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Published in:
International Wound Journal

DOI:
[10.1111/iwj.13372](https://doi.org/10.1111/iwj.13372)

Published: 31/08/2020

Document Version
Publisher's PDF, also known as Version of record

[Link to publication on the UWS Academic Portal](#)

Citation for published version (APA):
Lusher, J. (2020). Who's wound is it anyway? *International Wound Journal*, 17(4), 1092-1093.
<https://doi.org/10.1111/iwj.13372>

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LETTER TO THE EDITOR

Who's wound is it anyway?

Dear Editors,

Symptom management has traditionally been the dominant focus when it comes to treating 'the wound'. Instead of helping the patient to manage and overcome their illness, a healthcare professional treats the wound; and this drags up several misconceptions around effective wound management. The biomedical model assumes a traditional and scientific approach to disease. It sees the body as functioning in an automated fashion and illness as the result of changes in a physiological process.^{1,2} This theoretical approach dates right back to the birth of modern science and it is often associated with Descartes' view of the mind and the body as two separate systems.³ Working under this traditional framework, physical symptoms will remain the main focus of treatment in wound care and psychosocial features will remain largely ignored. By and large, wound research ultimately fails to recognise that not only does physical health influence our mental health, but that our mental health also affects our physical health. Yet we appreciate how stress impacts on immune function⁴ and recognise how immune function can impact on healing.⁵ Therefore, stress must have dual-directional effects on wounds,⁶ but this has yet to be delineated. We understand that stress can be impacted by feelings of loss of control and powerless; and so, it is logical to assume therefore that offering some of that control back to the patient will be advantageous.⁷ Furthermore, patient control and coping mechanisms (such as self-examination and help-seeking) can lead to early diagnosis and treatment. Moreover, it is well documented in wound care research that early detection is an important predictor of recovery from wounds.⁸ Indeed, this raises several social matters for wound patients, such as improving lives through reducing social isolation, loneliness, and depression; and increasing self-reported quality of life and well-being. A joint review of guidelines for treating venous leg ulcers highlighted that while it is acknowledged that patients and their caregivers play a proactive role in self-care, there is negligible reference made to patient well-being.⁹

This issue around patient-health care professional communication is gravitating toward the concept of

'wound ownership'. Empowering patients by promoting a sense of ownership over their wound has been shown to increase self-efficacy, self-esteem, and feelings of control over the illness.^{10,11} Bolstering mental well-being generally leads to improved health outcomes, which has been found to result in reduced health care costs.¹¹ This is the case particularly for patients who experience pain associated with having a chronic illness¹² such as a wound. Patients who learn positive coping strategies and take control over managing their illness have been shown to have better outcomes than patients who use negative tactics like catastrophizing and fear self-statements.¹³ In order to foster a more holistic and collaborative approach to medicine, patients can be proactive by explaining how they can take some responsibility for managing their wound more effectively.¹⁰ Further work is therefore necessary to understand how patients with chronic wounds and their caregivers can work more collaboratively on tackling this condition.¹² Ultimately, patients want to be treated as individuals, treated with dignity and respect, and to have their voices heard in decisions about their treatment and care and qualitative research methods are valuable in capturing those issues that matter to people, their experiences, the dimensions, and variations of complex phenomena, processes, systems and contexts.¹⁴

This critical perspective on wound ownership and management speaks to new approaches that could pave the way for novel regimes, patient-led ideas, and collaborative treatment packages for patients with wounds. The focus must shift now to consider the ways in which patients respond to their illness, how patients and health care professionals communicate, and how individuals experience being ill and being treated. This will maximise the impact of what we already know about the treatment of individuals with slow-to-heal wounds. Further research is needed to support interventions geared toward improving communication and relationships between patients and their caregivers, which will no doubt impact positively on treatment adherence and treatment effectiveness. So let us move away from the prevailing medical model to a more holistic and patient-centred approach to care. This is consistent with the aim

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of the NHS to pioneer and deliver new approaches to measuring quality and outcomes in health care. Indeed, this approach would guarantee to place the patient and person at the very centre of wound research. 'Patient-Centred Outcome Measures' is a concept that involves putting patients, their families, and caregivers at the heart of deciding the best course of treatment^{15,16}; and we can do this for people with wounds.

CONFLICT OF INTEREST

The author has no potential conflicts of interest to declare.

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