Field, place or space? A carnal ethnography of a therapeutic space-construct

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"What is a field – place, space? Or set of relations, people you live with in a particular field?" (Dr Felipe Neis Araujo speaking at the 'AHRC Network for Rethinking Research Ethics Frameworks and Processes' workshop on the 'Challenges and Problems of Conducting Ethical Qualitative Research' at the University of Manchester, 21st April 2022)

Introduction

The above question, posed in a panel presentation on post-field research ethics, encouraged me to reflect on the differences between the concepts of field, space and place in ethnography, and on the part played by the ethnographer in co-constructing their story of the examined social reality. Admittedly, I was not the first scholar to do so. For example, Kociatkiewicz and Kostera (1999) offered a narration of the spatiality of the field in a self-reflexive ethnography of empty organisational spaces, simultaneously conveying subtle differences between the three concepts. In their reading of Van Maanen (1988), 'field' has a professional quality as an unknown entity that draws in an ethnographer, who then makes sense of the unknown through their identity, curiosity, experiences and imagination. 'Place', as Kociatkiewicz and Kostera (1999) argue with support from de Certeau (1984: 116–117) is objective; a stable configuration of existing positions. Finally, 'space' is a place that has been practiced through time and motion, such that "what has happened in that place in the past shapes its future characteristics and possibilities" (Herod et al., 2007: 255). In this article, I make these abstract distinctions more concrete by empirically fleshing out an example of what I hereby frame as a therapeutic space from my fieldwork in places of community care.

Specifically, I draw on my polymorphic ethnographic research (Alvesson and Gabriel, 2013) in the Lindsay Leg Clubs – community organisations providing social support and wound care to older, often socially isolated individuals with unsightly, malodorous and stigmatising leg wounds. I explain the Leg Clubs as therapeutic spaces, co-constructed by patients, volunteers and nurses who mark the places of care with 'traits' (Deleuze and Guattari, 1988: 51) that make them meaningful, as well as by the ethnographer, initially attracted to the unknown field with academic curiosity (Van Maanen, 1988), but with time starting to act out aspects of the social reality (Wacquant, 2015). Such an explanation necessitated a level of intellectual understanding and visceral appreciation, of the kind

offered by a carnal ethnographic approach (Wacquant, 2015). In this text, I use the carnal perspective to focus on people's sensorial (Pink, 2009) navigation of the Leg Clubs, which have their own meaningful 'history of becoming' (Dutkiewicz, 2015). I show how these features become inscribed in the bodies, minds and hearts of patients (members, as explained below), volunteers and the ethnographer in a way that turns Leg Clubs into a therapeutic space-construct built around social relations of wound care community and de-stigmatisation.

The paper is structured as follows. I start with introducing Wacquant's (2015) carnal ethnographic approach as an alternative to mainstream ethnography, before outlining the polymorphic qualities of my Leg Club research. I then present the history of the Leg Clubs as embedded in social structures of the sick patient role (Parsons, 1951), followed by a carnal, multisensorial and reflexive reading of my ethnographic fieldwork. The discussion unpacks the Leg Clubs as a therapeutic space-construct. In my conclusion, I respond to the invitation contained in the opening quote to reflect on the field-place-space distinction and end with a brief consideration of the implications of my analysis for our understanding of the wider social practice of care.

Introducing the carnal ethnography approach

Mainstream ethnography has long favoured an objective approach to fieldwork, grounded in the Chicago tradition of observation from distance to protect the purity of the research. In such a mainstream approach, field is a foundational part of any ethnographic research. Access to the field is at the heart of extended observational work and relationship building aimed at understanding behaviour, activities and value systems in a particular setting (Buskermolen, 2023). By access to the field, we commonly mean permission to visit a physical place and spend time with the people who navigate the said place. We talk about entering the field, doing the fieldwork, and then leaving the field to refer to the stages of ethnographic research that happen in separate temporal slots outside and inside the specific places which bring together the people whose culture we are investigating. Field is, therefore, a concept that qualifies as a professional, or researcher's, category; something that the researcher can understand objectively and at a professional distance from it.

In contrast, there are scholars who challenge as naïve the unproblematic transfer of knowledge from the field and its participants to the researcher (see Mees-Buss *et al*, 2022). Wacquant's (2015) social ontology of carnal reflexive ethnography is one such approach. Recognising the interpretive challenges of understanding participants' live experiences – that "facts do not speak for themselves"

(Van Maanen, 1979: 416) – Wacquant (2015) calls on ethnographers to use their bodies as a research instrument to experience the field sites on a physical, sensorial and emotional level. Such carnal engagement can help appreciate the visceral dimension of human life and the embodied quality of cognition (Cerulo, 2015), made possible because by virtue of being carnal persons we can experience aspects of the human life in the same way as our study participants do (Contreras, 2015). Firstly, we are all sensate creatures, who experience the world through our senses and make sense of these experiences. Secondly, we suffer when our needs or wants are unfulfilled. Thirdly, we acquire and develop skills, through which we can make a difference to the worlds. Fourthly, we cultivate, or sediment, these skills over time. Fifthly, the way we accumulate the skills is an aspect of the specific context of our body situation vis-à-vis considerations of structures, such as roles, biography, occupation, ethnicity, or class, as not just external constrainers but also "dynamic webs of forces inscribed in the body as perceptual grids, sensimotor capacities, emotional proclivities, internal springs" (Wacquant, 2015: 3).

All these aspects of the carnate agent allow people to understand other people's social life if they enmesh themselves in the phenomena they study (Contreras, 2015). To realise the potential of the carnal sociology approach, ethnographers are encouraged to follow the method of enactive ethnography: "immersive fieldwork through which the investigator acts out (elements of) the phenomenon in order to peel away the layers of invisible properties and to test its operative mechanisms" (Wacquant 2015: 5). Doing the activity brings ethnographers in proximity to the phenomena being studied for a deeper understanding of the unfamiliar world. Here, the body is central as an instrument to understand the world and to produce knowledge not just intellectually as stacks of information but also viscerally as a carnal know-how.

To explore whether and how Wacquant's approach of tuning your body into the fieldwork could help me better delineate the field-place-space distinctions in ethnographic research, I decided to apply the carnal approach to my ongoing ethnographic engagement with the Lindsay Leg Club community.

Research context: introduction to carnal ethnography of Lindsay Leg Clubs

Lindsay Leg Clubs are organisations which operate at the nexus of health and social care and the charity sector. They were established in 1995 in Suffolk, England, UK. Currently, there are over 40 UK Leg Clubs, with additional ones in Australia, Germany, Finland and Italy, and the USA. Lindsay Leg Clubs are community sites where older people with, or at the risk of developing problems with

legs, can socialise with peers and receive drop-in, appointment-free care from National Health Service (NHS) nurses in a collective space. Leg Clubs operate from non-medical spaces, such as community or church halls to de-medicalise the leg problems as a disabling health condition. Patients are referred to as members, in an active effort to help them step out of the disempowering 'sick patient role' (Parsons, 1951). They are treated alongside each other in an open area by nurses, who are released into the Leg Clubs from their local NHS medical practices. Leg Club venues are organised and run by community volunteers, who are often retired community members willing to offer their time and resources to the betterment of the social condition of their local community.

The opening of the physical Leg Club must always start with a team of volunteers getting together to find a physical venue that would meet the requirements to deliver safe medical and social care. The place must be inclusive, with a kitchen, an accessible toilet and a private room for individual treatment upon request. The venue must be able to be divided into two sections – a section for collective treatment, where nurses can work together, and a section for social activities, where members await their treatment and/or socialise over refreshments organised by volunteers. It should also be possible to separate the two spaces, ideally with a medical screen. Each Leg Club should have a sluice room – a closed area for the safe disposal of human waste (such as water after washing of the legs) to prevent the spread of infections. In this case, the operation of the Leg Club, and the possibility of doing fieldwork in the Leg Club, is tied to the presence of a particular physical *place*, with a given layout, in a certain location, where specific material artefacts are available. Members and volunteers own their Leg Club and have the power to use the place where Leg Clubs are hosted to fit their physical and social needs. As I show below, they can 'practice place' in a way that turns it into a *space* that they own (de Certeau 1984: 117) – a space social support and community building, which feeds on people's in-person presence and the sociality, creativity, empathy, and serendipity it gives rise to.

As Mears (2013) argues in her carnal ethnography of fashion modelling, not all kinds of research contexts easily lend themselves to fieldwork through shared physical experience if the researcher has no prior personal experience of the setting. Studying gang activity (Contreras, 2015) or self-harm (Harris, 2000) come to mind. Drawn into the Leg Clubs as my ethnographic *field* (Van Maanen, 1988), I knew that a full bodily immersion in the nursing role was out of the question given my lack of a medical background. I also knew that Leg Club members' and volunteers' experiences required a type of physicality that I did not (yet) have (an elder body; and/or frail skin and weaker blood vessels due to ageing; and/or an ulcerated leg). However, some intellectual and visceral training for

understanding the experience of wounds and their treatments came from my doctoral research into clinician-patient relations in tackling the stigma of wounds and wounds care *[citation removed for review]*. My ten-month-long ethnographic interactions with patients, doctors, nurses and podiatrists in specialist outpatient clinics equipped me with some knowledge of the aetiology and manifestation of various types of wounds and their treatment, as well as an empathetic appreciation of the visceral experience of living with ghastly, smelly, weeping wounds that kept many patients home-bound, embarrassed and isolated. Reflecting retrospectively on time spent with members and volunteers, tasting the same refreshments, listening to the same background music, shaking the same hands, gently tapping the same shoulders, hearing the same heart-breaking stories, and, to say brusquely, 'smelling the same wounds', I realise I developed "*the operant capacity to feel, think, and act like a Whatever among the Whatevers*" (Wacquant, 2015: 7). Specifically, this compassionate social competency helped me become part of the Leg Club community. I offer a contextual timeline of this 'becoming' in the below account of my non-formulaic data collection (Alvesson and Gabriel, 2013).

Data collection

The data used in this article come from my ethnographic research carried out in the Lindsay Leg Clubs through various, multiple field engagements between September 2019 and March 2023. My first encounter with the Leg Clubs was serendipitous. During my PhD in outpatient wound clinics, one patient, whose consultation I was observing, told me she was a member of a Leg Club in her locality and invited me to visit the place. Captivated with the social health potential of what I saw, I later embarked on an ethnographic service evaluation of social value generation in the Leg Clubs. In the words of Yanow (2009: 189), although my choice of the Leg Clubs for my research field did not "originate in the academic literature" nor was "selected arbitrarily", my research was "no less scientific because of this".

This first 'leg' of my research was based on a 'relaxed ethnographic approach' (Lindsay, 2018: 111), which consisted of observations of life in the Leg Clubs and informal unrecorded chats with members and volunteers. The data collection lasted between October 2019 and January 2020. During this time, I repeatedly visited six UK Leg Clubs and spent 54 hours with members and volunteers, observing the unfolding activities and participating in them[1]. As 'more observer than participant' (Neyland, 2008), I spent my time watching how members and volunteers circulated in the Leg Club

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[1] My research was confined to the social side of the Leg Clubs, with nurses and nursing care excluded.

spaces, taking up their positions at the tables, participating in social activities, enjoying or serving refreshments, or undertaking light group leg exercises or sing-alongs (Wacquant, 2015). I also had numerous informal chats with the people in the Leg Clubs, out of whom 12 members and 13 volunteers provided written consent to share their stories.

In addition, I conducted a biographic interview with the founder of the Lindsay Leg Clubs, Ellie Lindsay OBE. The interview took place in April 2020 on Zoom and lasted two hours and 12 minutes. My relationship with Ellie as my key informant grew stronger over the course of the research as I shared versions of my various publications *[citations removed for review]* and my final study report *[citation removed for review]* with her. When the Covid-19 pandemic broke out, brining all UK Leg Clubs to a temporary standstill, I continued speaking to Ellie, and, with her support, speaking about my work at online global public health events (spring 2020, 2021, 2022 and 2023) and virtual meetings with Leg Club industry partners (September 2021, June 2022). With the easing of the coronavirus restrictions, I also attended three political meetings focused on advocating for older adults with leg problems (winter 2022 and 2023 and spring 2023). While issues around ethnographic truth run through my mind as our field relation grew (Van Maanen, 1979), my ongoing contact with the Leg Club volunteers practising the care 'on the ground' kept me 'grounded' in the perspectives of multiple and varied actors in the Leg Club community.

Alongside my virtual and in-person advocacy, I completed two further studies in the Leg Clubs. Between May and August 2022, I run a qualitative analysis of mostly semi-structured interviewees with 16 volunteers from three UK Leg Clubs, which aimed to explain the motivations for volunteering, experiences of volunteering and volunteers' objectives for the future *[citation removed for review]*. In November 2022, another study was conducted to evaluate the feasibility of introducing a customised technological solution, such as a mobile application, for volunteer communication in the UK Lindsay Leg Clubs *[citation removed for review]*. This final research was conducted in three Leg Clubs and involved qualitative interviews with 11 volunteers from the same Leg Clubs as in the second study.

In my polymorphic approach to research (Alvesson and Gabriel, 2013), in-between my field engagements, I became a volunteer project consultant to the Leg Club Foundation in recognition of my multiple policy and industry research-led presentations. Thrilled and conflicted, I struggled to manage my positioning to find a golden medium between being an intimate insider and an analytical distanced outsider (Neyland, 2008; Ybema and Kamsteg, 2009). It was true that I was neither an

elderly person with a leg ulcer, nor a registered volunteer in a tabard. However, the close relations developed over time with Leg Club actors, I gradually assumed an emic perspective, producing advocacy work that was disseminated with the support of the Leg Club Foundation (Harper, 1998). "It's as if it was written by you", said a Trustee of the Leg Club Foundation to Ellie Lindsay after reading my Leg Club report *[citation removed for review]*. With time, I could no longer be an objective and distanced observer, or argue that my analyses were free from bias (cf. Bolton and Laaser, 2021). This was also because my values – of empathy, support to the vulnerable, power of the community, my opposition to age discrimination and the exclusion of the older adult from social life – largely overlapped with those of the Foundation (cf. Shanahan, 2022). I became part of the story that I was telling (Bolton and Laaser, 2021).

Reflecting on my research in the Lindsay Leg Clubs, I realised I practiced carnal sociology without knowing it at the time (cf. Contreras, 2015). But rather than focusing on the procedures and techniques deployed in my research, in this text I demonstrate what my carnal reflexivity about my Leg Club research taught me about the field-place-space distinctions, as well as about the Leg Clubs themselves through the field-place-space lens (Alvesson and Gabriel, 2013). Following Dutkiewicz, I start with a presentation of the establishment of the Leg Clubs – their "biography of becoming" (2015: 29) as an important part of my "field study" that was physically inaccessible to me (Kociatkiewicz and Kostera, 1999; Neyland, 2008).

Setting the historical scene for the Lindsay Leg Clubs: sick patients and nursing practice

The Lindsay Leg Clubs officially started in 1995, but their formal establishment, and the 'bodily' name, had been significantly shaped by a long and evolving history of medicine – the sick patient role, societal stigmatisation of some medicala conditons, the allopathic model of nursing and a move to compassionate person-centred care. The sick patient role and the expectations it places on the clinician-patient relationship has been a topic of much interest since Parsons (1951) developed his theory of illness as a social deviance (Cockerham, 1981; Williams, 2005). In Parson's (1951) structural-functional, realist, formulation, the sick patient role is tied in with specific rights and obligations that reflect illness a dysfunctional and associated with physical abnormality. Concerning the former, patients are said to be neither intentionally choosing to be ill, nor able to get well on their own; as for the latter, they must want to recover and seek help from a healthcare professional (Williams, 2005). The clinician-patient relationship they then form is unequal because the clinician has authority over the patient's health-related actions by virtue of their superior medical competence.

The subsequent channelling of the relationship through pre-set social roles comes with predictable interactional expectations, values and attitudes (Cockerham, 1981).

Early analyses of these expectations, values and attitudes called upon the allopathic medical model, where patients are seen as relatively passive biological systems in hierarchical relationships with active clinicians who make most decisions for them (Lowenberg, 1989). The dominance of hierarchy was linked with the positivist foundations of the development of hospitals, which accorded value to bureaucratic patterns in staffing arrangements, decision-making and reporting of patient information (Wilson, 1992). The dominant view was that when an unwell person seeking medical care became a patient, they were often excluded from the decisions made by the healthcare team and suddenly devoid of their ability to exercise their basic social rights (for example, to privacy) or to play an active part in their care (for example, self-administer diabetic medication) (Buckenham and McGrath, 1983).

Empirical studies of nursing practice demonstrate that some nurses showed at least some allegiance to the medical model. For example, Wilson's (1992) case study of nursing structure evidences the operation of hierarchical chains of command, visible in instances of nurses' expectations that patients would settle into the routine of a hospital. Reed and Watson's (Reed and Watson, 1994) study of nurses' assessments of elderly patients' mobility shows that the medical model was compatible with the values of nurses seeking professional equality with doctors and with patient expectations of nursing work. Finally, Buckenham and McGrath's (1983) account of the social reality of nursing vindicates the strength of the medical model with nurses' lack of readiness to place patients' needs first and, in so doing, to give away the power to control the care situation and step out of the convenience of routinised care.

However, as medicine progressed, so did the understanding of the patient role in the healthcare division of labour. There was greater emphasis on the whole person approach, which required clinicians to consider not just the biological, but also social, cultural and economic factors of importance to the quality of patients' daily living (Cockerham, 1981). In the field of nursing, autocratic structures were declared things of the past and new conceptual models grew united by emphasis on the ideas of compassion and patient-centred care (for a review, see Fawcett, 2017)

Patient-centred or member-centred care: Ellie Lindsay and the Lindsay Leg Clubs

It is within the context of a move towards patient-centred care that then district nurse, Ellie Lindsay, witnessed unnerving tensions within the social realities of nursing practice in wound care. In her biographic interview, Ellie observed that individuals in her care were not always receiving holistic, compassionate individual-centred care; in contrast, they were stigmatised, lonely and unmotivated to follow treatment plans.

> *In my first week, I realised so quickly the acceptance of older people having leg ulcers. Whenever I went to see a new patient, it would be, 'Well, what do you expect at my age?' I learnt very quickly, and my response was repetitious! It was, 'This is nothing to do with age, that started years ago.' I realised there was no preventative education out there and people accepted living with leg ulcers, prolific leg ulcers. Our first charity organisation member had lived 30 years with leg ulcers! I knew I had to bring change, but I couldn't do anything because I was a community nurse. I went off and did my year of post registration district nurse training, I did my placements in London, and the trend was still the same: 'At my age, you get this'…*

Stigma can be a potent experience for patients with chronic wounds, who, historically "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" (Aguiar *et al.*, 2016: 2), Ellie vividly recalled individuals in her care with chronic, weeping and foul-smelling wounds, who were labelled by their healthcare providers as house-bound and non-healing and spoken of with interjections of disappointment.

> *My first member, she was labelled by the surgery. 'Oh, not her again'.*

These patients were resignedly accepting prolific leg ulcers as a correlate of older age, unmotivated to engage in positive health behaviours. They took on the sick patient role – a passive position under the professional authority of a nurse – which absolved them of normal social roles and responsibilities (Parsons, 1951) and subjected them to stigmatisation for need of medical care (Lowenberg, 1989).

Determined to bring about change, Ellie embarked on professional crusade to empower older individuals with wounds as whole persons and alter some nurses' portrayal of older adults in community wound care away from 'passive', 'sick' and 'home-bound'. Ellie's journey to change

formally began during her year-long post registration district nurse training. It was then that she extensively studied the value of Becker's Health Belief Model (1974), which provided a conceptual foundation for Leg Clubs. Becker's model devolves some of the power for moving towards a positive state of mental and physical health to the individual in the understanding that their health behaviours are shaped in relation to the experiences and support from their social networks. The Leg Clubs started as a single evidence-based 'social leg ulcer clinic'. However, in the sixth week of its operation the word 'ulcer' was dropped from the name and 'clinic' was replaced with 'club' in a shifting mood towards community and collective participation:

> *The social side went quiet … I said, 'What's going on? What's the matter?' You always get one. I can see her clearly now. She said, 'I haven't got an ulcer! Why do you have an 'ulcer' in it? And called it an ulcer clinic?' And I realised then, very, very quickly. One of my core elements of removing the stigma of an ulcer – I had reinforced it. Then somebody else said, 'I haven't got a leg ulcer either.' … And I said, 'What should we call it?' … They all looked at each other for support. And then somebody said, 'Well, we've all got the same problem with our legs.' So, I said, 'Why don't we call it something to do with legs?' 'Well, it's like a club, isn't it? And I said, 'Oh, I quite like that'. 'Yes, so do we'. So, they all voted on it. Then, as true as I'm sitting here, they said, 'And we're not patients, we're members!'*

A key foundation of the Leg Club model was its departure from the very terminology of the patient that inadvertently connotes and reaffirms Parsonian disempowering, sick role and treatment in an open space, with nurses working alongside one another. This collectiveness destigmatises members, but it also puts nurses' work on display, requiring them to let go of controlling the care situation (Buckenham and McGrath, 1983). This break-away from ritualism meant that Ellie has faced opposition from proponents of the medical model while advocating for the model represented by the charity organisation.

> *Once, I experienced during a presentation, in an auditorium, somebody get up and say in a very loud voice, 'Over my dead body are we having HER and that model here'. And walked out… I can't understand the animosity from management or nurses. All I can think of is their own perceptions or their lack of insight or 'want to be in control' and retain the status quo. Because you really do devolve power. Members don't see themselves as ill.*

Ellie alludes to the psycho-social Leg Club model being shaped against the historical principles of power relations underpinning the dominant medical paradigm, with the caveat that the two are not incommensurate. The "medical model is there when we need it", for diagnosis and assessment. Leg Clubs, instead, offer an alternative that completements, rather than replaces, the former. They are premised on distinctively different dynamics in the relationships between nurses and patients (members). Ellie persisted in her work to change the status quo at a distance from wound care actors doubtful of her determination to instigate hierarchical discontinuity in the nurse-patient relationship. She left the NHS and became an independent practitioner. In 2005, she established a registered charity to provide supporting infrastructure to an increasing number of organisational branches to improve wound care knowledge and reduce loneliness for older adults with wounds.

Following the above historical background, one can suspect that Leg Clubs, with their carnal and historical name, a bodily identity, and a specific use in design, can be experienced in multiple ways. The next section of my findings offers a carnal ethnographic vignette of the Leg Clubs as one approach which offers analytic gains with regards to appreciating these experiences that distinguish the professional Leg Club field for the researcher and the objective place that hosts the Leg Clubs from the Leg Club space as experienced in a myriad of ways.

Material arrangements, movement, sound, smell, and sight in Lindsay Leg Clubs

Walking into the Leg Clubs, I was always welcomed by a receptionist into a big open room, punctuated by wide tables furnished with plentiful chairs on one side and multiple treatment stations facing one another on the other side. The *material arrangement* of the Leg Clubs invites a bodily choreography that inscribes collectivity and interaction into the experience of attending a Leg Club. A visitor heads for a table, often accompanied by a chatty volunteer, and join(s) others or is/are joined by others in waiting for the treatment. When heading for the treatment, the default is to also face others. As an essentially a face-to-face to face service, where in-person interactions cannot be replaced by any digital communication channels *[citation removed for review]*, the bodily relating is crucial to appreciate the meaning and form of Leg Club. This reveals the interaction of bodies – able bodies, bodies on wheelchairs, or bodies supported with walking aids – with the material layout of the room as 'action in the making' (Wacquant, 2015: 5). It is the point at which the meaning of Leg Club attendance is shaped into one of a collective and shared experience on interpersonal interaction in accompanying people, serving refreshments, waiting for the treatment, and in the treatment itself. The interaction with others can be a therapeutic journey in itself as people are exposed to alternative

viewpoints, can 'share and halve' their problems through conversations and find meaning in helping others (Lindsay, 2018). The below quote from a former Leg Club member who became a Leg Club volunteer demonstrates:

> *I did go through a bad patch. And I got put on some antidepressant things. And then, I came here and it's totally different. You know, even people said, I'm a totally different person now, you know, which I am and it's thanks to this (interview with Leg Club member-turned-volunteer, May 2022)*

Given the centrality of social interaction, the Leg Clubs were opposite of quiet – they were filled with a variety of *sounds*. Some sounds were the noises of teaspoons swirling in the mugs, the chewing on crunchy chocolate biscuits, occasional 'mmms' in appreciation of deliciously mouth-watering home-made apple cakes. Others were musical notes from occasional piano performances from local community members (which meant one of my interviews could not be fully transcribed!), or a Christmas carol sing along. Yet other sounds came from the chatter and laughter of members filling the time with conversations, in which I participated when sitting at the tables with the members (see Atkinson, 2013).

For example, on a rainy November morning in 2019, I started a conversation with a glamorous looking female Leg Club member, starting with a humble: 'How are you today?'. 'Good for 95!', she responded jovially, explaining she had been coming to the Leg Club for a few months because she had been having problems with her ulcers. My fieldnotes from that conversation recorded a sensorial comment in brackets: 'I think I can *smell* them…'. In this regard, one cannot discount, by any means, the phenomenon of the smell in the Leg Clubs, which everyone with a healthy undisturbed sense of smell – including the ethnographer – participates in. Making smells explicit beyond the person who smells them is not easy in a carnal ethnographic representation of places, but a best possible approximation can evoke multisensorial ways of knowing the phenomena for the readers of ethnographies (Pink 2009: 144). The presence of the ethnographic note means the smell must have made me feel uncomfortable and reading the note, I could recall the sweet and sour aroma wafting through the air, although I am certain I did not grimace. This ability to remain professional mattered for people in the Leg Clubs. As explained to me by a head volunteer in one Leg Club, acting as a volunteer driver for the members:

> *"…is not just a standard taxi service. There is a specific aspect to transporting people, some of whom are poorly, and some of whom have smelly legs. The drivers*

need to be prepared for that. But so far no one has been phased out by the smell,
which is good." (fieldnotes, November 2019).

To the contrary, rather than being 'phased out by smell', volunteer drivers kept returning to the Leg Clubs, finding in them the space for the continuation of their professional identities after retirement, while enjoying the 'feel good' factor of helping others and interacting with them:

> *...the enjoyment I get and just saying good morning, picking them up, and make them*
> *laugh if you can or chatting to them. Um, bring them... dropping them off here,*
> *having a banter up here with the volunteers as well and then having a cup of tea and*
> *off you go... you're making life easy for them, aren't you?...I was a coach driver*
> *before (interview with Leg Club volunteer driver, June 2022)*

The experience of wounds is not purely olfactory, but a highly visual one, too, as the continued fieldnotes reporting my conversation with the 95-year-old member show:

> *She tells me [leg ulcers] are looking 'not very nice'. They are red and fleshy, but*
> *they are getting better. She does not mind being treated in the collective area, but*
> *she does not really look at other people. But she 'has seen some sights!', she adds.*
> *(fieldnotes, November 2019)*

The *sight* of wounds can indeed be intimidating for those unfamiliar with them. A member in one Leg Club told me she had not known wounds "could be this horrible" and that "it was all fresh meat" (*fieldnotes, October 2019*). Therefore, sharing them with others through a visual experience can be embarrassing. As explained to me by the chair of another Leg Club, "there used to be a lot of stigma around wounds" (*fieldnotes, October 2019*), which tend to be ghastly, unglamorous, raw and malodorous. In hospital wound clinics, where treatment happens individually and behind closed doors, that visual sharing of the wounds with others beyond the clinician-patient-relative relation is normally absent. The material arrangement of the room that separated the medical and social spaces did some work in managing the visual experience of Leg Club attendance for those who 'did not really want to look at other people's wounds'. For example, in one Leg Club, I heard a story of member who had only attended once, and never came back because she did not want to be treated in an open area due to privacy concerns (*fieldnotes, October 2019*). But in the collective treatment environment of the Leg Clubs, other members (patients), volunteers and the ethnographer become aware of the ghastly sights. Such visual participation in others' wounds experience means that one is better able to appreciate the socio-cultural difficulty around wounds in public spaces and members'

(patients') intention to hide them behind thick dressings and 'little white lies', as the below experience of one male member talking me through his medical wound photographs explains:

He opens his medical records on the last page that has the photographs of the wounds. He tells me that seven years ago, he had a big green hole in his foot. It smelt very badly – so badly that his grandchildren kept asking what the smell was, and he was telling them it was the sewage. He said that normally we do not smell our own smells, but he could smell his, and to him that was the sign that the smell was very bad. He said people could smell him at the supermarket and he felt so embarrassed he began staying at home. And then he started coming to the Leg Clubs, and his legs improved tremendously. Now he only has thin skin, which is dry and gets irritated, but there is no wound anymore. (fieldnotes, January 2020)

As noted by Pink (2009: 152), it is impossible to separate out the senses in ethnographic representations, as one sensorial reaction cannot be fully isolated from others; as she explains, "a smell alone does not fully communicate, nor does it register on the perceiving body sufficiently to capture the phenomena". The wound smell is only part of the reality, which, on its own, can be inadvertently misunderstood by others, potentially leading to 'public panic' (Marks, 2000: 212). Masking the reality of an out-of-place wound smell under the label of the familiar and more in-place sewage served as textual deconstruction of those sensorial features of wounds that can marginalise and exclude the people for whom this is part of their carnal reality. To construct the smell as part of the Leg Club experience one needs to become conscious of wounds appearance, of the pain, the social stigma it carries as well as appreciate the aims of the Leg Clubs to heal, accept and destigmatise, hosting the possibility for change for the people.

Discussion: Leg Clubs as a therapeutic space-construct

In seeking to make concrete the abstract distinctions between field, place and space, while recognising the researcher's own embodied subjectivity (Kociatkiewicz and Kostera, 1999), this research has made possible the theorisation of the Lindsay Leg Clubs as a therapeutic space-construct. Much research conducted in the Lindsay Leg Clubs to date has used a phenomenological perspective (e.g. Seckam, 2019; Upton et al., 2015), focusing on members' bodies and on their bodily experience of wounds and Leg Club attendance. Instead of treating the bodily experience as something on the side that the researcher studies, I have retrospectively used a carnal sociology lens that allowed me to use my bodily experience as the *'point of production'* (Wacquant, 2015: 5) of

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knowledge. Unlike in haptic analyses of glass-blowing (Atkinson, 2013; O'Connor, 2017) or rock climbing (Dutkiewicz, 2015), or olfactory studies of perfume production and consumption (Cerulo, 2015), my immersive research required few 'physical competencies' (Atkinson, 2013: 403) or mastery of tools and techniques to act out embodied skills. Instead, the embodiment was in my 'flesh and blood' (Wacquant, 2015), experience of the features of my Leg Club field: its sounds, smells, sights and movements within, which I sought to make explicit in the presentation of the ethnographic place (Pink, 2009: 144), while also reflecting on the structures of wound stigma, centre-stage physical bodies of members and the volunteers, the material arrangement of the room, and my own visceral and intellectual, biographical relation to my fieldwork (Wacquant, 2015).

But the challenge of the carnal sociology approach lies in converting the personal 'flesh and blood' experience of the phenomena in the field into contribution to a wider research project in a way that lays bare the benefits of the carnal approach (Atkinson, 2013; Contreras, 2015). This, Contreras (2015) argues, requires extra thinking to create a textual bridge between the ethnographer's body as an instrument of knowledge production, their intellectual thinking about the materiality of the place, people's sensorial apparatuses, and their role in meaning creation (O'Connor, 2017). In Kociatkiewiecz and Kostera's (1999) words, any space has a story, but it takes work to tell it. It is to the presentation of this story that I now turn (cf. Atkinson, 2013).

Leg Clubs are a space-construct that affords the possibility of therapy being achieved. They do not exist as objective and static places, but as multivalent spaces to which members, volunteers and visitors, including myself, relate to in many ways. It is through looking at how people experience the Leg Club that one can appreciate their form and meaning. The explication of Leg Clubs as a therapeutic space must go beyond the reporting of medical outcomes of the therapy to include how Leg Clubs were established to counter the medical model's disempowering sick patient role (Parsons, 1951) and wound stigma (Aguiar et al., 2016), how people physically arrived at the Leg Club with help from their volunteer drivers from the community, how they moved around the Club almost always in a collective space, how they followed the social conventions of the wound care community using a professional demeanour vis-à-vis wound sights and smells, or how they felt joyful and accepted inside the Leg Clubs. Following Dutkiewicz, who, himself, follows Mol's (2002) praxiographic conceptualisation, a Leg Club is perceived differently by different people. For some, Leg Clubs are a space for social interaction to overcome their shyness. For others, it is a space for continued societal functioning as a working professional. At the same time, it can be a place for a cup of tea and relaxing social interaction at shared tables for improved social health, in addition to a

space of destigmatising acceptance of bodily ailments and/or their medical healing. For yet others, the human experience contained within informs and drives activism. The perception of the Leg Club varies from person to person, but it is through embodied cognition that we can fully appreciate their therapeutic form and meaning.

My carnal engagement with the Leg Clubs did not neatly follow the classic ethnographic adage of immersion and distancing (Ybema and Kamsteeg, 2009). Carnality as a modality of my existence in the Leg Club had much to do with my prior research in the specialist outpatient wound clinics. As a result, when members said to me that wounds were 'not nice to look at', even though I was not joining them in the treatment side of the room, I knew what they meant. When they complained about the smell, I also understood what they meant. Over time, these multi-sensorial and biographical features deposited in my body and mind as Leg Club 'traits' (Deleuze and Guattari, 1988: 51); "the layered product of our varied individual and collective histories" (Wacquant, 2015: 4). This carnal experience, combined with my familiarity with wound care context, gave me a degree of an insider perspective, which then informed my presentations in political meetings about the qualitative perspective on living with a chronic wound *[citation removed for review]*. It is precisely through this immersion in the performance of the phenomena that I then unravelled how people in the Leg Clubs practiced place as a therapeutic space.

Conclusion

Wacquant's (2015) carnal sociology approach has provided me with a reflexive lens to understand the Lindsay Leg Clubs as space-construct of therapeutic form and meaning for people with stigmatising, hard-to-heal, malodorous and ghastly leg wounds. The therapeutic traits of the Leg Clubs were constructed and made sense of simultaneously by people in the Leg Clubs through their minds and their bodies with their sensorial apparatuses, so that the experience of being in the Leg Club was not just cognitive, but also embodied, with the structures of wound stigma and patient role first lived through then challenged discursively and physically. This, in turn, has implications for practising care in settings other than the Leg Clubs.

In narrating the story of the space of therapeutic Leg Clubs using a carnal sociology approach I was also able to empirically extend my comprehension of the field-place-space distinctions in ethnographic research (Kociatkiewicz and Kostera, 1999). Returning to the opening quote that inspired this intellectual and visceral investigation, I propose a response that delineates the three

ethnographic concepts as ontologically distinct, delineating *field* as a professional researcher's concept and imbuing *space* with an embodied quality to the form and meaning that people who inhabit it create over time as their practice the *place* through interactions with and withing the place.

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