In fact, sometimes we see extra patients. Some patients might turn up – don't ask me why they do that, they would not do it in the other clinics – but sometimes they will turn up and they will never get sent away. I think it's because of the research part of the job, cause you get to know these patients much better within the research cause you are seeing them every week, sometimes twice, or it might be three times a week. So, you get to know them very well (Mary, nurse).

Everybody, everybody, everybody seems to have got the time to explain everything to you ... they are very, very comprehensive in the way they explain things to us and we are very, very pleased with it (Elina, patient).

And that you're able to answer their questions and sort of put them at ease about what's going on with them, explain why you're doing things. And I think the easier way to gain that relationship is to give them enough information about their treatment. About what they've actually got. And keeping them well-informed means then that they trust you more and they're willing to give whatever you're putting in place a go, and

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|                                                                                                                                              | that they'll stick to it better (Megan, nurse).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Restriction of opportunities for developing a shared orientation                                                                             | <p>But there's some instances where you can see that the patient's choices are wrong. And then there are the odd patients where lifestyle... so smoking, being overweight – you probably noticed a lot of the patients are morbidly obese and that has a huge impact on so many types of wounds that we see, and that's a really difficult one to approach (Amanda, nurse).</p> <p>Clinician says patient is not telling the truth and is not really soaking their feet, which they can tell by the lack of staining on their toenails (fieldnotes, Bridge Clinic, July 2016).</p> |
| <b>Relational configurations in clinician-patient dynamics: opportunities and threats for de-stigmatisation or reiteration of status quo</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Exchange relations: relational goods for stigma alleviation by clinicians and patients sharing in the stigma alleviating enterprise          | <p>From when he started, even though it was different when he started here, you know, when he had to scrape and scrounge, got pushed from pillar to post in this hospital, you know, and then cause he has the research unit over across the road from here when you come in – that was lovely – and then he is back up here, but nothing is too much trouble for him (John, patient).</p> <p>And a lot of patients are what I would call expert patients. You've met some of them,</p>                                                                                            |

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|                                                                                                                                                                   | <p>you've talked to them. They know so much about themselves, their wounds, they are well-read. They're on the Internet, they are looking at the latest treatment, they discuss with [hospital specialist] some very complex treatments that perhaps I haven't heard of. So, there are some expert patients and they are useful to talk to because they know so much (Amanda, nurse).</p> <p>Patient and companion assure me that they are willing to help with my study (fieldnotes, Morgan Clinic, June 2016).</p> <p>Patient is happy to help with trials as a way of saying 'thank you' (fieldnotes, Morgan Clinic, June 2016).</p> <p>Patient willing to help with clinical trials as a 'thank you' for saving him from amputation (fieldnotes, Bridge Clinic, July 2016).</p> <p>Clinician says, 'You've made my day' to the patient after they agree to take part in clinical trials; the patient's participation in clinical trials is acknowledged with many thanks (fieldnotes, Bridge Clinic, July 2016).</p> |
| <p>Didactic relations: producing relational goods for stigma alleviation and relational evils for stigma (re)production to maintain status quo by reinforcing</p> | <p>Patient explains that he wants clinicians to make the care decision for him (fieldnotes, Bridge Clinic, July 2016).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

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| <p>traditional clinician-patient role divisions</p>                                                           | <p>Patient with Crohn's disease appreciates guidance and encouragement from clinicians. She likes to be guided and told, 'Come on, give it a try' (Morgan Clinic, fieldnotes, July 2016).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <p>Atomistic relations: risk (re)producing stigma<br/>relational evils around self-referential behaviours</p> | <p>I've seen a few patients where they've kind of accepted that their wound might not ever heal, but they are prepared to accept that and to trade-off in order to be able to do what they want or go where they want. I think those are the trickiest ones for me (Kate, doctor).</p> <p>The patient says he tends to cover the wound and scar tissue with [brand of skin care product available over the counter], and the doctor says that, whereas it might be good for the scar, it is like "sunbathing in olive oil", and she "would recommend avoiding sunlight completely". The patient also admits that he likes to take his dressing off when he is home, and the nurse says she will pretend she didn't hear that. She advises him not to do it, because the removal of the dressing actually exposes the wound to more bugs. She is visibly surprised when the patient tells the nurse that he uses [brand of antiseptic cream available over the counter] on his wound. The nurse says that he shouldn't do it, because it can actually irritate and dry the skin around the wound too much. She adds that [brand of antiseptic cream available over the counter] should never be applied directly onto the wound ... The patient leaves, puts his hat on and</p> |



adds, “So, continue as normal, except no sunlight, do not take your dressing off, and no [brand of antiseptic cream available over the counter]” – the comment feels a little sarcastic. After the patient leaves, the nurse says to me, “He does like to do his own thing” (fieldnotes, Davis Clinic, August 2016).

I don’t know what it is, whether it’s cause they don’t click with you. There are a few patients who just do their own thing (Mary, nurse).

Somebody had gone in the sea, somebody had maggots coming out of it... patients use [brand of antiseptic cream available over the counter], honey from the pot... amazing... I had an old lady when I was from the district, she used to put honey from the pot ... One patient read about sugar paste. So, she sent her husband to get granulated sugar, and put the sugar on the wound. And because it fell off, she mixed the sugar with an ointment that we use, and she put that on her leg. She had an infection. I don’t think I can be surprised anymore (Mary, nurse).

So, I went, and I was doing the same things, I was taking the boot off, I wanted to drive. Which was really speaking a bit silly. Patients can be a bit silly (Rhydian, patient).