Healing takes a team: why venous surgeons and tissue viability nurses must work together

Omer Hamza Dinc
Business Development Manager, The College of Phlebology and The Whiteley Clinic; Founder and Editor, Phlebology News*; Leg Club Foundation project consultant*

Working in business development in healthcare, I've spent years supporting both venous surgeons and tissue viability nurses. I am not a clinician, but I stand at a unique intersection — collaborating with both groups, hearing their challenges, understanding their goals and, most importantly, witnessing how gaps in communication can affect patients.

Venous leg ulcers (VLUs) are more than just wounds; they are a manifestation of chronic venous insufficiency that demand both medical intervention and long-term wound care. While technology now makes VLUs treatable and curable, successful outcomes do not come from surgery or wound care alone. They come from teamwork.

And yet, in many UK settings, a cold war of misunderstanding persists between surgeons and nurses. There is respect, yes — but also fragmentation. This article offers a call for change and a proposal for how Leg Clubs can serve as the bridge we need.

VLUs can be cured — but healing isn't instant

With modern techniques like endovenous thermal ablation and foam sclerotherapy, we now have highly effective methods for treating the underlying venous reflux that causes VLUs. As Prof Mark Whiteley emphasises: "Unless the underlying venous disease is treated, the ulcer will return" (Whiteley, 2011).

But surgery is just the beginning. These ulcers often take months or even years to fully heal. Even after a successful procedure, patients still need compression therapy, dressing changes, infection monitoring, and emotional support. This is where tissue viability nurses step in.

Yet too often, care is handed off — not handed over. There is no shared platform, no seamless follow-up, and no unified treatment plan.

The Cold War: Silence between two essential professions

From what I've seen, the barriers are not personal — they're structural. Nurses tell me they refer patients for scans or intervention and hear nothing back. Surgeons are frustrated that patients arrive at their clinics too late or return to poor community support after surgery.

In short, nobody sees the full picture — and the one who suffers most is the patient.

This professional disconnection leads to:

- Delayed referrals for surgical assessment
- Suboptimal wound care post-surgery
- Recurrence of ulcers, even after technically successful interventions.

But it doesn't have to be this way.

Leg Clubs: A platform for real collaboration

The Leg Club model, pioneered by Prof Ellie Lindsay (Lindsay, 2004), offers more than a community gathering. It's a proven system for integrated care that brings together nurses, GPs, vascular specialists and patients in a non-clinical, welcoming environment.

I've visited Leg Clubs where nurses manage wounds while chatting with patients over tea. In that relaxed setting, they're also identifying signs of deterioration, discussing vascular options, and reinforcing compression therapy — all while maintaining the dignity of the individual.

With proper engagement, Leg Clubs can also:

- Flag surgical candidates early
- Support patients post-op with continuity of care
- Collect data on healing times, recurrence, and outcomes
- Offer a realistic framework for cross-referrals.

It's a system that's working — and scalable.

A model for success in the UK

From an NHS perspective, the cost of treating chronic leg ulcers is staggering. The 2015 study by Guest et al estimated that leg ulcers cost the NHS up to £941 million annually, with VLUs accounting for a large share of that (Guest et al, 2015).

Integrated care could reduce that cost dramatically. Here's how we make it happen:

- **Pathways for two-way referrals:** Community nurses should be empowered to refer directly for duplex scans or surgical

consultations. Post-op, surgeons must ensure wound care plans are relayed to community teams

- **Joint education and multidisciplinary team training:** Co-hosted sessions can address misunderstandings, showcase each profession's strengths, and build trust
- **Championing the Leg Club model:** With their built-in multidisciplinary structure, Leg Clubs could serve as a pilot hub for collaborative venous care across the UK
- **Digital communication tools:** We need better platforms to share updates, photos, wound status and treatment summaries in real time between surgical and community teams.

Closing the gap

Healing VLUs is not a one-person job. It takes time, planning and, above all, collaboration.

From a business development point of view, the case is simple. Better communication improves outcomes and reduces costs. But from a human point of view, it is even simpler. Patients deserve continuity, not conflict.

As someone who works between these two worlds, I've seen both the potential and the problems. The Cold War must end — and the Leg Club might just be the bridge to peace.

References

Guest JF, Ayoub N, McIlwraith T et al (2015) Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open* 5(12): e009283

Lindsay E (2004) The Lindsay Leg Club Model: a model for evidence-based leg ulcer management. *Br J Community Nurs* 9(Suppl 6): S15–20

Whiteley MS (2018) *Understanding Venous Leg Ulcers: The Importance of Treating the Underlying Venous Reflux.* Guildford: Whiteley Publishing