Editorial

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Wound Care and Wound Healing: Two Sides of the Same Coin?

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Citation: Nicolosi, B. (2026). Wound care and wound healing: Two sides of the same coin? *International Journal of Wound Research*, 2(3): 173–177. https://doi.org/10.64115/ijwr-2026-817

For decades, wound care and wound healing have coexisted within the same scientific and clinical field, sometimes used almost interchangeably. Yet they describe different things. Wound healing is primarily a biological process: the coordinated cellular, molecular and tissue events through which damaged tissue moves towards repair and restoration. Wound care is what we build around that process: assessing the patient and the wound, identifying the cause, recognising barriers, establishing realistic objectives, selecting interventions and determining whether they achieve what was intended.

The distinction is useful. Their separation, however, is much more difficult to defend.

Our understanding of wound healing has advanced considerably. Inflammation, cellular senescence, extracellular matrix dysfunction, protease imbalance, angiogenesis, microbial burden and biofilm are no longer confined to experimental wound science. They increasingly influence how clinicians interpret wounds that fail to progress. Chronic wounds are not simply acute wounds that need more time. They may present persistent biological abnormalities capable of disrupting or prolonging the normal sequence of tissue repair (Falanga et al., 2022). This expanding knowledge has changed both the scientific language of wound healing and the expectations placed on wound management.

Wound care has also changed. The field has moved beyond wound coverage and dressing selection towards aetiological diagnosis, wound bed preparation, management of local and systemic barriers, multidisciplinary intervention and continuous reassessment. We understand more about why wounds fail to heal, but that knowledge has little clinical value unless it changes care.

This raises a question that is more than semantic: are wound care and wound healing really two separate perspectives, or are they different expressions of the same clinical responsibility?

Wound bed preparation helped bring these perspectives together by translating biological barriers into clinical objectives (Schultz et al., 2003). Frameworks such as TIME and its later extension, TIMERS, support this reasoning, connecting local assessment with repair, regeneration and patient-related factors (Schultz et al., 2004; Atkin et al., 2019). Their value lies in helping clinicians turn an understanding of healing into decisions about care.

But the wound bed, however carefully assessed, does not exist independently of the individual who carries it. Perfusion, metabolic disease, nutrition, pressure, venous hypertension, mobility, pain, treatment adherence, psychological burden, access to healthcare and social circumstances may determine whether even technically appropriate local treatment succeeds or fails. As wound bed preparation evolved, these wider

Funding: This research received no external funding. **Conflict of Interest:** The author(s) declare no conflict of interest.

determinants became increasingly difficult to ignore. More recent iterations of the paradigm explicitly place treatment of the cause and patient-centred concerns alongside local wound management and distinguish between healable, maintenance and nonhealable wounds (Sibbald et al., 2021).

Advances in wound healing science have also widened the scope of clinical care. Once fundamental barriers to healing have been identified and appropriately addressed, the clinician must determine whether the wound is progressing as expected and whether additional or advanced strategies are justified. Contemporary wound care is no longer limited to removing barriers to healing. In selected patients and wounds, it may include interventions intended to actively support repair and regeneration. The decision requires more than access to advanced technologies. It requires clinicians to understand when standard management is insufficient, why it is insufficient and whether an additional intervention has a biologically and clinically plausible role.

A biologically appropriate treatment can still fail if it cannot be integrated into the patient's life. Adherence, capacity for self-care, mobility, treatment burden, social support, economic circumstances, individual priorities and access to healthcare are not peripheral considerations to be addressed after the wound has been treated. They are part of the environment in which healing is expected to occur. Evidence supporting person-centred approaches in chronic wound management remains heterogeneous, but improvements have been reported in outcomes including patient knowledge, pain, self-care behaviour, satisfaction and quality of life (Gethin et al., 2020).

The wound is biologically central, but it is not clinically sufficient.

Healing science asks what biological conditions are required for tissue repair. Care asks whether those conditions can be created, maintained and translated into a meaningful therapeutic strategy for this particular patient. Neither question is sufficient on its own.

There is also a linguistic habit worth reconsidering. We frequently speak about "healing a wound". Strictly speaking, however, clinicians do not heal tissue; the organism does. Our responsibility is different. We diagnose, remove or reduce barriers, treat the underlying cause, optimise systemic and local conditions, protect tissue, control symptoms and, when appropriate, introduce interventions intended to support the repair process.

When a wound does not progress, the first question should not be which dressing should we use next? It should be why is this wound not progressing? Is the aetiological diagnosis correct? Is perfusion adequate? Has the underlying cause been addressed? Is pressure effectively relieved? Is venous hypertension appropriately managed? Is inflammation controlled? Is infection present? Is the wound environment compatible with progression? Are patient-related or social factors interfering with the therapeutic plan? Has the wound reached a point at which repair or regenerative strategies should be considered?

These questions become more pressing as products, devices and biological therapies multiply. Innovation matters, but an advanced technology cannot compensate indefinitely for an incorrect diagnosis, untreated aetiology, inadequate perfusion, persistent pressure or a plan the patient cannot follow.

Wound care should therefore never become synonymous with dressing management.

A dressing is an intervention within a strategy. It is not the strategy itself.

There is another reason why wound care cannot simply be considered synonymous with wound healing: not every wound can heal.

The distinction between healable, maintenance and nonhealable wounds challenges the assumption that complete closure must always represent the only meaningful endpoint of care (Boersema et al., 2021; Sibbald et al., 2021). Where perfusion is adequate, the cause can be corrected and relevant barriers can be managed, healing may reasonably remain the primary objective. In maintenance wounds, healing potential may exist, but patient-related, systemic or contextual factors may prevent implementation of the optimal therapeutic plan. In nonhealable wounds, irreversible disease, inadequate perfusion or other limiting conditions may make complete closure unrealistic.

Defining care exclusively by closure would make these situations therapeutic failures. They are not. The purpose of care changes.

Pain control, management of exudate and odour, protection of the wound and surrounding skin, prevention or control of infection, reduction of treatment burden, preservation

of function and maintenance of dignity may become meaningful clinical outcomes even when complete closure is not achievable. Management of maintenance and nonhealable wounds therefore make particularly clear what is sometimes less obvious in healable wounds: care is broader than healing (Boersema et al., 2021).

Healing may be an outcome of wound care, but it cannot be its sole definition of success.

This principle is also consistent with the growing attention given to patient-reported outcomes. Chronic wounds can affect pain, mobility, sleep, social participation, independence, emotional wellbeing and overall quality of life, creating a burden that extends well beyond the physical dimensions of the lesion (Olsson et al., 2019). The increasing development and evaluation of wound-specific patient-reported outcome measures reflects a recognition that wound area reduction or closure alone cannot describe the full impact of either the wound or its treatment. A systematic review identified 33 condition-specific PROMs used in chronic wounds, while also highlighting substantial variability in their development and measurement quality (van Alphen et al., 2023).

A wound can therefore improve before it closes. Conversely, a wound may become smaller while the burden of treatment remains unacceptable to the person living with it.

The argument also works in the opposite direction. Separating care from wound healing science is equally problematic.

Care without an understanding of healing can rapidly become procedural. The wound is cleansed, a dressing is selected, the dressing is changed and the process is repeated. When progress stalls, another product is chosen. The appearance of clinical activity may remain, while the connection between assessment, objective and intervention progressively disappears.

This is exactly what structured wound bed preparation was intended to prevent: a loss of the connection between what is observed in the wound and what that observation means for management (Harries et al., 2016). An assessment of tissue viability, inflammation, infection, moisture and wound edge progression is useful only if it informs a decision. That decision must also account for the cause of the wound, its potential to heal and the circumstances of the person receiving care.

Wounds, patients and circumstances change. Therapeutic objectives may change with them. Assessment must lead to intervention, intervention to reassessment, and reassessment to confirmation or modification of the plan.

Care is not what happens after assessment. Nor is it what happens when a product is applied. Care is the process through which assessment, aetiology, healing potential, patient priorities, therapeutic objectives, interventions and outcomes remain connected over time.

Understanding molecular and cellular mechanisms while ignoring the person would be incomplete. But person-centred care that fails to address the biological and aetiological requirements for healing would be equally incomplete. A treatment may be biologically appropriate but practically unsustainable. Another may be acceptable and easy to deliver but biologically inadequate. High-quality wound care exists in the ability to recognise and manage this tension.

This requires moving beyond the management of isolated interventions towards the governance of an entire clinical pathway.

The starting point is not the dressing. It is the person, the wound and its cause. From there come assessment of healing potential and barriers, definition of realistic objectives, preparation of the wound bed, selection of local and systemic interventions, consideration of repair or regenerative strategies where indicated, and continuous evaluation of outcomes. The process is inherently multidisciplinary because the determinants of wound healing rarely belong to one professional domain.

Regardless of aetiology, wound management is a continuous and dynamic clinical process in which wound healing and wound care are integral, interdependent and inseparable. This does not imply uniform treatment: the cause, healing potential, objectives and interventions remain specific to each clinical situation. What is shared is the connection between assessment, aetiological diagnosis, appraisal of healing potential, therapeutic objectives, intervention, reassessment and adaptation over time. Biological understanding and clinical care inform one another throughout. Their integration remains essential when healing potential is limited or absent, because recognising those limits is necessary to define appropriate goals.

Wound care and wound healing are not

synonymous. Maintaining a distinction between them remains useful. Healing describes the biological process we seek to understand and, whenever possible, support. Care describes the clinical responsibility of creating the best possible conditions for that process while responding to the needs, priorities and circumstances of the person.

Healing without care risks becoming biology without the patient. Care without healing science risks becoming intervention without direction.

Perhaps, then, two sides of the same coin is not a perfect metaphor. The two sides of a coin never actually meet. Wound care and wound healing must.

They meet whenever biological knowledge changes a clinical decision. They meet when the cause of a wound is addressed rather than another dressing simply being applied. They meet when an advanced intervention is introduced because the wound trajectory justifies it, rather than because the technology is available. They meet when a theoretically optimal treatment is reconsidered because it is not sustainable for the patient. And they meet when the therapeutic objective shifts from closure to symptom control and quality of life because complete healing is no longer realistically achievable.

The future of wound management will undoubtedly bring a deeper understanding of tissue repair and increasingly sophisticated technologies capable of influencing it. This progress is necessary. But the sophistication of our interventions must be matched by the sophistication of our clinical reasoning.

The challenge, therefore, is not to decide whether wound care or wound healing should take precedence. It is to ensure that each continues to inform the other.

Healing gives direction to care. Care creates the conditions in which healing can be pursued. And when healing cannot be achieved, care remains.

That may be the point at which wound care and wound healing cease to be merely two sides of the same coin and become what clinical practice has always required them to be: inseparable parts of the same responsibility.

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