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DIABETIC Medicine

COMMENTARY

Reframing the narrative in diabetes-related foot ulcer care: A primary care perspective

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Foot ulcers are among the most complex and costly complications of diabetes, with profound physical and psychological consequences. Although often managed in tertiary settings, primary care clinicians play a central role in wound care, education and long-term treatment care support. Guidance on language in diabetes care has expanded over the past decade,[1–3] yet evidence on diabetes-related foot ulcers (DFUs) from Asian contexts remains limited. This commentary focuses on primary care, where continuity, early intervention and sustained therapeutic relationships offer a unique context for embedding psychologically informed, healing-focused language. It highlights the impact of language on individuals' experiences and psychological well-being, illustrates foot-specific, person-centred terminology and contributes an underrepresented perspective to the global discourse on language and patient-centred care.

1 | THE HIDDEN PSYCHOLOGICAL BURDEN

Beyond the visible challenges of infection, delayed healing and amputation risk lies a profound yet often overlooked psychological burden. Chronic, recurrent wounds evoke frustration, shame and helplessness, impacting engagement with self-care.[4] Many individuals describe their experience as a 'constant battle' or 'vicious cycle', with those who have undergone amputation striving to reclaim identity, autonomy and confidence.[5,6] Foot complications are often perceived as personal failures, fostering resignation despite a desire for recovery. This tension between hope and despair underscores the substantial emotional toll of DFUs.[4,6]

DFUs extend beyond discrete biomedical events, constituting a chronic, unpredictable and psychologically taxing trajectory, even during periods of remission.[6]

Although the psychosocial burden of diabetes is increasingly being acknowledged,[7,8] these dimensions remain insufficiently addressed within DFU service design. In primary care—where relational continuity and therapeutic trust are pivotal—there lies both a pressing challenge and a strategic opportunity to provide holistic, psychologically informed support. Clinicians' language in DFU care is not neutral; it can harm or heal. A qualitative primary care study conducted in Singapore highlighted this tension, with one participant remarking: 'If you hope I get better, then I'm a dead duck… you are the doctor… you should make me (my wound) better'.[4] Such accounts illustrate the universal importance of person-centred, collaborative communication (e.g. 'let us work together towards healing').

2 | LANGUAGE AS A DOUBLE-EDGED SWORD

Language shapes not only clinician communication but also influences how individuals with DFUs perceive their condition, their self-care and themselves. Evidence suggests that shifting the language used in diabetes care can significantly affect emotional well-being, self-care behaviours and health outcomes.[2] However, the terminology commonly used in DFU care often carries unintended negative consequences.

Terms such as 'non-compliant', 'non-healing' or 'stagnant wound' may feel accusatory or demoralising, implying blame, futility or failure despite their clinical intent. Likewise, labels like 'diabetic foot patient', 'diabetic foot' or 'amputee' risk reducing individuals to their diagnosis or physical status, reinforcing stigma, depersonalisation and internalised failure. Framing ulcer recurrence solely as a consequence of 'non-adherence'—rather than recognising the complex, recurrent nature of DFUs—can perpetuate stigma-sensitive harms and contribute to disengagement from care.

Language does not merely describe clinical reality; it helps construct it. In qualitative studies within primary care, participants' beliefs about foot complications and self-care often diverged from medical evidence.[6,9] Ulcer recurrence, for instance, was frequently construed as personal failure or punishment,[6] reflecting a discourse narrowly centred on 'compliance'—that is, simply 'following rules'—rather than autonomy-supportive communication that acknowledges emotional resilience, personal goals or relational support.

3 | PSYCHOLOGICALLY INFORMED AND MOTIVATIONAL COMMUNICATION

Addressing the complexity of DFU care requires recognising language as a vital clinical tool. In settings where long-term engagement and psychological resilience are critical, communication driven solely by algorithms and performance targets risks undermining the human connection essential to healing. Evidence should instead be conveyed through conversations grounded in empathy, trust and partnership.[10]

Psychologically informed practice begins with intentional word choices. Small linguistic shifts—such as referring to 'a person living with a foot ulcer' rather than 'a person suffering from a foot ulcer' or 'foot ulcer patient'—can affirm personhood, reduce stigma and signal a commitment to person-centred care. Reframing deficit-focused terms like 'poor self-care' or 'non-compliance' as 'limited autonomy' 'reduced self-efficacy' or 'unmet support needs' moves the narrative away from blame and towards contextual understanding.[11] Language within consultations can either foster or diminish hope: overly clinical or negative communication can undermine self-efficacy in those already carrying the emotional burden of DFUs, whereas words that convey empathy, respect and possibility can reinforce agency and resilience.

Motivational interviewing (MI) offers a structured, evidence-based approach centred on autonomy, exploring individual motivations, barriers and values.[12] Rather than focusing solely on whether advice is followed, MI invites individuals to articulate what matters to them and how they interpret their condition. This is particularly relevant in DFU care, where clinicians and individuals can hold divergent beliefs about recurrence.[9] While clinicians may attribute recurrence to biomechanical issues, individuals may view it as related to stress or misfortune. Unspoken or disempowering language can quietly erode trust and engagement.

Primary care clinicians, supported by relational continuity inherent in general practice, are ideally positioned to adopt psychologically informed, motivational communication. Even brief consultations can transform when language shifts from instructing to exploring, from correcting to collaborating. HEALing (Healing through Empowerment and Active Listening) exemplifies this approach. This co-designed, nurse-led initiative integrates motivational dialogue into routine primary care to support self-care and psychological resilience.[11] By integrating person-centred conversations into wound care, HEALing enables individuals to prioritise concerns, enhancing knowledge, emotional support and therapeutic alliance. Participants valued discussing self-care challenges, which affirmed autonomy and strengthened trust with clinicians.

4 | EMBEDDING HEALING LANGUAGE IN EVERYDAY PRACTICE

The UK's emphasis on 'language and diabetes'[1] and 'personalised care and shared decision-making'[13] underscores the need to move beyond narrow biomedical protocols, extending these principles to the psychological and social realities of living with chronic wounds. Central to this shift is recognising the pivotal role of language in shaping individuals' experiences, behaviours and healing trajectories.

Primary care offers fertile ground for this transformation. Relational continuity provides psychologically safe spaces where person-first language and motivational communication can become routine practice. Unlike episodic specialist care, general practice enables clinicians to challenge unhelpful beliefs, support emotional adjustment and foster resilience over time, aligning with the chronic and recurrent nature of DFU trajectories.

Implementing these approaches requires not extensive resources but intentional choices—how challenges are framed, setbacks interpreted, and hope conveyed. A respectful, empowering lexicon lays the foundation for humane and effective DFU care. Optimising outcomes in primary care therefore depends not only on timely referrals and access to advanced therapies but also on attention to the emotional and communicative environment of care. Although centred on DFU care, these insights on the psychological impact of language and motivational communication extend to other diabetes-related complications, warranting broader research and advocacy.

Language is a clinical tool—one that can marginalise or empower, demoralise or motivate. DFUs are chronic, recurrent and deeply personal. The words clinicians use matter. Primary care practitioners hold both the opportunity and responsibility to reframe the narrative—beginning with how they speak and, just as importantly, how they listen. Language should not only inform, but also heal.

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CONFLICT OF INTEREST STATEMENT

The authors have declared no competing interests.

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