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Social Recognition of Wound, Ostomy, and Continence Nurse Specialists: A Hermeneutic Phenomenological Study Interpreted through Honneth's Theory of Recognition

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Abstract

Introduction: Wound, ostomy, and continence nurse specialists (WOCN) make a documented contribution to the management of complex wounds and stomas, with measurable effects on complication rates and patients' quality of care. This clinical contribution is not consistently matched by social and institutional recognition of the role. Persistent limitations in recognition have been associated with professional identity and career development. The study aimed to interpret the lived experiences of WOCN specialists regarding social recognition across their professional careers, using the dimensions of love, rights and solidarity described by Honneth as a theoretical interpretive lens.

Methodology: A qualitative study using a Heideggerian interpretive phenomenological approach was conducted. Fifteen WOCN specialists from five Colombian cities were recruited through purposive and snowball sampling. In-depth interviews were audio-recorded and transcribed verbatim. Analysis followed Diekelmann's seven-stage hermeneutic method, with both authors coding all transcripts independently. Honneth's theory of social recognition was used as a theoretical interpretive lens.

Results: Three main themes and nine subthemes were identified: (1) Vocational fulfillment: personal satisfaction and empathic sensitivity; (2) legitimacy and autonomy: clinical empowerment, job insecurity and pay inequity; and (3) social value of the role: continuous training, leadership, pedagogical role and market-based valuation of expertise.

Conclusions: The study evidences a paradox in the social recognition of WOCN. Although participants experienced vocational satisfaction and clinical empowerment that challenge traditional nursing hierarchies, they reported job insecurity and wage inequity that did not correspond to their level of expertise. The findings suggest that health policy could give further consideration to formal recognition of specialist roles and to equitable employment conditions.

Keywords: Wound, Ostomy, and Continence Nurses; Social Recognition; Honneth's Theory; Professional Identity; Interpretive Phenomenology

Introduction

Chronic wounds, defined as wounds persisting beyond three weeks or documented as hard-to-heal, have an estimated prevalence of 2.21 per 1,000 adults in the general population.[1] Health service records reveal a heavier burden. In 2017-2018 the UK National Health Service managed 3.8 million patients with wounds, 7% of the country's adult population.[2] Stomas create a parallel demand for care. Around one million people live with a urinary or fecal diversion in the United States and 700,000 in Europe;[3] no validated global estimate exists, and none has been published for Latin America. Both conditions require prolonged, technically specialized and psychosocially demanding care, which is what defines the scope of practice of the wound, ostomy and continence nurse (WOCN).[4] The cost is substantial. In the United States, wound treatment accounted for USD 22.5 billion in Medicare spending in 2019, covering 10.5 million affected beneficiaries;[5] in the United Kingdom, the National Health Service spent GBP 8.3 billion on wound care in 2017/2018, 81% of it in community settings.[2]

WOCN play a critical role that extends beyond technical competence in the treatment of complex wounds and the care of ostomies.[6] Their practice includes comprehensive patient assessment, evidence-based treatment planning, therapeutic education,[7] and interdisciplinary care coordination.[8] Their attention to psychosocial dimensions is particularly relevant, as it supports patients in reconstructing body image, adapting their daily lives and managing the emotional burden associated with their conditions.[9,10] This positions them as mediators between specialized knowledge and person-centred care.[6]

Clinical effectiveness and social recognition are produced through different mechanisms and do not necessarily coincide. Effectiveness is established by outcome measurement and circulates within specialist and research communities, whereas recognition is conferred intersubjectively and institutionally through the categories a health system uses to classify, contract and remunerate work. Where a role is not formally constituted within employment and regulatory frameworks, demonstrable clinical contribution has no institutional channel through which to become recognition. Axel Honneth's theory allows this discrepancy to be analyzed because it distinguishes three spheres in which recognition is granted or withheld.[11] Love, characteristic of relations of strong attachment, sustains self-confidence. Rights, which constitute the subject as a bearer of entitlements, sustain self-respect. Solidarity, which confers social esteem on contribution to shared goals, sustains self-esteem. Each sphere has a characteristic form of denial, which Honneth terms disrespect.[12] Recognition is therefore neither appreciation nor occupational status, but a relational process on which individual self-realization and autonomous participation in the public sphere depend.

This discrepancy warrants investigation rather than assumption, because it is not a failure of evidence dissemination but a structural feature of how recognition is organized, and its consequences are borne subjectively by the professionals concerned. Evidence on recognition among WOCN is limited and derives mainly from cross-sectional studies conducted in systems with established specialist regulation, where the role has registration, a protected title and a distinct salary classification. A larger literature documents, for nursing generally, the persistence of stereotypes implying subordination to medicine,[13] restricted professional autonomy,[14] and unfavorable working conditions.[15] That literature is drawn upon here to identify mechanisms rather than magnitudes, on the grounds that the pathways linking recognition to professional identity and retention are unlikely to be specialty-specific, whereas their prevalence and intensity may well be. Claims referring specifically to the WOCN role are supported by sources from that field.[16]

The absence of recognition has implications that extend beyond the individual. Nurses who receive greater social recognition report stronger professional self-esteem, a more consolidated disciplinary identity and higher organizational commitment,[17,18] factors associated in turn with the quality of care and patient satisfaction.[13,17] Conversely, a recognition deficit has been linked to higher turnover,[19] which compromises the continuity and quality of care. Despite a growing body of work addressing the social perception of nursing,[20,21] research examining in depth how WOCN themselves experience recognition from a phenomenological perspective remains scarce, particularly in Latin American contexts.

This gap is particularly relevant in Colombia, where the WOCN role is clinically established but institutionally unconsolidated. Clinical demand is considerable, as the country is undergoing an accelerated epidemiological transition and carries a heavy burden of trauma from violence and road traffic incidents, both of which generate stomas and complex wounds.[22] Institutional recognition, however, does not match that demand. Nursing is regulated by Laws 266 of 1996,[23] and 911 of 2004,[24] but the former defers the delimitation of the postgraduate-trained nurse's field of practice to special regulations that were never issued. As a result, the country has no specialist registry, protected title or distinct salary classification for nursing specialties.[23] Training in wound and ostomy care is delivered mainly through continuing education, and service-provision contracting is widespread in the sector and documented as a source of employment precarity.[25] The combination of high clinical demand, established expertise and the absence of institutional constitution of the role produces the mismatch between contribution and recognition that this study examines. This configuration is not uniquely Colombian, as the Pan American Health Organization has identified outdated regulatory frameworks and limited educational provision as principal barriers to the development of advanced nursing practice in Latin America.[26]

Previous studies of recognition among WOCN have measured perceptions of status and satisfaction through surveys, conducted in countries where the specialty has its own registration and a protected title. Such designs cannot access the meaning recognition holds for the nurses themselves, nor how that meaning is transformed across a working life. Nor has this experience been examined in contexts where the specialist's work is in high demand but the specialty lacks formal recognition. The present study addresses that gap. Recognition theory has already been applied to nursing, notably to interpret burnout as a social pathology arising from the non-recognition of care.[27] The contribution of this study therefore lies not in applying the theory to the discipline but in examining one specialty phenomenologically within a Latin American health system. The aim was to interpret the lived experiences of WOCN specialists regarding social recognition across their professional careers, using the dimensions of love, rights and solidarity described by Honneth as a theoretical interpretive lens. [11] The purpose was to generate contextual knowledge capable of informing professional development policy and disciplinary strengthening strategies.

Materials and Methods

The study adopted a qualitative approach grounded in Heideggerian hermeneutic phenomenology, used to interpret how WOCNs experienced and assigned meaning to social recognition within their professional, institutional and sociocultural contexts.[28,29] The inquiry did not seek to identify an essential or universal structure of the experience, but the meanings that experience holds for those who live it and the contexts that shape it. Reporting follows the Consolidated Criteria for Reporting Qualitative Research (COREQ).[30]

Axel Honneth's theory of social recognition, which posits mutual recognition as the foundation of individual self-realization and social justice, was used as a theoretical interpretive lens rather than as a predetermined coding framework.[11] The analysis initially remained open to meanings emerging from participants' narratives, after which the resulting themes were interpreted in relation to Honneth's dimensions of love, rights and solidarity. In the first, recognition occurs in relations of close attachment and sustains self-confidence. In the second, the subject is recognized as a bearer of rights, which sustains self-respect and encompasses formal professional recognition, the regulation of practice and the bodies that validate the role. In the third, contribution to shared goals receives social esteem, which sustains self-esteem.

The two theoretical resources employed operate at distinct levels of analysis. Heidegger's existential analytic operates at the ontological level and describes how recognition and its absence are lived, through attunement (*Befindlichkeit*), being-with (*Mitsein*) and care (*Sorge*).[28] Honneth's theory operates at the normative and social level and specifies the spheres in which recognition is granted or withheld and the disrespect produced by its denial.[11] The two are complementary rather than competing, since Honneth specifies what is at stake in recognition while leaving underdetermined how it is experienced, which is what a phenomenological account can supply. Neither resource functioned as an a priori analytical framework: coding was open and text-driven, and both sets of concepts were introduced at the interpretive stage, once the themes had been established. Consistent with the Heideggerian account of the fore-structure of understanding, the team's theoretical orientation was not suppressed but recorded and interrogated in the reflexive journal, and at each team meeting it was examined whether emerging categories were being prematurely assimilated to the three dimensions.

The homogeneity of the sample was defined at the level of the phenomenon rather than the context. All participants shared the condition that phenomenological inquiry requires, namely direct access to the experience under study, by virtue of holding the wound and ostomy specialist qualification and having practiced in that role within the specified period.[31] Contextual variation, by contrast, was deliberate. Participants came from five Colombian cities and from diverse practice settings, including high-complexity hospitals, private clinics, outpatient consultation and home care, because recognition is conferred institutionally and its experience may be expected to differ across organizational configurations. Restricting the sample to a single setting would have narrowed the range of accessible meanings without increasing comparability between cases, since the study did not seek to contrast contexts but to interpret a phenomenon common to all of them.

The inclusion criterion required participants to hold the wound and ostomy specialist qualification and to have practiced in that role at any point during the twenty-four months preceding recruitment. The criterion therefore defined currency of practice rather than length of experience, and no minimum number of years in the role was required. Participants' actual experience ranged from four to thirteen years. Nurses working exclusively in telemedicine or remote consulting, those performing only administrative functions without direct patient care, and those with communication limitations that would prevent an interview from being conducted were excluded.

The study established a systematic contact protocol with WOCN that prioritized accessibility and the building of trust. Thirty-two specialists were initially contacted by email, and twelve agreed to take part voluntarily. Personalized telephone contact was then made to address concerns, confirm the voluntary nature of participation, and arrange the logistics of the interviews. Five further participants were recruited through snowball sampling, referred by the initial volunteers,[32] bringing to seventeen the number of professionals who gave consent. Two of these withdrew before the interview, both citing limited time, leaving a final sample of fifteen participants. None withdrew after the interview, and no interview was excluded from the analysis. Table 1 presents the recruitment flow.

Snowball sampling was used for methodological and pragmatic reasons. WOCN are a geographically dispersed population that is difficult to enumerate, peer referrals generated the trust required to elicit accounts of sensitive professional experiences, and the procedure allowed the study's available resources to be used efficiently.

Table 1. Participant recruitment flow

Recruitment stage	**Number**
Invited by email	32
Consented following email invitation	12
Consented following peer referral (snowball sampling)	5
Total consented	17
Withdrew before interview (limited time)	2
Final analyzed sample	**15**

Data collection process

Data collection combined ten in-depth interviews conducted in person in the workplace and five conducted virtually through Microsoft Teams, between August 2022 and July 2023. The incorporation of virtual interviews responded to the geographical dispersion of participants across five Colombian cities and to the working demands of professionals employed by several institutions. The virtual modality afforded scheduling flexibility, reduced barriers to participation and maintained continuity of data collection. Virtual interviews were conducted under controlled technical conditions: a stable internet connection, private spaces free of interruption selected by the participants, and visual contact through the camera to sustain researcher–participant rapport.

The researchers explained the objectives of the study and obtained informed consent before each session. Semi-structured in-depth interviews were conducted (mean duration 42 minutes; range 36–57), recorded in digital audio and complemented with field notes. Recordings were kept under strict confidentiality and subsequently transcribed verbatim. Alphanumeric codes WOCN01 to WOCN15 were assigned to protect participants' confidentiality. No age, gender or origin restrictions were applied. Interviews concluded only when participants indicated that they had expressed their experience satisfactorily and had nothing further to add.

An interview guide developed from a literature review supported the interviewer. The main questions were: (1) From your experience, how do you perceive the role you perform as a nurse specialising in wounds and ostomies? (2) How do institutional protocols and health policies influence your ability to exercise that role fully? (3) From your experience, how do you think society and other health professionals recognize your specialty? (4) Have you experienced situations in which your expertise was underestimated? (5) How does a lack of recognition affect your motivation and well-being at work? These questions functioned as a starting point for dialogue. Follow-up prompts such as "Could you specify what you mean by…?", "Could you expand on this idea?" and "Would you have a practical case that reflects this situation?" were used to enrich the accounts obtained.[33]

Data analysis

The analysis was conducted in parallel with data collection and followed the seven-stage hermeneutic method of Diekelmann, Allen and Tanner.[34] The method was developed within the discipline of nursing as an operationalization of Heideggerian hermeneutics, from which it retains three central commitments: the hermeneutic circle, whereby understanding of the whole and of its parts corrects one another across successive readings; the fore-structure of understanding, which recognizes that all interpretation proceeds from a horizon of meaning that should be made explicit rather than suppressed; and interpretation by a community of readers rather than by an individual analyst.

The stages were applied as follows. First, all transcripts were read in full to obtain a general understanding of the meanings conveyed. Second, interpretive summaries were written for each transcript and coded for possible themes, supporting each interpretation with textual extracts. Third, selected transcripts were analyzed by the research team. Fourth, interpretive disagreements were resolved by returning to the text and, where necessary, to the participant. Fifth, texts were compared and contrasted to identify and describe shared practices and common meanings. Sixth, relationships among themes were established. Seventh, a draft of the themes with illustrative excerpts was presented to the team and to external readers, whose observations were incorporated into the final version. Stages three, four and seven prescribe collective interpretation and external validation, which renders the procedure congruent with the hermeneutic phenomenological design stated above.

Data collection continued until the researchers determined that additional interviews were not generating substantially new experiential meanings or thematic insights relevant to the research question. Although initial thematic saturation was reached after the 12th interview, three additional interviews were conducted to assess the stability and experiential richness of the emerging interpretations. Sample size was accordingly guided by information power, on the grounds that the study aim was narrow, the sample specific to a single specialist role, the analysis supported by an established theoretical framework, the quality of dialogue high, and the analytic strategy cross-case rather than idiographic.[35]

The analysis produced three themes and nine subthemes. The resulting themes were then interpreted in relation to Honneth's dimensions of love, rights and solidarity, which made it possible to identify not only what participants said, but the ways in which they were recognized or disregarded and how this affected their identity, self-esteem and sense of belonging. Both authors coded all fifteen transcripts independently. Interpretive summaries were written separately and compared in team meetings held after each set of three interviews. In the first round of independent coding of the 15 transcripts, an initial agreement rate of 83% was achieved. The main discrepancies (the remaining 17%) arose from differences in the delineation of text segments or nuances in the interpretation of the subjective experience. All discrepancies were discussed in depth during three alignment sessions until 100% consensus was reached on the final category tree. ATLAS.ti version 18 supported data organization, coding and retrieval.

The criteria of Lincoln and Guba were applied.[36] Credibility was addressed through member checking and researcher triangulation; dependability through external audit of analytical traceability; confirmability through a reflexive journal documenting decisions and preconceptions; and transferability through detailed description of the context, participants, sampling strategy and procedures.

Two credibility procedures were undertaken before the final drafting of the findings. In the first, an interpretive summary was returned by email to each of the fifteen participants, comprising the themes, the subthemes and the excerpts attributed to that participant, with a request for written comment and an offer of a telephone conversation. Fifteen participants responded; 13 supported the interpretation without changes, and no objections were received; therefore, no modifications were made to the analysis. In the second, two qualitative researchers external to the study reviewed the data and the findings obtained. One was a nurse with a doctorate in nursing and 10 years of experience in phenomenological research; the other was a nurse with a doctorate in sociology and eight years of experience in phenomenological research. Both reviewed the interviews, coding, themes, and subthemes. They suggested some adjustments to the coding and certain subthemes. These adjustments were incorporated into the research report.

The researchers are nurses, and the principal investigator has practiced within the Colombian health system. This proximity facilitated rapport with participants and an informed reading of institutional detail, but it also means that the interpretation of what counts as under-recognition is not independent of a professional standpoint with an interest in the answer. Preconceptions, emotional responses and interpretive decisions were documented throughout in a reflexive journal; emerging interpretations were questioned in collaborative analysis sessions and contrasted with participants' own readings through member checking.

The research received ethical approval from the Health Research Ethics Committee of the Universidad del Valle, Colombia, on 17 March 2022 (Act No. 003-022), and complied with international standards for research involving human beings. Prior to the study, participants were verbally informed about the research objectives, anonymity measures and the voluntary nature of their participation. Each participant subsequently read and signed a written informed consent form. The entire research process was conducted in accordance with the ethical principles established in the Declaration of Helsinki.

Results

A total of 15 WOCNs were interviewed. The average age of the participants was 41.07 years; the youngest was 31 years old and the oldest was 56 years old. Participants had between four and 13 years of experience working in wound and ostomy care. The sample was predominantly female, with 13 women (86.67%) and two men (13.33%) participating. The general information of the interviewees is detailed in Table 2.

Table 2. Sociodemographic characteristics

No.	Age	Gender	Level of education	Region of work	Years of experience	Area of expertise
WOCN01	42	Male	Specialist	Bogotá	9	Commercial
WONC02	32	Female	Specialist	Tuluá	9	Assistance
WONC03	56	Female	Specialist	Cali	9	Assistance
WONC04	34	Female	Specialist	Popayán	4	Health care and home care
WONC05	44	Female	Specialist	Cali	12	Health care and home care
WONC06	52	Male	Specialist	Cali	13	Health care, home care and education
WONC07	33	Female	Specialist	Cali	7	Assistance, home care, commercial and education
WONC08	31	Female	Specialist	Cali	5	Assistance, home care, auditing and education
WONC09	36	Female	Specialist	Cali	9	Assistance, commercial and education
WONC10	35	Female	Specialist	Cali	7	Health care, ambulance services
WONC11	35	Female	Specialist	Cali	9	Health care, ambulance services
WONC12	50	Female	Specialist	Bogotá	13	Assistance
WONC13	36	Female	Specialist	Medellín	6	Health care and education
WONC14	50	Female	Specialist	Cali	11	Assistance
WONC15	50	Female	Specialist	Cali	13	Health care and outpatient care

Following the analytic procedure described above, the research team identified three themes and nine subthemes. Both authors coded all fifteen transcripts independently, compared their

interpretive summaries in team meetings, and resolved discrepancies by returning to the text, as reported in the Data analysis section. The themes were developed from the transcripts through open, text-driven coding and were subsequently interpreted in relation to Honneth's dimensions of love, rights and solidarity, which functioned as a theoretical interpretive lens.

The three themes were vocational fulfillment, legitimacy and autonomy, and social value of the role. Together they revealed the significance participants attributed to their role, the challenges they encountered, and the mechanisms through which recognition was granted or withheld in their professional development.

Table 3 presents the three analytic levels and distinguishes them explicitly. The theoretical dimensions are those of Honneth's framework, applied at the interpretive stage of the analysis; the themes and subthemes were derived from the transcripts. This terminology is used consistently throughout the manuscript: three theoretical dimensions, three themes and nine subthemes.

Table 3. Themes and subthemes

Honneth dimension	Theme	Subthemes
Love	Vocational fulfillment	Personal satisfaction; empathic sensitivity
Rights	Legitimacy and autonomy	Clinical empowerment; job insecurity; pay inequity
Solidarity	Social value of the role	Continuous training; leadership; pedagogical role; market-based valuation of expertise

Theme 1: Vocational fulfillment

This theme comprises the emotional bonds participants established through caregiving and the mutual recognition these generated, which, as they described it, extended beyond technical competence into the affective dimension of their work.

Subtheme 1a: Personal satisfaction

Participants described a sense of fulfillment that arose not only from technical performance but from the transformative effect of their work on patients and their families. Patients' recovery generated a reciprocal movement in which the professional found meaning in their own practice. This pattern was identified across nine interviews and is illustrated by the following accounts.

"[...] *When you see that the patients you care for are recovering, you are filled with emotion. It makes you reflect and find meaning in what you do, in what you set in motion with those who need it* [...]" (WOCN07)

"[...] *There is great satisfaction in being a nurse; you feel the gratitude and appreciation of patients and their families. When they recover, they see you as the person who cared for them and helped them come through, and that feeling is priceless* [...]" (WOCN11)

Participants located the source of this fulfillment in the response of patients and their families rather than in institutional acknowledgement of their work.

Subtheme 1b: Empathic sensitivity

Participants described a sensitivity to the psychosocial, emotional and existential dimensions of their patients' condition, presenting it as a fundamental aspect of their practice rather than something incidental. This pattern was identified across eleven interviews.

"[...] The patient who has a wound is a patient who is going through pain, anxiety, anguish, so being able to understand and put yourself in that person's place makes you more sensitive, and therefore leads you to attend to them as best as possible together with the health team [...]" (WOCN06)

"[...] *Carrying out procedures on patients is one part of my work, but each of them has psychological and environmental challenges that you have to take into account for care to be comprehensive. Listening to them and responding to their emotional needs are part of what you as a nurse must do* [...]" (WOCN02)

"[...] *Patients express many emotional things to you, and it is hard to attend to so much need; what I do is talk with them and explain everything that is required to recover, and that considerably strengthens the healing process* [...]" (WOCN13)

Across both subthemes, participants linked recognition to the quality of the therapeutic relationship and grounded it in the response of patients and their families, describing it as something arising from the encounter with the patient rather than from their professional position.

Theme 2: Legitimacy and autonomy

This theme comprises the processes through which participants sought recognition of their professional and employment rights and of their institutional legitimacy within the health system.

Subtheme 2a: Clinical empowerment

Participants described specialization as conferring the standing of expert, with autonomy over clinical and administrative decisions, which they contrasted with historical models of nursing subordination. This pattern was identified across 12 interviews.

"[...] One of the most important things that also satisfies me is what we have achieved in nursing. We give the field of nursing a very good name. Actually, here in the wound clinic, the people who run the program and lead it are nursing staff. [...]" (WONC9)

"[...] *Being a specialist in wound and ostomy care has given me standing and credibility with people and with other professionals* [...]" (WOCN04)

"[...] *Being a specialist in this area gives you greater decision-making capacity, not only in the clinic but in all the processes we move through in patient care. That is how we advance as empowered nurses and strengthen the profession so that it is not subordinate* [...]" (WOCN08)

Participants described this empowerment as shared rather than individual and associated it with more horizontal working relationships with other professions.

Subtheme 2b: Job insecurity

Participants described a contrast between their expanded scope of practice and their contractual conditions. Nine participants reported that the proliferation of service-provision contracts generated instability and discontinuity in care processes.

"[...] *We are hired on service-provision contracts in the clinics; we are not permanent or appointed staff. This means we have no job stability and are not paid social benefits. Also, because the contract is interrupted in some months, the continuity of patient care is affected* [...]" (WOCN02)

"[...] *Even though we are specialists, our qualification is not recognized in salary terms when we are hired; it is different in other professions* [...]" (WOCN06)

Other participants, however, experienced the same contractual arrangement differently.

"[...] *In the jobs that I have had, the service provision figure is the one that I have chosen. I chose it for the sake of convenience, my schedule, my time and other activities that I carry out in other spaces outside the clinic* [...]" (WOCN05)

This divergence is reported here rather than resolved. Nine participants described contractual flexibility as a constraint imposed by the institution, three described it as an arrangement they had chosen and valued, and three did not address contractual conditions.

Subtheme 2c: Pay inequity

Accounts of remuneration were heterogeneous. Eight participants described salaries that did not correspond to their level of qualification or to the responsibilities they assumed, comparing their situation with that of other professions performing functions of similar complexity; five described a recent improvement; and two did not address the matter.

"[...] *Being a specialist does not guarantee that your salary will go up; you are better positioned in the services, but you are also assigned other responsibilities, and in the end the salary is not equitable if you compare it with everything you do* [...]" (WOCN13)

"[...] O*ur salaries have improved in some institutions, but in others it makes no difference whether or not you are a specialist, because there is no salary scale that is equitable enough to pay the professional according to their level of education* [...]" (WOCN14)

One participant expressed a different position: "[...] Regarding the remuneration and recognition of the wound specialist, it is more appropriate nowadays, and that has led more and more people to become interested in specialising [...]" (WOCN03)

Across the three subthemes, participants described a disjunction between the professional standing they had attained and the institutional conditions under which they practiced. Clinical authority was widely acknowledged, whereas contractual and economic conditions were perceived as inconsistent with that authority.

Theme 3: Social value of the role

This theme comprises the ways in which participants constructed and negotiated the social valuation of their role, created networks of professional solidarity, and described their contribution to shared goals.

Subtheme 3a: Continuous training

Participants described lifelong learning as a strategy of professional positioning. This pattern was identified across 11 interviews.

"[...] In 2018 I did a diploma in physical therapy for the management of lymphedema, to delve into venous pathologies and the pressure system. I have also taken refresher courses at the University of Barcelona, Spain. Being continuously trained is very necessary to be at the forefront, especially in wounds and ostomies [...]" (WOCN10)

"[...] *Anyone who stops at the nursing degree stagnates. The truth is that staying up to date is a requirement, because in the health field there are various changes and you have to stay at the forefront, learning whatever new thing is needed. That is why I have taken several courses* [...]" (WOCN04)

"[...] *The more educated we nurses are, the more we are recognized in the services and in the community, and if we act in line with that knowledge, our specialty is strengthened* [...]" (WOCN05)

Participants presented training not only as the individual acquisition of knowledge but also as the collective construction of professional standing for the community of specialists.

Subtheme 3b: Leadership

Participants described roles that combined clinical, administrative and educational functions. Nine participants described this expansion of their scope of practice.

"[...] We address complex injuries: we do the initial assessment, classification, diagnosis, establishment of a care plan, follow-up of patients, timely referral to services when required, support and feedback with interdisciplinary groups involved in the patient's rehabilitation, training of healthcare personnel to address complications, and guidance on injury care when required [...]" (WOCN12)

"[...] *We lead in different areas of the health system; one is the clinical area, where several of us colleagues work, another is the administrative area, which requires very well-defined processes to support the services assigned to us, and another broad one is home care* [...]" (WOCN01)

"[...] *Of the nurses who took the specialization, several of us work in different places because opportunities have opened up for us. Hospital managers speak very well of our work because we go beyond what is assigned to us* [...]" (WOCN04)

Participants associated this multifaceted leadership with recognition from colleagues and institutions, attributing it to the demonstration of competencies beyond those expected of the role.

Subtheme 3c: Pedagogical role

Participants identified themselves as intermediaries between evidence and practice. Eight participants described educational functions as fundamental to their professional identity.

*"[...] We are educators above all and we have the capacity to be able to expand the quality of the care we provide in each of the processes [...]" (*WOCN01)

"[...] The commitment that is acquired to be able to move the patient forward is through education with responsibility and ethics [...]" (WOCN08)

"[...] *As specialists we have a fundamental function of making known what we do in the health system through educational processes, but it is sometimes difficult to share knowledge because institutions do not have established plans for carrying out education* [...]" (WOCN08)

Participants described this educational function as a contribution to the wider professional community, achieved through the dissemination of and access to specialized knowledge, and reported encountering institutional obstacles in carrying it out.

Subtheme 3d: Market-based valuation of expertise

Three participants described entry into the pharmaceutical and health technology sectors as an expansion of their professional scope. The specialist credential was described as a factor conferring

standing and credibility in commercial settings and two participants linked this status to benefits for the patients they treat and for their colleagues.

"[...] The specialization has really helped me a lot to be able to open up my work environment and to be able to address other fields of work other than the care area; I am currently working in the commercial area, in a company that produces products for patients with chronic wounds. Being a specialist in wound and ostomy care has given me a position and credibility towards the people and professionals I visit to offer the products [...]" (WOCN01)

"[...] *The specialist role allowed me to join the setting of pharmaceutical laboratories, where I carry out various activities involving products and services related to the treatment of wounds and ostomies; This benefits not only the patients I care for and their families but also my colleagues, as I work in an environment where I have learned a great deal about the physiology of wounds and the wound-healing process* [...]" (WOCN07)

None of the participants described situations of tension between their commercial involvement and their clinical responsibilities, nor did they mention the existence of institutional or professional policies regulating this dual position.

Across the four subthemes, participants described the social value of their role as something they actively constructed through professional training, expanded leadership, and educational work and, in three cases, through their involvement in pharmaceutical settings. In the first three subthemes, this recognition came from colleagues, institutions, patients, and the professional community; in the fourth, it stemmed from commercial relationships, although participants linked this recognition to benefits for patients and colleagues.

Discussion

The findings of this phenomenological study reveal a complex and paradoxical experience of social recognition among WOCN. Participants described vocational satisfaction, empathic engagement, and clinical empowerment as important sources of recognition, while simultaneously reporting job insecurity and wage inequity. These findings suggest that professional recognition is experienced as multidimensional and may coexist with structural forms of under-recognition. Consistent with the analytic sequence described in the methods, the findings are interpreted below at two levels: Heideggerian concepts describe how recognition was experienced, and Honneth's dimensions situate it within the spheres in which it is granted or withheld.

Vocational fulfillment

Participants located the source of their professional fulfillment in the response of patients and their families rather than in institutional acknowledgement (subtheme 1a). This finding differs from previous reports of high levels of burnout and emotional exhaustion among nurses,[37] although professional satisfaction and burnout may coexist and should not necessarily be interpreted as mutually exclusive experiences.[38] An umbrella review of 14 systematic reviews estimated the global prevalence of emotional exhaustion among nurses at approximately one third,[37] whereas evidence based on the Professional Quality of Life framework shows that compassion satisfaction and burnout behave as distinct dimensions rather than as poles of a single continuum, with both reported at average levels in the same samples.[38] The studies cited on burnout examined general and hospital nursing populations rather than credentialled specialists, so the comparison is indicative rather than direct. A plausible explanation for the difference lies in the degree of specialization and autonomy that characterizes this group, which is consistent with evidence associating professional autonomy with job satisfaction.[39] The present findings *extend* that evidence to a specialist population not previously examined in this literature and indicate that the source of satisfaction was relational rather than institutional.

Read ontologically, the satisfaction arising in the therapeutic bond is not an emotion but a mode of care (*Sorge*) through which professional existence understands and projects itself; the specialist recognizes herself in the patient's vulnerability and finds in that affective reciprocity a form of being-with (*Mitsein*).[28] In Honneth's terms this corresponds to recognition in the first sphere, which sustains self-confidence.[11] It should be noted that Honneth restricts this sphere to relations of strong attachment and does not extend it to professional relationships; its application to the therapeutic bond constitutes a qualified extension of the theory rather than a straightforward application of it.

The empathic sensitivity participants described (subtheme 1b) *extends* a literature that has emphasized technical competence in specialist wound and ostomy care.[6,10] Participants presented attunement to the patient's suffering as constitutive of their practice rather than incidental to it, which converges with person-centered models of care[40] while adding the ethical and relational dimensions those models tend to formalise as procedure. This finding also stands in apparent tension with evidence reporting a decline in empathy across professional trajectories in health, documented mainly in medical education.[41]

Legitimacy and autonomy

The clinical empowerment described by participants represents an important dimension of professional recognition. Their autonomy and leadership may challenge traditional hierarchical relationships within healthcare and strengthen their sense of professional worth and legitimacy. From Honneth's perspective, these experiences may be understood as forms of social esteem and institutional recognition that support professional self-realization.[11] This *confirms* evidence that professional autonomy is associated with better clinical outcomes[16] and indicates that specialization in technically complex fields may operate as a mechanism for displacing historical relations of subordination.[14] The present findings *extend* that evidence by showing that participants described the displacement in collective rather than individual terms, attributing it to what nursing as a profession had achieved within their institutions rather than to their personal standing.

The coexistence of professional satisfaction with employment insecurity and wage inequality illustrates the paradoxical nature of social recognition experienced by participants. Although their expertise and clinical contributions were recognized in some contexts, structural employment conditions appeared to limit their economic and institutional recognition. This tension may undermine professional identity and well-being over time. In Honneth's terms this constitutes disrespect in the sphere of rights, not a denigration of the work, but a failure to constitute the worker as a bearer of the entitlements that work would otherwise carry.[11] The finding *confirms* previous evidence on employment insecurity in the health sector, which documents how structural vulnerability erodes well-being and professional identity,[15] and *extends* it by identifying the specific mechanism at issue, namely that a credential recognized clinically is not recognized contractually.[25]

Participants' accounts of service-provision contracting (subtheme 2b) diverged. Nine participants described the arrangement as imposed and destabilizing, while three described it as chosen and valued for its flexibility. Honneth's later work on recognition as ideology offers one reading of this divergence in which forms of recognition may be experienced as affirming while simultaneously securing consent to arrangements that withhold the institutional guarantees the recognized party might otherwise claim.[42]

Social value of the role

Participants' expansion into continuing education, clinical leadership and teaching (subthemes 3a, 3b and 3c) represents an evolution of the nursing role consistent with global trends in advanced practice.[26,28] These findings are interpreted primarily in relation to professional esteem, legitimacy and autonomy, the constructs most directly connected to the study's framework. Continuing education and international certification functioned as strategies of disciplinary legitimation, consistent with research on learning as symbolic capital.[43] The self-description as educators above all indicates that teaching has become an axis of professional identity for this group, which *extends* previous reports of educational functions in specialist nursing.[6] Participants also reported institutional obstacles to performing this function, which qualifies the finding in which the educational role was a source of esteem among peers but was not consistently supported by the organizations in which they worked.

Market-based valuation of expertise

Three participants described the specialist credential as conferring standing and credibility within pharmaceutical and health technology settings, and two of them linked that position to a benefit extending beyond themselves: for WOCN07, access to knowledge about wound physiology and healing that could be brought back to patients, families and colleagues; for WOCN01, knowledge of products that informed the care provided in her clinical practice. Read in Honneth's terms, these are claims of contribution to shared goals and therefore claims located in the sphere of solidarity, in which social esteem is conferred on what an individual contributes to collectively valued ends.[11] On participants' own account, what they received was not merely commercial standing but esteem for an expertise placed at the service of patients and of the professional community.

Two features distinguish this esteem from that described in the three preceding subthemes, and they are what make the finding analytically significant. The first concerns its source. In continuous training, leadership and the pedagogical role, esteem originated with colleagues, institutions, patients and the wider professional community, that is, with parties whose interest in conferring it was independent of the recognition itself. Here it originates within a commercial relationship, in which the party conferring the valuation stands to gain from the recognized party's continued alignment. Honneth's solidarity sphere presupposes a horizon of shared values against which contributions are assessed; that presupposition holds less straightforwardly when the assessing party is also an interested one.

The second concerns the form the contribution takes. WOCN01 described her position as beneficial to patients on the grounds that it enabled her to know which products best suited them, thereby presenting a commercial vantage point as a clinical asset. Honneth's account of recognition as ideology describes precisely this structure in which forms of recognition that are experienced as genuinely affirming and that are affirming while simultaneously securing the recognized party's alignment with interests that are not their own.[42] What distinguishes ideological recognition in that account is not that it is false but that it is real and consequential and that its effect is to render a particular arrangement unquestionable to those it recognizes. The absence of reported tension is consistent with this reading in which no participant described a conflict between commercial affiliation and clinical responsibilities, and none mentioned an institutional or professional framework governing the dual position.

Ideological recognition in Honneth's sense is a property of social arrangements and not of the persons who inhabit them. The wider literature establishes that interactions between nurses and industry are common and influential, that nurses participate in product selection decisions, and that these relationships remain largely invisible to conflict-of-interest policies designed around prescribing professionals.[44,45] Professional codes hold that a conflict of interest exists where commercial interests may interfere with professional responsibilities or patients' interests, irrespective of whether the individual is in fact influenced.[46] The present finding contributes to this literature with the observation that, in a setting where the specialist role lacks institutional constitution, commercial employment may become one of the few available channels through which specialist expertise is materially valued.

This subtheme returns the analysis to the tension the study as a whole identifies. Participants who found no institutional recognition in the sphere of rights, through registration, protected title or salary classification, found in the market a setting in which their credential was materially valued. The recognition available to them was thus displaced from the sphere in which it was denied to one in which it carried an obligation to the party conferring it. Whether this displacement should be read as a strategy of professional development, as an adaptive response to a regulatory vacuum, or as the ideological form Honneth describes, is not a question that a single interview with each participant can settle. What the finding does establish is that the question arises and that no institutional or professional framework currently addresses it.

Limitations

The study was conducted among a specific group of WOCN in Colombia, and the findings reflect the experiences of participants within this particular context. Because interviews were conducted at a single point in their professional trajectories, the study does not capture how experiences of social recognition may evolve over time. In addition, the study focused exclusively on WOCNs' perspectives and did not include patients, employers, policymakers, or other healthcare professionals. It should be noted, however, that the configuration described, of specialist practice that is clinically established but institutionally unconstituted, is not unique to Colombia, and readers in systems with comparable regulatory arrangements may find the interpretation transferable on the basis of the contextual detail provided in the methods.[36]

A further limitation concerns researcher positionality. Both authors are nurses and the principal investigator has practiced within the health system studied. This proximity facilitated rapport and an informed reading of institutional detail, but it also means that the interpretation of what counts as under-recognition is not independent of a professional standpoint with an interest in the answer. The reflexive journal, independent coding of all transcripts by both authors, and external review were intended to make this influence visible rather than to eliminate it, which in a hermeneutic design would be neither possible nor desirable. The findings should be weighed as a situated interpretation produced from within the profession studied. These limitations indicate the need for longitudinal, multicentre and multi-perspective studies.

Conclusion

This phenomenological study found that WOCNs experience social recognition as internally divided. Recognition was described consistently in the relational sphere, through the therapeutic bond with patients and their families, and in the epistemic sphere, through clinical authority and specialist standing. It was described as inconsistent or absent in the institutional and economic sphere, where contractual arrangements and remuneration did not correspond to participants' qualifications or to the scope of their practice. Participants constructed professional legitimacy actively through continuing education, expanded clinical and educational roles and, for some, movement into commercial settings. The pattern across the accounts was one of recognition obtained in care and withheld in employment.

The findings suggest that efforts to strengthen WOCN social recognition could include greater visibility of their leadership roles, recognition of the relational dimensions of care, and opportunities for autonomous clinical decision-making. At the policy level, further consideration should be given to formal recognition of specialist roles, equitable employment conditions, and mechanisms for involving WOCN in relevant professional and health-system decision-making. In nursing education, the findings also indicate scope for incorporating content on the ethics of recognition and on professional leadership and for academic communities and mentoring programs that support the construction of professional identity.

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Research Highlights

What is the current knowledge?

- WOCN provides specialized clinical, educational, and supportive care for patients with wounds, ostomies, and continence-related conditions.
- Professional recognition, autonomy, and working conditions can influence nurses' professional identity and well-being.
- Limited evidence is available regarding how WOCN themselves experience social recognition in their professional roles, and the evidence that exists derives largely from cross-sectional surveys conducted in settings with established specialist regulation.

What is new here?

- The study applies Honneth's theory of social recognition to explore how WOCN experience professional recognition within their clinical and organizational contexts. Recognition theory has been applied to nursing previously, but not, to our knowledge, to this specialist role or within a Latin American health system.
- The findings identify strategies through which WOCN seek recognition, including professional development, expanded clinical and leadership roles, and educational activities.
- The study highlights a paradox in which participants experienced recognition of their specialized expertise and clinical contributions while also reporting job insecurity and wage inequity.

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