Viewpoints

Medical partnership does not devalue specialty

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We were surprised and disappointed to read the reply to the editorial on the development of the Wound Management Unit from Messrs Butcher, White and Kingsley. Of greater concern was the negative attitude expressed in the language used to imply a predatory attack on the autonomy of the tissue viability service at Southend — 'takeover of the TV service', 'usurping the independence of the lead TVN' , 'substituting it with that of the clinical director', 'seized by or surrender to a rival service'. This does not rest easily with the development of a multidisciplinary team (MDT) approach to the complex problem of wound management and the subsequent improvement of care to our patients. To this team each member brings his or her own special skills and training. If these skills include a surgeon (vascular and general) who is able and willing to carry out the necessary surgery expeditiously, this can only be of benefit to all. The fact that he is clinical director of surgery (not medical director as implied), clearly helps with management issues, but that is his role for all aspects of the surgical directorate, i.e. to facilitate change.

The authors openly opine that the much vaunted multidisciplinary background of the tissue viability service gives it its strength but also its weakness — it lacks a medical framework — well that is exactly what we have achieved and this needs no 'defence'.

The evolution of this innovation, which has achieved national recognition, was not about the role and independence of tissue viability as a speciality, but about the management of wounds that require all aspects of care of which tissue viability is just one part. It in no way diminishes its role but enhances it. In this trust, and we suspect in most, the management of the difficult leg ulcer, the complicated diabetic foot, the non-healing amputation have not traditionally been the remit of the tissue viability service, but rather the vascular unit. Now, by combining all the skills, we have all greatly improved the management of all these problems.

The authors worry that this change has been achieved solely by the enthusiasm, dynamism and position of the surgeon concerned — this is clearly not the case. This could not have happened without the reciprocal enthusiasm, dynamism and energy of all concerned resulting in a cohesive, multidisciplinary team — each respecting each others' skills and roles to provide a comprehensive approach to wound care with independent nurse-led clinics, nurse-led ward rounds, independent ward care ready access to surgery. The end — improved patient outcomes. The means — entirely justified.

They recognise tissue viability is at a crossroads, yet retain a silo mentality that the speciality cannot progress without 'beneficient paternalism' and if forced into partnership with a medical specialty then who will be boss, will the partnership be one of equality? Well this was not a hostile bid to take over the assets of the tissue viability service into the surgical department, but rather to create a symbiotic relationship that may just lead the way to establish a new specialty — that of wound care in all acute trusts. While it is widely recognised that wounds are not given the priority that is needed, this could be changed by emphasising its importance to all healthcare professionals by forming a much greater part of the curriculum in the training of these people, especially the medics. In this way we might achieve a truly MDT approach that encompasses all disciplines on an equal basis, regardless of background and do away with this mutually non-constructive interdisciplinary rivalry.

Meanwhile, in Southend, are our patients 'bovvered' — we don't think so!

The debate about moist wound healing continues

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Since the pioneering work of George Winter and colleagues in the early 1960s, there has been a growing acceptance that the creation of a moist wound environment was the preferred method of achieving healing (Winter, 1963; Winter and Scales, 1963; Jones, 2005). So much so, that an industry has developed based on this principle, and that it has become a fundamental aspect of wound management and education. Over the past 40 years there have been many published articles extolling the advantages of moist wound healing (Kannon and Garrett, 1995; Jones et al, 2006; Benbow, 2008), particularly in chronic wounds (Olson et al, 2009). While objective review shows that the true picture is more complex than merely a 'moist' environment (Jones, 2005), the 'optimum' moisture balance at the wound surface is an integral factor in both modern dressing performance (Bishop et al, 2003), and in the concept of wound bed preparation (Schultz et al, 2003).

The recent publication of clinical trial data from chronic wound studies challenges the view that the optimal method of healing is by the creation of the moist environment (Michaels et al, 2009; Jeffcoate et al, 2009). The implications of these articles are potentially profound; before they

become accepted as the basis for changes in clinical practice, there should be a thorough review of all aspects of moist wound healing and of modern dressings, and an open debate on future policy in wound management.

The extent of the clinical problem is vast, and likely to grow further as the population ages. Chronic wound management requires an evidence-based, multidisciplinary, holistic patient-focused, and cost-conscious approach. Patients with chronic wounds such as leg, pressure and diabetic foot ulceration are subject to the considerable impact that such wounds have on quality of life, to the degree that healing *per se* is not always the goal of treatment.

Moist wound therapy has been shown to be clinically- and cost-effective in chronic wounds (Colwell et al, 1993; Eaglstein, 2001; Sharman, 2003), surgical wounds (Guest and Ruiz, 2005), and in burns treatment (Mishra et al, 2007). The concept has been extolled in many publications, and by the luminaries of wound healing. Therefore, any restriction in the availability of such dressings would be likely to compromise care. It is important that those clinicians with a commitment to the ongoing use of modern, moist healing products be prepared to defend their choices. Failure to act now could result in restricted care for those with chronic wounds, many of whom are significantly affected by their wound and for whom many have been offered significant care, based upon the evidence from the last 40 years.

The availability of, and access to, modern wound dressings has led to significant progress in the quality of patient care. The future of tissue viability, and all of the evidence relating to moist wound healing needs to be considered carefully, objectively and constructively, if we are not to be forced back into a 'dark age' of wound care. **WUK**

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