Managing stigma together: Relationality in the Wound Clinic

Introduction

Many studies of dirty work have focused on how workers who come into regular contact with stigmatised individuals cope with the social taint of stigma by association, or 'courtesy stigma' (Goffman, 1963). Examples include studies of clinicians looking after patients with HIV/AIDS (Bachleda & El Menzhi, 2018) or nurses and doctors providing abortion services (Ward, 2021). In these projects, researchers have concentrated mostly on how workers deal with courtesy stigma through developing strong workgroup discourses rooted in occupational values oriented at helping the stigmatised. In socially tainted dirty work, stigma is inevitably entangled with the complex relation between a dirty worker and their client (Olvera, 2017). However, in focusing on how workers symbolically cope with stigma that affects them, most dirty work research has overlooked the existence and significance of the key relations between the worker and their clients (Eriksson, 2023; Galazka & Wallace, 2023; Zhang et al., 2023).

Our paper studies the significance of worker-client *relations* as an important collective resource that can be tapped into by both workers when coping with courtesy stigma and clients dealing with social stigma (cf. Galazka & Wallace, 2023; Zhang et al., 2023). To make this point, we take a lead from critical realist social theorists Pierpaolo Donati and Margaret Archer (2015; see also Donati, 2016) who have argued that relations hold a distinct reality irreducible to individual agents and their activities. Moreover, Donati and Archer have deepened our understanding of how people steer relationships over time by generating relational goods (more on this below). However, philosophical thinking reaches its limits when the broad questions of relationality's existence, context and effects are translated into the more specific question of *whether and how workers and clients manage stigma together in specified settings?*

The expression "manage stigma together" is pivotal and deserves further qualification. Contrary to mainstream approaches, we do not view management as calculable top-down strategic design that must then be implemented against all resistance (Kotter, 1996). Instead, as Hendry (2013: 20) reminds us: '*Outside the work context, however, we often use the language of managing ironically, to suggest a lack of control (managing to break a leg), or as synonymous with coping, or getting by, where control has more to do with somehow preventing*

things from falling apart than with actively directing them.' Thus, although our study attends squarely to an instance of (dirty) work, we find nonetheless that the expression "managing stigma [together]" does better justice to participants' lived reality and daily efforts as long as we understand stigma management as coping with stigma and keeping it in check rather than as strategizing or implementing grand policies.

Moreover, by studying stigma management as coping, we can put to the use the analytical prism of Ashforth and Kreiner (1999) who suggest that people cope with stigma by reframing, reformulating and recalibrating. Reframing is about changing the overall meaning of dirty work into something positive. Recalibrating involves attaching greater weigh to certain (positive) elements of the work. Refocusing is about actively overlooking stigmatising properties of work. Through these techniques, workers discursively construct a cognitive shift in work meaning in their occupational communities that protects their identity from negative societal perceptions.

However, the word "together" in our focus on stigma management adds a distinctively relational dimension to our study. Rather than considering stigma coping strategies as practices of workers alone, we describe and explain them as collective organisational processes involving both providers and recipients of dirty work. We show how workers and clients, in our case clinicians doing the dirty work of wound healing and patients living with "dirty" wounds (Galazka, 2020), develop relations within which they produce *relational goods* (and *evils*) that bear, in turn, on stigma alleviation (or reproduction). We distinguish three broad types of relations and theorise their causes and effects. We suggest that worker-client (in our case study: clinician-patient) relations do not happen in a structural void but emerge from complex, ontologically heterogeneous, organisational arrangements which we refer to as *relational configurations*. Moreover, worker-client relations are not epiphenomenal but enable (or incapacitate) workers and clients to manage stigma. Thus, based on our case-study in clinical settings, we ask precisely: *How do clinicians (as workers) and patients (as clients) reframe, refocus and recalibrate stigma by drawing on (potentially complex) dirty worker-client relations?*

To address this question, we analyse an ethnography of an outpatient wound healing organisation. In wound healing, specialist clinicians perform dirty care work on unsightly,

malodorous, weeping wounds on the bodies of patients socially incapacitated by the impact of chronic skin breaks. Wounds are an ungraceful condition for the patients, the proximity to which risks challenging professional visibility and status for clinicians. In this context, patients and clinicians alike are affected by the stigma of wounds. Given that "he [the patient, sic] has a part in the medical division of labour, too" (Hughes, 1958: 74), it makes little sense to exclude either group from the analysis. The very relationships between patients and clinicians are of interest for understanding how individuals can moderate the impact that (courtesy) wound stigma has on them to develop a positive sense of self, at least in the context of the clinical interaction.

We add to the literature on dirty work by, firstly, foregrounding the relations between dirty workers and socially stigmatised clients, and secondly by theorising two important yet understudied mechanisms that sustain relationality (Donati & Archer, 2015). Regarding the first contribution, we offer a rare, detailed account of interactions between workers and clients. As for the second contribution, we show the existence of *relational configurations* that provide the context in which subjects thread inter-personal relationships. These relational configurations help understand how dirty workers cope both with stigmatised patients and with the courtesy stigma associated to clinical work, as well as how patients respond to clinicians' experience of courtesy stigma – through the generation of *relational goods* and *evils*, such as camaraderie or defiance, that orient the relational agency of individual subjects.

The paper is structured as follows. In the next section, we critique dirty work literature's oversight of the nature of worker-client relations, arguing instead that understanding these relations can help explain how dirty work becomes a matter of pride or of humiliation (Varman, Al-Amoudi & Skalen, 2023). We then offer a remedial realist relational framework for such analyses (Donati & Archer, 2015), and define the key concepts we employ. After presenting our research context and methods, we open with an account drawn from our ethnography of why and how wounds and wound healing are stigmatised. We then identify three broad types of patient-clinician relationships and examine whether and how each type of relationship allows clinicians and practitioners to reframe, recalibrate and refocus their otherwise tainted activities. For each type of clinician-patient relationship, we investigate their ontologically heterogeneous conditions of possibility (relational configuration) and their relevant effects on stigma (relational goods/evils). The last section discusses our study's significance for future studies of dirty work, stigma and relationality within, around and beyond work organisations.

Dirty work and stigma in organisational studies

The concept of 'dirty work' (Hughes, 1958) refers to occupations stigmatised through their association with physical, social, moral, and/or emotional 'taints', such as danger or disgusting materials and bodily fluids; a servile relationship to people and close contact with socially stigmatised populations; morally dubious issues (Ashforth & Kreiner, 1999); or clients' difficult emotions (McMurray & Ward, 2014). These 'taints', as symbolic qualities of work that society criticises, make work and workers 'dirty'. Therefore, dirty workers seek to discursively re-shape their stained identity. Most studies draw on Goffman's (1963) account of stigma management focused on symbolic interaction and impression management.

Management researchers attended in particular to three specific techniques of stigma management: reframing, recalibrating and refocusing dirty work. Reframing entails infusing work's means or ends with positive values to turn it into a badge of honour, or neutralising work's negative value (Ashforth & Kreiner, 2013). For example, prison workers neutralise the perception of their work as low status by infusing it with value that lies in protecting the communities from violence or claiming that by incarcerating the prisoners, they save their lives from substance abuse in the street (Eriksson, 2023). Recalibrating involves reviewing, retelling or exaggerating work to adjust "the implicit standards that are invoked to assess the magnitude and/or valence of a given dirty work attribute" (Ashforth & Kreiner, 1999: 422) so that the negative components are transformed into positives. For example, HIV/AIDS nurses deal with aversion from other medical colleagues by stressing how, at least, they know if someone has HIV and can take precautions to stop them from developing AIDS (Bachleda & El Menzhi, 2018: 776). Finally, refocusing involves actively shifting attention "from the stigmatized features of the work to the non-stigmatized features", such as its qualities and rewards, while leaving stigma intact (Ashforth & Kreiner, 1999: 423). For example, prison workers praise the flexibility of shift patterns that prison work affords them (Eriksson, 2023).

Dirty work occupations can be stained on more than just one dimension (Ashforth & Kreiner, 1999). For example, physically dirty care work can also be socially tainted when looking after patients with stigmatised conditions. Here, workers must grapple with courtesy stigma that attaches to people working in proximity to socially stigmatised populations (Goffman, 1963).

Examples include Muslim healthcare professional looking after patients with HIV/AIDS ostracised by religious groups (Bachleda & El Menzhi, 2018) and carers in incontinent long-term facilities (Ostaszkiewicz et al., 2016). Indirectly, Shaw (2004) and Williamson et al. (2014) discuss how patients' unrealistic demands, impatience and non-concordance with medical treatment intensifies workers' stigma experience by challenging their professional status. In the words of Olvera (2017: 255): "Evidence of courtesy stigma among professional shows that stigma is indeed relational".

Therefore, rather than focusing individualistically on workers' reframing, recalibrating and refocusing techniques alone, we must look to the worker-client relation to understand stigma management. Unfortunately, until recently, the nature of worker-client relations in dirty work has been largely overlooked (cf. Galazka & Wallace, 2023; Zhang et al., 20230). Some scholars inadvertently recognised in passing that the interaction between dirty workers and clients can shed light on how work becomes dirty or otherwise (e.g. Hansen, 2016; Malvini Redden & Scarduzio, 2018). For example, Hansen (2016) observed that when workers providing dirty rehabilitative care to the elderly focus on the resources that the older bodies hold, rather than on their disabilities, both groups can navigate their stigma situation from a more empowered stance. Moving beyond workers' tactics of impression management, Hansen (2016) shows how instructions for clients to, say, put on their underwear without help, can prevent them from becoming "vegetables" (p.1097). Therefore, the rehabilitation relationship becomes "a resource in homecare workers' taint management", making the work cleaner and more dignified, and helping older adults "see themselves as capable, resourceful and potentially self-reliant", challenging the stigmatising fourth-age decay narrative (p.1098). With an interest in relationality, we now turn to the theoretical framework we have chosen for its study.

Theoretical framework: dirty worker-client relations that emerge in relational configurations

Our interest in relationality as a context of interaction is distinct from Goffman's symbolic interactionist account of stigma management (1963), where subjective relationality is limited to social interactions that unfold over short time horizons and following ground rules, while participants are principally preoccupied with maintaining their public image. Instead, we chose a framework inspired by Donati and Archer's theory of the Relational Subject (2015). The

latter proposes that our social positionality guides our decisions and actions, not in Goffmanesque brevity and impersonality (p.14), but through reflexive consideration both of other people and of the relations through which we engage with them. Every person is a relational subject to the extent that they direct their concerns towards social relations and the relational goods and evils generated by the latter.

Donati and Archer (2015) use the term *relationality* to capture the fact that human interactions always happen throughout relations. Here, human persons are considered as 'relational selves' – neither voluntaristic self-sufficient individuals, nor passive concretions of social relations – but ontologically relational beings with a sense of collective agency (Donati & Archer, 2015: 90). On a micro-level, studying relationality consists in examining both the dependence of human subjective agency on inter-subjective relations and the processes through which these relations are established and transformed over time. In other words, what Ego can do at a certain time depends on her relations to Alters, and these relations are threaded and steered over time rather than produced ex nihilo in a timeless interaction.

Our entire argument pivots around the following mechanism that we borrow from realist social theory and apply into studies of dirty work: over time, people in organisations develop relationships through their interactions as *relational subjects*. These relationships are not produced ex nihilo but depend on the co-existence of several elements (forming together a *relational configuration*). It is through these relationships that individuals generate various *relational goods* and *evils* that hold the potential to alleviate or worsen stigma.

We use the expression *relational configuration* to refer to the complex context through which certain types of relationships can emerge. Ontologically speaking, they are an arrangement of diverse entities[1] constitutive of a social relation. In accordance with our realist meta-theoretical framework, we follow a relational sociological view of organisations (Mutch, Delbridge & Ventresca, 2006) that does not restrict the constituents of a relation to the human agents who engage in it or to the formal organisational roles that are connected by it. In addition to formal organisational roles, relational configurations include notably such components as: relations between persons and their physical bodies; formal relations between roles/positions; informal

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[1] The word 'entity' (derived from the Latin *ens*, to be) refers to anything that is, such as tables, people, justice, fleeting thoughts, change and nothingness. Contrary to a common misconception, entities may be relational, concept-dependent and processual.

positions emerging through interaction within relations; concerns held by participants; practices (individual and collective) in which subjects engage; physical reactions, material bodies; material artefacts; elements of architecture; wider social relations in society, ideas and cultural entities, modes of reflexivity exercised by the subjects; relational goods and relational evils. This list does not aim at theoretical exhaustivity but summarises, rather, the main social entities with which we have populated the present empirical study of a British wound healing clinic.

Following Donati and Archer, we define relational goods as "a type of goods that are neither material things, nor ideas, nor functional performances but consist, instead, of social relations and, for this reason, are called relational goods" (2015: 198). But while relational goods are relations, they can only emerge through anteriorly existing relations between participants. Thus, the term 'relational' connotes both the ontological nature and the process of emergence of relational goods.

The concept of 'relational configuration' is central to our study because it allows us to explain how relational goods and evils are generated through an analysis that considers both the relative freedom of agents (*contra* functionalism) and the relative weight of the organisational context within which they interact (*contra* symbolic interactionism). By focusing the analysis at the level of relational configurations, we have identified transfactual social structures that span beyond the narrow horizon of the interaction: across situations, across participants and, more tentatively, across organisations and fields of practice. Finally, the concept of relational configuration also offers a contribution to social theory as it provides a unit of analysis that is more specific than the clinical setting *tout court*, yet more generic than any specific relationship emerging in an organisational setting.

We attend to relationality's effects on dirt and stigma without forgetting that every relation is a relation of power (Foucault, 1983; Al-Amoudi, 2007; 2013) but without trying either to foreground power, domination and leadership. Our analysis foregrounds participants' subjective concerns and the relational goods and evils they produce together. Doing so helps us understand not only that multiple forms of relationality can coexist within the same organisation but also why this is the case. Our study seeks to understand why participants

threaded the relationships they did, and how this affected their experience of the stigma relation and wound (courtesy) stigma.

Organisational studies have recently taken an interest in relational goods (Bolton & Laaser, 2021). The latter are called 'relational' both because they are ontologically of a relational nature and because they can only be produced and consumed within relationships (Donati & Archer 2015). Examples of relational goods include trust, camaraderie, intellectual curiosity, romance, etc. They emerge whenever individuals in relationships reflexively "diagnose their situations…identify their own interests and…design projects they deem appropriate to attaining their ends" (Archer, 2003: 9). When doing so, subjects take their relational ties into account. They evaluate whether their differences are compatible and whether each actor can bring something new to the relationship (i.e. relational goods) that can help them attain their ends together (Donati, 2016). This relational reflexivity has consequences for the cultural and structural context of the relation, both for the good of individuals and that of the members of the surrounding community. Relational evils are the opposites of goods and emerge whenever relationships hinder human flourishing (Donati & Archer, 2015: 75). Examples include distrust, obtuseness, racism or jealousy.

The choice of the words 'goods' and 'evils' bears obvious moral connotations but these need not be moralistic in the sense of defending one specific vision of the good life at the expense of all others. In realist fashion, we attribute goodness to anything that is overall conducive to human flourishing (Collier, 2005; Sayer, 2011). While we appreciate that the notion of 'human flourishing' should remain open to political contestation (see Al-Amoudi 2023), moral considerations remain relatively uncomplicated whenever there is relative consensus between participants, researchers and readers on whether the relational goods considered can be said, overall, to favour human flourishing. These conditions seem to hold well in our empirical work's context where participants, researchers and (presumably) readers of this journal view stigma management as a good thing.

Context and methods

Our paper draws on 10 months of ethnographic fieldwork conducted in a UK specialist outpatient wound healing clinic to explore social relations between wound healing clinicians

and patients with chronic wounds. The organisation we studied was one of few specialist wound centres in the world, which run three weekly outpatient clinics in three National Health Service (NHS) hospitals to reach a wider population of patients (Figure 1).
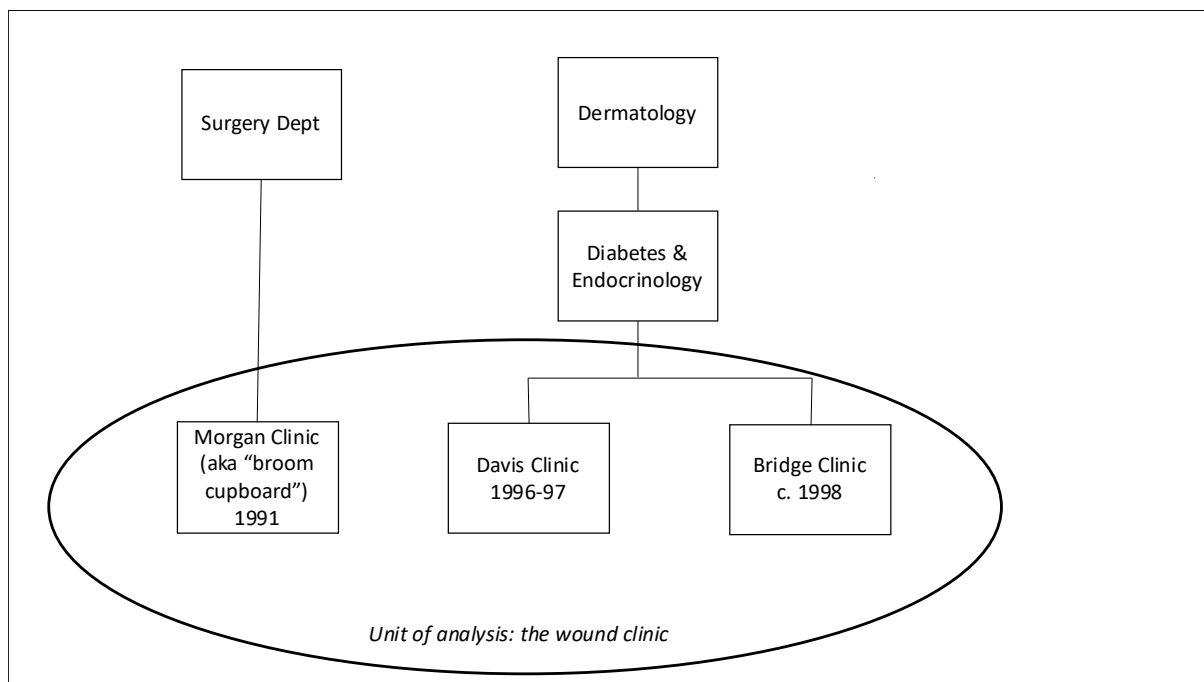

Figure 1: Scope of empirical study

The Morgan Clinic was established in 1991. Originally set up in a hospital's old broom cupboard, it grew into a complex wound clinic. Run at a teaching hospital once a week through the Surgery department, it originally treated post-surgical wounds. The unexpected consequence of giving it an all-embracing name of 'Wound Clinic' was that high numbers of patients with wounds of all origins sought care there. The Davis Clinic, set up around 1996-1997, operated under a different health management board to the Morgan Clinic. It had previously been managed by Surgery, but at the time of this research, it was managed by Diabetes and Endocrinology as part of Dermatology. Based in the outpatient department of a community hospital, it operated as a general wound clinic one afternoon a week. The Bridge Clinic was established shortly after the Davis Clinic and operated under the same administrative health unit. It was managed by the Diabetes and Endocrinology department as a multi-disciplinary diabetic foot clinic. It ran once a week as an informal site for concerned patients, with shorter waiting times for urgent patients.

Despite different administrative organisation, all clinics were 'staffed' by the same core of clinical academics committed to patient-centred care. In addition to delivering outpatient services, these clinicians had a unique interest and expertise in wound healing; they conducted clinical wound research, provided medical education and contributed to commercial training. Our ethnographic data were collected in the outpatient clinics during patient contact hours only.

Data collection and analysis

The first author conducted just under 120 hours of non-participant observations of consultations; approximately 44 hours in Bridge Clinic, 45 hours in David Clinic and 30 hours in Morgan Clinic. She kept fieldnotes about everyday experiences of working and living with wounds. All clinics displayed a similar architectural setting, with nurses or podiatrists simultaneously running consultations in individual rooms with medical beds, tools and dressings, a central clinicians' space reserved for medical note-taking, and a patient waiting area. Doctors would visit individual rooms for additional advice. Therefore, the researcher could only ever be in one treatment room, sometimes missing repeat visits from regular patients. On some days, the researcher followed a consultant doctor who looked after her around the entire clinic, visiting individual treatment rooms where podiatrists and nurses conducted the consultation. On days the consultant doctor was unavailable, she would observe consecutive consultations in a single room. In addition to observations, our paper is based on semi-structured interviews with 12 patients (some accompanied by their relatives), who were nominated by clinicians as willing to share their stories, and 12 wound healing clinicians (all but one member of the core clinical team). Participants' details are in the tables below.

(Tables 1 and 2 here)

We analysed our data iteratively, moving between the ethnographic material and the literature on social relations. We felt that to examine stigma it was not sufficient to look at the discursive level and episodic interactions. The lingering presence of wound malodour and ghastly wound sights, which affected patients, clinicians and the researcher on a visceral level encouraged us to consider embodiment and materiality as key elements of context. Furthermore, the oft-creative ways in which clinicians and patients acted out of their respective roles to manage

wound stigma made us gradually appreciate the importance of (formal and informal) organisational aspects of wound healing that are propitious to steering the stigma relation. We therefore felt encouraged to ask, at first in broad terms, how the organisation of relationality influences stigma management. To do so, we examined how different relational configurations are conducive to different types of relations which, in turn, influence stigma alleviation.

Stigma and relationality in the wound clinic

Patients and clinicians agreed that physically unglamourous cuts on wounded bodies are conducive to stigmatisation. For patients, stigmatisation is quite direct because wounds transgress cultural standards of visual and olfactory acceptability. In today's world where "external appearance is much more important than ever before" (Kate, doctor), yellow pus and necrotic tissue may appear "yucky and horrific" (receptionist, Bridge Clinic, April 2017), causing people to resist those with repugnant malodorous wounds. Repugnance is a (more or less reflexive) visceral reaction, potentially stronger than caring bonds and requiring time to adapt, as the experience of Mike being sick when changing his wife Jane's dressings shows:

> *I had to go out of the bathroom and then I would come back and do it again...It did make me sick. I would vomit.*

Distressed patients, too, were aware of the physical correlates of wounds beyond their familiar circles. "Welcome to the horror show", a patient greeted the first author in Bridge Clinic (fieldnotes, February 2016). The basis for stigmatisation had repercussions for patients' family relations and affected novice researchers in the field. For clinicians, time spent in their role meant they reflexively normalised their reactions to wounds to the point of acceptance:

> *The smell in the room is rather strong. As the patient is exposing more of the wound, her daughter is covering her mouth and nose, looking away, 'cringing': 'Why is my mother in pain, why is she suffering?' The nurse asks the patient's daughter for help with lifting her mum's leg up. She helps, but sitting down, she starts shaking her hands off. After the patient leaves, nurse Megan says she got used to the smell by now but she feels for me. (Davis Clinic, August 2016)*

Clinicians recognised their work's connection with dirty work. They admitted that chronic wounds can "turn people's stomachs" (Ella, podiatrist), which generated disgust and discouraged other clinicians from specialising in wound care (Deborah, tissue viability nurse). Additionally, some clinicians were concerned about how their social circles found work conversations off-putting, suggesting that they felt isolated because of their job's associations.

> *[Friends ask] 'Why do you want to do that?' Ha-ha! They do think I'm a bit nuts wanting to deal with wounds, day in and day out…I don't think they quite like the conversation about it. And it's like, 'Oh no, that's too much information'. So, I just tend to not really say a lot (Megan, research nurse).*

These findings echo Phillips et al. (2012), who found that the discomfort of discussing work socially indicated perceived courtesy stigma (Goffman 1963). There was also evidence that the physical taint run through the courtesy stigmatisation. Within the first week of the fieldwork, the first author, still shaken by the olfactory memories of encounters with infected wounds, offloaded to a close friend who was a medical student. "Looking after diabetic feet? Well, what a career choice!", the friend commented, degradingly (fieldnotes, June 2016).

Patients' accounts of dealing with clinicians from other specialisms contained further evidence of stigma enactment. Wound healing was perceived in the medical community as an inferior member of the profession that copes with patients whose challenging care does not 'fit' the mainstream model. This perception risked the isolation of wound care patients as some clinicians sought to distance themselves from patients with wounds:

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

As the quotes above showed, both clinicians and patients recognised the low-status perception of wounds, wound healing and wound care patients. Therefore, person-centred care was a key response of wound clinicians' medical repertoire and cultural archive for deflecting stigmatisation. Both clinicians and patients sought to reframe, or transform, the meaning attached to dirty worker-client interactions by infusing them with the constructive value of long-term familiarity as something that made the organisation of the wound healing clinic

positively distinctive and turned the interaction into relational spaces of acceptance not easily available to patients elsewhere. As in Bachleda and El Menzhi's (2018) study, where HIV/AIDS workers reframed their job as a fight against the expansion of the disease, here by giving patients "our place as an outlet" (Kate, doctor), clinicians argued they helped prevent patients' sense of stigmatising abandonment. As appreciated by Jane, an outpatient in Davis and Morgan Clinic, who had been attending for over two decades, this was in contrast to increasing urbanisation and anonymity in the contemporary medical system:

> *Years ago, the doctor would know your mother, your father, your auntie,*
> *your grandmother down the road. That doesn't happen anymore. And the*
> *kind of familiarity that there is in the wound clinic now is very unusual.*

Nurse Eva explained that in this clinic staff sought to move their relations with patients beyond the traditional bureaucratic hierarchical distinction of 'sick patients' and 'professionals in white coats' typical of a professional-patient consultation and towards personable care relations. The two-sidedness of this personable foundation was explained by podiatrist Ella:

> *...once they see that you're a human being and you're quite empathetic...*
> *When they start to see that you are a normal person, sometimes they start to*
> *talk more about their lifestyle, what their home is like...what the challenges*
> *are. They start to trust you.*

There was also humour in reframing relations, visible in how clinicians refocused patient interactions on their non-stigmatising associations, rather than their dirty wound. For example, patient John earned himself a nickname of "the broom patient", from when he first attended the Morgan Clinic when it ran from the broom cupboard 30 years before. The "broom patient" has since watched clinicians become parents and grandparents.

However, in navigating the clinical relation, patients' attitudes mattered. As Jane explained during an informal ethnographic corridor chat, "there is always going to be a power difference between a patient and a clinician". The patients' choice (agency) did not always mean steering the relation horizontally, but could sometimes entail reiterating the structurally embedded formal role divisions, with power sitting with the clinician and the relation steered towards its functional qualities:

> *There are some patients that...do not want to talk, they are quite closed down*
> *and you tried and still are not getting anywhere. You accept that this is what*

the relationship is going to be. But this is the patient's choice, it's not you
not being prepared to give the best, really, to the patient. Always a challenge.

Even when clinicians are willing to 'give their best', clinician-patient relations are neither uniform nor decidable by decree. Instead, they emerge from complex configurations that entail: patient relationships to their physical bodies, relations between persons, relations between social positions, informal powers produced over time through relational interactions, participants' concerns, and participants' practices. It is in this context that our study of social relations between clinicians and patients directed us towards the investigation of relational configurations and their emergent norms, through which formal organisational rules were sometimes countered, and other times replicated. We wanted to explain how subjects interact over time and how, through engaging in different modes of reflexivity, they re-produce inter-subjective relationships that produce in turn relational goods and relational evils (Donati & Archer, 2015). Moreover, we wanted to understand how participants relied on relational goods, or were hindered by relational evils, when reframing, refocusing and recalibrating stigma. Doing so prompted us to retrace three types of clinician-patient relational configurations, together with their above-listed constitutive elements and emergent relational effects (relational goods and evils).

Relationships of familiality

The relations of *familiality*[2] were a gold standard towards which clinicians aspired in their interactions with all patients, as outlined about. They were premised on reciprocity, shared decision-making, relative autonomy and trust about clinicians' and patients' commitment to healing. As the consultant explained, two-sided commitment allowed for delegating responsibility within the relationship while also guaranteeing the continuity of care determined by need rather than formal rule, to manage the unease of seeking help from specialties who might look down on wound healing.

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[2] We have chosen the term 'familiality' because it connotes a rich form of relationality that can be found more readily in (some happy) families than in bureaucratic organisations. We remain acutely aware that, within families, relationality can also involve the generation of relational evils and that family relationships can also involve legal-rational considerations (e.g. during a bitter divorce) and relations of obstruction (e.g. jealousy between siblings) as well as many forms of relationality that are not directly relevant to the case of wound clinics.

> *I'm delegating responsibility. 'You look after yourself. You manage this thing*
> *and if you're worried, give me a shout or come and see me. And I'm happy*
> *to see you without an appointment…Ring this number if it looks funny, feels*
> *funny, smells funny or whatever you're concerned about'.*

Turning the decisional process, typically associated with the medical expert, into a collective practice, allowed clinicians and patients to work together. Patients gradually acquired biomedical understanding of when the wound deteriorated to be able to self-care and greater power to set their own appointments, which reduced their subjugation to clinical dominance, lessening power asymmetries in the relation. Delegating responsibility created a foundation for clinicians to *reframe* their work away from hierarchical intervention into one of mentorship and friendship. Instead of seeing the patient as an ill-bodied, dependant and atomistic individual, the clinicians saw the relation as a resource to enable the patient to independently navigate their life (Hansen, 2016) while having a lifeline of support to reach out for care. The fieldnote below captures *refocusing* through blurring of the professional-personal boundary, showing how within the relational interaction of familiality patients felt wanted as persons with their non-tainted personhoods, increasing the camaraderie as a *relational good:*

> *Doctor Caitlin announces she will be leaving in August to return to*
> *Colorectal Surgery. Plenty of hugs follow. 'If I don't see you again…', says*
> *John's wife, and a hug follows. The doctor comments that she should have*
> *brought some cake. (Morgan Clinic, June 2016)*

A consequence of the development of personable relations with clinicians over years of medical interactions was that such patients grew genuinely interested in 'wound biz'.

> *…you're separating from a professional into a more general relationship…*
> *consequently when I see the consultant in three months' time…we might go*
> *in depth into an area of interest which we both have, as I said. I would show*
> *interest in the consultant and just generally, what the state in wound biz was.*
> *(Tony, patient)*

Frequently, we heard clinicians telling patients about latest dressings or treatment trials. Patients' interest showed in their participation in medical research and industry presentations, in which they drew on their own wound experiences to progress medical wound healing knowledge as a *relational good*. For example, patient Tim explained:

I'm staging my performance. Questions and answers. Because they're all looking at…wound healing…So, it's easy for me because I've had wounds, I've had chronic wounds. And I've made friends. The people are absolutely, they are all lovely people and we have a relationship.

The above quote is also an example of *recalibration* in stigma context, which corresponds with how prison workers in Eriksson's (2023) study presented routine order keeping as esteem-enhancing strategies for the prevention of prison violence outbreaks. In our study, clinicians and patients took the formal activity of participating in presentations of drugs and treatments for a 'dirty' condition and turned it into an avenue for the dissemination of medical knowledge to grow the profile of wound healing and increase camaraderie as *relational goods*. The relational goods were borne out of 'compatible differences' (Donati, 2016) between patients and clinicians. Concretely, clinicians could not do wound research and presentations without patients, whereas patients could not participate in such events without clinicians' support. However, they converged on the need to find ways to heal wounds better to alleviate stigma. Here, the patient invested time and effort because the positive attitude he held in clinics helped him to actively connect with the wound healing agenda. But he was still acting out of his roles in the relation. Tim was performing the role of an 'expert', drawing on his physical experience of a chronic wound, while also recognising the persistence of formal (scripted and hierarchical) relations between patients and clinicians.

Supporting the wound healing agenda was also a space for further *reframing*. The literature has shown how reframing involves stressing the scientific qualities of apparently simple tasks, such as hair treatments (Harness, 2022). Similarly, patient John, grateful for his expert care, offered his 'dirty wound' to research and education to *reframe* his 'disgusting' wound as an intellectual challenge. Undeniably, there was an element of self-interest guiding these commitments; "I keep thinking that the next trial is going to cure it", said John's wife. However, there was also an altruistic orientation visible in a sense of remote corporeal solidarity through empathic bodily sacrifice for other patients to progress medical knowledge (*as a relational good*):

He is much slower than he used to be… He's great, he keeps cheering, and you see somebody else worse off…Although it's not healed up, I think if we hadn't found the hospital specialist in the first place, I think he would have lost his leg because he was so bad before he took over…The care he's had over the years! That's why we're always happy to help anybody, really, with

their research because they have been second to none, haven't they?
(Martha, John's wife)

Patients who shared their stories of participating in wound healing research engaged in reciprocal behaviours of 'giving back' to clinicians in gratitude for the care received and spoke of a unique relationship with clinicians, likening the connection they had with them to *relational goods* of friendship and family, such that their relations took on quasi-familial qualities (Donati, 2016; Donati & Archer, 2015):

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

These patients, along with their relatives, positioned themselves as 'part of the big family' (Martha, John's wife). Here, we saw clinicians, patients and their relatives as relational subjects, engaging with their wound concerns in ways that were destabilising of the formal clinician-patient relationship yet had positive emergent outcomes of 'improving the resources' for raising the profile of wound healing. Participation in clinical trials certainly addressed patients' own wound concerns by giving them a greater chance of healing. But running trials increased the scope for clinicians to grow their specialty and improve future treatments, hence reframe wound care away from dirty work an into an emergent medical specialism based on high-level science beyond changing dressings (Galazka, 2020). This relational configuration sustained the emergence of less formal, more egalitarian relations, which fostered a shared sense of camaraderie and mutual obligations. In patient Tony's words', 'it takes two to tango'.

In the situation described above, informal roles (with associated rights and duties) emerged within the relation of familiality through refocusing, recalibrating and reframing. At the same time, the patient-clinician relation's continuous existence depended on the mutual respect, over time, of the emergent rights and duties. Moreover, relations between persons were never fully dissociated from formal relations between 'patient' and 'clinician' positions. Tim, when asked what made his relationship with clinicians special, highlighted the expertise of "proper wound nurses". Patients displayed faith in clinicians' competence and the rightness of the treatments selected for them as individuals with unique health concerns and distinctive personal lives. Clinicians' main concern was with making sure the treatment was right, for the right reason and the right time. As the quotes from Tony and Tim suggest, despite the emotional connection

of the humane interactions, the influence of hierarchies on the clinician-patient relation persisted and the emergent relation of camaraderie complemented rather than substituted the scripted patient-clinician relation.

Relationships of scripted compliance

> *I meet a patient in her 40s with a traumatic wound above her ankle. The patient suffered a work accident nine weeks ago, creating a clean but deep wound which refused to heal for the first six weeks. However, today it looks almost healed, as medical students in the room confirm. 'I don't care what they say, I want to know what you think' the patient says to the consultant, quickly apologising to the 'young doctors', 'No disrespect'. (Morgan Clinic, August 2016)*

Contrary to relations of familiality, sometimes, the clinician-patient relationship remained relatively impersonal, set within the boundaries framed by bureaucratic scripts of paternalistic and didactic dynamics between 'sick' patients looking for guidance from 'expert clinicians' (Parsons, 1951). In the above fieldnote, the patient believes the formal position of the consultant gave him the authority to make the final judgement on her care outcomes. The patient was not interested in lending her wound journey to medical education or listening to 'less knowledgeable' younger doctors. Some patients set the operative tone with the clinicians to fit a formal relationship.

In the relationship generating such *scripted compliance*, patients expect the clinician to provide instruction whereas they simply follow. For example, patients Elina, Chris and Steve stressed their satisfaction with the care as part of the medical treatment in a manner uncritically affirmative of a hierarchical care arrangement. Patient Derek repeatedly reiterated his deference to clinicians' expertise and preference for one-way transmission of knowledge ("You're the expert not me when I come here"), whereas patient Michael felt he lacked the motivation to overcome the role of a sick patient, preconditioned by prior paternalistic care structures:

> *To be perfectly honest I have no expectations and I'm like that anyway. It didn't bother me…Whatever they were gonna do, they do, so that's the kind of character I am.*

Relations of scripted compliance were maintained by default, unless patients and clinicians could steer their relation towards familiality. For some vulnerable patients, relations of scripted compliance were the only possible mode of engagement. Preserving functional roles was a *relational good*, though, as it also improved the chances of healing stigmatising wounds. It also gave clinicians space to *refocus* the work by concentrating fully on the cultivating and applying esteem-enhancing medical expertise, just as Bachleda and El Menzhi's nurses (2018: 776) refocused stigma by putting into practice everything they had learnt.

However, sometimes, clinicians suspected that some patients were unwilling to share the dirty tasks and preferred to delegate all care to clinicians. While impersonating humorously these kinds of patients, the consultant declared such patients' relationship to their own body was passive:

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

Ella added,

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

Maintaining traditional role divisions of 'I, the patient' (who makes little effort) and 'You, the expert' (who makes every effort) did not enable clinicians to steer the care interaction beyond the hospital treatment, reinforcing the clear line between clinicians' and patients' responsibilities. Akin to Hansen's (2016) study of the elderly's passivity increasing their vegetative, stigmatised state, patients risked reinforcing stigma by acting like a passive body, or a 'lump of meat'. This constrained clinicians' foundation for deploying the coping strategies, at best leaving them with the option to *recalibrate* their work on preventing wounds from getting worse, just as prisoners in Eriksson's (2023) study who recalibrated on counting prisoners and keeping records to stop bigger problems from occurring. Moreover, akin to HIV/AIDS workers' recalibration strategies (Bachleda & El Menzhi, 2018), while they could not involve such patients in medical research or presentations, at least they knew how to heal or manage the wound.

Moreover, commitment to scripted I-You relationships encouraged distancing between clinicians and patients as a *relational evil*. This choice for self-detachment was, sometimes, stemming from own social and professional contexts. Michael's son-in-law, Mark, recalled how prior interaction with district nurses conditioned them to expect the same relational dynamics of role division in the outpatient clinic:

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

Although the mode of reflexivity in relations of scripted compliance was based on actions oriented to formal rules, nevertheless, involvement through functional role preservation was a *relational good.* Rather than obstructing the provision of care, patients in relations of scripted compliance adhered to the treatment, increasing their chances of improving the sight, smell or condition of the wounds, helping themselves and their relatives, and indirectly helping clinicians boost the credibility of their work by potentially improving their metrics of success.

Relational configurations of obstruction

The third relational configuration of *obstruction* was suggested by podiatrist Ella, who explained that some patients sometimes acted egoistically, trying to obtain privileged and priority wound treatment for their own wound:

> *...we may have had patients that you had a good relationship with, that you have been seeing for a long time...they expect you to put them to the front of the list...it's not fair...They are still like, 'When am I gonna be seen?' Honestly! 'But what about me?' 'I demand this'.*

One patient's peculiar relationship with clinicians alerted us to emergent features of obstruction to clinicians' activities through self-referential and individualistic behaviours. Jane's interactions with clinicians were visibly marked by her own agenda, which sometimes clashed with clinicians' agenda. Jane's attitude may have stemmed from her compassion-*less* formative encounters with a dismissive doctor years before. Consequently, Jane developed a sense of independence and courage to speak up, sometimes controllingly showing clinicians how her own wound should be cared for:

> *Jane tells me that although she doesn't have the same medical knowledge as nurse Amanda, she knows her wound better than anybody else because she*

> *has had it for so long… As Amanda is experiencing problems with the padding, the patient's husband gets up and assists the nurse. 'Show her,' Jane says to her husband. He helps Amanda cut the padding to fit around the patient's leg. Amanda concludes: 'You might get around with one padding'. (Morgan Clinic, August 2016)*

Such bodily communication was crucial for Jane to *recalibrate* the stigma relation on her own treatment preference. By 'educating' clinicians about her own approach she felt she could counter their possible criticisms (cf. Bachleda & El Menzhi, 2018: 776). However, her construction of self-sufficiency was somewhat misguided. While Jane adhered diligently to some aspects of her care, she was also vociferously against compression treatment, thus impeding wound healing as a *relational evil* through selective compliance. Moreover, while she eagerly participated in most clinical trials, affirming that, at the very least, she was helping other patients in the future, Jane would sometimes abuse and instrumentalise her outreach activities to push forward her agenda:

> *The nurse who is new and unfamiliar with Jane, asks why she is not in compression. Jane replies that she has recently given a talk at an event saying that compression and elevation do not work. (Morgan Clinic, December 2016)*

The patient's lack of consent was ethically defensible on grounds of patients' rights, but it created tensions that risked degrading patient-clinician relations. Concerning relations between social positions, such patients' self-proclaimed expertise reduced clinicians' role to that of a 'medical servant':

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

Jane's support for clinicians' trials could have contributed to improving medical knowledge in the wider wound community as a *relational good*, potentially countering stigmatisation related to their work. Yet, her questioning of other treatments risked stalling progress in medical

knowledge diffusion as *a relational evil*. Her overall conduct seemed concerned with maintaining status quo rather than reaching satisfactory healing.

While a psychoanalytical interpretation of patients' unconscious motivations falls outside the present study, we noticed that in various instances of obstruction, some patients acted as if they, paradoxically, preferred to remain in a wounded state and retain the focus on dirtiness of the wound:

> *'Some patients enjoy their illness, sad as it sounds, and these patients always have the same outcomes, which is a lack of improvement'. (Mary, Morgan Clinic, August 2016)*

In relational configurations of obstruction, patients display an ambivalent attitude that combines excessive dependence and defiance, requiring clinicians to enter into a complex process of negotiation:

> *The patient might not be telling the truth about soaking her foot in water with potassium permanganate tablets, which normally discolour the leg. Not a case here. Finally, the patient admits the tablets are causing her pain and she avoids the soaks. The doctors suggest she try either using one tablet every day, or more tablets every other day. (Bridge Clinic, July 2016)*

In the fieldnote above, the patient's narrative of treatment adherence contradicts the bodily manifestation that clinicians could reasonably expect to see. Getting the truth required finding new ways to ensure that treatment would be followed, the wound would improve, or at least not deteriorate, therefore improving patients' experience of the wound and the clinicians' metrics of success. In this sense, damage control was a *relational good*.

Surprisingly, perhaps, clinicians too contributed unintentionally to reproducing the relational configuration of obstruction through their noble philosophy of never discharging patients:

> *What you find with these patients is if you discharge them, they will only pop up somewhere else…And they will start the whole investigation again…it will all come back normal…so how costly is that to the NHS? So, these patients, we never actually discharge them. (Amanda, nurse)*

As Christina explained, "I think as healthcare professionals sometimes we foster overdependence, because we get something from that as well. We feel good by helping, so we keep that going, I think". With patients in relations of obstruction resisting some clinical advice, and clinicians maintaining the status quo recognising that they were often the patients' "last chance to lose" (Christina, director of medical education), both groups pursued their personal reflexivity focused on personal agendas and contributed to keeping wound stigma intact.

Discussion: Relational configurations as conditions of possibility for stigma management

This study explored how wound stigmatisation for patients and courtesy stigma for clinicians in socially tainted wound healing work can be reframed, refocused and recalibrated by drawing on the relational resources of dirty worker-client relational configurations. Combining an ethnographic study of clinician-patient relations in outpatient wound healing clinics with the literature on dirty work and critical realist relational sociology (Donati & Archer, 2015), we distinguished three relational configurations (of familiality, scripted compliance and obstruction) through which clinicians and patients relationally challenge, but also reproduce, wound stigma. We theorise relational configurations as complex and ontologically heterogeneous totalities that include networks of relations but also ontologically diverse entities that bear different causal effects on relationships and the stigma. Which entities are relevant is likely to depend on specific contexts, however our empirical study identifies several mechanisms that seem relevant to managing wound stigma in clinical settings. Tables 3a and 3b summarise the constitutive entities of the configurations analysed above, following a relational sociological view of organisations (Mutch et al., 2006).

Table 3a here (entities common to all three configurations)

Table 3b here (entities specific to each configuration)

How individual agents manage wound stigma in relational configurations

Although relational configurations are real entities with causal effects, they never act on their own as efficacious agents. Rather, their causal powers are always mediated by agents' activities and internal conversations (Archer, 2003). We now theorise how individual agents, who are also relational subjects, produced relational goods and evils which enabled or disabled the

management of stigma through reframing, recalibrating and refocusing for workers and clients alike. The novelty of our paper is that we show how the capacity of workers and clients to reframe, refocus and recalibrate stigma depends on the type of relation they have formed together.

In relations of familiality, patients were concerned with maintaining the relationships they had developed with clinicians while contributing to growing the profile and knowledge of wound healing. They thus reordered their own concerns to fit in with this primary concern (Donati & Archer, 2015). There was a strong reflection about the relationship itself in addition to awareness of individual interests (Donati, 2016). Prior research has shown that when patients remember clinicians for "helping them through a hard time", that helps patient confront their stigma while also making clinicians feel "really good" (Ward, 2021: 520) to counteract the courtesy stigma effects. This is because "receiving clients' gratitude at the interpersonal level can buffer the negative effects of perceived work dirtiness" (Zhang et al., 2023: 8). Whereas the dirty work literature suggests clients are normally distanced from workers (Ashforth & Kreiner, 1999), in our setting many patients supported wound healing resources to help clinicians resist courtesy stigma through educating the medical community (Bachleda & El Menzhi, 2018) and to increase their own chances of healing through cooperation with clinicians (MacRae, 1999). Familiality can therefore be a resource for resisting wound stigma through *reframing* the situation to prioritise a strong clinician-patient connection and the scientific potential of treating stigmatising medical condition; *refocusing* through blurring professional-personal boundaries; and *recalibrating* dirty wound care as avenues for medical profess, growing wound healing profile and increasing camaraderie.

As for relations of scripted compliance, their distinguishing feature was their embeddedness in patients' preference for historical role division between active clinicians and passive patients (Parsons, 1951). Consequently, joint-ness of aspirations concerning wound stigma were absent. This is important, as most dirty work studies do not explain clients' behaviours through their agentic reflexivity but assume *a priori* that clients are aware of the dirt and stigma of specific jobs and seek distance from them (Hamilton et al. 2019; Hughes et al. 2017). Our analysis, instead, shows that some patients might not be too concerned with wound stigma or too interested in steering the scripted patient-clinician relationship towards a more egalitarian, and committing, relation of familiality. However, prior research has shown that even highly formal and asymmetrical worker-client relations can also be a way of managing stigma for the workers

who enjoy being able to make a difference to the life of a dependent client (Harness, 2022) through recalibrating on their expert knowledge and job's purpose. The effect of actions oriented towards role preservation is ambivalent. When treatments are followed, scripted roles can improve the medical condition of individual patients and, in the long run, improve the metrics of wound healing and make clinicians feel more useful and less tainted. However, because relations of scripted compliance also encourage distancing, they can leave dirty workers feeling, perhaps paradoxically, abandoned by their patients, exploited and even humiliated by lack of cooperation, which reinforces courtesy stigma (MacRae, 1999; Varman et al. 2023).

Finally, concerning relations of obstruction, patients' prior experiences may pre-condition them to become reclusively "self-sufficient" (Donati & Archer, 2015: 69) and tackle any wound stigma situations self-referentially, disrupting the conventional expectation that "patients are only too willing to co-operate" (Strong, 1980: 38). Research in medical settings has shown that patients who reject help from clinicians undermine the latter's professional status and legitimacy, making the work 'dirtier' (Shaw, 2004; Williamson et al., 2014), with lack of cooperation increasing courtesy stigma (MacRae, 1999). Our example of patients in relations of obstruction shows that by dismissing extant medical knowledge, they can contribute to both the generation of a narrow relational good of self-esteem for the patient and broader relational evils preventing clinicians from positively *recalibrating* the dirty work on their expert knowledge. This may also stall progress in wound healing knowledge and cause slow or interrupted healing, intensifying stigma for patients. Moreover, the policy of never discharging patients furthered the relational configuration of obstruction, which kept the wound stigma constant.

Conclusion

Our research has been one of few studies that explored in detail the nature of the interaction between dirty workers and their stigmatised clients. While extant studies assume that interacting with stigmatised clients creates taint for workers, we have explored instead how, over time, worker-client relationships can also be a powerful resource for managing stigma. Thus, instead of focusing all our attention on how workers discursively cope with courtesy stigma (Olvera, 2017; Bachleda & El Menzhi, 2018), we have theorised the worker-client

relationship, with help from realist relational sociology, as a relational resource that worker and client can mobilise if they both wish so, and if the relational configuration permits.

Our approach allowed us to examine how, in different types of relationships, workers and clients collaborate to manage stigma together. Taking a lead from Ashforth & Kreiner (1999), we analyse stigma management as coping with stigma through reframing, recalibrating and refocusing.

But our paper also goes a few steps beyond. Firstly, we attend to the relational activity of workers and clients managing stigma *together*. Thus, our account is deeply relational. In comparison, accounts exclusively centred on symbolic interaction appear highly individualistic. While we understand that most people care dearly about the impressions they convey, our research project also included people who cared more about other people's flourishing than about being admired by them. Thus, rather than putting impressions management at the centre of our analysis, we have attended to how dirty workers and clients produce and steer relationships that may be conducive to stigma alleviation, or not.

Secondly, although participants partake to a single stigma setting, we could notice remarkable differences in how workers and clients managed stigma together. These differences cannot be straightforwardly explained in terms of participants' discursive prowess. We found, rather, that the coping techniques of reframing, recalibrating and refocusing are not just grounded in workers' cultural ideas, but also in fleshy recipients of dirty work, with agency of their own that might put constraints on the difference the workers can make. By combining a realist relational approach with the social constructnionist[3] conception of coping we are not arguing against reframing, recalibrating and refocusing as valid coping techniques, but argue instead that these techniques do not depend only on people qua cultural agents as they also depend on the relations threaded over time between people qua material and relational subjects.

Thirdly, our research also hints at advisable management practices that cannot be deduced from previous studies of dirty work. While very few scholars in dirty work would call for cowboy management à la Kotter, many advise instead to carefully craft narratives that reframe, refocus

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[3] Following Al-Amoudi and Wilmott (2011), we interpret critical realism as a weak form of social constructionism.

and recalibrate dirty work. Our paper goes further and we would also advise to carefully consider the types of relationships that are possible between dirty workers and clients, the conditions of possibility of these relations, and the relational goods and evils they are likely to generate. For instance, studies of dirty work in Non-Western contexts frequently point to structural and cultural conditions that lack the constitutive elements of relational configurations of familiality. In the context of cleaning work in India, for instance, Mendoca et al (2022: 2-5) remark that "with the rise of outsourcing and contractual work, cleaners' employment relations are characterised by extreme insecurity and indignity … Cleaners have been rendered voiceless due to declining collective action pushed by the neo-liberal agenda". In such a relational configuration, we should not be surprised to find out, with Varman et al. (2023), that even relations resembling familiality are laced with inequalities and humiliations that turn them into relations of toxic maternalism that generate more relational evils than goods. Since context weighs on relationality and relationality weighs on people's capacity to cope with stigma, we certainly need more studies of dirty work that attend to the macro-sociological and historical context of interaction.

Finally, we hope our relational study of wound stigma will also inspire future social and organizational studies beyond salaried work. How people occupying different roles manage stigma together is indeed relevant to broader, other-facing care settings where stigma is tied-in with the relation, such as, the invisible work of family members caring for relatives with stigmatising mental and physical health conditions, where cooperation and dedication as well as opposition and disengagement may equally well emerge (MacRae, 1999; Phillips et al., 2012).

Table 1. Details of interviewed patients and relatives

Patient	Profile	Relative
Derek	Diabetic foot ulcer for 12 months	
Michael	Diabetic foot ulcers for 12 months	Mark (son- in-law)
Jack	Foot ulcer for five months	
Elina	Vascular ulcer for seven years	Charles (husband)
Jane	Vascular ulcer and eczema for 33 years	Mike (husband)
Tim	Blisters on feet and pressure ulcers for 20 years	
Tony	Diabetic foot ulcer for 14 years	
John	Leg ulcer for 32 years	Martha (wife)
Robert	Post-surgical abdominal wound for five months	Joanna (wife)
Chris	Vascular ulcer for one year	Janet (wife)
Eleri	Self-harm thigh wound	
Steve	Diabetic foot ulcer for six years	Caitlin (wife)

Table 2. Details of interviewed clinicians

Clinician	Medical background
Ella	Research podiatrist
Phil	Surgeon and general practitioner
Amanda	District nurse
Eva	Acute care nurse
Mary	District nurse
Christina	Psychiatric and general nurse
Claire	Tissue viability nurse
Deborah	Tissue viability nurse
Kate	Surgeon
Sam	Podiatrist
Megan	Surgical emergency nurse
Wound healing consultant	Background in general practice

Table 3a. Entities constitutive of all three relational configurations

Nature of entity	Instances in the wound healing clinic
Architectural settings	individual consultation rooms; clinicians' area; waiting area
Material artefacts	Beds; medical tools; dressings (e.g. compression); medical notes; medical coat
Wounded bodies	bodily wounds; pus; necrotic tissue; leg ulcers; wound malodour
Physical reactions	repugnance; resistance; distress; concern; horror; disgust; feeling or being sick; reflexively tampered or normalised over time by some participants to the point of acceptance
Wider social relations in society	increased urbanisation and anonymity; bureaucratisation and hierarchy of clinician-practitioner relations
Ideas and cultural entities	cultural standards of visual and olfactory acceptability; medical knowledge; best practices as part of the medical repertoire / cultural archive; perception of wound healing as inferior medical field; patient-centred discourse
Formal organisational rules	never abolished but sometimes counteracted by emergent norms specific to each relational configuration

Table 3b. Entities specific to each relational configuration

	Familiality	Scripted Compliance	Obstruction
Patient relationship to her/his/their body	Bodily sacrifice	Passive bodies	Controlling bodies
Relations between persons	Patients able and willing to self-care Continuity of care determined by need rather than formal rule Shared decision-making Reciprocity Mutual gratitude; Quasi-familial relations; friendly relations	Relatively impersonal Oriented to bureaucratic scripts	Patients' (misguided) construction of self-sufficiency Clinicians as patients' 'last chance to lose'
Relations between social positions	Preservation of some functional commitments and respect for hierarchical role relations while moving towards greater egalitarianism	Functionality associated with bureaucratic role division – sick patient and expert clinicians Clear line between clinicians and patients' responsibilities	Patients as self-proclaimed experts and clinicians as servants
Informal powers produced over time through relational interactions	Patients as experts in wound care Patients have more power to set their own appointments to access medical expertise Reduction in degree of clinical dominance Clinicians as mentors and friends	None identified	Patients' and clinician's 'abuse' of familiarity for personal agendas
Participant concerns	Having a channel to reach out for care 'Disgusting' wound	Wound healing Own social and professional contexts	Privileged and priority wound treatment

			Own wound Own preference and approach to treatment
	Expertise of wound specialists Making sure the treatment was right, for the right reason and the right time	Following bureaucratic script	
Practices	Delegation of care Self-care Reciprocal behaviours Mutuality of obligations Lifeline of support Participation in wound research and presentations Interest in 'wound biz'	Top-down didacticism Didactic interactions One-way transmission of knowledge Paternalistic care delivery Patients delegate their care to clinicians	Self-referential and individualistic behaviours Selective compliance Never discharging patients
Modes of reflexivity	Relational steering concerned with relational goods	Actions oriented to formal rules	Personal reflexivity
Relational goods	Progress in medical knowledge Increasing wound healing profile Camaraderie Friendship and family	Functional role preservation	Improving medical knowledge in the wider wound community Damage control of wound worsening Narrow self-esteem for the patient
Relational evils	None identified	Distancing	Impeding wound healing Stalling progress in the wider diffusion of wound healing knowledge

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