Is there a need to decolonise the teaching of wound care in higher education?

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Our skin is amazing and so important. It's our largest organ and accounts for around 16% of our body weight. It reacts to pressure, transmits sensation and responds to touch, it regulates our body temperature, regenerates daily and, importantly, it is the first thing that others see when they look at us. Our melanin content dictates the pigment of our skin, and it is often this that 'defines' what others see. The amount of melanin we have is a personal characteristic but, sadly, this can provoke racism, prejudice and discrimination.

Wound care, tissue viability and dermatology are all important areas of clinical care delivery that have our skin as their focus. Breaks in our skin or wounds affect many people; indeed, in 2012-13, 2.2 million patients presented to a health care professional with a wound (Guest et al, 2015). Wounds impact significantly on an individual's quality of life and their day to day functioning, they are often painful, and require cleansing, dressing and reviewing by a range of health care professionals.

Recent attention, energised by the 'Black Lives Matter' campaign, may inadvertently have prompted a watershed moment and encouraged us to make a tangible difference to a range of fundamental areas of clinical care, not least the care of our skin. Indeed, to this end, Malone Mukwende, a 2nd year medical student at St George's, has created a handbook entitled 'Mind the Gap', to show how disease appears on darker skin. This was developed in response to being taught predominantly about diagnosis of conditions in white patients and is awaiting publication.

As an academic with considerable experience in the area of wound care, recent work within my institution to decolonise the curriculum has highlighted to me an urgent need to decolonise my area of expertise, that of wound care. Following a decolonising session I helped to facilitate, I reflected on my involvement in wound care over the years and had to personally acknowledge that my delivery of education in this area has tended to have a 'white skin' bias, not through any conscious intent but influenced by the limited resources available, my lack of insight that this was an issue and, to an extent, a genuine fear of offending someone if the wrong language was used. Any search of wound care textbooks, online resources, publications and wound images available on the internet, reveals an almost complete absence of images of wounds on black or brown skin and scant attention to differences in presentation; that is despite Black, Asian and minority ethnic groups making up 14% of our population.

Wound care education for health care professionals of all disciplines, teaches the recognition of a variety of diagnostic indicators that aid in the assessment of a wound. These indicators support decisions about the wound type, level of bacterial colonisation, perfusion and the condition of the surrounding skin. All of these indicators, however, are fundamentally linked to the pigment of the patient's skin and, as such, may not be reliable for those in our population whose skin is not white. Such indicators include erythema, cyanosis, inflammation, discolouration, blanching and scarring, to name a few. The presentation of wound-specific diagnostic indicators will be considerably different on black and brown skin; yet this barely, if ever, gets a mention, even within reputable textbooks.

If we are to fully equip our health care professionals to care for all, irrespective of race, we need to address this considerable oversight in our wound care curriculum. We need to ensure that educational resources that support the provision of optimal care for our largest organ truly reflect the diversity of our population.

Guest JF, Ayoub N, McIlwraith T et al. Health economic burden that wounds impose on the National Health Service in the UK. BMJ Open. 2015; 5(12):e009283. http://dx.doi.org/10.1136/bmjopen-2015-009283