

# Attitudes, beliefs and personality of staff affect tissue viability practice

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Staff attitudes and beliefs are an underestimated and under-researched area of tissue viability practice (TVP). It is time for colleagues to consider the fact that TVP is interpreted and delivered by people. We must understand that the context of TVP is one of vested interests, motives, preferences, values, beliefs, attitudes, personality, and so forth. Given that resources are scarce in both emotional and financial terms, all the factors just listed must compete for space with other health concerns. Furthermore, people who are not specifically interested in TVP think of it in a simplistic way, and their approach will affect care adversely. There is research-based evidence to support these assertions (as summarised below). Therefore, it is in everyone's interest to put more effort into explaining the human context in which wound care is done.

## Connectedness

As the poet John Donne wrote, 'no man is an island entire of himself'. Individual staff are not free to indulge their own desires in a working day. They are always part of a team, and their actions and beliefs affect colleagues, and have a societal impact in the widest sense. Figure 1 illustrates just a few things that affect professionals delivering health care. Clearly there are interacting or even competing psychosocial factors.

Consider the thorny matter of restricted formularies from the perspective of a procurement manager for a hospital. Your procurement director has charged you with reducing the cost of dressings in the NHS trust. This scenario is replete with intricate nuances of power — the senior manager has the last say; moral implications — the greatest good involves doing things cheaper; distancing — no personal responsibility to the patient; no experience of a complex

wound — failure of knowledge of clinical implications; personal motivation — want to keep job; and so forth.

Now, consider it from the ward nurse's perspective. They are oblivious to the fact that this patient had a pain-free wound regimen under the care of the community nurse (because they have never seen the patient before, and have not read their history in detail). They do not know that the ward stock (cheaper) dressing is likely to adhere and cause

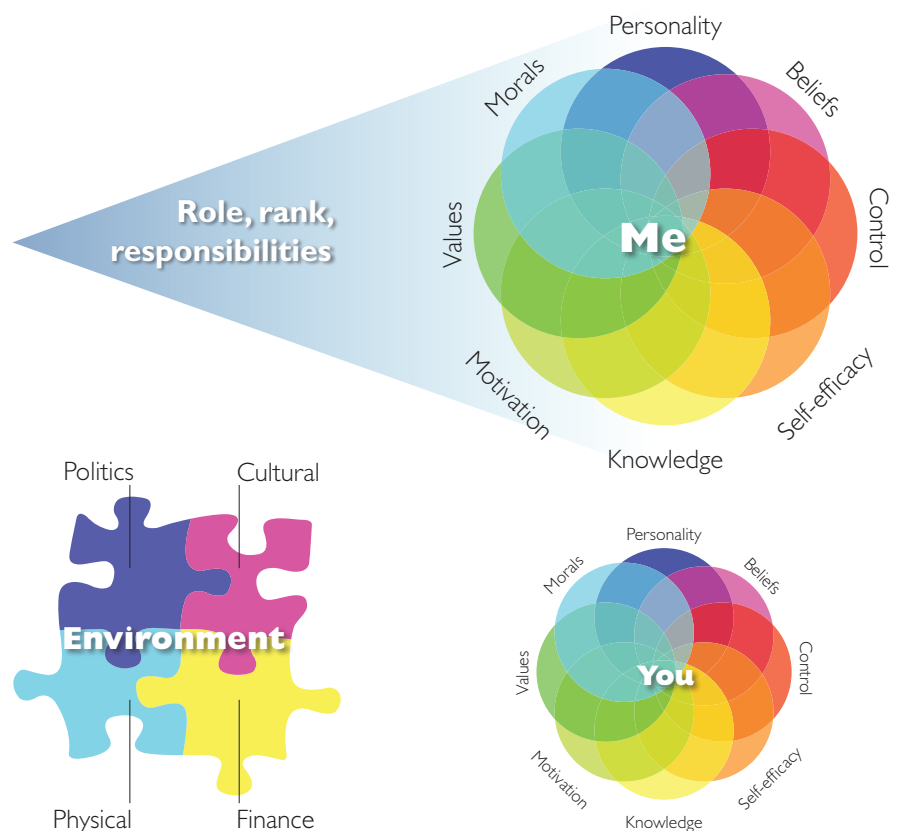


Figure 1: Interconnected nature of tissue viability practice and human attributes.

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pain on removal (an issue of knowledge and experience). They believe that they do not have any choice in the decision about stock (perceived powerlessness and external locus of control). They are unaware of an alternative method of treatment and fall back on what they have used before (failure to keep up to date). The patient has come into the ward because they had a stroke and the focus of the nurse's attention is on maintaining the patient's airway (an issue of perceived severity regarding potential consequences: the wound can wait). The nurse dislikes wounds, they are smelly and time-consuming and they feel uncertain about what they should do (an issue of primal revulsion and fear). Other patients are demanding attention and the nurse goes off duty in an hour (an issue of prioritisation and primacy).

I will briefly describe some psychosocial research applied in the context of wound care, and suggest other areas that ought to be more fully investigated.

### Personality type

There are aspects of TVP that can be related to personality type theory (Briggs-Myers and Myers, 1980; Maylor, 2006) (Figure 2). There might be a type of person who makes a good (or not so good) tissue viability nurse. This has important implications regarding the tools used to assess wounds or pressure ulcer risk. Information is processed differently by different personality types. Learning style theory advises that teachers adapt teaching to the interpretive styles of an individual learner. Psychologists adapt psychometric scales to allow for individual differences. Although investigation of such correlations in TVP is in its infancy, it is possible to show by semantic analysis that nurses fall into at least two types in their approach to wound assessment. 'Concrete collaborators' are mostly concerned with measuring a wound through their sense-based faculties (the eyes inform the mind). 'Abstracters' generally want to know whether overall interactions indicate that a wound is healing (the mind informs the eyes) (Francis et al, 2004; Maylor, 2006). Wound assessment

forms are lists of wound-related phenomena which might or might not be reliable as indicators of wound healing or deterioration. They take no account of styles of information processing; and they are erroneously assumed to be free of the 'observer effect'. An observer cannot help but participate in what they are observing: 'We don't see things as they are, we see things as we are.' (Anais Nin, 1903–1977).

Some confirmation of this phenomenon has been derived through two studies (Maylor, 2005, 2006). It was found that nurses differ in the total number of words they suggest for a hypothetical wound assessment form (ANOVA  $F=12.388$ ,  $df=60$ ,  $P<.001$ ).

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Further, nurses use significantly different words to describe the three phases of a wound (stasis, healing, deterioration) ( $\chi^2=274.9$ ,  $df=10$ ,  $P<.001$ ). Imagine a blind person and a deaf person trying to describe a thunderstorm to each other. They are talking about the same phenomenon, but not necessarily communicating or understanding each other.

This implies that wound assessment forms need tailoring to an individual nurse's preferred styles and preferences if real communication is to happen. It is likely to mean that a nurse could choose to use either form A or form B as long as they agree to do the same thing following assessment, even if they understood what they assessed in different ways.

When the personality indicators (Figure 2) are combined they describe stable characteristics associated with occupational groups. Myers-Briggs Type indicator uses a combination

Personality type dyads		
I	versus	E
S	versus	i
T	versus	F
J	versus	P

Figure 2: Pairs (dyads) of personality type descriptors.

of four letters to indicate each of sixteen personality types. For example, ESTP (extraversion, sensing, thinking, perception type) are observant, practical, realistic, straightforward, and assertive. But, they can make ill-founded decisions and might not see the wider ramifications of their actions and decisions. They tend to be unaware of the impact of their actions on others, and are impatient with discussion or exploration of relationships. Surgeons are represented by the ESTP type (Briggs-Myers and Myers, 1980), whereas many general practitioners are represented by the ENTP type (extraversion, iNtuition, thinking, perception). They are creative, imaginative, analytical, rational, assertive, and questioning. But, when frustrated they can become rude, brash, abrasive, and critical of others they consider to be inefficient or incompetent.

Personality theory also helps to explain how people approach problem-solving. Some 'types' seem to be logical and systematic, whereas others just spontaneously react, often without planning beforehand. Nurses tend to have dyad combinations favouring sensing and feeling (SF), or intuition and feeling (NF), like people in customer relations and sales. Proportionately less nurses than doctors are 'rational' by type-preference. If we come across wounds dressed with illogical combinations of products, there might be a personality type explanation for this, e.g. the nurse just 'felt' that it would work. How do we exploit their 'feelings' about dressings, so they feel happy to use them in the right circumstance? Visual, auditory, and kinaesthetic models of teaching and learning do take such things into account.

### Locus of control

Another major influence on TVP is perception of who controls it. Put simply, some people expect that they personally control outcomes (internal locus), while others expect powerful other people to do so (external locus), or that fate controls things (external locus) (Maylor, 2001). This theory has been explored (Maylor, 1999/2000) in relation to pressure ulcer prevalence. Again, the effect of this aspect of human belief and attitudes has received little interest, although compelling statistics should encourage much more thought about how this is affecting TVP (Maylor 2001, 1999/2000).

It was discovered that control expectancies had a statistically significant correlation to a knowledge score (in terms of knowledge of pressure ulcer prevention) (Maylor 1999/2000). When the nursing staff of a department thought only powerful others controlled prevention, they would learn a little about prevention (Spearman correlation  $r=.16$ ,  $p=.001$ ). For the sisters/charge nurses of the department with this belief, the effect was a lot more powerful (Spearman correlation  $r=.85$ ,  $p=.001$ ). In other words, when the sisters thought that powerful others controlled prevention (it was not stated who these others might be); they tended to know more than other staff about prevention (Maylor, 2001). But this did not necessarily translate into lower prevalence in their department.

In fact, when sisters thought they themselves were in control of prevention, there was a higher prevalence (Spearman correlation  $r=.64$ ,  $p=.003$ ). So, it could be unhelpful for them to believe that they can personally control prevention. The most startling correlation was that the more sisters thought pressure ulcers were caused by chance (i.e. were bound to happen), the less the prevalence (a strong Spearman correlation  $r=-.82$ ,  $p=.001$ ). Clearly this is counter-intuitive and suggests that we should not strive so hard to achieve accuracy in risk assessment scales, or to encourage people to put too much confidence in equipment, etc. Part of the explanation also involves valuing

something; recognising its importance, and desiring to achieve it.

### Following orders

Effort has been put into research about compliance in TVP (e.g. patients wearing compression hosiery), but I am not aware of any study that has yet examined whether staff are compliant with recommendations for wound care made by tissue viability specialists. Yet, there are indications from audit that staff had not followed tissue viability advice on appropriate dressings in up to 50% of cases (Tait and Gibson, 2007). Clearly, we need to understand why staff choose to follow advice, or to acquiesce with poor care.

The Milgram Experiment (1963) (Milgram, 2004) showed that when there is less personal responsibility obedience increases. People were allocated to be either a 'teacher' or a 'student' in an experiment to increase learning of words by administering an electric shock. In reality, the 'student' was an actor collaborating with a mock setup where the 'teacher' thought that they were actually administering shocks (they were not). Psychologists predicted only 4% of 'teachers' would administer the highest level of shock (450 volts). In European re-runs up to 85% were prepared to administer 'lethal' shocks. They did what they were told.

When Milgram's study was conducted in a run-down office in the city, obedience levels dropped. In a laboratory and white coats at Yale University, obedience was significantly higher. When the experimenter dressed in everyday clothes obedience was very low. People tend to obey orders from other people if they recognise their authority as morally right and/or legally based, although this was challenged at the Nazi Nuremberg trials. It is easier to resist the orders from an authority figure if they are not close by. We need more research on the subject of nursing responsibility (or failure to act responsibly) in TVP.

### Conclusions

I have argued that when we fail to account for human characteristics

in TVP, we do not get the best out of staff. If we assume that everyone sees wounds in the same way, we will expect 100% accurate communication. However, wound care is inherently multifactorial as is the person doing it. Personal expectancies of control can be correlated to pressure ulcer prevalence in unexpected ways, and we might be able to exploit counter-intuitive findings perhaps to protect patients. For example, I would argue that the concept of 'risk' is poorly understood. It is rightly assumed to be intrinsic or extrinsic to the patient, but the latter includes the application of a nurse's sense of duty, perceptions, personality and control expectancies, etc.

There is a need for personal commitment to TVP, but not everyone has this. Care costs us in terms of emotional effort. In the NHS people have reached their limit and they will 'revert to type' in order to protect themselves from burnout. Many aspects of human caring have yet to be researched. **WUK**

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