SPECIAL FEATURE

Transitions in pharmacy practice, part 4: Can a leopard change its spots?

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Abstract: The personal and social characteristics of pharmacy practitioners that predispose them to reacting in a certain way to a change in practice are examined.

Individuals tend to choose vocations they perceive to be a match with their personality. Studies suggest a dominant personality type among pharmacists characterized by a strong sense of responsibility, conscientiousness, practicality, logic, and, in about 20% of practitioners, fear of interpersonal communication. As the profession seeks to adapt to new practice models, individual practitioners may find a significant mismatch between their personality and aspects of the new models. Pharmacists' professional socialization—the process by which expected roles, behaviors, and attitudes are acquired—is another major contributor to their receptiveness to changes in practice. Managers wanting to promote practice changes face considerable variance in the professional socialization of their individual staff members. Few staff members have been socialized for pharmaceutical care. Some may not have any of the values or attitudes of the idealized professional, and may simply have "a job." Although personality is largely fixed, professional socialization is an ongoing process, so there is potential to resocialize practitioners for new practice models.

Pharmacists are shaped by their personalities and professional socialization. Conflict may occur if a pharmacist's personality does not mesh with new professional roles. Most pharmacists will need resocialization to prepare them for changes in practice.

Index terms: Administration; Job description; Pharmacists; Pharmacy; Psychology; Sociology

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In previous installments in the "Transitions" series, we described the wide-ranging changes occurring in health care because of shifting societal demands and the profound effects this reorganization is having on the pharmacy profession. "Transitions in Pharmacy Practice, Part 2: Who Does What and Why" described the competencies associated with the five practice models that make up total pharmacy care—a systems view of effective contributions by pharmacy to health care delivery.[1] In "Transitions in Pharmacy Practice, Part 3: Effecting Change—The Three-Ring Circus," we presented a model for the leadership role of pharmacy department managers and community pharmacy owners that will maximize the possibility that desired changes in practice will occur among individual practitioners.[2] In this "Transitions" article, we examine the personal and social characteristics of pharmacy practitioners that predispose them to reacting in a certain way to a suggested change in practice.

Managers who propose to their staffs the idea of a change in practice are not dealing with people who will all view and react to any request for change in the same way. Some pharmacists will immediately and enthusiastically embrace the change, some will change after a period of consideration, and some will never adopt the change. Understanding something about how people come to be who they are and knowing some general personality characteristics of pharmacists can help managers appreciate and accept the limits on what practice changes will be possible to achieve. Two major factors affect individual pharmacists' inherent receptiveness to a change in practice: their personality and their current state of professional socialization.

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Personality

The development of personality predates a pharmacist's professional socialization. Using a wide range of personality inventories, researchers have established that individuals tend to choose vocations they perceive to be a match with their personality type.[2-7] In fact, J. L. Holland[8] asserts that when there is a mismatch between personality and work environment, one can expect "gross dissatisfaction, ineffective coping behavior, and probably leaving the environment."

Definition of personality. Personality has been defined as "the configuration of characteristics and behavior that comprises an individual's unique adjustment to life, including major traits, interests, drives, values, self-concept, abilities, and emotional patterns."[9] Each of us has lifelong patterns of behavior, thought, and feelings.[10] The sources of personality are multiple, including "heredity and constitutional tendencies, physical maturation, early training, identification with significant individuals and groups, culturally conditioned values and roles, and critical experiences and relationships."[9] A person's personality is generally regarded as relatively stable. While personality changes do happen, they "occur only if there is some alteration of fundamental perceptual, motivational, ideational, or responsive tendencies."[11]

Personality traits of practitioners. While several studies have examined personality in pharmacy students, there have been fewer studies of practitioners. Although we do not know as much as we should about the personalities of practitioners, we know enough to at least outline the personality patterns with which the manager must deal in facilitating practice change.

From 1976 to 1997 there were only three published studies of the overall personality of pharmacists, each involving a different personality measure. There were also two studies that examined a single manifestation of personality. More than two decades ago, Manasse et al.[12] used the Sixteen Personality Factor Questionnaire in examining 68 practitioners who were preceptors for students. The researchers found that the preceptors' personalities were characterized by four general attributes:

- Intelligence: bright.
- Emotional stability: mature, faces reality, calm.
- Conscientiousness: persistent, moralistic, staid.
- Persistence: controlled, exercises willpower, socially precise, compulsive, follows self-image.

In 1994, Lowenthal[4] reported a survey of 170 practitioners with the Myers-Briggs Type Inventory (MBTI), a measure of personality that identifies eight core personality preferences using four bipolar scales: E/I (extravert/introvert), S/N (sensing/intuitive), T/F (thinking/feeling), and J/P (judging/perceiving) (appendix). The men had personalities that were predominantly ISTJ, whereas the women had personalities that were predominantly ESTJ. This illustrates a consistent pattern of sensing, thinking, judging personality types among practitioners.

In the third study of overall personality, Cocolas et al.[13] reported in 1997 the scores of 340 pharmacists, practicing in all environments, on the Gordon Personal Profile—Inventory (GPP-I). Pharmacists were above the national means for U.S. adults in seven of the eight measured characteristics. The three most noticeably elevated traits were cautiousness, typified by careful consideration of decisions; responsibility, meaning perseverance and determination; and emotional stability, characterized by freedom from worry, anxiety, and nervous tension. The one personality component in which practitioners scored below the national mean, albeit slightly, was sociability, defined in the scale as liking to be with and work with people.

The two studies of pharmacists that examined a single manifestation of personality present additional insights. In 1973 and 1978, Karmel[14] administered the Locus of Control Scale to a total of 79 hospital pharmacists. The researcher concluded that this subset of the profession has a greater belief than the average person in personal control over the work environment. One would, then, expect these pharmacists to search for information they need to exercise job control, initiate activities they perceive as controlling what is happening, constructively resolve their anxiety and frustration, be skilled in their work, resist manipulation by others, and be involved in their jobs.[14] Since Karmel did not report how the pharmacists were chosen for inclusion in the study, one needs to apply caution in generalizing this finding to all hospital pharmacists.

In 1992, Anderson-Harper et al.[15] reported the scores of 771 practitioners in community and hospital pharmacies on the Personal Report of Communication Apprehension. Communication apprehension is a cognitive problem in which the individual fears the act of oral and even written communication. People with communication apprehension tend to avoid situations

The "Transitions in Pharmacy Practice" series proposes a model for helping pharmacy department directors and their staff developers facilitate changes in practice by staff members. The model was conceived in response to continuing reports of widespread failure to persuade practitioners to fill more roles in clinical pharmacy and pharmaceutical care, despite supervisors' attention to traditional managerial theory about motivation for workplace change. The first few articles in the five-part series build an appreciation for how the complexity and diversity of the current pharmacy environment demand an innovative approach to practice change. Subsequent articles present the model for change and detail a theory-based approach to the component least understood by department directors and staff developers: motivation. The articles are intended to be read in the order published. The series started with the article in the September 1 issue and continues monthly, in the first issue of the month, to January 1, 2000.

in which they will have to verbally interact with others because of the anxiety it provokes.[16] In some situations, the communication-apprehensive person's anxiety may be so severe as to interfere with accurate receipt or processing of communications from others.[5] The study by Anderson-Harper et al. found that the prevalence of communication apprehension in practitioners was consistent with the 20% prevalence in the general population.[15,17] Since this study involved a representative national sample, it seems safe to generalize the findings to all pharmacy practitioners.

The five studies suggest a dominant personality type among pharmacists characterized by a strong sense of responsibility, conscientiousness, practicality, logic, and, in about one practitioner in five, fear of interpersonal communication. This personality pattern should not be a surprise. One need only remember the established tendency to self-select vocations that match one's personality and the perception of pharmacy that prevailed when most current practitioners made the decision to become pharmacists: an occupation consisting largely of technical problem solving and limited contact with patients and other health care professionals. As Lowenthal[4] speculated, current practitioners chose to enter pharmacy because they "prefer well-planned, routine work."

Mismatch between personality and newer practice models. Comparing what we know about the prevalent personality type of practitioners with the job responsibilities, knowledge, skills, and attitudes associated with the five practice models in total pharmacy care,[1] we see a potential for major dysfunction among some of those currently in the profession in any proposed shift to newer practice models. Given the earlier analysis of the five practice models, one could conclude that a pharmacist with a personality profile lacking GPP-I traits of ascendancy (independent decision-making), original thinking, personal relations (patience and understanding), and sociability would be a mismatch for the newer practice models. Likewise, the one in five who is afraid of and avoids communication with patients and colleagues is unlikely to adopt any practice role requiring such communication. Distributive practice is comfortable for people who like to work alone, who enjoy technical problem solving, and who prefer minimal social interaction with patients and other health care providers. Those are precisely the dominant personality characteristics of many current practitioners.

The drug information model offers a match for someone who likes at least some social interaction and enjoys searching through and interpreting a body of information. The pharmacist practicing clinical pharmacy prefers resolving complex clinical dilemmas, with or without direct interaction with the patient. Move to self-care, and you will find pharmacists who accept regular interaction with patients, but who prefer to restrict their role in the professional relationship to one of authoritative dispenser of advice.

On the other hand, it is hard to conceive of a pharmacist being good at or enjoying the practice of pharmaceutical care who does not like direct contact with each patient, possess the "people skills" needed to engage in collaborative decision-making, and prefer to work on problems with no clear right or wrong answer.

Given the differences between drug distribution and the newer practice models, it seems likely that we have within the profession today a large proportion of individuals whose personalities matched well with pharmacy when distribution was the primary model. However, when these same individuals are asked to deal directly with patients, work on clinical problems in the context of a team approach, or solve problems having no clear right or wrong answer, they experience incongruity with their basic personality.

Something else that bears consideration is that seeking a match with self in one's work environment persists throughout one's work life. Such a match is achieved by 74.6% of men and 72.3% of women ages 21 to 25 and increases to 91% of men and 90% of women ages 61 to 65.[18] Thus, one could expect that pharmacists in their 40s and 50s will feel increasing discomfort when their jobs demand responsibilities that are not congruent with their personalities. Of particular importance is the projected role for pharmacists requiring willingness and ability to communicate. Pharmacists with communication apprehension may not be willing to fulfill this professional responsibility, and even when they make attempts to do so, they may not be successful.[17]

Managers would be wise to begin motivating their staffs to change practice with an acceptance that there may be some practitioners who will be unable, by virtue of their personalities, to make the requested change. One can probably not judge with certainty the compatibility of a proposed change for a particular pharmacist. As a result, to avoid unnecessary guilt for a failure that is embedded in personality and not the motivational skills of the manager, we recommend a systematic approach to motivation, as presented in the fifth part of the "Transitions" series.

Professional socialization

Pharmacists' professional socialization is the second major contributor to their receptiveness to changes in practice. Professional socialization is the process by which a student or young practitioner acquires the roles, behavior, and attitudes expected of a member of the profession involved.[9] According to a Kellogg Foundation-funded consortia of health professions schools, "The essence of health professions education is socialization; while the acquisition of knowledge is important, it is not the essence. It is through socialization that one acquires the values that shape one's notion of professional self."[19]

The professional socialization of the student is influenced by faculty members, internship preceptors, and student peers. Professional socialization is not complete at the end of pharmacy school, but continues with entry into practice. The end result of professional socialization is an internalized set of attitudes and values regarding one's role. These attitudes and values help determine the pharmacist's conceptualization of the "good" pharmacist and thus influence day-to-day decisions about what is or is not appropriate to do and the relative priority of tasks.

One source of conflict in the professional socialization of pharmacists has been the competing roles of the entrepreneur and the professional. In 1975 Manasse et al.[20] reported a resulting inconsistency in the socialization of pharmacists, the development of "incompatible or conflicting behaviors, beliefs and values from formal or informal sources due to the absence of uniformity or agreement within the idealized group model into which he [the pharmacist] is being socialized." Hatoum and Smith[21] in 1987 reported inconsistency "when it comes to issues that tie the professional member to pharmacy within their profession."

We are aware of no studies concerning the status of professional socialization among pharmacy practitioners. Perhaps this is because we have no statement endorsed by the whole profession on the essential values of the "good" pharmacist. As late as 1997, initial developmental work by the American Association of Colleges of Pharmacy still awaited refinement, prioritization, association with pharmacy-specific professional behaviors, and dissemination to faculty.[22] Beck et al.[23] suggested for pharmacists a professional socialization model built on a research-based set of six characteristics of the ideal professional, as proposed by Kerr et al.[24]:

1. Expertise, normally stemming from prolonged specialized training in a body of abstract knowledge.
2. Autonomy, a perceived right to make choices that concern both means and ends.
3. Commitment to the work and the profession.
4. Identification with the profession and fellow professionals.
5. Ethics, a felt obligation to render service without concern for self-interest and without becoming emotionally involved with the client.
6. Collegial maintenance of standards, a perceived commitment to help police the conduct of fellow professionals.

Despite the lack of a model and despite professional training's "catch-as-catch-can learning experiences relating to 'professional socialization,'"[25] one readily observes "idealized" professionals in practice, as well as those missing significant pieces of the professional's view. Walk into any pharmacy and you are likely to encounter pharmacists who endeavor to stay current with advances in practice, seek opportunities to move their practice forward, and maintain active professional association membership. Alongside these pharmacists will be others who regard continuing professional education as a ticket punch for relicensure, maintain no professional society memberships, and believe that any learning associated with changes in practice is the employer's responsibility and should be done on company time and at company expense.

The reality, then, is that managers wishing to promote changes in practice face considerable variance in the professional socialization of their individual staff members. Few staff, if any, will have been socialized to acquire the values and attitudes of pharmaceutical care. Some who were trained in the past 20 years may be socialized for clinical pharmacy, some for distributive practice, and some for other practice models. Some may not possess any of the values or attitudes of the idealized professional, and may simply have "a job."

What can managers do when the professional socialization of some or all of their staff does not match the envisioned change in practice? The prognosis is much more favorable than in the case of a mismatch in personality. There is no reason to think that professional socialization is anything but an ongoing process. Indeed, we have models all around us that attest to this. Every time a practitioner makes a wholehearted commitment to a changed practice, we can conclude that new attitudes and values about practice have taken root in that individual. We contend that professional resocialization is a form of "attitude adjustment" that must occur for a pharmacist to move successfully from one practice model to another. Furthermore, we believe that this change in professional attitudes and values is best accomplished through a systematic motivational process that will be presented in the next, and final, article in this series, "Transitions in Pharmacy Practice, Part 5: Walking the Tightrope of Change."

Conclusion

Pharmacists are shaped by their personalities and by professional socialization. When professional roles change to encompass tasks that are not readily compatible with a pharmacist's personality, serious conflict may ensue. While it may not be possible to change personalities, managers need to be aware of the potential value of professional resocialization as a way to encourage changes in practice.

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Appendix—Bipolar scales on the Myers-Briggs Type Inventory[4]

E/I: How a person is energized. An extravert (E) draws energy from other people and thinks out loud. An introvert (I) draws energy from within and keeps thoughts to himself or herself.

S/N: How a person gathers data. A sensing (S) person gathers information by using the five senses, acts more practically, is oriented toward the present, and does well at gathering detailed information. An intuitive (N) person gathers information by using intuition and "gut-level" feelings, is oriented toward the future, and does well at showing relationships and patterns.

T/F: How a person makes a decision. A thinking (T) person makes decisions logically, analytically, and objectively, does so by following an impersonal process, and uses his or her "head." A feeling (F) person makes decisions with people in mind, does so by relying on values, and uses his or her "heart." Some 60% of women have F personalities, and some 60% of men have T personalities.

J/P: A person's lifestyle or orientation to the outside world. A judging (J) person prefers a planned, organized style and is decisive. A perceiving (P) person prefers a spontaneous, flexible style and is process oriented.