

# Biopsychosocial Dysfunctions: Insights for Medical Social Work from Exploratory Clinical Case Studies on Pressure Ulcers

**R. Vinodh Rajkumar**

Medical Anthropologist, Physiotherapist & Gerontologist.  
Pursuing Master of Social Work at Tamil Nadu Open University, Chennai.

Corresponding Author: R. Vinodh Rajkumar

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## ABSTRACT

Many diseases have the inherent potential to force the patients to be in prolonged immobilization accompanied by intractable biopsychosocial dysfunctions. In fact, even short-term immobilization could disturb homeostasis and trigger multiorgan health complications that are explained in research studies on the basis of immobilization timeline. Such critically ill patients also might become fully dependent by losing their ability to perform basic activities of daily living that can be quantified through Barthel Index (feeding, bathing, grooming, dressing, bowel and bladder continence, toileting, bed to chair transfers, mobility on level surface, stair climbing). Though not widely noticeable in the society, individuals under long-term immobilization are at the risk of excruciating pressure ulcers (bed sores) as their Barthel Index score continues to decline or remain very low without any improvements. Preventing pressure ulcers should be one of the primary priorities in the rehabilitation of patients in critical condition (palliative care, hospice care) whose diseases are well-known for their devastating secondary complications arising out of highly restricted physical activity, compounded by unfavorable social determinants of health (SDOH) and substandard health-related social needs

(HRSN). Findings of few exploratory clinical case studies are discussed in this article with an aim of inculcating the utilization of early mobility to prevent pressure ulcers including the possibility of healing them through infrared radiation therapy before they grow deeper due to excess loss of tissue. Such interventions must be promptly attempted without missing the best window of opportunity by integrating the family social capital and expertise of medical social workers. Applying 'satisficing healthcare approach' based on bounded rationality and limited available resources may bring unexpected positive outcomes even for critically ill patients. Competent medical social workers may also be capable of improving downstream determinants (individual-specific healthcare, lifestyle, family dynamics) by influencing and improving upstream conditions (macro-level policies), eventually minimizing the prevalence of pressure ulcers and improving the quality of palliative or hospice model of healthcare.

**Keywords:** Pressure ulcers, Bed Sores, Decubitus ulcers, Medical Social Work, Social Determinants of Health, Health-related social needs, Biopsychosocial model, Infrared radiation therapy, Physiotherapy, Barthel index

## INTRODUCTION

Prolonged immobilization after any disease or injury is usually accompanied by disturbances in homeostasis and intractable biopsychosocial dysfunctions. Medical conditions like fractures, amputation, neurological ailments and frailty due to aging could cripple the patients through severe forms of secondary complications like pressure ulcers (bed sores), if appropriate timely interventions are not incorporated to improve the functional independence. “Prolonged immobility is harmful with rapid reductions in muscle mass, bone mineral density and impairment in other body systems evident within the first week of bed rest which is further exacerbated in individuals with critical illness. Addressing the deleterious effects of immobilization is a major step in treatment of critical illness survivorship”.<sup>[1]</sup> Pressure ulcers have been a silent epidemic and a global public health burden. “Decubitus ulcers, also known as pressure ulcers, pose a significant public health challenge due to their substantial impact on morbidity, mortality, and health care expenditures. Regional disparities in healthcare access and outcomes underscore the need for targeted interventions to reduce the burden of decubitus ulcers, particularly in resource-constrained settings”.<sup>[2]</sup> “Traditional approaches for preventing bedsores include regular repositioning, nutritional assessments, the use of pressure-relief devices, and wound care protocols. Despite these approaches, the incidence of bedsores remains a challenge, and there is a need for further studies on customized pressure redistribution (smart mattresses and cushion, monitoring pressure, temperature and humidity, adjustable firmness and contour redistribution pressure, wearable sensors, pressure mapping systems)”.<sup>[3]</sup> “Only 2 hours of immobility in a bedridden patient or a patient undergoing surgery is sufficient to form the foundation of a decubitus ulcer. Waterlow, Norton and Braden are the three main recognized pressure injury risk assessment scales.

Evaluation of pressure injury includes risk assessment, staging and documentation of existing injury, maintenance of detailed examinations at regular intervals, and use of technologically advanced tools when indicated. Effective management of pressure injuries requires collaboration among specialties, depending on the affected anatomical areas and the patient’s comorbidities”.<sup>[4]</sup> Patients with bed sores also suffer of musculoskeletal issues like muscular atrophy, joint stiffness, deformity, contractures, all interacting in favor of worsening the disease status in association with adverse impact on mental health of both patients and their families, eventually necessitating the expertise of social workers to prevent or minimize psychosocial dysfunctions or maladjustments. “It is possible for a pressure ulcer to not heal and become chronic. This unanticipated clinical course of the ulcer leads to frustration for patients and their families, and increases emotional upset. Social workers need to assess the family support networks and community resources of the patient and family. Each health discipline (nursing staff, aides, physician, dietitian, occupational and physical therapists, and social worker) has its own role to play in the assessment and management of the patient with pressure ulcers”.<sup>[5]</sup> “The role of hospital social workers is considered fundamental for several reasons: emotional support and assistance, services coordination, needs assessment and treatment planning, advocacy and rights defence, and child protection. The biopsychosocial model of health is now universally accepted and necessitates the existence of social work in the hospital setting”.<sup>[6]</sup> Medical social workers uniquely evaluate the social drivers of health that are the non-medical factors that determine the biopsychosocial dimensions of the well-being of individuals. “Social determinants of health are the conditions where individuals live, learn, work, and socialize that significantly influence health disparities and patient care outcomes. SDOH can be categorized into

five key domains: economic stability, access to quality education, access to quality healthcare, neighborhood environments, and social support. Understanding and addressing the role of SDOH at every stage – from initial care-seeking to post-discharge recovery – is vital for healthcare systems to deliver equitable, inclusive care and improve long-term outcomes for vulnerable patient populations”.<sup>[7]</sup> “Dr. B. R. Ambedkar, an iconic figure in Indian social reform and the driving force behind the Indian Constitution, acknowledged the significance of the social determinants of health influencing health outcomes. Ambedkar famously stated, “What we want is not equality, but equity, for equality does not necessarily mean equity”.<sup>[8]</sup> Systematic inquiries to comprehend the psychosocial phenomenon of pressure ulcers is essential because mere clinical approaches are not adequate enough to prevent or cure them. Before entering into large scale experiments or interventions, even in-depth single case might be instrumental. Case studies are quite feasible for both healthcare and social work practitioners. “Single case studies with their exploratory characteristics often disclose new phenomena that have remained unrecognized before, and only when the phenomena have been uncovered can they become targets of confirmatory studies. Neglecting single case studies would deprive the scientific landscape of a better understanding of cognitive processes”.<sup>[9]</sup> Very surprisingly, even critically ill old age patients respond remarkably well to functional rehabilitation programs and therapeutic modalities like infrared radiation therapy (IRR) during palliative and hospice care which actively combines both satisficing and optimizing strategies. The use of phototherapy (light or laser) used as an adjuvant, non-surgical intervention, with the aim of having a therapeutic effect on healing has increased recently.<sup>[10]</sup> Herbert Simon introduced a theory of bounded rationality, accordingly to which individuals satisfice (an amalgamation of satisfy and suffice) rather than maximize because they

cannot evaluate all potential alternatives and their consequences due to their limited cognitive and information-processing abilities, time constraints, and incomplete knowledge.<sup>[11]</sup> The principle behind satisficing is that there must be a point (threshold) at which obtaining more information or computation becomes overly detrimental and costly; the use of heuristics helps the decision maker stop searching before this threshold has been crossed.<sup>[12]</sup> This article is centered around three clinical case studies on critically ill patients with different biopsychosocial dimensions to understand the barriers of leveraging ‘satisficing’ for ‘optimizing’, using limited resources of domiciliary healthcare services.

### **Biopsychosocial dysfunctions of pressure ulcers [Three clinical scenarios]**

Critically ill bedridden patients with or without pressure ulcers can be seen with maladaptive coping mechanisms or immature defense mechanisms (denial, distortion of reality) and long-standing social disengagement. Let us have a look at three different clinical scenarios of patients who received domiciliary palliative care.

**Clinical scenario 1:** A 65 years old female patient was completely bedridden from the beginning of the year 2026. She maintained walker-supported ambulation inside the home, without structured exercise-based interventions after surgical fixation of her right femoral neck fracture in the year 2021. In fact, she had a left femoral neck fracture also in the year 2017 for that also she did not do appropriate training for balance and muscular strength. Quite obviously, she displayed highly complex biopsychosocial dysfunctions including pressure ulcers at multiple sites (low back, right elbow. outer surface of legs, plantar surface of feet). Her husband was the only caregiver and breadwinner (auto rickshaw driver). Her only son (20 years old, unemployed) could do only minimal assistance for the family because he is autistic. In that stage of debilitation, she completely refused to cooperate for pressure ulcer healing and

functional rehabilitation programs, hence the domiciliary care could not be even successfully initiated (Figure 1, 2 & 3 are

the images taken on 29.04.2026). She passed away by the last week of May 2026.



**Figure 1:** Deformed toes and plantar ulcers acquired during prolonged immobilization. All the joints of lower limbs displayed excessive loss of mobility. Bed hygiene was also extremely poor.



**Figure 2:** Developed pressure ulcer in the right elbow region due to incorrect unsuccessful getting up mechanism using right elbow support from supine lying posture. In fact, she lacked arm strength, spinal and lower limb strength and mobility, to independently move from supine lying to sitting posture.



**Figure 3:** She developed pressure ulcer in the sacral region. She was not willing to turn either to right or left side. After repeated encouragements, she turned to the left side for Infra-red radiation therapy but her cooperation to this extent was only for a brief period of time during the first consultation. She completely resisted to cooperate even for simple breathing exercises in the subsequent scheduled physiotherapy sessions.

**Clinical scenario 2:** A 75 years old female patient was bedridden after right below-knee amputation due to gangrene (Figure 4). Her left foot also got affected by gangrene with complete loss of sensation and mobility in ankle and foot joint but it never got amputated till her death. An open wound was found on the stump of the amputated right leg also. She developed pressure ulcers on the lateral surfaces of hips. Her son and daughter-in-law were the care takers but both were in the circumstance to go to office too. Due to debilitation, she lost her social connectivity but despite being in a chronic critical illness state, she had better cognition and ability to cheerfully communicate. Though she initially resisted mobility program, gradually she cooperated for Infrared radiation therapy for pressure ulcers and simple exercises for arms and legs in lying position. It should be noted that Infrared radiation (IRR) therapy was implemented with a hope of healing the pressure ulcers through improved blood circulation which surprisingly yielded satisfactory outcomes in six weeks (Figure 5, 6 & 7). But IRR therapy is not routinely used in pressure ulcer healing in either institutional or domiciliary settings, hence the research literatures in this connection are hard to find. It was believed that she would

cooperate further for advanced exercise programs after successful healing of pressure ulcers but she refused to even sit on the bed, and preferred to be in lying posture or rest, so the exercise therapy sessions were also stopped. Despite discontinuation of exercise therapy and IRR therapy sessions from 25.09.24 onwards, the pressure ulcers had not relapsed. She passed away by the mid-November 2024.



**Figure 4:** Right below-knee amputation. Left foot was completely gangrenous. After a month of basic mobility program, she was able to sit briefly if only assisted but her frailty did not support further progress. Physiotherapist was only contacted by her family after nearly 10 months of immobilization post-amputation. Nearly 6 weeks of Physiotherapy services were “Pro bono health service model”.



**(a)**



**(b)**

**Figure 5:** She began to receive IRR therapy from 07.08.2024 onwards, everyday for about 6 weeks, followed by 15 minutes of basic active exercises for all the limbs including basic breathing exercise and sponge ball gripping exercise. Her bed hygiene was well-maintained and her bed had pressure-relief system (air mattress) but still she had developed pressure ulcers due to prolonged immobilization. IRR lamp was kept at a distance of 50 cm approximately from the side of the hip to be treated. IRR therapy for each side was given for 5 minutes. Though during the initial few sessions, low heat intensity was chosen; after confirming the absence of side-effects (burns or blisters), high heat intensity from the IRR lamp became the standard option. Throughout the 5 minutes of IRR therapy for each side of hips, the Physiotherapist kept assessing the extent of heat on the patient's skin surface using the dorsum of hand (apart from the patient's feedback). This precaution helped in successfully avoiding adverse effects on the skin. (a – left lateral surface of hip before commencing IRR therapy. b – right lateral surface of hip before commencing IRR therapy).



**Figure 6:** Status of pressure ulcers as on 24.09.2024. During the 6 weeks of IRR therapy, it should be noted that the family had stopped topical agents and dressings for the pressure ulcers which increases the likelihood of the efficacy of IRR therapy in pressure ulcer healing. Basic mobility exercises for all the limbs in supine lying also could have played a supportive role in this healing process. The healing process was fluctuating (getting better or worse) throughout those 6 weeks because she preferred side-lying posture also during rest and sleep.

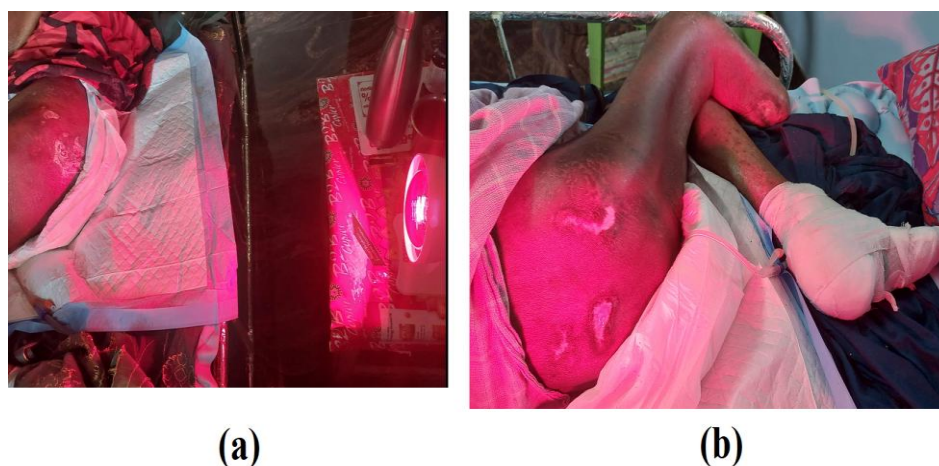


**Figure 7:** Positioning for IRR therapy to the left and right lateral surfaces of hip in side-lying posture. This IRR lamp is portable and affordable.

**Clinical scenario 3:** A 67 years old female faced a road traffic accident on 06.01.2026 and got immediately admitted in Intensive Care Unit. Subsequently she had to undergo a sternotomy surgery to fix her broken ribs. She was sent home after two months of institutional care with intact artificial airway (tracheostomy) and nasogastric feeding tube. Her body weight was 45 kg after approximately 20 kg weight loss due to highly restricted food supply through nasogastric tube. Literatures reveal the harmful effects of prolonged indwelling nasogastric tube and tracheostomy tube to avoid complications like nasogastric tube syndrome and abnormal alterations in the pharyngeal and laryngeal structures. Eventually, she became bedridden and fully dependent, and started experiencing

continuous excess sputum production and coughing. In such circumstance, such life-saving procedures (nasogastric tube and tracheostomy tube) could create a self-reinforcing vicious cycle which is usually evident through excess loss of weight, widespread atrophy of muscles and severely restricted mobility. Pressure ulcers cannot be easily prevented in this stage of increasing critical illness. “Prolonged indwelling nasogastric tubes and tracheostomy tubes might lead to abnormal alterations of the structure and function in the arytenoid cartilage, epiglottis, tongue base, and pharyngeal cavity which could impede the recovery of swallowing function and decannulation”.<sup>[13]</sup> Nasogastric tube syndrome may be under-reported due to misdiagnosis or lack of awareness with

respiratory compromise (life threatening respiratory distress) due to nasogastric tube syndrome may require tracheostomy.<sup>[14]</sup> But there is a possibility of breaking this vicious cycle through removal of nasogastric tube (to commence nutritional intake through mouth) and tracheostomy tube (decannulation – in order to breath naturally through nose). Family members were encouraged by the Physiotherapist using social work skills to discuss about this with the concerned medical experts, fortunately, both these tubes got detached at the hospital on 26.03.2026. After detachment of these tubes, patient's health condition began to improve rapidly as a result of natural nasal breathing, oral intake of fluids and food, and better lung function without much secretions and cough. Three physiotherapy sessions per week were planned to rebuild muscular strength, endurance, balance and

flexibility. Importantly, she never developed pressure ulcers. Various exercise techniques were implemented in tandem with the signs of incremental progression. Her Barthel Index score reached 100 on 26.05.2026 after she achieved independent stair climbing ability also (Figure 8). Barthel Index score of 100 means an individual able to do all basic self-care activities independently. Her body weight had increased from 45 Kg (during bedridden state) to 55 Kg associated with improvements in balance, strength and cardio-respiratory fitness in 5 months, reflecting the conjoint interactions of improved calorie intake and balanced energy expenditure during exercises. In fact, the weight gain became better after the training frequency got reduced from 3 sessions per week to 1 session per week, after she had attained maximum Barthel score in two and half months.

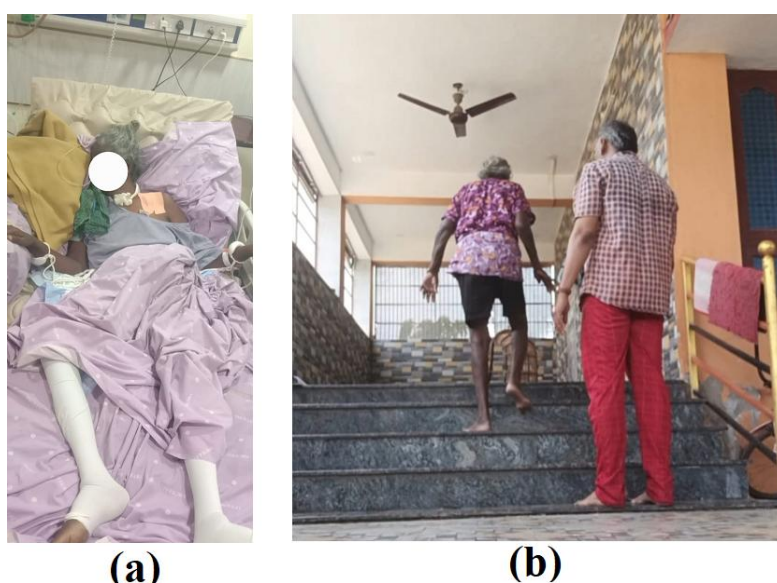


**Figure 8:** Stair climbing is the hardest milestone in the endeavor to transform Barthel Index score from 0 to 100. She was admitted in the Intensive care on 06.01.2026. Home-based functional rehabilitation program under the supervision of Physiotherapist (3 exercise sessions per week, 1 hour each) began on 14.03.2026. Her walking speed improved from 1 Km/h speed to about 6 Km/h speed in 4 months of structured training. Quite a lot of patients usually accomplish or somehow manage all the self-care tasks of Barthel Index functional independence scale except stair climbing (with or without support), hence their social engagement with peers and the society becomes permanently disabled or discontinued.

These three scenarios can be summarized to comprehend the possible influential factors that led to success or failure (Table 1 & 2).

**Table 1:** Family cohesion is highly instrumental in palliative and hospice care. Patients generally show poor progress if the support of the family is weak (due to disputes or conflicts or caregiver burnout), and if the beloved family member is not nearby but renders genuine long-distance caregiving. Family dynamics can be at least superficially understood by simply observing their communication (verbal and non-verbal interactions), and in-depth through disclosure of family relationships and circumstances as the professional rapport increases – ‘Johari Window’.

|                   | <b>AILMENT STATUS</b>                                                                                          | <b>FAMILY COHESION</b> | <b>PATIENT'S COOPERATION FOR REHABILITATION</b> |
|-------------------|----------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------------------------|
| <b>SCENARIO 1</b> | Critical (post-fracture, developed pressure ulcers)                                                            | Low                    | Nil                                             |
| <b>SCENARIO 2</b> | Critical (post-amputation, developed pressure ulcers)                                                          | Medium                 | Low                                             |
| <b>SCENARIO 3</b> | Critical (post-fracture, breathing through tracheostomy, nasogastric feeding, never developed pressure ulcers) | High                   | High                                            |

**Table 2:** Data in this table were not collected through a structured questionnaire or interview schedules. Economic stability and educational status shown in this table belong to primary caregiver of the patients. Social Workers could be able to systematically understand the upstream and downstream social determinants of health. Patients generally respond well and recover, or manage to live longer with irreversible disorders if their families do not face caregiver burnout. Family cohesion may be the strongest determinant of patients’ recovery and longevity.

|                                           | <b>SCENARIO 1</b>                                                                                                                   | <b>SCENARIO 2</b>                                                                                                                                                        | <b>SCENARIO 3</b>                                                                                                                                                                                                                     |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ECONOMIC STABILITY</b>                 | Lower middle class, self employed (Auto rickshaw driver)                                                                            | Lower middle class, self employed (xerox, typing, e-services)                                                                                                            | Upper middle class, Assistant professor                                                                                                                                                                                               |
| <b>EDUCATIONAL ACCESS AND QUALITY</b>     | High school                                                                                                                         | U.G.degree                                                                                                                                                               | Doctorate                                                                                                                                                                                                                             |
| <b>HEALTHCARE ACCESS AND QUALITY</b>      | Insufficient understanding about the importance of home-based functional rehabilitation program.                                    | Insufficient understanding about the importance of home-based functional rehabilitation program.                                                                         | Sufficient understanding about the importance of home-based functional rehabilitation program.                                                                                                                                        |
| <b>NEIGHBORHOOD AND BUILT ENVIRONMENT</b> | Well-built house. Poor bed hygiene. Excreta were not removed on time and completely. Toileting activities on bed (diaper-assisted). | Well-built house. Satisfactory bed hygiene. Air mattress to protect against pressure ulcers. Toileting activities on bed (diaper-assisted, indwelling urinary catheter). | Well-built house. Satisfactory bed hygiene. Air mattress to protect against bed sores. Toileting independence was achieved quickly through exercise programs targeting balance and locomotion.                                        |
| <b>SOCIAL AND COMMUNITY CONTEXT</b>       | Confined to bed, lack of societal integration and isolated due to lack of awareness about downstream determinants of health.        | Confined to bed, lack of societal integration and isolated due to lack of awareness about downstream determinants of health.                                             | Mobility program began at the right time. Almost no chances for isolation because of her son’s family support. Integration with society intentionally delayed though full self-care functional independence was achieved in 3 months. |

### **Key Exercise Maneuvers to Prevent Bed Sores**

Breaking the cycle of dependency on bed or chair is crucial for not only preventing

pressure ulcers but also to set a foundation for ambulation with or without assistive device. Though there are numerous scientific exercise techniques involved in

functional rehabilitation programs, all these exercise techniques should help in accomplishing two important maneuvers as

early as possible; (i) Lying to sitting (ii) Sitting to standing – (Figure 9 & 10).



**Figure 9: SUPINE LYING TO SIDE-SITTING.** This is very important functional ability to relieve the pressure on various bony prominences like sacrum, greater trochanter and heels. Lot of patients naturally safeguard themselves from pressure ulcers through the ability to sit from lying independently, even its importance is not formally taught. Functional independence needs to be trained further to progress to stand from sitting position but some patients may not easily achieve standing because of the type of their ailment or impairment.



**Figure 10: SITTING TO STANDING (ARM-SUPPORTED).** This is another vital biomechanical strategy to completely get rid of the risk of pressure ulcers. As shown in this image, arm-supported getting up from the chair should be accompanied by forward leaning posture. Standing to sitting should be also accompanied by arm support and forward leaning posture. For patients who lack sufficient balance or confidence, a walker can be kept in front of the chair for safety. Alternately, for such patients, this practice can be done just next to the window, so that the patient can ensure balance by gripping window rail or grill.

For bedridden patients, accomplishing these two maneuvers may not be biomechanically possible without systematic individual-specific long-term training. It is better to educate and motivate the patients about the importance of these two essential functional milestones before they become dependent or acquire pressure ulcers.

## DISCUSSION

Practitioners should be aware of both upstream and downstream determinants of health and biopsychosocial dysfunctions, including health-related social needs (HRSN). Bedsore is a global problem concerning the bedridden, infirm, debilitated and malnourished patients in hospitals and community set ups.<sup>[15]</sup> “Pressure ulcers develop primarily from pressure and shear; are progressive in nature and most

frequently found in bedridden, chair bound or immobile people. Loss of movement, failure of reactive hyperaemia and loss of sensation are the three predisposing factors for pressure ulcers”.<sup>[16]</sup> “The prevalence of pressure ulcers is higher in patients receiving palliative care and it does not necessarily mean that inadequate care has been provided. Skin failure, as with other organ failures, may be an inevitable part of the dying process for some patients”.<sup>[17]</sup> Bedsores incidence was higher among the patients who had advanced age, lower educational status, lower economic status, lower awareness about bedsores, a longer hospital stay, limitation in movement and chronic diseases.<sup>[18]</sup> Many factors are involved in the causation of pressure sores. Some of these are directly related to the patient’s physical and mental state, his

activity, his ability to change his position in bed unaided and the degree of incontinence.<sup>[19]</sup> “When the caregivers are knowledgeable about preventing pressure ulcers, it will help the patient to achieve the best quality of life and spend the last days of life peacefully and comfortably with dignity. It is essential to develop evidence-based guidelines for caregivers of palliative care patient on pressure ulcer prevention”.<sup>[20]</sup> “Providing evidence-based clinical practice guidelines and structured teaching programs can improve the knowledge of caregivers. Measures to improve the availability of helping hands at home through volunteer training, ensuring the necessary equipment and regular supervision are crucial for contributing to patient comfort and safety, which will enhance the quality of life of palliative care patients”.<sup>[21]</sup> Survival of critically unwell patients has improved due to advances in critical care medicine and some of these survivors develop cognitive, psychiatric and physical disability after treatment in intensive care unit (ICU) which is recognized as post-intensive care syndrome.<sup>[22]</sup> Post-intensive care syndrome (PICS) can last long after hospital admission and can cause significant physical, emotional, and financial stress for patients and their families.<sup>[23]</sup> “Families of critically ill patients are predisposed to tremendous burdens when their relatives are admitted to the intensive care unit. Post-intensive care syndrome family (PICS-F) can be described as a devastated life, encompassing psychological, physical, and socioeconomical burdens that begin with the emotional impact experienced by the family when the patient is admitted to the ICU”.<sup>[24]</sup> “Professional social workers are trained to manage psychosocial issues associated with ailments and health, and their theoretical imbibing in systems theory, biopsychosocial and person-in-environment perspectives enable them to visualize the patients in their totality and provide help on non-clinical issues of illness and disease. The presence of social worker in the hospital is important

in the interest of patient, doctor and community”.<sup>[25]</sup> “Social workers play multiple roles such as counselor, educator, enabler, advisor, facilitator, broker, care-coordinator, trainer, researcher, consultant and community organizer. They are powerful advocates of patients and a strong link between the patient, the doctor and the organizations. Progress in hospital social work has not been very satisfactory and professional social workers are struggling with several issues and challenges in performing their role in medical settings”.<sup>[26]</sup> “The realm of healthcare is not solely confined to the diagnosis and treatment of medical conditions; it encompasses a holistic approach that addresses the multifaceted needs of individuals within society. Medical social work plays a pivotal role in ensuring comprehensive and quality healthcare delivery, particularly in hospital settings. Medical social work ensures the patients receive comprehensive assistance to navigate the complexities of their health challenges. Despite the significant transition in medical governance (replacement of Medical Council of India with the National Medical Commission), no changes have been implemented regarding the appointment of Medical and Psychiatric Social Workers in medical colleges”.<sup>[27]</sup> The vital roles of medical social workers within a multidisciplinary team must be recognized, appreciated, and supported to foster the quality of healthcare provided to patients in a hospital setting.<sup>[28]</sup> “Hospitals are well-positioned to incorporate a groundwater approach beyond “fixing the fish” to target the underlying system shaping the health of the communities they serve. They can leverage their economic power, policy influence, and influential leadership to address the uneven distribution of Social Determinants of Health”.<sup>[29]</sup> “Policies that improve the overall social and economic well-being of individuals and families will reverberate across a variety range of health outcomes and help to reduce health disparities and achieve health equity.

The best available evidence suggests that a health policy framework addressing social and behavioral determinants of health would achieve a better population health”.<sup>[30]</sup> “The principle of health equity advocates that everyone irrespective of their race, ethnicity, socioeconomic status, gender, age, or geographic location should have the opportunity to attain the highest level of health. Governance mechanisms for planning and monitoring social determinants of health as an integral element of Sustainable Development Goals need to be established at all levels of functioning to achieve health equity”.<sup>[31]</sup> Old age patients with long-standing health issues and chronic dependency can be seen prolonging their lifespan without pressure ulcers or pains if the family’s support is shared by hired care givers which is quite obviously feasible to wealthy individuals. If all or part of the beloved family members are not physically nearby (physical proximity) but are providing healthcare support from distance (long distance caregiving, geographic separation) through hired care givers or therapists, expensive assistive devices or advanced life support, patients may not respond well to the treatment as expected which includes negative impact on the long-distance care givers too. “Long-distance care givers experience high levels of stress and dissatisfaction because they are not able to get first-hand knowledge of the care recipient’s condition”.<sup>[32]</sup> “The changing landscape of families combined with population aging present unique challenges and pressures for families and health care systems. It is important to address ways to ease caregiving or shift the burden away from families through a variety of policies, such as greater resources for in-home aid, creation of older adult residential communities that facilitate social interactions and social support structures, and patient advocates to help older adults navigate health care systems”.<sup>[33]</sup> “When assessing ageing well at home, the capability approach could be a possible way to focus on what older people are effectively

able to do and be, when considering contextual factors as well as individual choice. Functionings in the capability approach are described in relation to people’s valuable goals, and capabilities refer to their abilities to realize valuable goals”.<sup>[34]</sup> There are instances in which family members dissociate, display low family social capital and neglect the systematic care for their diseased family member, despite their strong financial stability. There are also instances in which family cohesion remains high but patient’s clinical condition is intrinsically complicated. Both family and professional caregivers could suffer from ‘caregiver burnout’ due to physical, emotional and mental exhaustion. Needless to say, the outcomes of palliative or hospice care crucially depend upon compassionate or conflictual caregivers of the family or institution. Patients could be either intrinsically motivated to cooperate with therapeutic interventions, or straightforwardly resisting the administration of therapies which may or may not be tackled through eclectic counselling based on the severity of the ailment and autonomy of the patients. A moderately universalist stance is recommended for social work, as valuing both diversity and human rights.<sup>[35]</sup> Individuals should also take responsibility to steer their recovery and healthy aging trajectory to retain or improve their functional independence and resistance against diseases. Conditions like Gravitational Torque Deficiency Syndrome should be avoided or counteracted through prophylactic exercise regimen in favor of successful aging.<sup>[36]</sup>

## CONCLUSION

In addition to the original clinical condition, severe immobility, malnutrition (restricted calorie intake) and diminished cardio-respiratory fitness keep the patients at high risk of pressure ulcers and various secondary complications. Holistic rehabilitation of patients requires

comprehensive understanding of the individual-specific biopsychosocial barriers and strengths. Medical social workers possess unique expertise in assessing the social determinants of health, rendering crisis intervention and mobilizing necessary resources to support the mental health of the patients and their families that are usually neglected in biomedical model of healthcare. Interdisciplinary functions of Physiotherapists and Medical social workers should be strengthened to provide adequate biopsychosocial support because both physiotherapy and professionalized social work services are provided in clinical settings and patients' homes/community as well. Additionally, social workers are competent in conducting in-depth social diagnosis (person-in-environment, social determinants of health), and providing a wide range of contributions to the society through their micro-level to macro-level practice. The researches of social workers aim to bring significant social change through upstream determinants by influencing policies and institutions for the benefit of entire population. Basic proactive strategies and inexpensive interventions against pressure ulcers discussed in this article can be (i) further systematically researched, experimented and disseminated to carve out them as widely accredited gold standard protocols, and (ii) incorporated in the resource mobilization plans and recommendations of medical social work practice to eliminate the treatment gap in both palliative and hospice care that causes immense sufferings of all the critically ill patients, with special emphasis on marginalized demographics.

#### **Declaration by Authors**

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