
Professional project for wound healing clinicians

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Abstract This article explores the professional project for an emergent subaltern specialist community of wound healing clinicians. Drawing on the literature on professions and boundary work, it examines how wound healing clinicians challenge the perception of their work as ‘dirty’ and seek its transformation into a specialism of ‘woundology’. The article is based on an ethnography of a UK multidisciplinary team of doctors and nurses with an interest and expertise in wound healing, who work as clinical academics and provide wound care services in outpatient clinics. It demonstrates that wound healing clinicians vindicate their professional status by seeking to enthrall the medical community in ‘dirty wound care’ as a focused clinical specialty of ‘woundology’. Through training nurses to do medical wound care work, educating clinicians from other specialties about wounds and undertaking wound research, wound healing clinicians assert the professional boundaries of their specialism and its fit with mainstream medicine without embellishing the dirty aspects of their work.

Keywords: professional project, boundary work, dirty work, wound healing, wound care, woundology

Introduction

Wound healing is a novel medical area focused on the treatment of skin tears. Until the second half of the 20th century, the understanding of wound healing hinged largely on changing bandages. As the demand for advanced wound care has grown in ageing western populations, the past 60 years have seen progress in its biomedical knowledge base (see Harding 2015). However, scientific advancements in wound healing have not been matched by a professional recognition of ‘woundology’ as a standardised evidence-driven medical specialisation focused on diagnosing and treating patients with wounds (Harding 2008). As observed by Madden, ‘[m]ost of the care of people with chronic wounds in the UK is undertaken by nurses with involvement from a wide range of health and social care services and specialisms including tissue viability, surgery, dermatology, care of the elderly, podiatry, physiotherapy and occupational therapy’ (2012, p. 2047). The very language of ‘care’ conveys a focus on *caring*, rather than on actively healing wounds (Lusher *et al.* 2018, emphasis added). Moreover, academic and clinical interest in the field has been ‘limited and patchy’ (Harding 2015, p. 318). At present, there is no formally recognised specialty of ‘woundology’ (Queen 2019).

Wound healing clinicians’ claims to a professional status are further challenged by the routine physical proximity of their work to pus, scab and malodour from ‘mucky’ wounds

(Lindahl *et al.* 2010). Wound healing has attracted sporadic designations as paradigmatic dirty work (e.g. McMurray 2012, Stacey 2005) – work below the dignity of a profession (Hughes 1958) and away from professional prestige (Ashforth and Kreiner 1999). ‘Dirt’ is seen as something to resist, because it degrades professional legitimacy. For example, Håland’s (2012) study of a hospital being transformed by new technologies shows how doctors engaged in boundary work to separate themselves from less esteemed secretarial tasks considered to be dirty. To defend their status, clinicians sought professional closure around prestigious biomedical knowledge. Indeed, Pawson and Tilley argue that ‘[t]he greatest opportunity for professional closure comes when the authority for the knowledge base rests on “science”’ (Pawson and Tilley 1997, p. xi).

The development of distinctive knowledge is also a focus of much of the literature on professions and professionalisation (Abbott 1988, Friedson 1970, Larson 1977). In medical sociology, scholars such as Broadbent (1998), McDonald *et al.* (2009) or Timmons and Nairn (2015) studied how healthcare workers seek occupational closure by developing own areas of practice to operate in as professionals. Contemporary wound management literature suggests that wound healing clinicians, too, try to legitimate their field of work. For example, Harding (2008, p. 597) advocates the dissemination of knowledge about ‘local initiatives that will contribute to the creation of woundology’. Queen (2017, p. 597) calls for a focus ‘on both the research efforts and the clinical specialisation development’. Both authors speak together of the development of national initiatives for wound research and clinical standardisation (Queen and Harding 2012). However, neither the field of dirty work, nor the sociology of professions, has yet explored how wound healing clinicians seek to legitimate their dirty work.

This article offers such an examination. It asks: ‘how do clinicians with an interest and expertise in wound healing engaged in dirty work seek to vindicate their professional status in medicine?’ The article starts with a brief review of sociological literature depicting wound healing as dirty work. Next, it summarises seminal contributions on professionalisation and professional projects (Abbott 1988, Friedson 1970, Gieryn 1983, Halpern 1988, Larson 1977, Weisz 2006). Empirical material for this article came from an ethnography of clinical academics who worked in three UK specialist outpatient wound healing clinics and did wound research at a nearby university. The findings focus on how their professional project was underpinned by wound education and research that unfolded against the backdrop of the dirty characteristics of wound healing work. These scientific activities are theoretically considered in the discussion of ongoing boundary work, through which wound healing clinicians seek to enthrall the medical community in ‘woundology’ without embellishing the dirty work it entails.

Dirty work, professionalisation and wound healing

‘Dirty work’ is a sociological concept used to study stigmatised occupations whose activities fall ‘physically, socially or morally beneath the dignity of the profession’ (Hughes 1958, p. 122). According to Hughes, dirty work:

... 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)

Much literature focuses on how individuals doing dirty work deal with the stigma their job poses to their personal identity. The coping strategies include reframing the meaning of dirty jobs, recalibrating its standards and refocusing attention on positive job characteristics

(Ashforth and Kreiner 1999, Ashforth *et al.* 2007). Adams (2012, p. 152) argues that these strategies 'can reasonably be used in a broader sense to transform the overall cultural perceptions of a given industry'. In his analysis of the professionalisation of cosmetic surgery, stigmatised for engaging in body modification practices, Adams highlights the importance of establishing professional institutions, standardising procedures and using medical regulation, interventions and language for acceptance within the medical community. Similarly, Cahill (1995) demonstrated how funeral directors, stigmatised for working with dead bodies, used the terminology of mortuary science and specialised technical skills to prove their professional legitimacy by stressing their affiliation with the institutional authority of medicine. In both studies, medicalisation was a key mechanism driving the transition away from dirty work and towards formal recognition, with medicine treated as a model profession and the opposite of stigmatised dirty work.

Outside of the dirty work field, medicine has been a paradigmatic professional case (Friedson 1970) driving the modern theory of how occupations establish and protect their interests (see Henriksson *et al.* 2006, p. 176). According to Kernahan (2018), since the 1970s the sociology of professions has been dominated by models emphasising various aspects of professionalisation. Some highlighted historical specialisation of new fields. For example, Halpern (1988) concentrated on the origins, development and institutionalisation of paediatrics. Others focused on the establishment and contestation of professional boundaries to secure a service monopoly. To this aim, Larson (1977) offered an actor-centred concept of a professional project, while Abbott (1988) focused on competition between occupational groups to delineate own 'jurisdiction' – 'the exclusive right to practice in a service domain' (Wallace and Schneller 2008, p. 767). According to Abbott (1988, p. 82), the 'cultural legitimacy for jurisdiction' is largely supported by 'effective academic work'. This resonates with recent work by Weisz, who argued that historically, specialisation was 'understood as a function of medical research and teaching' (2006, p.xiv). Halpern, conversely, overlooked the impact of science on professionalisation, offering a 'history of medical institutions, not an account of innovations in diagnosis and treatment' (1988, p. 4, cited in Meckel 1989, p. 847).

Just as the sociology of professions is theoretically contested, empirical research reveals tensions in the praxis of medical professionalisation. For example, Wallace and Schneller's (2008) analysis of the development of an intra-professional role of a 'hospitalist' in US health care illustrates problems with Abbott's (1988) concept of exclusive control over the application of a distinctive body of knowledge. Hospitalists were specialist care managers who orchestrated patient care and drew on the medical knowledge of various existing specialties, such as internists or intensivists (p. 776), rather than on any single specialist knowledge base. Similarly, Timmons and Nairn's (2015) analysis of the professional project for emergency medicine showed that it relied on knowledge created elsewhere. To secure legitimacy, emergency doctors shifted the scope of their jurisdiction away from a body of knowledge they could call their own to the application of knowledge from other specialisms within a space-time frame of emergency admissions. Like emergency doctors (Timmons and Nairn 2015) or hospitalists (Wallace and Schneller 2008), wound healing clinicians rely on knowledge that cannot be contained within the boundaries of a single specialism:

... which specialties should see patients with wounds? For patients with leg ulcers is it the dermatologist or vascular surgeon who should coordinate care? For pressure ulcers, is care of the elderly, rehabilitation medicine or plastic surgery required? For diabetic foot ulcers, is it the responsibility of the endocrinologist or orthopaedic surgeon? Additionally, what is the role of nursing, podiatry and other therapists? (Harding 2015, p. 318)

As Wallace and Schneller observed, '[s]ince Abbott formulated his theory, there have been significant changes in medical professional work, its knowledge base, perceptions of the legitimacy of exclusive jurisdictions . . . The system of professions is not what it was, so theorising professions must keep pace with the times' (2008, p. 777). They called for a pluralistic approach to understanding the establishment of new professional roles that recognised the concomitance of sources of authority from a process perspective.

In this regard, the concept of boundary work has become a useful heuristic. Gieryn (1983) originally defined it as the 'attribution of selected characteristics to the institution of science . . . for purposes of constructing a social boundary that distinguishes some intellectual activities as "non-science"' (p. 787). However, he observed the principles of boundary demarcation are equally applicable to distinguishing specialties (p. 792). Boundary work has since been used in medical sociology to show how the process of demarcating the lines between professions is not fixed but may involve an ongoing, ambiguous negotiation. For example, Allen's (2000) analysis of the occupational demarcation of UK clinical nursing pointed to an ambivalent dynamic of some managers devolving medical tasks to nurses, while others withholding them within the scope of doctors' responsibility. Mizrachi *et al.*'s (2005) elaborated the simultaneous dynamic of inclusion and exclusion in boundary work – what Allen (2000) alluded to – in their study of restricted integration of alternative medicine into biomedicine in an Israeli hospital. To defend their professional knowledge, biomedical doctors insisted on alternative medicine maintaining terminological uniformity with biomedicine, confining alternative doctors' newly granted control to the familiar turf. The germane point here is that the development of new professional roles is an ongoing process of boundary creation, preservation and contestation, which might offer a way of dealing with the problematic notion of professional jurisdiction in multidisciplinary fields.

Methods

This article comes from a larger, exploratory ethnography involving a multidisciplinary team of clinical academics working together on wound research and attending the clinics of three hospitals in the UK NHS to provide service to patients with wounds. This research was conducted between 11th June 2016 and 3rd April 2017 in three specialist outpatient clinics referred to as complex Morgan Clinic, general Davis Clinic and diabetic Bridge Clinic. Given the clinical academic character of the setting, students and visiting clinicians interested in wound healing were in regular attendance. Each clinic run once a week for half a day. Once a month, Bridge Clinic and Morgan Clinic operated as combined clinics, with specialists from other fields present on-site. I conducted just under 120 hours of observations of work in the outpatient clinics and 19 semi-structured interviews with clinicians: 12 wound healing doctors and nurses; six clinicians from other specialties working in combined clinics, and one clinician not affiliated with wound healing recruited for my study by my work colleague. Table 1 provides additional information on study participants. Moreover, I attended two lectures on clinical evidence and two presentations on the challenges and opportunities to wound healing at a nearby university and paid two visits to community-based wound care clinics. The additional data this generated gave me a better understanding of the context of wound healing.

I followed data collection protocols approved by the South East Coast – Brighton and Sussex Research Ethics Committee. The wound healing clinicians advised new patients to expect my presence in the clinics by attaching my information sheets to their appointment letters. I sought written consent from clinicians to observe their work for the entire duration of the study when introducing it for the first time. I then sought verbal consent for observation from

Table 1 *Details of interviewed clinicians*

<i>Pseudonym in study</i>	<i>Professional profile (some details have been changed for confidentiality reasons)</i>
Ella, podiatrist	Research podiatrist; employed by the university
Phil, doctor	Clinical research fellow, background in surgery and general practice; employed by the university
Amanda, nurse	Former district nurse; advanced specialist nurse; employed by the university
Eva, nurse	Former acute care nurse; employed by the university
Mary, nurse	Former district nurse, wound research nurse; employed by the university
Christina, director of clinical education	Background in psychiatric and general nursing; employed by the university
Claire, tissue viability nurse	Part of the community wound healing team; employed by the NHS
Deborah, tissue viability nurse	Background in community nursing; employed by the university
Kate, doctor	Wound healing clinical fellow, doctor in training, general surgical registrar background; employed by the university
Sam, podiatrist	Advanced podiatrist; employed by the NHS
Megan, nurse	Nursing background in surgical emergency admissions, wound research nurse; employed by the university
Wound healing consultant	Acclaimed consultant, runs an academic department of wound healing; employed by the university
Julia, lymphedema therapist	Radiographer specialising in lymphedema, in combined Morgan Clinic; employed by the NHS
George, vascular surgeon	Vascular surgeon, in combined Bridge Clinic; employed by the NHS
Andrew, prosthetist	Prosthetist, in combined Bridge Clinic; employed by the NHS
Camilla, paediatrician	Paediatrician not affiliated with wound healing; employed by the NHS
Catherine, diabetic nurse	Diabetic nurse in combined Bridge Clinic; employed by the NHS
Jordan, orthotist	Orthotic and prosthetic scientist in combined Bridge Clinic; employed by the NHS
Helen, orthopaedic specialist	Podiatrist working with foot and ankle surgeons in combined Bridge Clinic; employed the NHS

anybody in the room in the presence of a fully consenting healthcare professional. When medical visitors were in clinics, I would join them in shadowing a consultant, who would secure permission from patients for us to observe. In the absence of visitors, I remained in one treatment room with permission from clinicians. Participation in my interviews was voluntary. All but two clinicians approached agreed to be interviewed, either in clinics or in their university offices.

Data analysis

The fieldnotes and verbatim transcriptions of audio-recorded interviews were analysed in a 'detective-like approach' (Sherer 2019). According to Sherer, this approach is suitable for a study

of professions when ‘something seems odd’ (2019, p. 94) about the observed phenomena but considerable information is not readily available to resolve the puzzle. While sociological literature alluded to wound healing as dirty work, casual conversations with wound healing clinicians about their desire to enter the medical mainstream led me to editorials in relevant journals as academic support for my observations of their efforts to legitimate wound healing. As Bolton (2005) noted is often the case, casual conversations and reactions to observed interactions between actors in the field may provide great insights for understanding dirty work.

The data were analysed manually, repeatedly moving between the literature and the data. Coding employed a two-stage analytical method recommended by Gioia et al. (2013). Accordingly, I began by identifying relevant groups of words, distinguishing them as 1st-order concepts with the participants’ own words or my descriptive phrases. Then, I searched for similarities and differences among the codes to group them into 2nd-order themes, derived from my reading of the data and the literature on dirty work, professions and wound care. Finally, I collected similar themes under a 2nd-order aggregate dimension. To visualise the interrelationships between the codes, I assembled them into a data structure (Table 2).

Table 2 *Data structure for professional project for wound healing*

<i>1st-order concepts</i>	<i>2nd-order themes</i>	<i>2nd-order aggregate dimension</i>
Wound healing work is physically dirty Limitations in understanding and knowledge about wounds Seeking professional legitimacy in the medical community	Social situation of wound healing	Establishing and contesting professional boundaries around ‘dirty wounds’
In-house training for nurses in clinics Skills that wound healing clinicians should have Nurses’ position in clinic undermines medical hierarchy	Challenging medical hierarchy in work setting	
Reasserting medical hierarchy between nurses and doctors Educating medical students on dirty wound care Scientification of dirt Discursive professional marker: ‘woundology’ Educating other clinicians about wound care	Reaffirming and contesting professional boundaries	
Professional boundaries and multidisciplinary Struggles with jurisdiction – specialists, generalists or orchestrators? The value and unrecognised complexity of wound research Scientific development of wound healing The profile of wound healing is changing	Asserting professional credibility through research	

According to Gioia et al. (2013, pp. 20–21), building a data structure is a crucial step in demonstrating rigour in qualitative research. Moreover, it 'compels us to begin thinking about the data theoretically, not just methodologically'. The remainder of the paper elaborates this data structure.

Wound healing and dirty work: a professional project

A patient in a wheelchair is brought into the clinical room . . . with heavy dressings on both her swollen legs, she is unable to transfer onto the bed on her own, so her brother and nurse Eva gently position her on the couch. As doctor Carrie, a surgical registrar, takes the bandages off, a pungent smell of rotten flesh 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 – dead. The wound healing consultant is called in. He lifts the patient's foot and holds it up in the air, close to his face, so that Carrie can begin 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.

(fieldnotes, July 2016).

The above vignette from my first visit to Bridge Clinic illustrates why wound care tends to be perceived as dirty work. The evocatively captured activities bare their underpinning physical 'dirt', visible in viscerally repugnant skin tears (Ashforth and Kreiner 1999). Here, the paradigmatic dirty work fell in the hands of doctors, rather than nurses as the literature would present it (e.g. McMurray 2012). In Sherer's words, 'something seem[ed] odd' (2019, p. 94). Soon after, nurse Amanda described an emerging and, in her view, overdue change in how wounds and wounds healing were seen in the medical community:

[Wound healing] 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'. But we know, and particularly from our clinic, that you need that multidisciplinary team, you need podiatrists, you need researchers, you need the clinical academics, you need [consultants], you need nurses.

On the surface, the medical community's recognition of the said 'scientific knowledge' of wound healing may still be hindered by connotations with working with feet – the most inferior and, literally, dirty part of the human physique. Moreover, at the time of undertaking this research, medical training placed little emphasis on wound care in the university curricula across the UK and specialist wound healing clinics were far and few. As a result, there were limitations in terms of knowledge and skills, misunderstanding of wound healing as a specialism and under-appreciation of its value:

'Oh, I don't know how you do your job, I don't know how you deal with feet all day' . . . 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 . . . Health-care professionals, that is the big challenge at the moment, getting people to understand the role that we do, the work we do with wounds, and getting people to recognise us. (Sam, podiatrist)

To elevate the profile of wound healing, clinicians simultaneously did three things. Firstly, they took steps in the direction of standardising wound care by training nurses to do medical wound care tasks traditionally assigned to doctors. Secondly, they tried garnering the interest of other clinicians in their dirty work through continuously negotiating flexible professional

boundaries in a way that respected the professional hierarchy. Thirdly, they emphasised the academic and research-oriented nature of their work.

Standardising wound care: training nurses to perform medical tasks

As recognised in wound management literature (Madden 2012), much of wound care in the UK is undertaken by nurses. This was the case in these wound clinics. Nurses often managed the entire medical encounter: from collecting patients from the waiting area, through gathering medical history, examining the wound, diagnosing and deciding on the care plan before sending patients home with a carefully crafted intervention plan, with indicators for treatment success. Thus, in these clinics, nurses had the autonomy to work independently above their normal role.

However, it was felt that UK nurses in general, at the front line of care for patients with wounds, did not always have the knowledge and skills needed to manage the wound or to help it heal.

I think there is an awful lot of patients out there that are getting poor wound management because the healthcare professional, whether it would be the nurse or the podiatrist, do not have the knowledge and skills. (Christina, director of clinical education)

One strategy for elevating the status of wound healing involved the wound healing consultant providing nurses with the required in-depth theoretical knowledge and practical skills. This included the ability to: diagnose wounds, identify healing and non-healing, attend to wound infection and choose local personalised treatments. In practice, the consultant would ask the nurses to perform a diagnosis or recommend a treatment plan before giving his medical verdict:

[Wound healing consultant] asks the nurse present in the room to suggest what treatment is needed. 'I'd use antimicrobial dressing,' she says. He confirms that the nurse is, indeed, an expert. (fieldnotes, Morgan Clinic, November 2016)

... if I wasn't there, they would have nobody to teach them. (wound healing consultant)

In addition, nurses in these clinics were taught by the consultant to surgically debride wounds. Debridement involved removing the build-up of dead tissue and debris with a scalpel. Physically, debridement could be considered a dirty work task, because it required nurses to maintain proximity to yellow slough or black necrotic tissue surrounding the wound. However, symbolically, it was 'cleansing' for the nurses, because being able to debride conveyed their uniqueness in these clinics from having superior knowledge and surgical skills to work above other nurses unable to implement this standard of care in their own practice.

He does that all in the clinic so he would supervise us for that because that's a skill that's unique to us whatever. I wouldn't expect every nurse to debride, you know, you see us with a scalpel, that's unique to us, that's not what you would see you right across the board. (Amanda, nurse)

In training nurses in this particular work setting to do the medical tasks elsewhere seen as belonging to a specialist domain, the consultant was taking local steps in the direction of standardising all wound care. However, as explained by podiatrist Ella, part of his job was to disseminate wound healing knowledge and improve standards of care beyond these focal clinics. For example, the consultant used to visit other healthcare settings to give advice on treating patients with complex wounds.

A nurse new to this clinic says to the consultant that she met him 25 years ago in a clinic, when he was called in to give advice on treating a patient with a pressure ulcer so deep that it was possible to put an entire arm in it. The consultant then told her what to do (and what not to do) about the wound. A year later, she cured the patient. This is when she got interested in wounds. 'It is my fault, then', jokes the consultant. (fieldnotes, Morgan Clinic, December 2016)

Therefore, there was some evidence that the efforts to educate nurses about wound healing and 'sell' wounds, generally seen as dirty, were bearing fruit.

Reaffirming and contesting professional boundaries

In general, the wound healing consultant eagerly delegated some medical tasks to nurses. Moreover, doctors sometimes relieved nurses of some of dirty tasks, like cleaning wounds:

Doctor Phil walks into the room and, as nurse Megan starts getting her equipment ready to clean the patient's wound, Phil offers to relieve her. As he sits at the bottom of the bed and starts removing dead skin from the wounded foot, the patient looks at me, his foot and doctor Phil in disbelief, uttering an amazed 'I can't believe [he is doing it].' (fieldnotes, Davis Clinic, March 2017)

The division of labour in the dirty wound healing tasks was blurred. Doctors and nurses alike would get 'their hands dirty', 'dealing with drainage from wounds' (Thomas 2014, p. 905). Even the wound healing consultant was occasionally seen rolling up his sleeves and clearing couches. As he explained, 'it's trying to create a sense of worth or a sense of ownership or a sense of commitment in the team to say that we're all in this together'.

Despite this, doctors used their strategies of standardising wound care across the hierarchy of occupational groups strategically. On some occasions, as described above, they blurred the hierarchy by freeing nurses from work of a perceived lower status. On others, however, they reasserted the hierarchical structure by placing limits on the delegation of medical tasks (see Broadbent, 1998).

The nurses play a massive part in choosing local treatments, but in terms of other more systemic treatment those tend to be down to the doctors. (Kate, doctor)

Nurses did, indeed, perform most wound care work because of their significant role in managing consultations. And yet, as explained by doctor Kate, in choosing systemic treatments, doctors remained 'the medical practitioner as opposed to the nursing person in the consultation'. There was a purpose to the preservation of some hierarchy in professionalising wound healing. Doctors' occasional involvement in dirty wound care tasks reaffirmed the message of 'we're all in this together', but it also helped clinicians build a closer integration with medicine for the wound care specialism precisely because their involvement in dirty tasks was demarcated as occasional. Reasserting professional boundaries between 'medical practitioners' and 'nursing persons' sought to reassure the medical establishment of the fit of wound healing with the medical mainstream because if all occupational groups did the same wound care tasks, it could weaken the said integration of wound healing with the hierarchical structure of medicine. Maintaining some traditional ways of working, aligned with the professional hierarchy, was the 'logic that spoke to' the medical community (Mizrachi *et al.* 2005), whose approval wound healing clinicians were seeking.

Another logic familiar to the medical community, which wound healing clinicians took advantage of, was the conception of wound healing as 'dirty work'. Therefore, clinicians did not vehemently oppose the dirty designation. Instead, they exploited this view as a starting

point for conversations to demystify the specialism for interested and potentially interested visitors to the clinics, such as healthcare providers from other specialties and medical students. For example, the wound healing consultant once joked to the medical students in Davis Clinic, 'You need an afternoon off after seeing wounds all week, you will need to hide in a dark room and cry' (fieldnotes, October 2016). 'You wouldn't get excited about scabby feet, would you? It's a tough job, but somebody's got to do it', he added.

The above quote suggests that clinicians located the ungraceful aspects of wound care within the boundaries of medical science. As wound healing specialists, they had to be professionally comfortable with ungraceful sights and unpleasant smells. They knew they had to sidestep their own bodily reactions and focus on implementing best practice to heal the wound:

... by looking at the underneath, you are actually seeing what's going on ... the internal side. People very often go, 'Eww, that's disgusting, eww, that's gross' but actually, that's probably the best side of the job because that's what gets the job done and that's what gets the wounds healed. (Sam, podiatrist)

As further explained by Sam, it did not matter how the physical aspects of wounds made clinicians feel. Primary emphasis was on actively healing, and symbolically cleaning, dirty wounds through scientific medical interventions. It was the biomedical knowledge about wounds that 'made' medical wound healing specialists, or 'woundologists', as the wound healing consultant described them.

The term 'woundologist' was an important, symbolic boundary marker of wound healing clinicians' professional project. The consultant used it repeatedly to humorously reaffirm the centrality of dirty wounds to the specialty's jurisdictional boundary vis-à-vis other medical occupations:

... there was a set of famous adverts on the TV ... If you didn't have an 'ology', it wasn't a science ... To say, if you've got a problem with your heart or your guts, cardiologist, gastroenterologist. ... who do you go and see if you have a problem with a wound? It could be anybody. And I would argue that if you have a problem with a wound, you should go and see a 'woundologist.' (wound healing consultant)

The informal discourse of woundology signalled a desire for changes in the professional perception of wound healing. However, 'woundology' as a professional boundary marker was also contested. As explained by Christina, 'wounds apply to people, not specialisms, to neonates, to palliative care of the elderly'. Therefore, wound healing clinicians needed to collaborate with other healthcare providers. As doctor Kate observed, '... the wound healing consultant will ... say, "I'm not a diabetologist, refer them back to get that sorted out and we'll just be the kind of conductor of the orchestra with the wound at the centre of what you're trying to achieve."' Therefore, wound healing clinicians had to treat patients holistically; they needed to 'be more of a generalist than a specialist' (Phil, doctor).

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 [the patient's case] back. If you can't do it, still give [the patient's case] back to me so that I will still sit in the middle.' Not taking ownership – sounds too paternalistic. But it's my responsibility to coordinate care for that patient. So, 'We've had the opinion from that specialist. Right, it's not the operation. We've had the opinion from that specialist. We can't give you that drug. We've had the opinion from that

specialist that you've got to get your diabetes under better control before we can help your foot ulcer.' So, that's how I see it. (wound healing consultant)

The jurisdiction of clinical wound care overlapped with those of other specialties. This required a close multidisciplinary collaboration without inadvertently devolving the responsibility for patient care to other specialisms and losing sight of the importance of wound care. The wound healing clinicians addressed it by practising 'orchestration' (Wallace and Schneller 2008). Jurisdictional interdependencies were embraced opportunistically for two-way upskilling across occupational groups. In interacting with other clinicians in combined clinics, 'woundologists' increased their knowledge base, from which they could then draw when working independently. Likewise, other specialists said they gained from the expertise in the wound clinics. In saying that, they reaffirmed wound healing clinicians' knowledge as at least partially distinctive and deserving of professional credibility:

We're reasonably good at removing bits that need to be removed, but we are not as good at the healing of the wounds. And I think that what the wound healing consultant brings to the partnership, really, is an expertise in local wound healing. (George, vascular surgeon)

I've been coming to the combined clinic ever since and I've found it very beneficial to me. [Wound healing consultant] is very inclusive, and couches you, encourages you to come, to be a part of that and it's not something that I want to stop. (Andrew, prosthetist)

Therefore, the development of the treatment of wounds as a clinical specialty may have come at the cost of blurring its professional boundaries. Albeit fuzzy, they were boundaries nonetheless, providing the basis for recognising a specialty focused on wounds, made richer through interdisciplinary discussions with other clinical fields.

Asserting professional credibility through research

The final piece in the complex jigsaw of the professional project for wound healing was medical research, in which clinicians tested new treatment techniques with support from outpatients met in the clinics. According to the wound healing consultant's estimates, approximately 12 per cent of the patients attending the clinics were simultaneously taking part in clinical trials. Wound research happened on the academic side of the clinics in a nearby university and was not observed in the outpatient NHS clinics that were the setting for this ethnography. However, the significance of wound research for elevating the profile of wound healing emerged clearly in interviews with clinicians as part of their professional project:

... although we were seeing lots of patients, we weren't doing much research. So, to give us academic credibility we needed to create this academic group. (wound healing consultant)

Clinical academic nurses reported that their involvement in wound research put them in a privileged position that led to the extension and the expansion of their role as wound care providers (McDonald *et al.* 2009). Regarding the former, the opportunity to trial new products meant that nurses could gain new knowledge on treatment and work 'out of the normal range' (Amanda, nurse). Concerning the latter, their academic commitment to the subject granted them access to additional scientific resources for raising their expertise, which they saw as a positive change for the aspirant profession of wound healing:

It is not just about putting a dressing on. Now you've got all the AMPs [antimicrobial peptides] behind it, you've got all the science behind it. So yes, it is moving in that way. But

the knowledge you gain from working with someone like the wound healing consultant is unbelievable, and he does share his knowledge, which is good. We do a lot of reading, we read a lot of journals. We do the research side, you have to write. So, when you are writing up things you obviously have to gain knowledge from reading other things. (Mary, nurse)

The quote above shows that clinical academic nurses enjoyed a degree of autonomy to read journals and publish their research. However, they also acknowledged they leaned on the consultant doctor to acquire new knowledge in support of their research. Professional progress for nurses appeared linked with the doctors' willingness to strategically contest the professional medical hierarchy and the division of knowledge it implied. Nonetheless, for the wound healing specialty as a whole, research facilitated the advancement of the professional project.

Timmons and Nairn (2015) note that recognition of a full specialty in UK medicine is symbolically linked with the creation of a specialist college. Using this criterion, wound healing did not yet enjoy full recognition at the time of this research. However, the position of wound healing clinicians as academics creating links between their occupation on the one hand, and training, education, multidisciplinary collaboration and research on the other, enabled them to progress their professional project (Broadbent 1998, Larson 1977, p. 503). To conclude with the words of the wound healing consultant:

For somebody who's been involved in this for a number of years where you were a voice crying in wilderness . . . I'm now at the stage where I can look back and say, 'Okay, there is still an awful lot to be done, but I can honestly see progress has been achieved over the last 20-30 years.'

Boundary demarcation for 'woundology'

This article has examined the professional project for an emergent subaltern specialist community of wound healing clinicians. It has argued that to challenge the devaluing designation of their work as 'dirty' and elevate their status in medicine, clinicians are drawing boundaries around the best practice of caring for 'dirty' wounds through teaching across professional healthcare hierarchies, collaborating across medical silos and undertaking academic wound research. Moreover, the article has distinguished a discursive strategy used by clinicians to symbolically demarcate their professional practice around the scientific foundation of a specialism of 'woundology'.

The approach to dealing with the designation of one's work as dirty presented here is different from most dirty work studies, which focus on how individuals discursively counter the stigma conferred by dirty work on their personal identity. Instead, in this article I have followed Adams (2012) in showing how dirty work can be legitimated through highlighting its alignment with the cultural authority of medicine. In addition, like Bolton (2005), I have stressed actual activities that drive a change in the perception of dirty work, and not just symbolic struggles around the meaning of 'dirty'. Finally, my research advanced the theorising of handling dirty work with use of the literature on professionalisation and boundary work (Gieryn 1983), alluded to in this journal (Håland 2012).

Gieryn's (1983) conception of boundary work to mark out distinctions between professional entities as 'ambiguous', 'flexible', 'contextually variable' and 'internally inconsistent' (p. 792) is particularly useful for theorising my findings about the aspirant specialism of 'woundology'. My engagement with the concept of demarcation presents it as a process of combined strategies that make professionalisation both multidimensional and nuanced. As Mizrahi *et al.* (2005) have observed, the drawing of boundaries between healthcare professions may entail simultaneous processes of exclusion and domination on one side, and inclusion and

containment on the other. I have demonstrated similar contestation in wound healing clinicians' handling of a lack of distinctive body of knowledge over which they could achieve complete jurisdictional closure. Their inclusive orientation towards multidisciplinary collaboration, coupled with their desire to 'sit in the middle' of the processes of coordinating care for patients with wounds, revealed the importance of orchestration in establishing their professional, boundary-spanning role (Wallace and Schneller 2008). Therefore, wound healing clinicians claimed jurisdiction over orchestrating the care of dirty wounds as a resource for demarcating 'woundology' in a way that Abbott's (1988) notion of jurisdiction would overlook. In this context, they did not have to 'contend' (Abbott 1988) with other specialties because the general level of interest in the dirty activities of wound healing was relatively low.

The acceptance of an unbreakable connection with physical 'dirt' was key for improving the standards of wound care. The explicit framing of wound care work as dirty, in collaboration with other healthcare providers and medical students, was a basis for demystifying misunderstandings about what wound healing work involved. To outsiders, it offered a form of stigma preview, which Ashforth et al. (2017) conceptualised as a technique for adjusting newcomers to stigma by offering them a realistic job overview. The authors noted that 'stigma preview' might not apply to higher-status occupations like medicine, where exposure to job 'dirt' normally occurs in formal education. However, this was not the case for wound healing, which was overlooked in medical educational curricula. Here, Gieryn's (1983) conception of boundary work helpfully underlies how specialties can exploit various features of their scope of practice, depending on where they want to draw their boundaries in any given context and what goals they want to achieve. Wound healing clinicians drew on dirty characteristics of their work as a practical heuristic for garnering the interest of other members of the medical community in the poorly understood field of their work.

In the background of the woundology-medicine boundary work, the professional project for wound healing featured a second type of subtle boundary work between nurses and doctors. Broadbent (1998) and, later, McDonald *et al.* (2009) called attention to the nursing profession having their own project for elevating their status from that of 'para-medical professionals' (Mizrachi *et al.* 2005, p. 34). In these clinics, doctors generally supported this project. They took on the dirtier aspects of wound care and they supported nurses' new skills to help them deflect taint through offering them new tasks, elsewhere seen as specialist. Undoubtedly, the meaningful blurring of the occupational division of labour created a more egalitarian system of care that challenged the relegation of work by doctors to nurses, with the said 'relegation' seen as the defining feature of dirty work (Ashforth and Kreiner 1999). However, nurses were still performing most of the dirty tasks; changing dressings was a 'nurse thing' (McDonald *et al.* 2009, p. 1209). Therefore, it was impossible not to notice some links with 'the structural and historical parameters of patriarchal-capitalism' (Witz 1992, p. 102) in medicine. Although the nursing-medical boundary became blurred, some hierarchical structure remained.

As explained by Gieryn (1983, p. 792), ambiguity in boundary work has 'several structural sources. First, characteristics attributed to science are sometimes inconsistent with each other because of scientists' need to erect separate boundaries in response to challenges from *different* obstacles to their pursuit of authority and resources'. In the professional project for wound healing, empowering nurses to do medical wound care was a strategy for improving the standards of the specialism as a whole. Research, in particular, was the cornerstone of wound healing specialisation (Weisz 2006) and nurses were involved in conducting scientific studies and publishing their results. However, the simultaneous reinforcing of boundaries between nurses and doctors in some aspects of care was a way of marking the fit of woundology with the medical establishment. As Gieryn noted, '[s]o secure is the epistemic authority of science these days, that even those who would dispute another's scientific understanding of nature must

ordinarily rely on science to muster a persuasive challenge' (1999, p. 3, cited in Mizrachi *et al.* 2005, p. 31). Likewise, Adams (2012) observed that stressing one's alignment with the cultural authority of medicine is a way of legitimating dirty work. Here, the hierarchy between occupational groups of nurses and doctors was undermined when the goal of the wound healing project was growing 'woundology' as a standardised specialism, but it was highlighted when the goal was to fit with the mainstream medical community.

More research is needed to explain the relationship between the nurse-medical boundary work and woundology-other specialisms boundary work in the professional project for wound healing. This article identified ambiguity to these co-occurring dynamics. However, further research is needed to theorise the identified conflict in the data beyond the insights on the embeddedness of medical boundary work in the fluid dynamics of inclusion and exclusion borrowed from Allen (2000) and Mizrachi *et al.* (2005). For example, future sociological research could explicitly examine the part that developing a specialist wound care nurse role (Bale 2002) plays in the professional project for wound healing. It is also unclear whether wound healing clinicians' embracement of jurisdictional interdependencies in assuming the orchestrator role could grant them recognition as an 'individual' clinical specialty. Moreover, while I focused only on clinicians who were insiders to growing the profile of wound healing, which is common in research on professional projects (Broadbent 1998, McDonald *et al.* 2009, Timmons and Nairn 2015), the inclusion of a comparison case (Adams 2012) or seeking the opinions of other healthcare providers would allow for a better understanding of whether wound healing clinicians managed to 'enthral' the medical community.

That said, existing studies of professional projects recognise that such projects do not always have to be fully realised to make a meaningful difference to practice (McDonald *et al.* 2009). A professional project is precisely that – a project, not a static entity, but a process of drawing boundaries. Demarcation is not analytical but is achieved practically in everyday settings (Gieryn 1983). The professional project of developing wound healing as the science of 'woundology' is ongoing, faced with tensions and in need of future sociological attention.

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Author Contribution

Anna Milena Galazka: Conceptualization (lead); Data curation (lead); Formal analysis (lead); Funding acquisition (lead); Investigation (lead); Methodology (lead); Project administration (lead); Resources (lead); Software (lead); Validation (lead); Visualization (lead); Writing-original draft (lead); Writing-review & editing (lead).

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Patient consent statement

Not applicable for this article.

Permission to reproduce material from other sources

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Research data are not shared.

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