Education Provision in Wound Care – Does It Make a Difference?

In 1992 Bennett (1) carried out a UK based postal survey of 27 medical schools to determine how much teaching there was on wound care, the dismal truth was that very little wound care was included (from 19 responses 2 said definitely no teaching, 4 probably no teaching and the average amount was 6 hours). Almost 20 years later when there is widespread acknowledgement of the increasing number of patients with chronic wounds and acknowledgement of the spiralling costs of this care world wide (2), it would be fabulous to think that the situation had improved and that all relevant healthcare professionals – doctors, nurses, podiatrists, pharmacists etc were given high quality education on the care and management of patients with wounds. However, if anything, it seems things have become worse. Patel et al. (3) identified that the average medical student still only receives 9·2 hours of didactic education on wound healing and tissue repair in 4 years. In the UK undergraduate nurse training has little if any wound care, community nurse training (despite wound care accounting for on average 50–60% of their workload) is much the same.

Changes in education provision and moves to all graduate professions alongside global economic difficulties have reduced the opportunities for clinically focused professional development with attainment of academic awards being seen as the gold standard. Post graduate study is an excellent form of professional development, but it is only beneficial when the basics are in place and that all relevant healthcare professionals – doctors, nurses, podiatrists, pharmacists etc were given high quality education on the care and management of patients with wounds. However, if anything, it seems things have become worse. Patel et al. (3) identified that the average medical student still only receives 9·2 hours of didactic education on wound healing and tissue repair in 4 years. In the UK undergraduate nurse training has little if any wound care, community nurse training (despite wound care accounting for on average 50–60% of their workload) is much the same.

Changes in education provision and moves to all graduate professions alongside global economic difficulties have reduced the opportunities for clinically focused professional development with attainment of academic awards being seen as the gold standard. Post graduate study is an excellent form of professional development, but it is only beneficial when the basics are in place and the healthcare professional engaging in this higher level study has a good understanding of the fundamental aspects of the subject area – which it seems are sadly lacking. In the UK and many other countries there are no minimum standards for wound care or wound care education, and no requirement to include the basics (physiology, impact of chronic disease, wound assessment, pressure ulcer prevention, how dressings work etc) in undergraduate training – this can not be acceptable. Across the world the focus is on work based learning as we attempt to maintain the clinical focus of professional development and ensure our wound care practitioners are both competent and confident practitioners. However, work based learning requires skilled professionals to facilitate the process and support the learner, and I am not confident that these people exist – or at least exist in sufficient numbers to provide the level of support required. We have some excellent Masters level programmes in wound healing and tissue repair but they are undertaken by a small number of dedicated health professionals and again there is no consistency or standard across programmes. In countries such as the USA where there is certification and accreditation (with education programmes to meet these requirements) considerable confusion remains with a plethora of certification designations, programme names and requirements (4).

In addition to the growing numbers of patients with need for skilled wound care provision, as Ennis et al eloquently states 'wound healing has evolved from the use of simple gauze bandages to proteomics and gene analysis of wound tissue to drive therapeutic options'. This increasing complexity demands a focus on knowledge and skill acquisition – that it seems is sadly lacking. As healthcare agendas across the globe focus on quality initiatives and resource management, to achieve patient focussed outcomes perhaps more consideration should be given to getting the basics right, first time, every time (5).
means that education and training should be focused on quality, be patient centred, clinically driven and flexible (6).

In wound care it seems we are a long way from achieving these goals – and that no one is taking a stand to try and improve the situation other than on a very local basis. Take a look at recent conference programmes, think about the societies that you belong to – how many of them have a strong education, training and development theme – and how much communication, coordination and consistency is there on a National, let alone International, basis?

My goal with this editorial is to stimulate a flood of responses telling me that I’m wrong – but on a broad perspective I think it’s sad but true – we don’t have good basic programmes in place.

Recognising it’s politically difficult (and let’s not forget that Higher Education provision is a competitive market) to get wound care educators to work together. I also know most clinicians think to some extent – it’s not their problem, but come on – we all need to work together on this, those confident competent clinicians are the people I want caring for me when I get old (which is a long time off!) and develop a chronic wound. Isn’t that what we should be working towards?

REFERENCES