



UNIVERSITY OF LEEDS

This is a repository copy of *The ghost of Nora Batty: a qualitative exploration of the impact of footwear, bandaging and hosiery interventions in chronic wound care.*

White Rose Research Online URL for this paper:
<http://eprints.whiterose.ac.uk/82723/>

Version: Accepted Version

Article:

Madden, MT (2015) The ghost of Nora Batty: a qualitative exploration of the impact of footwear, bandaging and hosiery interventions in chronic wound care. *Chronic Illness*. ISSN 1745-9206

<https://doi.org/10.1177/1742395314566824>

Reuse

Unless indicated otherwise, fulltext items are protected by copyright with all rights reserved. The copyright exception in section 29 of the Copyright, Designs and Patents Act 1988 allows the making of a single copy solely for the purpose of non-commercial research or private study within the limits of fair dealing. The publisher or other rights-holder may allow further reproduction and re-use of this version - refer to the White Rose Research Online record for this item. Where records identify the publisher as the copyright holder, users can verify any specific terms of use on the publisher's website.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.



eprints@whiterose.ac.uk
<https://eprints.whiterose.ac.uk/>

Title

The Ghost of Nora Batty: A qualitative exploration of the impact of footwear, bandaging and hosiery interventions in chronic wound care. *Chronic Illness*

Pre-publication accepted version (2) 4 January 2015 DOI: 10.1177/1742395314566824

Author

Dr. Mary Madden, School of Healthcare, University of Leeds.

Contact details

Dr. Mary Madden,

Lecturer in Applied Health Research

School of Healthcare, Faculty of Medicine and Health

Room 2.19, Baines Wing

University of Leeds

Leeds

LS2 9JT

0113 343 1286

Abstract

Objective

To explore the impact of footwear, bandaging and hosiery interventions in the everyday lives of women and men undergoing treatment for chronic, complex wounds in a city in England, UK.

Methods

This study draws on data generated in semi-structured interviews with patients exploring outcomes and impacts of undergoing treatment for leg and foot ulcers undertaken as part of a UK National Institute for Health Research (NIHR) funded study.¹ Footwear, bandaging and hosiery are explored here as aspects of material culture, not only in functional terms as a treatment supporting or hindering healing, but also as part of the means by which people receiving treatment for two of the most common complex, chronic wounds, leg ulcers and foot ulcers, negotiate and understand their embodied selves in every-day life.^{2 3}

Findings

Physical and social discomfort associated with interventions can lead to ambivalence about effectiveness. Not being able to dress appropriately impacts on the ability of people to feel comfortable and take part in special occasions and everyday events. In this context, the removal of bandaging or refusal to wear support hosiery which may be viewed as 'non-compliance' by a health professional may feel like a strategy of self-care or self-preservation from a patient perspective.

Discussion

The study of material culture explores how inanimate objects work and how they are worked with in carrying out social functions, regulating social relations and giving symbolic meaning to human activity.⁴ The interviews show some of the ways in which footwear, hosiery and bandaging play a role in controlling the boundaries between the private (wounded and potentially socially unacceptable smelly, leaky, embodied) self and the public presentation of self.

Keywords: wound care, material culture, qualitative research, chronic illness, self-care

Introduction

This article focuses on the role of footwear, bandaging and hosiery in the care of two of the most common complex, chronic wounds in the UK, leg ulcers and foot ulcers. A multi-service, cross-sectional survey undertaken across a city in England during two weeks in spring of 2011 produced a point prevalence estimate of leg ulcers of 0.44 per 1000, and of foot ulcers of 0.22 per 1000.⁵ The mean age of those with leg ulcers was 76.46 years and the mean age of those with foot ulcers was 74.78 years. These wounds are closely associated with underlying conditions and co-morbidities which become more prevalent in older age and are a common, serious and costly global health issue.^{6 7 8} Leg ulcers are mainly due to venous and/or arterial disease and many, but not all, foot ulcers are caused by vascular and neurological complications of diabetes. Although prevalence increases with age, developing a chronic, complex wound is not a condition exclusive to older age. For example, intravenous (IV) drug use is a risk factor for developing venous leg ulcers. The sub population of IV drug users with chronic, complex wounds is relatively young.¹

In the UK, most people with leg and foot ulcers are managed by community nurses with referral to specialist services, including tissue viability, surgical specialties (e.g. vascular and orthopaedic surgery), podiatry and dermatology. People with these wounds often experience repeated cycles of ulceration, healing and recurrence which have a significant and detrimental effect on their lives.^{9 10 11} The following analysis draws upon a constructivist sociological perspective that assumes that the embodied self is fundamentally (bio-)social and is developed and maintained through social relations. Subjective, social and emotional experiences are viewed here as integral to experiencing ill-health and not only of interest as psychological sequelae or as emotional barriers to understanding or adherence to treatment regimens.¹²

The study of material culture, in this case bandaging, footwear and hosiery, explores how inanimate objects work and how they are worked with in carrying out social functions, regulating social relations and giving symbolic meaning to human activity.⁴ For example, shoes have been ascribed the capacity to have 'transformative' powers and to serve as markers of, gendered identities, life course stage, social class, work and leisure activities, health and illness and transitions between these.¹³ The prescription of orthotics, bandaging and hosiery to aid healing and prevent recurrence in people with complex wounds has an impact on their ability to make everyday choices about footwear and other clothing at a heightened time when embodiment is brought to the fore of consciousness. Therefore, in addition to their important function for promoting physical health, footwear, bandaging and hosiery are explored here as items by which people with wounds negotiate and understand their embodied selves in every-day life.

The title of this study comes from an interview with a woman receiving treatment for leg ulcers who said that what she most wanted was to get the bandages off and, "not look like Nora Batty", a character in the long running British situation comedy series *Last of the Summer Wine* who wore famously wrinkled stockings. Norah Batty is in the British tradition of the comic 'battle-axe' and while much loved, such characters are part of an ongoing debate about how the reductive range of representations of older women in the British media may link to wider discriminatory practices.¹⁴

The study

Aim/s

To explore the impact of footwear, bandaging and hosiery interventions in the everyday lives of women and men undergoing treatment for chronic, complex wounds in a city in England, UK.

Design

This study draws on data generated in semi-structured interviews with patients and health professionals which explored outcomes and impacts of treatment for leg and foot ulcers and was undertaken as part of a National Institute for Health Research (NIHR) funded UK study under its Programme Grants for Applied Research funding scheme (RP-PG-0407-10428). Interviews allowed participants to generate naturalistic data on what they considered successful in terms of treatment outcomes. As part of this, patients narrated their experiences of developing, living with and managing their wounds. Methods have been reported in full elsewhere.¹ Here, the respondents' views on footwear, bandaging and hosiery are explored not only in functional terms of a treatment supporting or hindering healing, but also in relation to the role they play in supporting social identity.¹⁵ Material objects shape us as users and consumers of them and mediate a wide range of interactions between the self and other objects and people, while themselves constituting a part of the immediate physical world. The focus in this sub-study is on the meanings and use of these material objects as interventions which form part of the daily physical interface between the self and the world.

Sample/Participants

Purposive sampling was used to ensure that as broad a range of patient experience of chronic wounds as possible was recorded in the interviews and in order to meet the wider programme aim of including the views of injecting drug users with chronic wounds, which are seldom heard in the existing literature. The sample size aimed to maximise diversity across the patient group. This meant adopting an iterative sampling approach moving back and forth (iterating) between sampling and analysing data so that preliminary analytical findings shaped subsequent sampling choices. A sampling frame was drawn up by the researcher with National Health Service (NHS) clinician partners based on discussions about the profiles of patients using the service. The researcher had no access to patients' medical records. This study draws on material from the whole sample of 19 interviews with people who had lower limb ulcers (eight of whom had venous leg ulcers, six of whom had leg ulcers due to injecting drug use and five of whom had foot ulcers as a result of diabetes). Hosiery, bandaging and footwear interventions form part of the treatment landscape for these participants. At the time of the interviews, the four-layer compression bandage system (four-layer bandage) is regarded as the gold standard compression system to treat venous leg ulceration.^{16 17} The bulky nature of this system has an impact on the footwear that can be worn while being treated; the patient's own shoes may no longer fit, forcing changes in accustomed and preferred choices of both footwear and clothing.¹⁸ Special footwear and casts to prevent weight bearing are also frequently used as a treatment for diabetic foot ulcers.

Data collection

Interviews using a topic guide were conducted between 2010 and 2013 in the participant's home, referring service or place of work as they deemed appropriate. Interviews lasted between 25 and 60 minutes, were digitally audio-recorded and transcribed verbatim. Issues about footwear, bandaging and hosiery were raised in response to various interview prompts that did not explicitly mention these items. For example: describe the treatment received; how valuable do you think this is?; are you bothered by pain, odour, itch, leakage, infection, anything else (which is/was worst?); has the treatment caused you any limitations?; how has having the wound impacted on daily life?; do you have any coping strategies or advice you could share with others experiencing this condition? A series of open and closed prompts sought to offer all interviewees the same terms of reference while also allowing them to talk freely about their experience of the wound and its treatment.

Ethical considerations

The study was subject to full ethical review. It received approval from a university research governance committee and an NHS Research Ethics Committee (REC reference number: 09/H1311/88). Participants were recruited through the services delivering their wound care; they were given verbal and written explanations about the study and time to consider their participation. Care was taken to ensure that potential participants did not feel pressured to become involved in the study.

Participants were assured of the confidentiality of their responses and that taking part in or withdrawing from the study would not affect their treatment. A £10 shopping voucher was given to each lay participant to thank them for their participation and cover any out of pocket expenses.

Data analysis and rigour

The analysis stage focused on speech content rather than discourse construction and broadly followed the pattern of the framework approach.¹⁹ This allowed the treatment outcome themes identified a priori to be specified as coding categories from the outset and combined with other themes or concepts that emerged when subjecting the data to inductive, thematic, content analysis. All transcripts and interview notes were read and re-read. Recurring themes were identified during this familiarization process and grouped together into similar themes in order to be organized into a conceptual framework, or index. Descriptive summaries and explanatory accounts were written under index headings. Inductive analysis was checked and affirmed through re-examination of unusual cases and data that did not fit the categories developed. Preliminary findings were scrutinised by members of the programme team. The role of footwear and hosiery in everyday life was an emergent theme. After data analysis answered the primary research question,¹ a more detailed and theoretical analysis was conducted on this subset of data, returning to the original transcribed data on the emergent theme and paying analytic attention to the similarities and differences to themes and sociological concepts in previous research on material culture, identity work and chronic illness. Preliminary findings from this analysis were presented for discussion at an interdisciplinary symposium.²⁰

Findings

Full demographic details of this subset of 19 patient interviewees are in table 1. There were 11 women and eight men ranging in age from 21 to 97 years old. The mean age of women was 84 (range 75-97) and men 48 (range 21-72); overall mean 63. Participating injecting drug users were all men and this group were the youngest in the sample. All but one of the interviewees were White British and spoke English as a first language. One person of German origin had been using English as a second language for many years. Everyone had left school by the age of 16. The duration of their present wound ranged between three months and 38 years.

Compression bandaging

All of the participants with venous leg ulceration were receiving or had, at some point received treatment with the four-layer bandage. Some who had previously spent a long time trying other interventions were relieved to be in compression: "it was lovely...within six weeks they were healing up marvellous" (LU1). Others had past experience of the system and were willing to try it again. However, many experienced difficulties with it and four had stopped using it. Many patients spoke about the bulky nature of the bandaging, "so your legs sort of finish up $\frac{3}{4}$ inch bigger each side and them makes them quite difficult to operate" (LU4). Some experienced difficulties walking, "because my leg's constantly swollen with the clots and now I've got the compression on it, it makes it a little bit harder... to walk" (IVLU3). Some had experience of compression bandages being misapplied or slipping:

I hate talking behind their back...but one of the nurses had put the bandage on and they'd not put it far enough up...it started to go a bit necrotic (LU3).

She's [nurse] going to start dressing it twice a week now. Because I go on a Monday, well by Thursday it's wrinkling and I look like Norah Batty (LU5).

A 97 year old woman who had frequently recurring leg ulcers over 38 years had tried compression but it caused irritation and she could not tolerate it: "Pressure's supposed to be the thing. But for me it's no good" (LU6). One man had tried it but had to stop because, "[the consultant] said... you're stopping the circulation" (LDFU5). One participant said he was not using the bandages, "because I don't like them... it makes my feet swell up ...I couldn't basically handle it." (IVLU6). Another said he knew that, "that's what's going to heal that wound up, the compression" and he knew the practice nurse did not like it, but he no longer wanted compression bandaging because, "it gets stinking it's not nice...when you are sat on the bus and that, and people are sniffing...And when I took the compression off, all the wound's been like green." (IVLU4). Five people said that the thing that most bothered them about their wound was the social embarrassment of smell and some associated this with the bandaging more than the wound itself:

No, it's never been odorous (LU4).

But the legs do [smell]...But it's not the ulcers...it just seems to be the bandages...I don't know whether it's because of the ...warmth of the bandages. Or it's just one of those things (wife and carer of LU4).

One man used an odour eliminating product because, "it's a better smell than rotting flesh" (LU3):

... if I had shares in that [odour eliminating product]...because it got to a point where I wouldn't go on a bus or anything...if I could smell it, I'm sure other people could smell it and it's embarrassing (LU3).

Whether smell was a concern or not, bulky bandaging inevitably had a knock on effect in terms of the choices people could make about what to wear:

I hate this being on. I do, I really do hate it...Because I can't wear a skirt...My granddaughter...she's having a hen party...And she said, 'oh you've got to come, Nan. I know you like a dance.' But I thought, there's no way am I going like this. So I'm going on Friday to see the nurse and I'll tell her that a week on Friday this bandage is coming off and she can put a dressing on...the trouble is I can't get these bandages on myself... (LU5)

One man said he might consider less compression because, "I don't have as many layers on for that...I've only got like three tracky bottoms that I can wear. Because they won't fit on top" (IVLU4). People also disliked compression bandaging because they found it awkward getting shoes on:

I had to have bandages and bandages and obviously it distressed me because I can't wear... proper shoes...I mean I haven't got a small foot size to begin with ...they have surgical...I once tried them around the garden. I don't know how many times I fell in them. No, no, no. I'd rather sit in here...they're like an elephant...believe me once seen never forgotten...I keep asking my nurses [if there is anything better] and so far it's no...if there was something more to look at but I don't even care about looking, but the size...(LU2)

This woman stayed in most of the time and used a laced sandal when she did venture out. Another interviewee said that all her shoes were too tight when she wore compression bandaging, "now I've got piles of shoes that are too big but I'm not parting with them" (LU1). Concerns were expressed about the size, social appropriateness and weather appropriateness of footwear in interviews about leg

ulcers and that, “nobody seems to discuss that with you” (LU5). For those who had not given up on compression there was a sense that “you have to persevere”:

...and maybe with a bit of luck it will heal up and you will for a few months be able to wear shoes and walk properly (LU2).

I mean...I know I'm on about the stockings [bandaging] and that and they look ugly but its working...because I'm not in the pain that I was in (LU5).

Hosiery

One interviewee attended a leg ulcer clinic and was an ambassador for compression to prevent recurrence:

When I first came out of the four layer bandaging I just wore them [support stockings] to below the knee but then [the nurse] said, 'I think you need them to the thigh'. And on both legs...You're glad to get them on in the morning and then you're glad to get them off at night. Especially in the heat...but they've improved so much...and they keep my circulation going don't they? (LU1)

This interviewee said she wore sand coloured stockings in summer and black in winter but had trouble getting an appropriate suspender belt. She needed a belt with three suspenders on each stocking but most suspender belts she could find only had two. She needed an elasticated belt for comfort and not lots of fiddly hooks and eyes because of her arthritis. Suspender belts tended to be only on sale in lingerie shops at Christmas and Valentine's Day. However she was pleased that, “while sheltering from the rain” in an out of town retail centre she happened to find a supply and managed to stock up. She had also found a device made from parachute silk which

helped getting the stockings on. The one she could get on prescription was “all rattly” and made it hard to be discrete when staying with people.

After trying FarrowWrap™, which they said looked like “the old fashioned puttees,” and a long and poorly supported period of “full blown bandaging”, one husband and wife couple talked about the “normal sexy stockings” he was given (LU 4 + wife/carer). The wife helped her husband put them on. They said they laughed about them but the main problem was that because he had lymphoedema, compression made his legs leak and the sticky fluid that dried on the stockings was causing his skin to pull off. Another man explained his reluctance to wear a stocking to prevent reoccurrence in a healed ulcer:

I'm supposed to wear a stocking on my other leg...[on] the one that's got rid of...but I don't put it on all the time...I don't like them. I feel girlie in them, they're not the right colour... I have asked for the black ones but I still haven't got them...[I've got] brown like I'm wearing women's tights... I've had the white ones as well but they're not very sexy either...The black ones are good...they're more acceptable for a bloke but even a dark blue, navy blue would be better...but if I have to wear them, then I have to wear them...but...the ones that I've got at home are a little bit big and they're doing nothing for me. I can tell that. It's only like me wearing a tight pair of socks (IVLU1).

His dislike of the hosiery seemed to lead to ambivalence about their effectiveness, he said he would wear them if he had to but doubting their efficacy might mean he does not have to.

Shoes

Interviewees with diabetic foot ulcers described their experience of shoes for outside wear and shoe-like offloading devices for use in the house and in the shower:

[After a recent operation to remove three toes and half of his foot] they fetched me a boot so I could get a shower but I can't get a shower because we haven't got a shower...So at the minute it's flannel, soap and strip wash ...They gave me a boot ...it's not for walking to the shops...just for walking around [the house] but it's not a comfortable boot and it tends to hurt my heel more than my slippers (DFU1).

This man had no idea he was diabetic until he had the infection which led to partial amputation of his foot. The standard procedure was a full amputation. He found the sudden restrictions on his mobility very restricting and was considering a full amputation because it seemed to promise a clearer pathway of rehabilitation. A woman who had a foot ulcer for over eight years was ambivalent about the shoes that had been made for her:

I suppose it's the shoes that you need to wear. I've got them in the hall there. They give you them soft ones at first while they measure your feet up...at the hospital...they were enthusing on them [the finished shoes], they said, 'ooh, you know'. And I said, well they look like walking boots. I'd be all right on the fells with these...[T]hey are strong, strong shoes, which I suppose they have to be. But they are comfortable. On me they feel heavy...I said see if you can get a lighter weight pair...but you just have to have what...I can't wear dresses and that now, you know, and skirts. I've got clothes there that I can't wear... (DFU4).

It was not clear whether the shoes were in the hall in readiness for use or 'parked'. A man who had ulcers for three to four years and had just had new shoes made for him said they were the best he had had so far:

They don't look orthopaedic, or whatever...they sort of improved the style. You wouldn't really notice...Not that I'm vain or anything! But they did look big and cumbersome and they sort of looked what they were – heavy shoes. Which is all right on some occasions. Not that I put a suit on very often these days. But they looked a bit out of place...You're allowed two pairs. Now, how can anybody manage with two pairs of shoes? Only a man, not a woman!...I suppose I'd like at least three... (DFU3).

Many of the interviewees made references to the costs of the interventions and services they were using: "they're a heck of a lot of money, aren't they?...about £255 for a pair of these shoes" (DFU4).

Discussion

Boundaries between the private and public self

The body is a vehicle for social interaction and also a social anchor. It enacts itself partly through material culture. Clothing and footwear form part of the social presentation of the self.²¹ These interviews show some of the ways in which footwear, hosiery and bandaging play a role in controlling the boundaries between the private (wounded and potentially socially unacceptable smelly, leaky, embodied) self and the public presentation of self. This includes socialising (relationship building), social status and aspirations. Interviews with people with leg ulcers describe people's efforts to apply/have applied and maintain the uncomfortable compression which

promises healing. While undergoing this treatment some people restrict their public presentation and retreat into the private sphere where restrictions on usual domestic comforts can also apply, for example slippers that no longer fit and prohibitions on washing in case bandages get wet. Such retreats were premised on the hope that once the wound healed, or the obvious device removed, life would return to normal. However, given that these complex, chronic wounds are symptomatic of underlying chronic illness this healing could prove elusive. Others were determined to carry on:

...it hasn't stopped me. I still go out every day. I have to force myself some days. But I'm not easily beaten and I will do it (LU5).

In these interviews, the potency of footwear, its capacity to restrict or enable the body in motion has an importance that transcends functionality and this can be seen in concerns about being lost, trapped, or weighed down in huge, heavy, socially incompetent shoes. There are different shoes for different kinds of motion; interviewees describe dancing shoes and fell walking shoes and the requirement to wear these in the right setting and accompany them with the appropriate types of clothing. Not being able to dress appropriately impacts on the ability of people to feel comfortable and take part in special occasions but also everyday events, including going to the shops and sitting on a bus. In this context, the removal of bandaging or refusal to wear support hosiery which may be viewed as 'non-compliance' by a health professional may feel like a strategy of self-care or self-preservation from a patient perspective.¹

Evoking and restricting embodied identity

Footwear, hosiery and bandaging evoke and restrict the possibility of particular kinds of embodied gender, sexuality, class and so on. One of the running jokes in *Last of*

the Summer Wine was the character Compo's affection for Norah Batty, whose wrinkled stockings frequently inflamed him despite their unsexiness. Nora Batty in her curlers and wrinkled stockings does not hide the usually hidden preparatory work that goes into the presentation of the finished article and is always in her working outfit. Part of the comedy lies in the fact that not only does Norah not hide the effort she makes but rarely do we get to see the finished article. Being seen in bandages is bad enough but being seen in wrinkled bandages is too much for the interviewee who does not want to look like Norah Batty.

Putting on clothes and shoes can change the way people feel about themselves.¹³ Women in these interviews were 75 and older but resisted exchanging the bandaging and heavy shoes of illness and old age for the skirts and feminine shoes they were used to wearing. Nobody wanted their shoes to "look orthopaedic" (DFU3), including a 70 year old man aware that being concerned about footwear is associated with women and might make him seem "vain" (DFU3). In contemporary Britain, stockings are considered feminine attire unless worn over the face by an armed robber. The norm is for men to wear socks not "stockings", a recommendation to wear them is a disruption of the assumptive world of masculinity for this interviewee, a 35 year old man in the midst of the disruption of coming to terms with chronic wounds, an unanticipated consequence of his addiction: "I feel girly in them, they're not the right colour... like I'm wearing women's tights" (IVLU1). The use of the word 'stocking' rather than 'sock', the restriction on colour choice and the lack of hosiery and suspender belts suitable for use by those with arthritic hands can be seen as small cumulative obstacles and disincentives to the long term maintenance of circulation which may prevent the reoccurrence of wounds.

Stigma and abjection

Odour has been documented as one of the distressing physical symptoms of leg ulceration which leads to people restricting their activities and becoming concerned about the impact on those around them.¹¹ Here it was found that some people attributed the cause of this to the bandaging rather than the leg ulcer itself. Theories of stigma and abjection are useful in exploring the linkage of smell with potential social exclusion. Injecting drug users already negotiate a stigmatised identity as a group with implied negative character traits which is compounded by the physical stigma of a wound made obvious by smell.²² Bataille originally used the term 'abjection' to describe the structural inability of the lower classes to avoid contact with and free the self from dirt, dirty work and disease.²³ Within a post-structuralist psychoanalytic frame, Kristeva uses the term to describe that which disrupts social order in the gendered management of corporeal boundaries. The abject is associated with the body of the mother from which the subject must separate.²⁴ Gilleard and Higgs²⁵ argue that the division of older life into a third and fourth age²⁶ means that fears about the aged body as an object of disgust are projected into the fourth age, 'real' old age which those with the physical and social capital to 'age actively' seek to avoid as long as possible.²⁷ For older people, the smell of a wound may therefore threaten to transgress a boundary which triggers the stigma of the fourth age.

Costs of the interventions and services they were receiving were mentioned in many of the interviews and some spoke about the associated costs of having to buy new shoes and clothes. Consumer desires were tempered by awareness of demands on public services, the context of healthcare rationing and, especially for those of working age, being seen as a drain on resources:

So that made me feel really good [waiting in hospital to access treatment in the community], because I were a leech... And then you pile a load of weight on because you get inactive and then, ooh, you're a fat leech. That's even better... But people do think like that, because...it's on the tele all the time. You shouldn't be overweight and you shouldn't be a drain on the NHS and all that. And you do, you do feel inadequate, sort of thing. You know what I mean, it's very unpleasant (LU3).

The "fat leech" metaphor is used by the same man above who wished he had shares in an odour elimination product company. The metaphor can be read in the context of the contemporary political imaginary of social abjection²⁸ which includes the imperatives of bodily control and not to becoming a drain on the welfare state.

Relevance for clinical practice

From a clinical standpoint, bandaging, hosiery and footwear interventions in wound care seek to rectify biomechanical incapacity in order to restore physical independence and mobility. These 'mundane' technologies are an important and increasingly costly aspect of healthcare management. Some of the health professionals interviewed as part of the original study were well aware that while footwear, bandaging and hosiery are technical interventions in wound care they are also interventions into a patient's everyday life which may require time and support in adopting and adapting and may have negative outcomes for patients, including social embarrassment which could lead to reduced social engagement.¹ However, the service model in which these health professionals operated followed the model of the 'specialist healing route',¹¹ focusing mostly on putting interventions into place, in particular applying bandaging and dressings with a view to short term healing as an

outcome. As seen above, some of those expecting relatively short term healing may withdraw socially, putting their lives on hold while they wait to get better and for others the physical and social discomfort associated with interventions can lead to ambivalence about effectiveness. A shift to the 'chronic condition route' would put more focus on community nurses supporting the individual in using interventions for both healing and the prevention of wound recurrence as part of living a life while managing a long term condition. ^{11 1}

The results of a randomised controlled trial published since the data in this study were collected found that less bulky two-layer compression hosiery is a viable alternative to the four-layer bandage.²⁹ The trial found that it is equally as effective at healing venous leg ulcers, can be worn with ordinary shoes and that there was a significant reduction in recurrence in the hosiery group. So there is now an evidence-based alternative for those who do not like bulky bandaging. However, participants in the trial's hosiery group changed their treatment more frequently than those in the bandage group because of discomfort. This suggests that hosiery might not be suitable for all patients. Those designing the study initially thought that because people would be more used to using hosiery and because it relied less on applicator skill that people would be more likely to tolerate its use. Understanding users' experiences of discomfort is therefore an important area for further exploration and refinement of the intervention. Paying research attention to the interaction between the individual and their social world including their use of material culture can help to improve the knowledge base on how and why people engage with interventions while paying attention to social engagement as an aspect of independence.

Limitations

The sample for this study derives from a wider study. It is a limited white working class sample. A stand alone study could further explore the extent to which the use of material culture in chronic wounds gives rises to different subjective narratives depending on for example, point in the lifecourse experience and socioeconomic position. Injecting drug users are overrepresented because the aim of the original study was to include the views of this seldom heard group. The offer of a £10 voucher, while usually seen as too small to offer an inducement to take part, may have been perceived as an inducement by those who were particularly impoverished in this group.

Acknowledgements

Thank you to all of the people who contributed their time for interviews and to Nicky Cullum for comments on the draft article.

This paper presents independent research funded by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research programme (Grant Reference Number RP-PG-0407-10428). The views expressed are those of the author and not necessarily those of the NHS, the NIHR or the Department of Health.

References

1. Cullum N, Buckley H, Dumville J et al. Wounds Research for Patient Benefit *PGfAR NIHR* forthcoming.

2. Charmaz K. Loss of self: a fundamental form of suffering in the chronically ill. *Sociology of Health and Illness* 1983; 5(2): 168-195.
3. Bury M. Chronic Illness, Self-Management and the Rhetoric of Empowerment. In Scambler G and Scambler S. (eds) *New Directions in the Sociology of Chronic and Disabling Conditions: Assaults on the Lifeworld*. Basingstoke: Palgrave Macmillan, 2010, pp
4. Woodward, I. *Understanding material culture* London: Sage, 2007.
5. Hall J, Buckley H, Lamb et al. Point prevalence of complex wounds in a defined United Kingdom population. *Wound Repair Regen*. 2014. doi: 10.1111/wrr.12230. [Epub ahead of print].
6. Margolis D, Malay D, Hoffstad O et al. *Prevalence of diabetes, diabetic foot ulcer, and lower extremity amputation among Medicare beneficiaries, 2006 to 2008*. Diabetic Foot Ulcers. Data Points #1 (prepared by the University of Pennsylvania DEcIDE Center, under Contract No. HHS290200500411) AHRQ Publication No. 10(11)-EHC009-EF. Agency for Healthcare Research and Quality, Rockville, MD, 2011.
7. Graham I, Harrison M, Nelson E et al. Prevalence of lower-limb ulceration: a systematic review of prevalence studies. *Adv Skin Wound Care* 2003; 16 (6): 305-16.
8. Reiber, G. The epidemiology of diabetic foot problems. *Diabetic Med* 1996; 13 (Suppl 1): S6-11.
9. Siersma V, Thorsen H, Holstein PE et al Importance of factors determining the low health-related quality of life in people presenting with a diabetic foot ulcer: the Eurodiale study. *Diabetic Med* 2003; 30(11):1382-7.

10. Ribu L, Birkeland K, Hanestad B et al. A longitudinal study of patients with diabetes and foot ulcers and their health-related quality of life: wound healing and quality-of-life changes. *J Diabetes Complicat.* 2008 Nov-Dec; 22(6):400-7.
11. Briggs M and Flemming, K. Living with leg ulceration: a synthesis of qualitative research. *J Adv Nurs* 2007; 59 (4): 319-328.
12. May, C. Chronic illness and intractability: professional and patient interactions in primary care *Chronic Illness* 2005 1; 15.
13. Hockey J, Dilley R, Robinson V et al. Worn Shoes: Identity, Memory and Footwear, *Sociological Research Online* 2013;18 (1). Available at: <http://www.socresonline.org.uk/18/1/20.html>
14. Dolan, J. and Tincknell, E. (2013) *Representing older women in the media: The key issues*. A Report to the Labour Commission on Older Women Labour Party, House of Commons.
15. Jenkins, R. *Social Identity*. London: Routledge 3rd edition, 2008.
16. Iglesias C, Nelson EA, Cullum N et al. VenUS I: a randomised controlled trial of two types of bandage for treating venous leg ulcers. *Health Technology Assessment* 2004; 8: 1–105.
17. O'Meara S, Cullum N, Nelson E et al Compression for venous leg ulcers. *Cochrane Database Syst Rev* 2012; 1: CD000265.
18. Hyde C, Ward B, Horsfall J et al Older women's experience of living with chronic leg ulceration. *International Journal of Nursing Practice* 1999; 5:: 189-198.
19. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG, (eds). *Analyzing qualitative data*. London: Routledge, 1994 pp. 173–94.

20. Madden M. The Ghost of Nora Batty: Shoes, stockings and suspenders in chronic wound care. Unpublished paper presented at *Dressed Bodies: A Symposium* Interdisciplinary Centre of the Social Sciences; Sheffield; 2013 July 17.
21. Goffman E. *The Presentation of Self in Everyday Life*. New York: Anchor, Doubleday, 1959.
22. Goffman. *Stigma: Notes on the Management of Spoiled Identity*. New York: Simon and Schuster, 1963.
23. Bataille G. Abjection and miserable forms (Tr Shafir, Y). In Lotringer S (ed) *More & Less*. Cambridge: Mass: MIT Press, 1999 pp. 8-13.
24. Kristeva J. *Powers of Horror: An essay on abjection*. (Tr. Roudiez, L.S.) New York: Columbia University Press, 1982.
25. Gilleard C. and Higgs P. Ageing abjection and embodiment in the fourth age. *J Aging Stud*. 2010; 25: 135-142.
26. Laslett P. *A Fresh Map of Life: The emergence of the third age*. Cambridge, Mass: Harvard University Press, 1991.
27. World Health Organization (2002). *Active ageing: A policy framework*. Geneva: Noncommunicable Disease Prevention and Health Promotion Department.
28. Tyler I. *Revolting Subjects: Social Abjection and Resistance in Neoliberal Britain*, London: Zed Books, 2013.
29. Ashby R, Gabe R, Ali S et al. Clinical and cost-effectiveness of compression hosiery versus compression bandages in treatment of venous leg ulcers (Venous leg Ulcer Study IV, VenUS IV): a randomised controlled trial. *Lancet* 2104; 383: 871–79.