INTERVIEW

Interview With Pamela Scarborough

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I was first asked by Steve Abraham to interview some of the prominent figures in our “wound care world” for the online journal of the College of Certified Wound Specialists almost a year ago. I have to admit, I was a bit intimidated. I have been fortunate enough to work with and learn from some of the foremost people in this ever-growing arena of health care, both as a practicing clinician and now as a clinician in industry. Yet the thought of sitting down and actually interviewing one of them seemed daunting. I think everyone would agree that we would not be where we are today without the clinical contributions of these pioneers. Who would I choose and why? Better yet, would they be willing to share their thoughts and insights with me? What would the audience like to know about them, not only as a clinician but as a person? In the end, I chose Pamela Scarborough for a very simple reason. Pamela was one of the first people to teach me, hands on, about debridement. I am sure she doesn’t remember that day, 10-odd years ago, when she taught me how to wield a scalpel, but I sure do. She greatly impacted my decision to specialize in wound care as a PT. Many of us have seen her lectures and experienced her vibrant personality, but here is a closer look at Pamela as a person. Thanks, Pam, for your willingness to be taken under the microscope and for the time it took to so thoughtfully answer these questions.

Question:

How did your career path take you into wound care?

Answer: Patients with chronic wounds were a part of my patient load from the beginning of my career. The nastiest of the nasty wounds were sent to my hydro room for cleansing and sharp debridement. Boy was I surprised!! I remember thinking to myself, “Wound care . . . are they nuts? I didn’t get this in school!!!!” It became obvious that I was not prepared to provide quality care for this patient population because of a lack of education and training from my physical therapy curriculum. So fairly early in my career, I began to search out information related to chronic wound care.

Question:

Tell me about some of your mentors. Who were they, and how did they influence you?

Answer: As I searched for information on wound care, I was lucky to find several physical therapists that were ahead of me

on this journey. I’m not sure they will be flattered to know they were role models and mentors for me, but they were. This list includes Luther Kloth, Carrie Sussman, Joe McCullough, Harriet Loehne, Pam Unger, and Jim Burke. I’ve been blessed not only to have these people influence my growth as a wound care clinician but also to call them my friends. We have all taken “the road less traveled” to become leaders not only in the physical therapy profession but in the wound care arena in general. Those were some of my PT mentors, but there were others who added to my overall body of knowledge. There were nurses and physicians (MD, DO, and DPM) from whom I learned a great deal, either from the books and articles they wrote or at the wound symposiums. A few of these talented people include Diane Krasner, Bill Ennis, Rob Kirsner, and Dot Weir. I looked for and found the knowledge and mentors wherever I could. Wound care doesn’t belong to one credential; each profession brings a unique perspective to this challenging specialty. I also began reading the few wound care books that were published 20 or so years ago and taking courses with some of the above-mentioned leaders. In addition, I attended as many wound care symposiums as I could afford to go to, all in an effort to garner

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more knowledge in this specialty. It took years to accumulate the knowledge to be what I considered competent in wound care. I'm still reading and searching for venues to learn and stay abreast of updates in this ever-changing area of care.

Question:**What kinds of wounds do you like seeing the best?**

Answer: None. That would mean no one had chronic non-healing wounds. Now, back to reality. I'm particularly drawn to wounds in the lower extremity, especially arterial wounds in patients with diabetes or venous wounds with an arterial component, which are not a candidate for vascular correction. I have found that oftentimes I can use exogenous energy, such as electrical stimulation, ultrasound, or infrared light, to name a few, and help the patient's limb heal itself by enhancing blood flow to the "starved" tissues. This culminates in wounds that close, ultimately preventing a primary or secondary amputation. I get incredible outcomes in threatened limbs by using comparatively inexpensive energies.

Question:**What most interests you about wound care?**

Answer: The updates and changes that are based on the research. I love attending talks given by members of the Wound Healing Society. Now, please understand, I'm not an intellectual, and my background of study makes following some of the talks and understanding them challenging, to say the least. I often pick up an idea or two and think, "WOW, I can't wait to see where this goes." For instance, what we've learned in the past few years about biofilms. This information has changed the way we look at the wound bed. As we learn more, we will have a better understanding of which interventions to use and how and why they work.

Question:**Do you think that the United States will begin to follow the example of such countries as Canada and promote more preventive medicine?**

Answer: One of my heroes is Dr. Kenneth Cooper, in Dallas, Texas, who began the Cooper Institute. I began my career in sports medicine and spent 6 years in cardiac rehab, which was one of the most wonderful segments of my physical therapy career. Early in my career, preventive medicine seemed to me to be one of the sanest concepts there was related to health and wellness. Healthy aging was an option I wanted to support for myself, my family, and my country. Unfortunately, our medical reimbursement structure does not support the preventive medicine concept. It did and still does pay for illness, not wellness. Can we adopt socialized medicine in the United States? I don't know the answer to that. Canada and the United Kingdom have their issues with socialized medicine. For instance, when you really need a specialist, the waiting period often contributes to the aggravation of the medical problem,

with a loss of the "window of opportunity" to mitigate the health impairment. On the other hand, everyone does have some level of health care. I wonder if a hybrid of some sort would be functional in the United States. I think both systems are broken, and I personally don't have an answer as to what would work better for the people and for the different countries. I am hopeful that someone smarter and with better "vision" than I have can come up with a feasible answer so everyone can have good basic health care with prevention and wellness as a core component of the system.

Question:**What changes have you seen in the profession and the way we treat wounds over the years? Are these good or bad?**

Answer: The treatment of wounds has, overall, improved considerably since I've been learning and teaching wound care. There are still older clinicians, and new ones, who have not gotten up to speed on current wound prevention and intervention strategies. However, it is exciting to watch how rapidly the science of wound care is evolving. We are seeing more research that is revealing the impairments that contribute to chronic nonhealing wounds. I still have a level of frustration when inappropriate clinical assessments and treatments are done on patients with wounds. Clinicians unschooled in wound care provide outdated, sometimes harmful, and oftentimes ineffective interventions. I think, as a whole, we are improving in the arena of wound care.

Question:**How do you think the way PTs deliver wound care sets us apart from other disciplines?**

Answer: I've always thought our knowledge of how exogenous energy is used to enhance wound healing opportunities was one of our special gifts to the wound care world. However, not all PTs are up to speed on wound care or on the energies we can use to help with difficult wound cases. I also think the profession of PT looks at function from a broader perspective in general when it comes to wound healing and care. My wound care always involves mobility, transferring, gait, exercise, ADLs, etc, when and where appropriate. I am always thinking, How can we modify this patient's function to enhance the wound healing opportunities?

Question:**Do you think the DPT will impact wound care services? Will it give us more freedom in the future? Do you think that the tDPT would be beneficial for wound care clinicians?**

Answer: This is a hard one since much of the care we give is dependent on the law and our individual state practice acts. As the profession of PT goes toward a doctoral degree,

we need to understand that it will be years before the state practice acts catch up. So in the short term, no, I don't think the DPT is going to make a difference. In the long run, and I mean years, 5 at least and as many as 10 or 15, then, yes. Having a doctoral professional degree will make a difference and provide even more autonomy to care for our patients.

I do think the tDPT is important for any clinician who wants to be relevant in the next 5 to 10 years and beyond.

Question:

Where do you see wound care going in the upcoming years? What role will PTs play in that?

Answer: I wish I had a crystal ball for this one, but I don't. I think wound care will be driven by two things: economics and research. Oftentimes, the economics will win out. What role will PTs play? That depends. It depends on whether the profession of physical therapy continues to rattle the doors of the wound care world and let others know we also want to and intend to play in the wound care sandbox. If we become complacent, intimidated (I don't really see that happening), or quiet (I don't know many quiet PTs), then we will slowly but surely be edged out. Not in a malicious way in most cases. We must remain vigilant to be sure we are visible to the other professions that do wound care. I am sometimes intimidated when I know my words are we must let the other professions know what we can do and what we have to offer to enhance the patients' wound care outcomes. They are not going to beat down our doors insisting we come to the wound care table. We will have to politely remind the other professions, Medicare, and our faculties or places of work that we have valuable knowledge and tools to bring to the wound care program.

Question:

What advice can you give younger clinicians who want to get involved in either the American Academy of Wound Management (AAWM) or the American Physical Therapy Association (APTA)?

Answer: Well, we're talking about two very different things here. At this time the AAWM is the only organization that has an accredited wound care board certification process that is available for the profession of physical therapy. The APTA has a special interest wound care group that has been working for years to be more visible in the eyes of the APTA. With strong leadership significant inroads have been made for recognition of wound care as a physical therapy specialty. I'm not sure at this time whether we will have an APTA-recognized wound care specialty or when it might happen. In the meantime, I would suggest the physical therapist or physical therapist assistant sit for the AAWM's wound care board exams, which are a very challenging multidisciplinary wound care board certification.

Question:

If you could do it all again, would you choose the same path or go down another?

Answer: An interesting question. I think I often take the long and sometimes harder road to get to where I'm going. I must say that I am content with who and where I am. I think most of us might do things a little differently if we knew then what we know now, but we don't get "do-overs" in most instances in life. So I think it is much healthier to be satisfied with where we are now and appreciate who we are now and give the best we have to give now.