Scandinavian Journal of Caring Sciences

WILEY

ORIGINAL ARTICLE OPEN ACCESS

How Nurses Communicate About Amputation and Death in Specialised Outpatient Wound Clinics—A Qualitative Study

Emma Sandberg Nautrup[1] | Kristoffer Marsaa[2] | Heidi Bergenholtz[3] | Ulla Riis Madsen[4]

[1]University of Southern Denmark, Odense, Denmark | [2]Steno Diabetes Centre Copenhagen, Herlev, Graested, Denmark | [3]Zealand University Hospital, Research Support Unit & REHPA, the Danish Knowledge Centre for Rehabilitation and Palliative Care, Odense University Hospital and Department of Clinical Research, University of Southern Denmark, Odense, Denmark | [4]Vascular Surgery Department, Zealand University Hospital, Roskilde; Orthopaedic Department, Holbaek Hospital & REHPA, the Danish Knowledge Centre for Rehabilitation and Palliative Care, Odense University Hospital & Department of Clinical Research, University of Southern Denmark, Odense, Denmark

Correspondence: Ulla Riis Madsen (riismadsen@sdu.dk)

Received: 2 July 2025 | **Revised:** 21 January 2026 | **Accepted:** 23 January 2026

Keywords: advanced care planning | communication | palliative wound care | wound care

ABSTRACT

Aims: To explore how nurses communicate with patients at risk of amputation due to chronic leg wounds, with a specific focus on discussions regarding amputation and death and to explore the perceived barriers that nurses face when engaging in conversations about prognosis, treatment options and end-of-life care.

Methods: An exploratory qualitative design was employed, utilising non-participant observations and focus group interviews conducted in specialist wound clinics across four hospitals in Denmark. The observations included 85 consultations involving 84 patients with chronic leg wounds, and four focus group interviews were conducted with 13 registered nurses. Data analysis followed a qualitative content analysis procedure and is reported according to the COREQ guidelines.

Findings: The study revealed that the primary goal of nurses is to achieve wound healing, which often overshadows the need for discussions about amputation and death. Five key themes emerged: ‘Professional responsibility shaped by emotional involvement’; ‘Meeting patients with honesty rather than compassion’; ‘Avoiding conversations about amputation and death’; ‘Timing dilemmas in conversations about amputation and death’; and ‘Biomedical confidence and psychosocial uncertainty’. Nurses expressed a desire for deeper conversations but felt constrained by institutional practices and personal beliefs.

Conclusions: This study highlights the critical need for a systematic approach to communication about amputation and end-of-life care in chronic wound management. By identifying barriers and emphasising the importance of holistic, patient-centred care, the findings contribute to the ongoing discourse on improving palliative care practices for patients with chronic wounds. The insights gained can inform training and guidelines to enhance nurses' competencies and foster more open discussions about difficult topics, ultimately improving patient outcomes and quality of life.

Recommendations for Clinical Practice:

- Several barriers hinder nurses from discussing amputation and death with patients, including perceived incompetence, time constraints, lack of systematic approaches, unclear roles among healthcare professionals, and personal beliefs.
- The strong emphasis on achieving wound healing can overshadow the need for compassionate discussions about potential amputation, the broader implications of living with chronic wounds, and the risk of dying.
- Nurses often prioritise the practical tasks around wound healing over holistic patient care, which can lead to neglecting important conversations about prognosis and end-of-life care.

https://doi.org/10.1111/scs.70198

1 | Background

Living with a chronic leg wound affects all aspects of quality of life, and everyday life is determined by the problems the wound causes [1, 2]. Patients pendulate between hope and despair [2]. Hope for the wound to heal—hopelessness and despair when the process is delayed and the threat of amputation moves closer. Moreover, leg wounds that do not heal are often symptoms of advanced ischaemic disease, which increases the risk of not only amputation but also early death [3], and mortality rates in this population are higher than those of most cancer diagnoses [4]. Although several of the foundational studies describing these problems were published more than two decades ago, subsequent advances in wound care have not eliminated the profound impact of chronic wounds on patients' daily lives [5].

There is a growing awareness that not only patients with cancer but all patients with life-threatening diseases can have palliative care needs [6]. The goal of palliative care is to relieve the patient's suffering, whether physical, psychological, social, or existential [7]. To achieve this goal, a multidisciplinary, holistic approach is crucial. It is recommended that palliative needs be systematically identified and assessed with validated instruments and that patients be offered systematic conversations about future treatment and care [8].

In wound care, the role of palliative care has primarily focused on managing wounds in critically ill patients within specialist palliative care settings [9, 10]. However, patients with chronic wounds have extensive needs, e.g., pain, dressing, odour, and not least the psychological and social consequences of long-term wound treatment [1, 2], and these needs are not systematically identified and met by their healthcare providers [11]. Consequently, patients are left to address the problems themselves, not least their thoughts about both the risk of amputation and death [12]. Furthermore, there is a pronounced tendency among healthcare professionals to focus on the treatment of the wound to maintain the foot or leg at any cost, more so than a holistic approach to the person who has the wound [12, 13]. Based on existing guidelines, implementing a palliative approach in chronic wound care would include systematic conversations about the prognosis for wound healing, treatment options like amputation, and end-of-life care for the patient to make decisions for their life. This approach is not routinely offered to patients attending specialist wound clinics today, and little is known about how nurses communicate with patients about either amputation or death [12] or potential barriers and facilitators to implementing such counselling in daily wound care practice [14].

1.1 | Aim

To explore how nurses communicate about amputation and death with patients at risk of amputation due to chronic leg wounds. A second aim is to explore nurses' perceived barriers to engaging in conversations about prognosis, treatment options, and end-of-life care.

2 | Methods

2.1 | Design

An explorative qualitative design was adopted, using participant observations [15] and focus group interviews as methods. The study is reported according to the Consolidated criteria for reporting qualitative research (COREQ) [16].

2.2 | Setting and Participants

The study was conducted in specialist wound clinics at four hospitals in Denmark. All registered nurses employed at the participating specialist wound clinics during the study period were eligible for inclusion and were invited to participate by their daily managers, constituting a convenience sample. No additional inclusion or exclusion criteria were applied, and all nurses working in the clinics during the observation days consented to participate. The clinics have approximately 10–20 patients daily, referred with wounds of all causes for specialist treatment. The analytical focus of the study was on nurses and their role in clinical practice. However, because nursing work was carried out within multidisciplinary teams, observations necessarily included interactions with other professionals, such as surgeons and podiatrists. These interactions were considered in relation to nursing practice and interprofessional collaboration, rather than as separate objects of analysis. All health professionals who participated provided informed consent prior to data collection.

All participating nurses and surgeons were familiar with the researcher prior to the study through various professional and clinical contexts. The researcher had no managerial or supervisory role in relation to the participants. This pre-existing professional familiarity was considered to facilitate trust and openness during both observations and focus group interviews, while reflexivity regarding potential pre-understandings was continuously addressed throughout data collection and analysis [17].

3 | Data Collection

The observations of consultations between surgeons, nurses, patients, and relatives were performed from July to August 2019. Data were collected through non-participant observations (last author) [15] of existing practices during wound consultations. All nurses present in the clinics during the observation days participated in the observations ($n = 12$), together with surgeons ($n = 7$), constituting a consecutive sample of available consultations. The observations included all consecutive consultations involving patients with chronic leg or foot wounds scheduled on one of the three days the observer was present at each clinic. Patients were eligible for inclusion if they attended a consultation during the observation days and had a chronic wound on the leg or foot. Patients were informed about the study before the consultation by the nurse and were given the opportunity to decline participation. No patients declined. The observations included 85 consultations, with 84 patients having chronic wounds on the leg or feet (lasting two months to 12 years). Among these 84 patients, 15 had a minor or major amputation at some point. Each consultation lasted from 5 to 75 min, with a mean duration of 45 min.

The four focus group interviews (one in each hospital) performed May–August 2020 involved 13 registered nurses in total, all of whom had participated in the observations, except one nurse who had been absent during the observation period. They had a mean experience in specialised wound clinics of 15 years (from three to 26 years). The participant characteristics are presented in Table 1. The interviews were conducted in a meeting room at the hospital, outside the wound clinic, after working hours. The participants were reimbursed for the time used.

The observations focused on how consultations were structured, which topics were addressed, how and by whom topics were initiated, and how communication unfolded between nurses, surgeons, patients and relatives, with the aim of describing current practice related to communication about prognosis, amputation risk, and life-threatening aspects of the condition. The observations were guided by an open-ended observational focus rather than a fixed checklist, allowing attention to both anticipated and unanticipated aspects of clinical communication.

Observations were documented in handwritten field notes on the spot and then elaborated and rewritten electronically immediately after. A semi-structured interview guide (see additional file A) was developed on the basis of the observed practice, literature on needs among patients with chronic wounds [18, 19], and literature about barriers to advanced care planning in other settings [14, 20]. The interview guide included five themes. Firstly, four themes on how the nurses think about and communicate with patients on the expected course of treatment; the fact that their condition is/can be life-threatening; the risk of amputation; and how to prepare for an amputation. Secondly, a final theme about having difficult conversations and the nurses' perceived competencies, opportunities, and limitations. The interviews were performed from April to June 2020 and were recorded and transcribed verbatim by two research assistants. Transcripts were not returned to participants for comments, and data were managed without use of additional software.

TABLE 1 | Interview participants characteristics.

Hospital	Participant	Wound care experience/years	Gender
A	1	10	Female
	2	10	Female
	3	4	Female
B	1	26	Female
	2	7	Male
C	1	25	Female
	2	15	Female
	3	14	Female
	4	20	Female
D	1	11	Female
	2	3	Female
	3	25	Female
	4	20	Female

4 | Analysis

A qualitative content analysis procedure [21] was used to analyse data, to explore how nurses communicate about amputation and death with patients at risk of amputation due to chronic leg wounds; and to explore the nurses' perceived barriers to engaging in conversations about prognosis, treatment options, and end-of-life care with patients at risk of amputation due to chronic leg wounds. Firstly, the last author read the observational field notes several times to obtain a sense of the whole. Secondly, clinical communication practices in wound consultations were examined across the four clinics to describe current practice, labelled with codes, sorted, and gathered in one overall description. Thirdly, this description informed the interview guide and provided a contextual description of current practice, rather than constituting a separate analysis.

The transcribed interviews were thereafter, together with the above-mentioned description of the context, analysed as a whole, not referring to specific hospitals or individuals. The process of analysis had three steps: first, the text was read several times to obtain a sense of the whole by the first and last authors. The text was then sorted into content areas, which constituted the units of analysis. Hereafter, condensed meaning units were extracted and labelled with codes. The whole context was considered when condensing and labelling meaning units with codes, including findings from the observations. The various codes were compared on the basis of differences and similarities, and a process of reflection and discussion resulted in agreement about how to sort the codes in subcategories, which constituted the manifest content. These tentative categories were discussed by all authors and revised. Finally, the underlying meaning, that is, the latent content, of the categories was formulated into one main category and five themes (Figure 1). Examples of codes, subcategories, and themes are given in Table 2.

4.1 | Ethical Approval and Consent to Participate

Principles for research given in the Helsinki Declaration and the Northern Nurses' Federation were followed [22]. In accordance with Danish law, formal ethical approval of the study was not needed. The Danish Data Protection Agency of Region Zealand, Denmark, approved the data storage (REG-084-2020). The participants provided written and oral consent for participation after being informed of the aim of the study, data storage, anonymized handling procedures and the possibility of withdrawing consent at any time before publication.

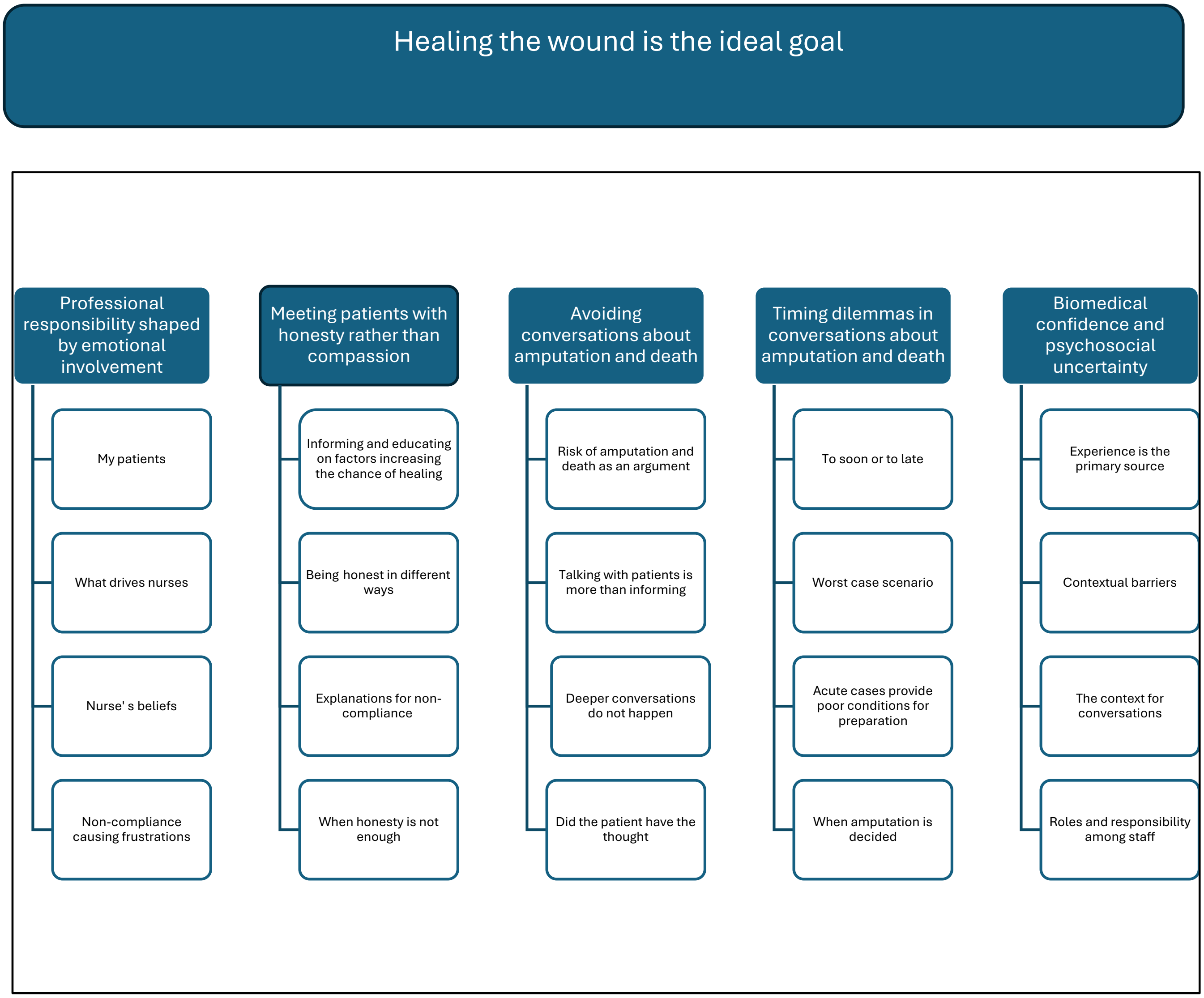

FIGURE 1 | Main category, themes and sub categories.

5 | Findings

5.1 | Healing the Wound Is the Ideal Goal

The analysis resulted in one overarching main category, 'Healing the Wound is the Ideal Goal', describing a dominant biomedical orientation that shaped nurses' communication with patients at risk of amputation. Within this main category, five themes were identified: 'Professional responsibility shaped by emotional involvement'; 'Meeting patients with honesty rather than compassion'; 'Avoiding conversations about amputation and death'; 'Timing dilemmas in conversations about amputation and death'; and 'Biomedical confidence and psychosocial uncertainty'. Together, these themes illustrate how a strong focus on wound healing structured nurses' professional values, emotional responses, and organisational practices, influencing if, when, and how conversations about amputation and death were addressed in daily wound care practice (Figure 1).

5.1.1 | Professional Responsibility Shaped by Emotional Involvement

This theme describes how nurses' communication with patients was shaped by a strong sense of professional responsibility intertwined with emotional involvement. Observations showed that nurses often developed close, long-term relationships with patients through repeated consultations, fostering commitment and a sense of responsibility for the patient's wound healing trajectory. Healing the wound was closely linked to nurses' professional identity and sense of achievement, whereas lack of healing often generated frustration.

During consultations, nurses were observed to focus primarily on wound treatment, including dressings, compression therapy and lifestyle-related factors such as smoking cessation. Patients who adhered to recommendations were implicitly perceived as cooperative, while patients who did not follow advice were sometimes met with a more reserved or directive communication

TABLE 2 | Example: content analysis.

Text	Condensation	Codes	subcategory	Theme
D: I also believe this assessment of our current status and the art of what is possible is vital, and I make a point of emphasising collaboration, as some tend to shift all responsibility onto us. It is important to convey that this is a partnership; I cannot manage this alone by merely attending every fourth or sixth week. Participation is also required from their end. B: I believe we often discuss the importance of being honest with the patient, conveying that we cannot guarantee the healing of their wound, and they must be aware of this—even during the first appointment, where there may already be indications that further surgical intervention is not possible, and we are confronted with a deep wound.	We frequently discuss the importance of being honest with patients, informing them that we cannot guarantee the healing of their wound, and they must be cognizant of this. If, during the initial visit, we observe certain conditions—such as indications that further vascular intervention might not be possible and the presence of a deep wound—where does that leave us?	We must be honest with the patient Don't promise them that the wound will heal and they must be aware of that	Being honest in different ways	Meeting patients with honesty rather than compassion

style. Frustration related to non-adherence was occasionally articulated by staff, as illustrated by a surgeon's remark during an observed consultation:

> It is difficult to understand that giving up smoking and alcohol is too big a sacrifice, compared to sitting there without legs.

In the focus group interviews, nurses described how long treatment courses and emotional investment made wound healing professionally meaningful. Successful healing was associated with professional satisfaction, while prolonged non-healing challenged nurses' motivation and sense of efficacy:

> *However, it is also hard because it is much more fun to see the wounds heal, is not it*?
>
> (D4).

Non-adherence was often explained by nurses as reflecting patients' different priorities in life, which sometimes conflicted with the nurses' goal of achieving wound healing. Some nurses expressed difficulty accepting that patients might prioritise quality of life or personal habits over medical recommendations, even when aware of the risks involved.

Nurses' beliefs about amputation and death further influenced their communication. These outcomes were commonly perceived as worst-case scenarios and were often understood through nurses' own imagined reactions if placed in a similar situation. This personal identification contributed to emotional discomfort and reluctance to initiate conversations about amputation or death:

> *'You know very well what you thought when you were 40 and what you expected from life and what you should do.'*
>
> (A1)

In some cases, this led nurses to avoid such topics and instead focus on helping patients endure their current situation and maintain hope. One nurse described prioritising the patient's ability to cope over addressing life-threatening aspects of the condition:

> *'Then, it is about getting him to a place where he can endure the wounds he has or get amputated so he does not have those wounds anymore.'*
>
> (A3)

Overall, this theme illustrates how nurses' professional responsibility was closely intertwined with emotional involvement, shaping communication in ways that prioritised hope of wound healing, while making conversations about amputation and death emotionally challenging.

5.1.2 | Meeting Patients With Honesty Rather Than Compassion

This theme describes how nurses prioritised honesty and factual information in their communication with patients, based on a belief that this would promote adherence to treatment. Nurses emphasised the consequences of non-adherence, particularly related to lifestyle factors such as smoking, diet, insulin use and mobility, and framed patient contribution as essential for wound healing and limb preservation:

> *'If it is to heal, you need to contribute, because otherwise it will worsen, and you run the risk of not having a leg to walk on.'*
>
> (A2)

However, both observations and interviews showed that this approach was not always effective. Across observed clinical encounters and interview accounts, nurses demonstrated limited curiosity about patients' own priorities or life situations and communication was primarily focused on biomedical facts rather than emotional or existential concerns. Patients' capacity to receive information varied and younger, well-educated patients were perceived as more receptive, while others appeared overwhelmed or disengaged. Repeated non-adherence often led to frustration and discouragement among nurses:

> *Either they do not hear it at all and are actually ignoring it.* (A3)

Overall, this approach was viewed as a professional obligation, but the limited inclusion of patients' perspectives sometimes constrained meaningful dialogue.

5.1.3 | Avoiding Conversations About Amputation and Death

This theme describes how conversations about amputation and death were largely avoided in everyday wound care practice, despite staff often anticipating poor outcomes. Observations showed that many patients were severely ill with multiple comorbidities, yet discussions about prognosis, amputation or mortality were rare. Communication during consultations primarily focused on wound treatment, and sensitive topics were often bypassed, sometimes replaced by small talk. One nurse described the difficulty of addressing such issues while concentrating on the wound, referring to '*talking with the head down in the wound*' (A2).

In the focus group interviews, nurses explained that conversations about amputation and death were uncommon due to lack of skills and fear of diminishing patients' hope. Some questioned whether such discussions belonged in the outpatient wound clinic at all:

> *The deeper conversations do not happen, but it is neither a job for the outpatient clinic; they have to manage that at home. (*D2)

When death was discussed, it was often linked to persuading patients to accept amputation rather than to exploring existential concerns. At the same time, nurses described that some patients themselves raised the issue of amputation, often driven by pain or exhaustion from prolonged treatment:

> *'Can't you just take that toe, because now I simply cannot stand it anymore.'*
>
> (D1)

A few nurses viewed conversations about death as potentially supportive, allowing patients to express fears they might otherwise keep to themselves (B1).

Overall, this theme highlights a gap between patients' likely concerns and the limited space given to explicit discussions about amputation and death in routine wound care.

5.1.4 | Timing Dilemmas in Conversations About Amputation and Death

This theme describes nurses' uncertainty about when conversations about amputation and death should take place. Nurses expressed divergent views on timing, but many felt that such discussions often occurred too late in the disease trajectory. Some described a tendency to avoid direct conversations about seriousness and prognosis, while others perceived surgeons as being overly confrontational when addressing amputation. One nurse reflected:

> '*We often say too little rather than saying it too early; we tend to dance around the maypole instead of discussing how serious it can quickly become.*'
>
> (C2)

Views on discussions about death also varied. Some nurses preferred to wait for patients to initiate such conversations, while others supported gentle, explorative dialogue. Fear of removing hope remained a recurring concern, now explicitly linked to questions of timing rather than whether such conversations should take place at all.

> *'I think you take away hope from those people if you give them a time horizon.'*
>
> (A3)

Nurses described that they sometimes encouraged patients to consider amputation as a way to relieve pain or as an alternative when prolonged wound care no longer seemed beneficial. Early conversations were viewed as potentially increasing patient readiness, acknowledging that patients often need time to understand the seriousness of their condition. However, nurses also noted that acute or subacute situations were poor contexts for preparing patients for amputation.

Once a decision about amputation had been made, the focus often shifted to practical and organisational tasks, sometimes at the expense of addressing patients' emotional needs:

> *'Then our mill runs… there is so much purely system-wise you have to do.'*
>
> (C1)

If nurses felt that amputation had occurred later than appropriate, they attempted to comfort patients by reassuring them that all options had been explored, aiming to reduce feelings of regret or self-blame.

Overall, this theme highlights timing as a central dilemma, shaped by concerns about hope, readiness, and professional responsibility.

5.1.5 | Biomedical Confidence and Psychosocial Uncertainty

This theme describes how nurses felt confident addressing biomedical aspects of wound care, while experiencing uncertainty and lack of competence when engaging in conversations about amputation, death and psychosocial concerns. In both the observations and focus group interviews, nurses emphasised their expertise in wound treatment and practical care, but described difficult conversations as challenging and insufficiently supported by training or organisational structures.

Nurses generally viewed surgeons as primarily responsible for informing patients about prognosis, treatment options and decisions regarding amputation. Nurses' role was described as supportive and follow-up oriented, often dependent on whether a surgeon had already introduced these topics. Some nurses described prompting surgeons when they felt a conversation was overdue:

> *'Sometimes, I have had to tell the doctor that I think, with this development, that we should have a talk now.'*
>
> (D1)

Trust and continuity were considered essential when addressing sensitive issues and nurses emphasised that such conversations should ideally be conducted by familiar staff. Experience was described as the main source of competence in difficult conversations, while formal training in communication and psychosocial care was perceived as limited. Nurses expressed uncertainty and self-doubt about their approach, and 'soft matters' were often deprioritized in busy outpatient settings.

Time constraints and practical demands further limited opportunities for deeper conversations. Some nurses believed that such discussions could take place during wound care, while others found the outpatient context unsuitable:

> *'I think it is a bit difficult in an hour in an outpatient clinic to have a truly big talk about it.*
>
> (D1)

The absence of systematic approaches or guidelines meant that communication about amputation and death varied widely and depended on individual nurses' experiences and assumptions:

> *'It is not very structured… it is very random.'*
>
> (B1)

Overall, this theme highlights how strong biomedical competence, combined with limited psychosocial support and unclear roles, reinforced a wound-focused approach and contributed to inconsistent communication about amputation and death.

6 | Discussion

Our study identified several barriers that hinder nurses from discussing amputation and death with patients, including perceived incompetence, time constraints, lack of systematic approaches, unclear roles among healthcare professionals and personal beliefs. These barriers are consistent with previous research on challenges faced by nurses in advanced care planning conversations [14, 20]. Additionally, the biopsychosocial model [23], introduced in 1977 as an alternative to the strictly biomedical model, emphasises the importance of considering biological, psychological, and social factors in understanding illness. This perspective raises questions about whether it is enough for healthcare providers to inform patients about medical issues or if they should also explore the deeper human reasons behind potentially harmful behaviours.

The nurses' lack of a systematic approach in communicating about amputation and death leads to conversations being influenced by their personal beliefs. Many perceive these outcomes as the worst for patients, resulting in hesitance to discuss them for fear of damaging patients' hopes. Chochinov describes this as the 'golden rule,' where providers treat patients as they would want to be treated [24]. He suggests adopting the 'platinum rule,' which emphasises treating patients according to their own wishes and preferences, recognising that one cannot assume without allowing patients to express themselves. Research indicates that patients with wounds may have different perceptions of their condition's severity compared to healthcare professionals, impacting their adherence to treatment [12, 25]. This highlights the need for clinical decisions to be tailored to individual patients rather than generalised assumptions on 'patients like this' [26].

When patients did not follow staff instructions, nurses felt frustrated, believing that patients were shirking responsibility for their healing despite being informed that collaboration was essential. This dynamic may arise from a culturally ingrained problem-solving orientation among healthcare professionals, leading them to assume that wound healing aligns with patients' interests and plans treatment accordingly. Nielsen and Larsen differentiate the role of healthcare from the roles of the problem solver and companion, suggesting that when a patient's problems become unsolvable, the focus should shift from action to supporting patients' and families' wishes and needs [27]. This palliative approach could take away the responsibility of solving patients' problems and provide nurses with alternative options to meet the needs of patients with compassion, potentially lowering the nurses' frustrations and relieving the patients' suffering.

This study highlights a gap in communication between nurses and patients, primarily focusing on practical biomedical information while neglecting psychosocial aspects. Nurses often assumed patients would seek necessary information independently, and observations revealed that nurses sometimes disregarded patients' attempts to express their concerns, thereby deeming them unimportant. Additionally, prioritising practical tasks over addressing patients' emotional needs increases the likelihood of patients feeling ignored and disconnected. Research indicates that patients desire timely information about their conditions and treatment options to manage their care effectively [5, 27]. Conversations about critical issues like amputation and death were often delayed until they became unavoidable, making it challenging to discuss patients' wishes and needs adequately [28]. Additionally, patients who are informed and involved in decision-making tend to receive less intensive end-of-life treatment [29], which reflects good palliative care practices. However, when healing the wound is the ideal goal, the clinics can miss the opportunity to discuss broader goals of care with severely ill patients.

This study highlights that while nurses understand the importance of discussing amputation and death with at-risk patients, they face several barriers that hinder these conversations. To tackle these issues, Susan Michie et al. developed the behaviour change wheel, which identifies targets for implementation interventions and effective strategies [30]. The barriers encountered by nurses relate to motivation, opportunity, and capability—components that are interconnected. The nurses felt untrained and unprepared to facilitate difficult discussions, indicating a need for training [31]. Additionally, fostering a culture that values conversation, clarifying responsibilities and providing communication training are essential for enhancing nurses' confidence in these discussions. Environmental barriers like time constraints and a focus on practical tasks further complicate the situation, suggesting that formal guidelines could help prioritise these conversations. However, there is a risk of losing compassion in standardised approaches to communication. The literature presents two perspectives on advance care planning (ACP): one advocates for ensuring patients fully understand their conditions [32], while the other emphasises a more compassionate, gradual approach to involve patients in their care [33].

7 | Strengths and Limitations

A strength of the study is the comprehensive data material collected across four specialist wound clinics, combining observations and focus group interviews, which enabled an in-depth exploration of communication practices. All data collection was conducted by one researcher, which may be considered a limitation, particularly in relation to focus group interviews. However, having one researcher ensured consistency across sites and methods, and potential bias was addressed through researcher triangulation during the analysis, where interpretations were discussed within the research group to enhance credibility [34].

The observations were based on handwritten field notes rather than audio- or video recordings, which may have limited the level of detail. The presence of an observer in the consultation room may also have influenced participants' behaviour. However, the observer was well known to staff prior to the study, which likely reduced reactivity, and observations were conducted over several days at each clinic, allowing participants to become accustomed to the observer's presence.

A limitation of this study is that the data are relatively old and were collected from 2019 to 2020. However, the study results have been presented to the participants in the intervening period, who recognised and acknowledged the continued relevance.

8 | Conclusion

This study shows that nurses' communication with patients at risk of amputation is strongly shaped by a dominant focus on achieving wound healing, which is deeply embedded in professional identity and daily practice. While nurses strive to provide honest information to support adherence and preserve hope, this focus often limits conversations about amputation, prognosis, and death. As a result, patients may be insufficiently prepared for potential life-changing outcomes.

Several barriers to such conversations were identified, including nurses' perceived lack of competence, unclear professional roles, time constraints, and the absence of systematic approaches to discussing prognosis and end-of-life issues. Together, these factors contribute to inconsistent and predominantly biomedical communication practices.

For clinical practice, the findings highlight the need for clearer role clarification, structured approaches to difficult conversations, and targeted training in psychosocial and palliative communication within wound care. Future research should explore patients' perspectives on these conversations and evaluate interventions that support earlier, more holistic communication about amputation risk and end-of-life concerns in chronic wound care, as part of a palliative approach to chronic wound care.

Author Contributions

Emma Sandberg Nautrup, RN, master student with experience in qualitative work; analysis and writing the manuscript. Kristoffer Marsaa, MD, both experienced in palliative care and qualitative studies; analysis, critical appraisal of the manuscript. Heidi Bergenholtz, RN, phd, associate professor respectively, both experienced in palliative care and qualitative studies; analysis, critical appraisal of the manuscript. Ulla Riis Madsen, RN, phd, associate professor, female, experienced in the field of wound and amputation care; planning the study, conducting all observations and interviews, analysis, writing manuscript.

Acknowledgements

We thank all patients and healthcare professionals who bravely invited us into their daily clinical practice and shared their reflections on these sensitive topics.

Funding

This work was supported by the Novo Nordisk Foundation (NNF18OC0051995 in the call ‘Postdoc Fellowships in Nursing Research’) and by a grant from Steno Diabetes Centre Zealand. The authors have no conflicts of interest to declare.

Consent

Principles for research given in the Helsinki Declaration and the Northern Nurses' Federation were followed (34). In accordance with

Danish law, formal ethical approval of the study was not needed. The Danish Data Protection Agency of Region Zealand, Denmark, approved the data storage (REG-084-2020). The participants provided written and oral consent for participation after being informed of the aim of the study, data storage, anonymized handling procedures, and the possibility of withdrawing consent at any time before publication.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are not available due to privacy or ethical restrictions.

References

1. G. R. Tennvall and J. Apelqvist, "Health-Related Quality of Life in Patients With Diabetes Mellitus and Foot Ulcers," *Journal of Diabetes and Its Complications* 14 (2000): 235–241.

2. B. Ebbeskog and S.-L. Ekman, "Elderly Persons' Experiences of Living With Venous Leg Ulcer: Living in a Dialiectal Relationship Between Freedom and Imprisonment," *Scandinavian Journal of Caring Sciences* 15 (2001): 235–243.

3. M. Teraa, M. Conte, F. Moll, and M. Verhaar, "Critical Limb Ischemia: Current Trends and Future Directions," *Journal of the American Heart Association* 5 (2016): e002938.

4. U. Madsen, N. Hyldig, and K. Juel, "Outcomes in Patients With Chronic Leg Wounds in Denmark: A Nationwide Register-Based Cohort Study," *International Wound Journal* 19 (Generic) (2022): 156–168, https://doi.org/10.1111/iwj.13607.

5. C. A. Hansen, C. M. H. Hjelmgaard, M. O. Kristensen, and C. Berthelsen, "Patient Involvement in Diabetes-Related Foot Ulcers: What Do Patients Need and Prefer When Undergoing Treatment at Multidisciplinary Outpatient Foot Centres? A Phenomenological Hermeneutic Study," *International Wound Journal* 21, no. 12 (2024): e70128.

6. L. Llop-Medina, Y. Fu, J. Garcés-Ferrer, and A. Doñate-Martínez, "Palliative Care in Older People With Multimorbidities: A Scoping Review on the Palliative Care Needs of Patients, Carers, and Health Professionals," *International Journal of Environmental Research and Public Health* 19 (2022): 3195.

7. WHO, "Definition of Palliative Care," (2023), https://www.who.int/europe/news-room/fact-sheets/item/palliative-care.

8. J. Van Der Steen, E. De Wit, M. Visser, et al., "How International Experts Would Define Advance Care Planning: A Content Analysis," *Annals of Palliative Medicine* 13, no. 6 (2023): 1409–1419.

9. A. Walsh, "Palliative Wound Care: Case Studies," *Journal of Hospice and Palliative Nursing* 24, no. 1 (2022): 15–21.

10. D. Koumaki, G. Kostakis, S. Boumpoucheropoulos, P. Ioannou, and A. C. Katoulis, "A Narrative Review of Management of Wounds in Palliative Care Setting," *Annals of Palliative Medicine* 12, no. 5 (2023): 1089–1105.

11. J. Green, R. Jester, R. McKinley, and A. Pooler, "Nurse-Patient Consultations in Primary Care: Do Patients Disclosure Their Concerns?," *Journal of Wound Care* 22, no. 10 (2013): 534–539.

12. M. Kragh Nielsen, H. Bergenholtz, and U. R. Madsen, "Thoughts and Experiences on Leg Amputation Among Patients With Diabetic Foot Ulcers," *International Journal of Qualitative Studies on Health and Well-Being* 17, no. 1 (2022): 2009202.

13. W. J. Jeffcoate, "Wound Healing-a Practical Algorithm," *Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy* 28, no. 1 (2012): 85–88.

14. D. Blackwood, D. Walker, M. Mythen, R. Taylor, and C. Vindrola-Padrós, "Barriers to Advance Care Planning With Patients as Perceived by Nurses and Other Healthcare Professionals: A Systematic Review," *Journal of Clinical Nursing* 28 (2019): 4267–4297.

15. J. P. Spradley, *Participant Observation* (Harcourt Brace College Publishers, 2008).

16. A. Tong, P. Sainsbury, and J. Craig, "Consolidated Criteria for Reporting Qualitative Research (COREQ): A 32-Item Checklist for Interviews and Focus Groups," *International Journal for Quality in Health Care* 19, no. 6 (2007): 349–357.

17. K. Malterud, "Qualitative Research: Standards, Challenges, and Guidelines," *Lancet* 358, no. 9280 (2001): 483–488.

18. R. G. Frykberg and J. Banks, "Challenges in the Treatment of Chronic Wounds," *Advances in Wound Care (New Rochelle, N.Y.)* 4, no. 9 (2015): 560–582.

19. J. Green, R. Jester, R. McKinley, and A. Pooler, "Patient Perspectives of Their Leg Ulcer Journey," *Journal of Wound Care* 22, no. 2 (2013): 58–66.

20. J. E. Pedersen, H. Eide, M. G. Sandsleth, I. Taylor, and L. H. Førsund, "Advanced Practice Nurses' Roles and Responsibilities in Advance Care Planning for Older Persons-A Mixed Methods Systematic Review," *Journal of Advanced Nursing* 81, no. 10 (2025): 6224–6249.

21. U. H. Graneheim and B. Lundman, "Qualitative Content Analysis in Nursing Research: Concepts, Procedures and Measures to Achieve Trustworthiness," *Nurse Education Today* 24 (2003): 105–112.

22. "Helsinki Declaration," (2013), https://www.med.or.jp/dl-med/wma/helsinki2013e.pdf.

23. G. L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196, no. 4286 (2012): 129–136.

24. H. M. Chochinov, "The Platinum Rule: A New Standard for Person-Centered Care," *Journal of Palliative Medicine* 25, no. 6 (2022): 854–856.

25. T. V. Aagaard, S. T. Skou, S. Brorson, and U. R. Madsen, "Patients' Behaviour After Referral to a Wound Care Clinic for Diabetic Foot Ulcer Care: A Grounded Theory Study," *Journal of Wound Care* 33, no. 6 (2024): 432–440.

26. M. A.-O. Kunneman, I. P. M. Griffioen, N. H. M. Labrie, M. Kristiansen, V. M. Montori, and M. M. van Beusekom, "Making Care Fit Manifesto," *BMJ Evidence-Based Medicine* 28, no. 1 (2023): 5–6, https://doi.org/10.1136/bmjebm-2021-111871.

27. K. A.-O. Marsaa, J. A.-O. Mendahl, S. Nielsen, L. Mørk, P. A.-O. Sjøgren, and G. A.-O. Kurita, "Development of a Systematic Multidisciplinary Clinical and Teaching Model for the Palliative Approaches in Patients With Severe Lung Failure," *European Clinical Respiratory Journal* 9, no. 1 (2022): 2108195, https://doi.org/10.1080/20018525.2022.2108195.

28. J.-L. Ethier, T. Paramsothy, J. J. You, R. Fowler, and S. Gandhi, "Perceived Barriers to Goals of Care Discussions With Patients With Advanced Cancer and Their Families in the Ambulatory Setting: A Multicenter Survey of Oncologists," *Journal of Palliative Care* 33, no. 3 (2018): 125–142.

29. K. M. Detering, A. D. Hancock, M. C. Reade, and W. Silvester, "The Impact of Advance Care Planning on End of Life Care in Elderly Patients: Randomised Controlled Trial," *British Medical Journal* 340 (2010): c1345.

30. W. Robert, M. M. van Stralen, and M. Susan, "The Behaviour Change Wheel: A New Method for Characterising and Designing Behaviour Change Interventions," *Implementation Science* 6 (2011): 42.

31. L. Atkins, J. Francis, R. Islam, et al., "A Guide to Using the Theoretical Domains Framework of Behaviour Change to Investigate Implementation Problems," *Implementation Science* 12, no. 1 (2017): 77.

32. T. A.-O. Róin, B. Jurlander, G. A.-O. Juhl, et al., “Taking a Stand, Ready or Not: Navigating Sensitive End-Of-Life Care Conversations in Patients With End-Stage Heart Failure,” *European Journal of Cardiovascular Nursing* 24, no. 3 (2025): 401–410, https://doi.org/10.1093/eurjcn/zvae170.

33. K. Marsaa, M. B. Guldin, A. Marques, H. Pinnock, and D. J. A. Janssen, “Understanding Nonpharmacologic Palliative Care for People With Serious COPD: The Individual and Organizational Perspective,” *Chest* 167, no. 1 (2025): 112–120.

34. I. Korstjens and A. Moser, “Series: Practical Guidance to Qualitative Research. Part 4: Trustworthiness and Publishing,” *European Journal of General Practice* 24 (2017): 120–124.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Appendix S1:** Supporting Information.