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Perceptions of patients with wounds due to chronic limb-threatening ischemia

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Abstract

Patients with chronic limb-threatening ischemia (CLTI) face numerous barriers to caring for lower extremity wounds. We explored the perceptions of CLTI patients to their wound/management and sought to determine attitudes towards their vascular provider as well as willingness for management through telemedicine. Patients admitted to hospital for treatment of Rutherford Grade 5 and 6 CLTI were asked complete a wound evaluation survey and took part in a semi-structured interview. Semi-structured interviews were recorded, transcribed, and analyzed using an inductive coding strategy. Codes were grouped for thematic analysis and aggregated into assertions. Eleven patients with a mean age of 60 years (35–79 years) were interviewed. All patients had peripheral artery disease (PAD) and eight patients had diabetes as well. Three overarching themes were identified. First, patients appear to have limited coping mechanisms and are overwhelmed by the care of their wounds. Second, in this cohort of patients, many had become passive observers of their care as demonstrated by a limited understanding of their disease processes and detachment from wound management. The third theme was how strong the desire to do everything to prevent limb loss was, but patients acknowledged this is hard to translate into real life with limited resources. Patients with CLTI have concerns that vascular providers must recognize and address to build strong patient–provider relationships and increase activation for management of their wounds and other medical conditions. Patients who have access to technology and with guidance may be able to understand getting care through remote medicine.

Keywords

amputation; critical limb-threatening ischemia (CLTI); patient-centered; patient education; peripheral artery disease (PAD); quality of life; wound care

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Supplementary material

The supplementary material is available online with the article.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Introduction

Approximately 11% of patients with peripheral artery disease (PAD) develop chronic limb-threatening ischemia (CLTI) annually.¹ Multidisciplinary wound clinics and post-revascularization wound management for patients with CLTI have resulted in healing rates of up to 92% at 12 months.² The care needed to achieve this often requires frequent visits for wound care, multi-provider consultations, invasive procedures, and also time to attend appointments for additional medical tests. The burden of treatment and these visits falls on the patient and, more frequently, caregivers when the patient is older, frail, and/or cannot drive. These treatments have financial, emotional, and opportunity costs and frequently require care in a metropolitan area. It is well documented that patients living in high poverty, or in lower-income rural areas, have a 39% higher risk of limb loss compared to patients that live in urban or high-income areas.³

Limited studies exist about how and what patients experience regarding treatment decisions for CLTI. When faced with treatment options for CLTI, 58% of patients would prefer shared decision making when considering undergoing vascular interventions, but only 31% of patients feel they are given the opportunity to participate in the decision process when discussing treatment options with their provider.⁴ In addition, a study of patients who underwent amputation for CLTI found 15% of patients were very displeased with their treatment course, which stemmed from two main issues. First, 54% of patients did not understand amputation was the outcome if treatment failed. They reported that: *'While I was told I had artery disease, I wasn't told that I could lose my leg. I would have taken better care of myself.'* Second, 15% of patients felt they should have undergone amputation sooner so they could move forward.⁵

Owing to the complex nature of modern health care, our goal was to investigate perceptions that patients with CLTI had about their current wound and wound management. We also sought to determine the patient's attitudes towards their wound, including the current management and the provider. We also wanted to determine if the ability to use remote medicine was possible in order to manage the wound.

Methods

Setting and patient selection

The study was conducted in a 700-bed academic medical center. Over a 3-month period from January to March 2018, all patients diagnosed by a board-certified vascular provider with Rutherford Grade 5 or 6 CLTI admitted for elective or urgent limb salvage revascularization who stayed more than one night in the hospital were considered for participation. Patients were included if they consented to be interviewed and were able to complete the written survey or provide responses when the survey was read out loud to them. Patients with Rutherford Grade 6 disease who underwent primary amputation were excluded. The study was approved by the Institutional Review Board at UC Davis.

Data collection

Survey administration and all face-to-face interviews were conducted by two members of the research team (JM or MCR). One member spoke fluent English and Spanish (MCR). Eleven patients participated and were interviewed in either English (10 participants) or Spanish (one participant) using a semi-structured interview guide with additional prompts specifically created for the study. For the participant who was interviewed in Spanish, the transcript was translated to English by the research team. To avoid participants feeling hesitant to report their concerns, the interviewers introduced themselves as members of the vascular division and gave participants a specific document with the lead vascular provider's contact information should they want to speak to them. The interview started after patients verbally consented to participate and after ensuring they did not have barriers to participation, such as administration of recent pain medications, fatigue, or scheduled therapy visit conflicts.

The participants were initially asked to complete a written survey (online supplemental material), which consisted of basic demographics, education level, and understanding of their diseases that led to the wound (Table 1). For patients who could not read or spoke Spanish, the survey was read out loud and their answers were recorded. The survey and responses were read in Spanish and translated to English for one participant. Patients were asked to complete the written portion prior to the interview in order to prime them for the topics to be discussed. A specific interview guide was created for the study. The interview guide focused on open-ended questions and asked participants to think aloud about their thoughts and feelings for each of the questions. The interview guide was broken into three general sections (Table 1). The first section explored the patient's current issues and treatments regarding lower extremity ulcers, as well as barriers encountered and adjustments in their life. The second section focused on willingness to see a provider outside their area who had specific experience in limb salvage and the resources needed to do this. The final section explored patients' capability to see a provider using technology through the internet. Interviews lasted approximately 30–45 minutes. Interviews were conducted in the patient's hospital room, audio recorded, and transcribed verbatim. Responses were anonymized before proceeding to the analysis.

Analysis

Transcripts were examined line by line and coded independently by three members of the research team (MDH, JM, and MCR). After the first four patients were interviewed, the three members reviewed coded responses. Predetermined codes were used for the first round of coding based on the research purpose and interview guide. All members of the research team met to review the transcripts and individual codes. New codes were developed during meetings based on consensus and data review. If there was no group consensus on one code, then the data were coded with two codes, or a new code was developed. This initial individual coding was done by hand using printed transcripts. Transcripts were imported into NVivo 12 (QSR International, Melbourne, Australia). Handwritten codes were transferred to the imported transcripts. Codes were then merged to develop a thematic framework. After seven interviews the codes and themes were reviewed again, and new codes and themes were developed by the same method as above. This final set of codes was used to analyze the remaining transcripts. Saturation was determined when no new codes or themes were

identified by any of the three reviewers during transcript review. This was found after a total of 11 interviews. Themes were aggregated into assertions and the final analysis extracted illustrative quotes based on the themes. Filler words were removed if deemed to have no impact on the statement.

Results

A total of 20 patients were considered for this study. Eight patients declined participation and one blind patient could not complete the survey. Eleven patients undergoing revascularization with or without minor amputation were interviewed with a mean age of 60 years (range: 35–79 years). Three of the patients were women and eight were men (Table 2). The mean length of time the patients had been treating their wounds was 6.2 months (range: 0.1–36 months). Six patients (55%) felt their doctor had never explained to them why they had the wound. When asked in the survey about specific diseases associated with the wound, 10 patients (91%) clearly understood if they had diabetes or not. Only one patient was not sure if he/she had diabetes. Five patients (45%) had never heard the term PAD and were unsure if they had arterial disease, while two (18%) patients believed they did not have PAD. Only 36% of the patients understood they had PAD. Six of the patients (55%) felt very confident in their primary care provider, three of the patients (27%) were somewhat confident, and two patients (18%) were unsure that their primary care provider knew how to manage the wound.

Participants were very open with their thoughts about living with their wounds and how they felt about the treatment of the wound. We found three overall themes (Table 3) reflected by patients regarding their wound and management: limited coping mechanisms/overwhelmed support systems; passive observers of their care; and a desire to do everything to prevent limb loss. For questions related to using technology for treatment, the central theme was a very limited understanding of the role of technology in treating wounds.

Limited coping mechanism/overwhelmed support systems

Prior to the current admission, all patients were living at home. Only four (36%) of the participants were married or lived with a caregiver. Six (55%) had difficulty performing activities of daily living, and four (36%) were unable to walk without significant assistance. The limitations for many patients were perceived as significant, and four (36%) patients were unable to leave the house because of the wound. One patient with congestive heart failure and multiple children to help care for her wound described how she felt about her inability to leave her house:

‘What I’m gone [sic] do, is get a plastic bag and tie it around my leg so I can walk without leaving no big puddles ... I’m scared to fall.’

Even for more simple tasks at home, having the wound limited patients’ ability to do daily activities such as cooking or moving around the house. One patient specifically described his/her limitations as follows:

‘I can’t do simple tasks like the dishes because I can’t stand for that long ... I have to use a walker and I can’t cook because I put something on the stove and

sometimes, I have to sit down. Then it gets burned because I can't get up to check on it.'

While the wound stopped people from being able to leave their homes, the need for continued help evoked a sense of helplessness. Patients were overwhelmed with how much they frequently relied on others to help them. One patient's description was:

'And so, I don't know it gets ... sometimes I just cry because I feel so sorry for myself because it's a lot of stuff that I am so used to doing on my own ...'

Passive observer of care

One of the more challenging themes seen throughout the interviews was how patients had become passive observers of their care. While they expressed control in other areas of their life, when it came to their wound, they were unable to clearly describe their care and were more separated from the treatment plan. Patients reflected this through two major sub-themes: limited understanding of their health condition and detachment from wound management.

Limited understanding of their health condition.—All patients included in this study had PAD and were undergoing procedures to treat their arterial disease. On two occasions in the interview, they were asked whether they had the arterial disease in different ways. When directly asked, 'Has your doctor explained to you that you have peripheral artery disease?', 64% stated 'no' ($n = 2$) or were 'unsure' ($n = 5$). In one case, the patient's explanation of whether they had PAD was:

'Maybe, but I don't know. I have a lot of artery trouble. I had a heart bypass, and they may have said it was something similar.'

In a second, more general question later in the interview, patients were asked, 'Has your doctor told you that you have bad blood flow?' To this question, 10 patients answered 'yes' and only one patient answered 'no', although most patients described learning about their blood flow problems only after seeing a specialist. In the case of one patient who had been treated for 5 months, the patient described:

'I was washing my foot in saltwater. I would boil salt in the water and then use that to clean the wound, but then I stopped when I saw the specialist. They told me it was because of the blood circulation and it was not going to heal until I went for surgery.'

Patients were also asked very directly, 'Did your doctor explain why you have the wound?' Six (55%) patients answered 'no'. Patients were then asked to explain in their own words why they believed the wound had developed. Some patients had not been aware of the wound due to vision issues or not checking the condition of their feet. One patient specifically stated:

'They asked me how long have your toes been like that? I didn't know what they were talking about, so I was like I really don't know. So, while I was down in the emergency room, either on Friday night or Saturday morning, I got to get a look

at my feet and what they were talking about, and yeah, the last two toes, the two smaller ones on my right foot, were totally black.’

A patient whose wound had been present for several months, who was initially being treated by his primary care provider (PCP), described his course:

‘When I first got the foot ulcer, it got infected and that made it worse. I took a lot of antibiotics to treat the infection ... I really did not know what a foot ulcer was at the time ... I understand what it is now, I just don’t know what causes it.’

Patients who felt they had an understanding of their wound commented on the source of the wound as it related to aspects of their medical history they were familiar with or that their doctor had explained multiple times. Specifically:

‘Well, the only thing they really told me, which I knew, was that I got it because of my diabetes and the neuropathy and everything that I have in my legs and feet.’

Most patients also did not understand the likelihood that their wound would heal or what the outcome of treatment could be. When asked, ‘Did your doctor explain how likely the wound was to heal?’, six (55%) patients again answered ‘no’. Three of these six patients also did not know what the next steps would be if the wound did not heal and had not been told amputation was a possible outcome. For patients who did understand the outcome, there was still a sense of uncertainty that was very unsettling to them. This was described by one patient:

‘Well, they told me that I could lose my leg ... So now I’m sitting here wondering am I or am I not? It’s a lot to think about.’

Detachment from wound management.—When patients were asked about the current appearance and care of the wound, even those who did not initially know they had a wound could now describe the appearance and if there was gangrenous tissue present. When asked about the care of the wound, three (27%) patients were doing the wound care themselves, five (45%) had a caregiver or health aid that was doing the wound care, and three (27%) patients were not doing any kind of wound care. In the eight patients caring for their wounds, care was being attended to on a daily basis. When asked specifically which provider recommended the wound care and was treating their wound, patients had limited understanding of the role their vascular provider played in their wound management:

‘Well, I get confused sometimes, because she’s [the vascular provider] the doctor but when I go to the clinic, I see different people. Also, I had a stroke and she treats me for that, so I think she is just my overall doctor. I don’t know if she is taking care of the wound.’

For patients who had active support persons involved in managing the wound, the driving force for care in some cases was the support person. Patients expressed a release of decision making for their wound to the support person. Some patients indicated a lack of concern for the wound, but felt obligated to decisions made by their caregiver regarding their wound:

‘My wife cares for it ... and when she saw it, she said we are leaving right now for the hospital. I got dressed and got in the truck. I got mad and argued all the way to

the hospital, but I lost. I had to leave dinner on the table, but she [the wife] wasn't having any of it ...'

Desire to do everything possible to prevent limb loss

Despite feeling a sense of helplessness or having limited resources, patients expressed a willingness to do whatever it took to prevent amputation. When asked about hypothetical scenarios regarding limb loss, there was a strong inclination to use all resources available in order to avoid the possibility. Only four (36%) patients could drive; the majority ($n = 7$, 64%) of patients relied on someone else to take them to appointments. Nine patients answered 'yes' to questions about their willingness to travel and see a physician outside their region. When asked how far they were willing to drive to see a provider, seven (78%) were willing to drive 1–2 hours often if needed. But if the drive to see a provider was longer than 2 hours, only 44% ($n = 4$) of patients said they were willing to make the drive often. Patients who expressed a willingness to travel stated:

'If the visits were needed, I would make multiple trips a week to see the doctor even if it meant traveling up to 2–3 hours a week.'

While patients had a theoretical willingness to do whatever it took when asked about challenges the patients were open about care decisions and how they affect their ability to travel. When patients were asked, 'Could your caregiver take you to multiple appointments a week?', patients were less certain it would work:

'Well, my doctor sees patients on Monday. So, my daughter asked if she can work from home on Mondays or she takes time off on Mondays if needed to take me to the doctor. If her work would not let her do this, then I don't know how I would get back and forth from the doctor. If we had to travel more than 2 hours and my daughter had to take time off work, I don't know if that would be possible very often.'

Limited understanding of the role of technology in treating their wound

The final section of the interview guide briefly asked patients if they would use remote technology to receive care for their wounds. None of the patients was currently using the electronic medical record or email to communicate with their provider. None of the patients had previously participated in a telemedicine visit. Ten patients had access to a computer: nine patients had one at home and one patient through a caregiver. Seven of the 10 (70%) felt comfortable communicating through the internet, but only four (40%) would be willing to see a physician through the internet for the first time.

When asked to express concerns about seeing a provider remotely for the first time, patients cited trust as the main concern:

'I'd rather see them face-to-face, talk with them, feel them out, you know? I would have concerns through the screen making mistakes about what he [the doctor] tells you to do.'

Discussion

This work represents a rare insight into how patients are coping with lower extremity wounds in their daily life, the impact it has, and their efforts to prevent limb loss in a health system that is often difficult to navigate. We also were able to glean an initial understanding of patients' potential for using home-based technology to receive care for their wounds and to connect with a provider. Numerous studies using large data sets have demonstrated patients with lower extremity wounds have multiple comorbidities including renal failure, diabetes, and advanced age. Rural location also compounds the socioeconomic factors associated with limb loss and severe PAD.^{6,7} Yet prior studies have not been able to provide much insight into factors related to patients' lives or what they feel going through the management of the wound. As with most qualitative studies, this work raises questions for future interventions and drives new hypotheses about how to treat patients better with lower extremity wounds due to PAD and/or diabetes.

During this study, the most overarching observation from researchers was how overwhelmed patients were with their wounds and how this led them to become passive observers of their care. Many of these patients tell stories of being strong central figures, driving their lives. In the management of their wound, however, they appear powerless, being told what to do by doctors, nurses, and/or family members. There are many models of doctor-patient relations, from paternalistic to informative. It has also been well documented that the severity of a patient's condition, older age, limited education, and male sex predicts the preference for a passive role in the doctor-patient relationship.⁸ These characteristics mirror characteristics of patients with CLTI, and are clearly represented in this cohort of patients. Other medical conditions, specifically depression, are associated with increased passive decision making in health care, and depression is increased in patients with CLTI.⁹ Second, decision making in cases of limb-threatening ischemia is frequently done in a relatively urgent fashion. Patients meet a vascular specialist and may have to make the decision to amputate once, or even twice, within a period of months.¹⁰ The patient and provider also enter into this new relationship with very formal roles, and because of the relatively quick decisions needed the provider may not have a complete understanding of the patient's value system. The result is that physicians are often forced into more paternalistic decision-making roles which would not be justified in other situations as all for the good of the patient.¹¹ Finally, because patients struggle with the concept of prognostic certainty (the chance that a procedure will result in limb preservation vs limb loss), many rely on the paternalism of providers to help make decisions. Providers, being busy and having a desire for certainty, develop a treatment plan and then move on to formulating an operative plan. Ultimately, this continues the cycle of allowing patients to be passive in their care unless a patient stops the process by exerting a new level of autonomy.¹² Measures of patient activation are not routinely collected in medical care, but perhaps they should be. By understanding patient activation, methods to engage patients to include shared decision aids, electronic wound care books or scrap books, or more interaction through store-and-forward wound management using mobile telehealth platforms could increase engagement of patients in the management of their wounds.

In this study, seven of the 11 patients did not understand they had PAD. When asked in laymen's terms, those seven patients and three additional patients did understand that

they had bad blood flow. A provider's understanding of patients' health literacy is an important factor in providing medical information in a comprehensible way, encouraging shared decision making, and increasing patient satisfaction. Studies have shown that lower health literacy is associated with poor health outcomes and lower utilization of health care services.^{13,14} In a study assessing United States Veterans with vascular disease, only about 20% of patients demonstrated health literacy.¹⁵ Patients who do not understand they have PAD or CLTI are not getting appropriate resources to manage their health conditions. This is evident by multiple studies showing that patients with CLTI are not on appropriate medical therapy. Specifically, statin therapy ranges from 45% to 61%, as much as 30% of patients with PAD are not on appropriate antiplatelet treatment, and up to 50% of patients may not be on an ideal hypertensive regimen.^{16,17} This is a wake-up call to vascular providers. In the current era of minimally invasive treatment, multiple subspecialties are providing vascular care. Other specialties outside of vascular providers have made strong arguments as to why they are best suited to do endovascular care.¹⁸ These groups have accepted that minimally invasive treatment is appropriate in all patients, however, whereas vascular providers have the unique perspective of understanding the risks and benefits as well as long-term outcomes of treatment. In addition, the long-term relationship established by vascular providers gives the ability to continually educate patients about their conditions. By understanding the limited health literacy of our patients and recognizing the confusion in medical care, vascular providers have an opportunity to partner with communities to increase patient activation and enable providers to increase awareness of peripheral artery disease in a highly impactful way to improve population health. We also have the ability to partner with primary care providers and the organizations for these providers in order to increase awareness and understanding of evidence-based interventions for PAD treatment.

There are currently 273 million smartphone users in the United States, 53% of whom are over 65 years old. Even with income levels below \$50,000, 78% of people have smartphones.¹⁹ In our study, 10 of the 11 patients had access to a device that could perform a telemedicine visit. The idea that technology can serve as an augmented platform for care in vascular medicine is well known. Technological advances in endovascular devices are moving faster than most practitioners can keep up with, but how we deliver care to patients using technology has not significantly evolved. From a provider perspective, the greatest barrier to the implementation of telemedicine is reimbursement.²⁰ In this limited cohort, only 40% of the patients would be willing to see a provider for the first time through telemedicine. Other studies have also demonstrated that while patients understand the benefits of telemedicine, the desire to have an initial in-person visit is the greatest barrier to telemedicine for patients.²¹ This is likely to change, however. Understanding these barriers allows us to design telemedicine referral pathways and consultations for patients that both increase their comfort with telemedicine and allows them to get exceptional care without the burdens of health care visits.

Study limitations

It is important to acknowledge two specific limitations in this work. First, thematic saturation was reached after just 11 interviews. The interview guide in this work was designed through an iterative process, but there was a focus to keep the entire interview

under 45 minutes in order to limit patient fatigue. With a broader interview guide or more time for each interview, themes could have been further explored; specifically, with regards to how telemedicine can be used for these patients and distrust in providers. Despite this limitation, the researchers were able to not only develop a hypothesis and understanding about the use of technology in these patients but also develop a second interview guide for another study in telemedicine. Additionally, the work has helped to develop a hypothesis as to disparities in outcomes for patients that may be more related to trust, patient activation, and health literacy than treatment selection. The second limitation is patient selection, since these patients were all hospitalized for treatment of their wounds. This patient population was chosen because they represent patients requiring the most intensive treatment possible for their wounds. Some patients are able to be treated entirely in the outpatient setting. Those patients may represent patients with a higher level of activation and/or are not passive observers of their care. We chose not to focus on them for this study, but do believe the use of a patient activation tool may help to determine early which patients need more intensive support care to prevent limb loss.

Conclusions

This work provides further insight into how much patients are struggling with the management of wounds due to CLTI. It also brings to the forefront patient factors such as activation and health literacy that need to be considered when treating patients with CLTI. This work also clearly indicates that patients are trying to do everything they can within their capacity to prevent limb loss. As practitioners in a cutting-edge field, we may have new methods of care delivery that can prevent limb loss. We believe that a more intensive look at patients' perspectives related to telemedicine in the management of wounds and CLTI is the next logical step, and may potentially lead to vast increases in both patient accessibility to and satisfaction with vascular care in the future.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1.

Interview topic focus.

Topic	Subtopic
Patient characteristics	Demographics Level of education and household income Understanding of current diseases that contributed to the wound
Current foot ulcer issues	Description of ulcer and length of time present Who is managing the wound and what they are doing? Experiences and attitudes towards the current treatment of the ulcer Changes in activities of daily living because of the foot ulcer
Willingness to see a provider outside the region	Transportation issues associated with current visits to doctors Experiences building relationships with providers, especially new providers Attitude and willingness to see providers outside of the immediate region
Use of technology for health care	Access to a computer or portable devices that can connect to the internet Experience using technology independently and communication through the internet Experiences with health care provided through the internet

Table 2.

Demographics of patients with CLTI.

Characteristics	<i>n</i> (%)
Sex	
Male	8 (73)
Female	3 (27)
Race	
Caucasian	6 (55)
African American	3 (27)
Hispanic	2 (18)
Married or equivalent	4 (36)
Diabetes	8 (73)
Patient believed they had PAD	
No	2 (18)
Yes	4 (36)
Unsure	5 (45)
Education	
Some high school	1 (12)
High school degree/GED	5 (45)
Some college	3 (27)
College degree	2 (8)

CLTI, chronic limb-threatening ischemia; GED, Graduate Equivalency Degree; PAD, peripheral artery disease.

Table 3.

Major themes regarding patients' wounds.

Theme	Comment
Limited coping mechanism/ overwhelmed support systems	'Every 30 or 40 minutes there is leaking sometime, and I don't know what to do with it... I just leave puddles everywhere ... there is burning and itching.' 'My children had to come up with a schedule ... My daughter is off on Mondays, so if the appointments are on Monday, she takes me, but if it's not, she has to find someone to take me. Sometimes my granddaughter will take me ... she was my chauffeur for almost 3 months so my daughter would not have to take off work.'
Passive observer of care	
Limited understanding of disease	'I was washing my foot in saltwater. I would boil salt in the water and then use that to clean the wound, but then I stopped when I saw the specialist. They told me it was because of the blood circulation and it was not going to heal until I went for surgery.' 'When I first got the foot ulcer, it got infected and that made it worse. I took a lot of antibiotics to treat the infection ... I really did not know what a foot ulcer was at the time ... I understand what it is now, I just don't know what causes it.'
Detachment from wound management	'My wife cares for it ... and when she saw it, she said we are leaving right now for the hospital. I got dressed and got in the truck. I got mad and argued all the way to the hospital, but I lost. I had to leave dinner on the table, but she [the wife] wasn't having any of it...'
Desire to do everything to prevent limb loss	'If the visits were needed, I would make multiple trips a week to see the doctor even if it meant traveling up to 2-3 hours a week.' 'Well, my doctor sees patients on Monday. So, my daughter asked if she can work from home on Mondays or she takes time off on Mondays if needed to take me to the doctor. If her work would not let her do this, then I don't know how I would get back and forth from the doctor. If we had to travel more than 2 hours and my daughter had to take time off work, I don't know if that would be possible very often.'
Limited understanding of the role of technology in treating their wound	'I'd rather see them face-to-face, talk with them, feel them out, you know? I would have concerns through the screen making mistakes about what he [the doctor] tells you to do.'