

# Transitions in pharmacy practice, part 5: Walking the tightrope of change

CHRISTINE M. NIMMO AND ROSS W. HOLLAND

In this final article in the Transitions in Pharmacy Practice series, we complete our discussion of a leadership model for facilitating practice change in pharmacy. Pharmacy's transition to pharmaceutical care will not be instantaneous but will continue for an indefinite period to include a shifting balance of five practice models: drug information, self-care, clinical pharmacy, pharmaceutical care, and distribution. Achieving professional competency in any of the five practice models requires psychomotor and problem-solving skills, professional socialization for the attitudes and values of the practice model, and development of judgment in its use. Furthermore, skills, attitudes, values, and judgment are significantly different for each of the models.

The Holland–Nimmo model of practice change posits that three leadership responsibilities must concurrently be fulfilled to ensure that practice change will actually take place: (1) An environment conducive to the desired practice must be established, (2) learning resources sufficient to meet any required practitioner learning needs must be provided, and (3) motivational strategies that result in a commitment by individual practitioners to change their practice must be applied. Of the three leadership responsibilities, applying effective motivational strate-

**Abstract:** A systematic process for reformulating the practice-related attitudes and values of pharmacists to help them adapt to a new practice model is described.

The key to motivating pharmacists to commit to practice change lies in fostering a change in intrinsically held professional attitudes and values, not in emphasizing a structured extrinsic reward system. As a systematic process by which managers can motivate their staff to change attitudes and values, the authors offer a customization of the taxonomy of learning in the affective domain proposed by Krathwohl, supplemented by contributions from the literature on the diffusion of innovation, dissonance theory, the trans-theoretical model, and instructional psychology. Krathwohl's taxonomy shows affective learning as a five-level hierarchy with stages within each level. Managers can guide prac-

tioners through the first four levels. Practitioners who have been socialized for the distributive model and who then adopt a new practice model such as pharmaceutical care will start by simply receiving information about the new model. Next, they will actively respond to learning about the model and begin to value it as desirable. As their regard for the new model grows, they will reorganize practice priorities.

Managers can help pharmacists adopt a new practice model by guiding them through stages of attitude and value formation.

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gies that will work in the current pharmacy environment is the least understood.

In the fourth installment in this series,<sup>1</sup> we began presenting a systematic process by which managers can motivate staff to commit to practice change. We showed that personality—which is relatively fixed—is a key factor in a practitioner's response to a given model of practice. We also examined the impact of professional socialization on practitioners' views concerning desirable practice and suggested that the proper role of motivational strategies lies in resocializing practitioners for

the desired practice model.

As we resume our discussion of a systematic process for motivating practice change, we assume that readers have read the preceding articles and understand the limitations imposed by practitioners' personalities and socialization.

## Why a different motivational model?

Why do we believe that pharmacy needs to move beyond established, research-based approaches to managing change in the workplace and customize its own model for motivation? The need for a tailored approach rests in

CHRISTINE M. NIMMO, PH.D., is Director, Educational Resources, American Society of Health-System Pharmacists, Bethesda, MD. ROSS W. HOLLAND, PH.D., ED.D., M.A., FPS, FSHP, FASCP, FAIPM, MACPP, is Dean, Australian College of Pharmacy Practice, Canberra, Australia.

Address reprint requests to Dr. Nimmo at ASHP, 7272 Wisconsin

Avenue, Bethesda, MD 20814, or to [cnimmo@ashp.org](mailto:cnimmo@ashp.org).

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the magnitude of change required to move from a product-oriented practice to a patient-centered one. A switch to clinical pharmacy, pharmaceutical care, or self-care involves, for the bulk of practitioners, not only the acquisition of complex new skills, but also professional resocialization—the reformulation of practice-related values and attitudes.<sup>2</sup>

Current models of motivation are failing pharmacy in two respects. First, many of the traditional job incentives are not available to today's pharmacists. Demands to contain pharmacy budgets make salary increases difficult; and, where organizations are flattening their structure, recognition through promotion is rare. Second, managerial models for motivating change in the workplace tend to focus on attaining compliant behavior, without giving significant attention to achieving changes in values.

In fact, none of the managerial models have as their central focus the recasting of attitudes and values. Encouraging compliance with specific duties is an acceptable approach for people who have "jobs." Mere compliance, however, is not a sufficient role for those who practice professions. As we discussed in part 4 of this series,<sup>1</sup> much of what pharmacists will do or not do during a workday is driven by their professional values—by what is important and what obligations are to be met—rather than by some carefully defined list of tasks.

Our present inconsistent approaches to motivating practice change are having an impact in four important areas. First, the transition to another practice model is unnecessarily slowed. Practitioners who are reluctant to change block forward movement, consuming managerial time and energy better spent elsewhere. Second, ineffective motivational strategies render practitioners who might otherwise choose to adopt a change indecisive. This leaves them dissatisfied with their work, and both they and the organization suffer. Third, ineffective motiva-

*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 continued monthly, in the first issue of the month, through January 1, 2000.*

tion means that some practitioners who might have made worthwhile contributions if only they had shifted their values will choose instead to leave pharmacy. Finally, pharmacy department directors and store owners feel personal failure for not succeeding in changing some of their pharmacists' attitudes and having to fire them.

The profession, the practitioner, and the manager all have a big stake in the creation and universal use of an effective motivational process that helps ensure that a majority of practitioners who are suited to making a transition in practice will make a commitment to doing so. In this article, we present a process for changing the attitudes of practitioners so that—if their predisposing personal characteristics allow for it—they will be more likely to commit to a change in practice.

#### **"But I might fall off the rope"**

Since we know that the attitudes and values acquired during professional socialization determine the pharmacist's choice of action in practice, we view professional resocialization as the key to commitment to practice change. This view suggests that the best chance of facilitating practice change is afforded by fostering a change in practitioners' professional attitudes and values rather than by emphasizing a structured extrinsic reward system.

Thus, our proposed approach to motivating practice change is rooted in a conscientious effort to promote professional attitudes and values associated with the desired practice model. In this way, there will be cognitive dissonance, for the practitioner, between

the new attitudes and values and those of his or her current practice. This is in keeping with Festinger's dissonance theory,<sup>3</sup> which suggests that the urge to resolve the dissonance will propel a practitioner to do what it takes to perform in the new role. In presenting a systematic process by which managers can motivate their staff to change their attitudes and values, we offer a customization of the taxonomy of learning in the affective domain proposed by Krathwohl et al.<sup>4</sup> This is supplemented by contributions from the literature on the diffusion of innovations,<sup>5</sup> the transtheoretical model,<sup>6</sup> and instructional psychology.<sup>7</sup> The approach to motivating practitioners set forth in this article is an amalgam of these four models and thus is grounded in time-tested research.

We base our approach on learning theory rather than on the literature of change or motivation because, in the current health care environment, the rate of change does not allow for passive or nonassertive methods of bringing pharmacists up to speed. At stake are the perceived future of the profession and the current livelihoods of individuals. In this dynamic situation, we believe that managers need to actively facilitate motivation.

Krathwohl's taxonomy was developed in the 1950s as part of a move by educators to achieve a common reference and language for learning. Taxonomies were developed for all types of learning: affective, from Krathwohl; cognitive, from Bloom<sup>8</sup>; and psychomotor, from Simpson.<sup>9</sup> Krathwohl's work has become the standard point of reference for educators at all levels who

attempt to teach values and attitudes.

Krathwohl's taxonomy shows affective learning as a five-level hierarchy with stages within each level (appendix). Practitioners who have been socialized for the distributive model and who then adopt the attitudes and values of a new practice model such as pharmaceutical care will start by simply *receiving* information about the new model. Next, they will actively *respond* to learning about the model and will subsequently *value* it as a desirable approach to practice. As pharmacists' regard for the new model grows, they will *reorganize* practice priorities to engage in this type of practice. Some practitioners will ultimately come to embrace the new model so strongly that its philosophy will *characterize* their approach to life in general. Table 1 shows how the five levels relate to growing interest in and appreciation of the new practice model, the development of the attitudes and values associated with the model, and the levels at which the practitioner will adjust behavior as the new attitudes and values are acquired.

The manager can use Krathwohl's taxonomy in a systematic approach to encouraging staff to change their practice. The motivational technique is intended to reprofessionalize practition-

ers for the desired model of practice and to help them commit to doing whatever is required to engage in the new practice.

We have chosen to enrich our approach with findings from research on the diffusion of innovations model and the transtheoretical model. Both of these models for explaining change look at the role of attitudes and values in change and thus are sources of ideas complementary to Krathwohl's. While neither model is directly adaptable to motivation for practice change, both have strong parallels in the stages of change they identify, and some of the techniques they elaborate are effective in moving individuals through these stages. Table 2 compares the two models of change with Krathwohl's affective taxonomy.

**Using the affective taxonomy to motivate practice change**

Managers who are considering using the proposed approach to motivate pharmacists to change their practice will begin with one of two perspectives. In the first, they will have a vision of the practice change they wish to achieve but will not yet have taken steps to convey that vision to their staff. Alternatively, they will have already initiated change but have en-

countered variability in staff acceptance. In the latter case, some initial identification of candidates for "attitude adjustment" has taken place. For individuals who have already determined to pursue practice change, motivation is complete, and the manager should provide necessary learning resources to facilitate their acquisition of any needed knowledge and skills.<sup>10</sup>

As a prerequisite to engaging in the motivational strategy, we urge managers to consider the existing characteristics of the staff on whom they will focus their efforts. The development of new attitudes and values is most efficient when one has some understanding of each practitioner's personality and previous socialization. Even when the manager uses the motivational strategy skillfully, some pharmacists may choose to not change. When a practitioner has not been persuaded to commit to change, it may be helpful to acknowledge either a possible incongruence of personality with the proposed new practice or the strength of earlier professional socialization. One can expect the process to be most effective when activities aimed at forming new attitudes and values recognize the practitioner's current attitudes. Table 1 can serve as a quick diagnostic tool for this purpose. If there is any doubt as to

Table 1.  
**Levels of Development of Professional Attitudes and Values<sup>a</sup>**

Krathwohl Level of Learning and Associated Stages	Interest	Appreciation	Attitudes	Values	Adjustment
1.0. Receiving					
1.1. Awareness	X				
1.2. Willingness to receive	X				
1.3. Controlled or selected attention	X	X			
2.0. Responding					
2.1. Acquiescence in responding	X	X			
2.2. Willingness to respond	X	X	X	X	X
2.3. Satisfaction in response	X	X	X	X	X
3.0. Valuing					
3.1. Acceptance of a value	X	X	X	X	X
3.2. Preference for a value	X	X	X	X	X
3.3. Commitment			X	X	X
4.0. Organization					
4.1. Conceptualization of a value			X	X	X
4.2. Organization of a value system					X
5.0. Characterization by a value or value complex					
5.1. Generalized set					X
5.2. Characterization					X

<sup>a</sup>Adapted from reference 7, with permission.

Table 2.

**Comparison of Stages in Krathwohl's Taxonomy, Prochaska's System, and Innovation-Decision Process<sup>a</sup>**

Krathwohl's Taxonomy of Affective Learning <sup>4</sup>	Prochaska's Stages of Change <sup>6</sup>	Stages in Innovation-Decision Process <sup>5</sup>
1.0. Receiving 1.1. Awareness 1.2. Willingness to receive 1.3. Controlled or selected attention	I. Precontemplation 1. Awareness of the problem 2. Initiate thinking about solving the problem	I. Knowledge stage 1. Recall of information 2. Comprehension of messages 3. Knowledge or skill for effective adoption of the innovation
2.0. Responding 2.1. Acquiescence in responding 2.2. Willingness to respond 2.3. Satisfaction in response	II. Contemplation 3. Increased attention to overcoming the problem 4. Not yet ready to act	II. Persuasion stage 4. Liking the innovation 5. Discussion of the new behavior with others 6. Acceptance of the message about the innovation 7. Formation of a positive image of the message and the innovation 8. Support for the innovative behavior from the system
3.0. Valuing 3.1. Acceptance of value 3.2. Preference for a value 3.3. Commitment	III. Preparation 5. Formulation of intent to take action 6. Action not yet taken	III. Decision stage 9. Intention to seek additional information about the innovation 10. Intention to try the innovation
4.0. Organization 4.1. Conceptualization of a value 4.2. Organization of a value system	IV. Action 7. Change enacted	IV. Implementation stage 11. Acquisition of additional information about the innovation 12. Use of the innovation on a regular basis 13. Continued use of the innovation
5.0. Characterization by a value or value complex 5.1. Generalized set 5.2. Characterization	V. Maintenance 8. Integration of the change 9. Consistency of use of the change	V. Confirmation stage 14. Recognition of the benefits of using the innovation 15. Integration of the innovation into one's ongoing routine 16. Promotion of the innovation to others

<sup>a</sup>The stages and levels have been arranged to show correspondence among the three models. Horizontal blocks show the comparable progression of change described by each model. Note that Krathwohl's third level within 2.0. Responding (2.3 Satisfaction in response) has been judged to fit best with Prochaska's level III (Preparation) and the Innovation-Decision Process level III (Decision stage).

which level to begin at, the lower level should be chosen. This is because the Krathwohl taxonomy is hierarchical: Each set of new attitudes and values must be achieved before the next is possible.

The scene is now set. The manager wants the staff to adopt a new model of practice and has already attended to two components of the Holland–Nimmo practice change model: (1) The work environment has been adapted to allow the new type of practice and (2) provision has been made to meet any learning needs that arise during the transition. The next step is to gain the staff's commitment to the new

idea. Already, the manager has compared staff members' personalities with that required for the desired practice model, noting any potential mismatches. Further, by noting the current professional orientation of staff members, the manager has gained a clear picture showing not only which attitudes and values require nurturing but any disparity between the current and desired situations. With this background, an effective motivational strategy can be customized for individual staff members.

We will now describe what the manager needs to know to devise such a strategy. We will discuss each level of

affective development and the stages within each level and give tips for recognizing the practitioner's current stage. We also suggest strategies for achieving movement through one level to the next.

#### Level 1.0: Receiving

The starting point for professional resocialization is getting practitioners to recognize the existence of a different way to practice and to pay some attention to the idea. Within the receiving level there are three stages: awareness, willingness to receive, and controlled or selected attention. The progression is from the manager capturing the

practitioner's attention to the practitioner self-directing attention to the new practice model.

**Stage 1.1: Awareness.** "I'm aware that some pharmacists do these things, but I couldn't care less about it." This statement, representative of those pharmacists in the awareness stage might make, indicates the beginning of awareness that a different practice exists. In checking for awareness, it is important to note that the practitioner may possess all the knowledge and skills required for the new practice model but have no interest in it. Such a person may be described as "able but unmotivated." As illustrated by the professional competency equation in part 2 of this series,<sup>11</sup> knowledge and skills are cognitive or psychomotor attributes, not affective attributes. One way to check for pure awareness is simply to ask the practitioner if he or she is aware of the new practice model. A yes, even if coupled with no further apparent interest, indicates awareness.

**Stage 1.2: Willingness to receive.** Representative statement: "Well, I guess it's possible for pharmacists to do that." Practitioners at this stage are amenable to the idea of the new practice approach but have suspended any judgment about its value. As a consequence, they will not avoid a discussion of the topic, but neither will they seek it out. To check for progression to this stage, the manager might ask the practitioner if he or she would be willing to talk about the new practice model. If the response is, "No, it holds no interest for me," the pharmacist is not yet at this stage. If the response is yes and, in the course of the discussion, is followed by such comments as "I'm not sure about that," "It's an interesting idea," or "Well, I guess it's possible," then the practitioner has reached this stage.

**Stage 1.3: Controlled or selected attention.** Representative statement: "This idea about practice intrigues me." The practitioner actively directs attention to learning about the new practice model but still reserves judgment about its value. As noted in Table

1, this is the stage at which appreciation for the changed form of practice begins to grow. There are a number of ways in which the manager can confirm this stage beyond asking directly what the practitioner is thinking. One way is to ask the practitioner about the consistency with which he or she has been reading about the practice model; regular reading is evidence of this stage. Another way is to note the practitioner discreetly observing another pharmacist who is using the new practice model (e.g., listening in as another pharmacist interacts directly with a patient or discusses a possible dosage modification with a physician). Another indicator of this stage is frequent conversation with peers about the new model.

**Strategies for facilitating receiving.** Acquiring knowledge of the proposed practice change is critical. Practitioners cannot be persuaded to consider a change until they have sufficient knowledge on which to base their consideration. Staff pharmacists who do not participate in professional associations, who regard themselves as having "9-to-5" jobs, or who view continuing education as a ticket punch for relicensure may not recognize that there are different types of practice emerging or that the changing scene may have a profound impact on their work life. These pharmacists may have little or no understanding of any practice model other than their own. In a second scenario, managers will relay the message that change is imperative, but for some of their staff, it is as if the message had never been sent. We can, possibly, explain this phenomenon by observing that the manager cannot and should not assume that the new practice idea is entering neutral territory. Practitioners bring their personalities and professional socialization to the table. These work together to form their mindset, with which the new practice model is viewed.<sup>2</sup> This may facilitate or hinder willingness to recognize or think about the new model.

Mindset is influenced by previous cognitive learning, emotional experi-

ence, and personal values. Consider the influence exerted by pharmacy school training that is heavy on basic sciences and technical problem solving and by professional socialization that teaches that the pharmacist's role is in service to the physician, with limited interaction with patients. When information that is incompatible with the pharmacist's mindset is presented, he or she may distort the information. Also, pharmacists may take longer to perceive that which is negative, from their point of view, than that perceived as neutral or positive. Thus, if a practice model involving direct patient care is presented to a pharmacist who has come to believe in other work values for a pharmacist, just recognizing the new model may come slowly, if at all.

To get the practitioner's attention actively focused on the new model, arrange for an interactive lecture followed by a guided discussion in which the practitioner is exposed to the new practice idea. An interactive lecture is a technique in which the presenter provides new information in the lecture format, interrupting at critical junctures with carefully framed questions that provoke the desired level of thinking among participants. A guided discussion is another technique in which carefully framed questions from the discussion leader generate the desired level of thought. The interactive lecture or guided discussion should take place in a nondistracting environment because the initial goal is to get the practitioner's attention, and practitioners who do not welcome new practice models will use the distractions to tune out.

The discussion leader should be a "near-peer," or a practitioner with the same professional school training as the pharmacist to be motivated and a similar organizational status, as well as personal experience with the practice change. Acceptance of the idea will be enhanced if the facilitator also happens to be an opinion leader.<sup>5</sup> Careful staging of this introduction to the new idea helps staff members overcome the belief that

the new idea has nothing to do with them or that they could not adopt it.

During the interactive lecture or guided discussion, attempt to connect practitioners' current practice model with the proposed practice model, stressing similarities as well as differences.<sup>5</sup> In this way, the staff will not perceive the new model as completely disconnected from their current attitudes and values. Save the best argument for the new practice model for the end of the presentation, increasing the chance of a lasting impact.

Present the new practice model in a simplified version so that it is totally clear to the practitioner. Also, provide examples of real-life applications. For instance, describe a typical day for a pharmacist who has adopted the model.

Address the philosophical issues that underlie the proposed practice change. Research on the diffusion of innovations has shown that individuals who get "how-to" knowledge but not a knowledge of the principles underlying the innovation are in greater danger of misusing the new idea and ultimately discontinuing it than are those who have a complete picture.<sup>5</sup>

Apply the principle that only when the practitioner engages in active thought about the idea does learning take place. Merely covering the idea in a lecture is no assurance that the discussion leader has actually produced understanding. In the group discussion, the leader needs to ensure that everyone engages in the dialogue, pays attention, and understands what is said.

Once the pharmacists show interest in learning more about the new practice model on their own, provide opportunities for them to do so. Call their attention to articles that discuss the new practice idea. Encourage them to observe pharmacists who already engage in this type of practice; if necessary, arrange a field trip to another health system or pharmacy.

Encourage, among colleagues, informal discussion centered around the new practice idea. Perhaps arrange a

brown-bag lunch that brings together those who engage in the new form of practice with colleagues who do not yet do so.

Monitor where practitioners are in the continuum of attitudinal change by noting what they say about the new practice idea. Do not move to the next step until they appear to have advanced through the previous level.

#### Level 2.0: Responding

As pharmacists pass through the three stages of responding—acquiescence, willingness to respond, and satisfaction—they advance from merely complying with a request that they learn more about the new model of practice to deriving personal pleasure from the learning. The reason for learning more moves from extrinsic to intrinsic—from "I'm doing what I'm told" to "I'm doing this because I want to." At this point, the practitioner has only a very small commitment to the new practice idea. The model is not yet held as a value, but interest in its possibilities is sufficient to stimulate learning by doing. Thus, the pharmacist becomes willing to experiment with the idea.

**Stage 2.1: Acquiescence in responding.** Representative statement: "I do what I'm told." Practitioners in this stage are compliant with what they have been asked to do. However, because they have not fully accepted the reason for this behavior, other than that there has been a directive, there is passiveness in initiating the activity. Thus, while the practitioner is reading about or discussing the new model, it is because he or she is "supposed to"—and might stop if the obligation were not there.

Managers who motivate their staff to achieve acquiescence may ask why further motivation is necessary. One must remember that, at this stage, the practitioners' impetus to comply is external. Without further internal change in the practitioners, the practice change will not become self-directed. This results in practitioners placing a narrow definition on the desired

practice behavior. They will not look elsewhere for other opportunities to provide care, and, if all conditions are not perfect for the practice activity, they will see that as a logical reason for not doing it. Beyond the acquiescence stage, many of the external work-motivation tools, such as salary increases, promotion, and recognition, become less effective as internal motivation begins to operate.

Practitioners who are at this stage do what they are asked to and do it consistently, but when there is an opportunity, they slide back into not thinking or learning about it. Indicative comments include "I don't like to do it," "It bores me," and "I do what is required." The more frequently the manager has to remind the practitioner of the necessity of learning more about the new form of practice, the greater may be the entrenchment at this stage.

**Stage 2.2: Willingness to respond.** Representative statement: "I'm interested in learning more about this new kind of practice." Any remaining elements of resistance to the new practice idea fall away at the willingness stage as the practitioner tries to learn more about it by informed, voluntary choice. Intrinsic motivation to learn more by doing forms, and there is voluntary adjustment of behavior.

Pharmacists at this stage search for articles on the new practice model, seek specific information from colleagues, and may look for opportunities to try out the new practice tasks. Differentiating this cooperative behavior from mere compliance requires observing the pharmacist. If the behavior is consistent, if there is no backsliding, and if there is no need to issue reminders, a pharmacist is probably at the willingness stage. If, in addition, the pharmacist does even more exploration of this type of work than is required, it is reasonable to assume that he or she has moved to cooperation.

**Stage 2.3: Satisfaction in response.** Representative statement: "I'm enjoying the idea of playing around with this new kind of practice." At this stage the

overt behavior remains the same—the pharmacist explores the new practice model on a consistent basis—but professional satisfaction is generated. The greater the enjoyment, the more encouraged the practitioner is to deepen the involvement.

As with the two earlier stages of this level, the key to identifying this stage is ascertaining what is prompting the practitioner to act. In this case, it is an intrinsic desire for the pleasure that learning more about the practice model brings. Some pharmacists at this stage freely articulate their enjoyment of what they are doing.

**Strategies for facilitating responding.** As practitioners move through the learning hierarchy to acquire new professional attitudes and values, there are two questions they will ask and answer: “Can I do it?” and “Do I want to do it?” The first question is answered at the receiving and responding levels through attaining an understanding of the practice idea and identifying (or not identifying) with others of similar background and status who are applying the new practice model. The answer is reinforced by opportunities to try out the new practice on a partial basis. “Do I want to do it?” starts to be addressed at the responding level. Such a decision requires personal introspection as practitioners consider what they have to gain by adopting the new model and whether they are compatible with it.

Table 2 can be helpful in visualizing what is occurring at the responding level. Growing attitudes and values influence both the persuasion and decision stages of the innovation-decision process and the contemplation and preparation stages of the Prochaska model. Tremendous advancement toward the development of professional attitudes and values occurs at the responding level. To move a person from a vague appreciation for a new practice idea and compliant behavior to voluntary learning, with inner satisfaction as the motive force, is no small feat. This appears to be where many managers become mired. The strategy we now

suggest is offered to facilitate movement through this critical level.

Research on the diffusion of innovations suggests that trying out a new practice idea on a partial basis can speed up the formation of attitudes and values concerning the practice because direct experience helps the practitioner overcome uncertainty about what it would be like.<sup>3</sup> In some cases, contact with near-peers who are opinion leaders and who have adopted the new practice may serve as vicarious experience. For some, then, the near-peer serves as a successful proxy.<sup>5</sup> It should be made as easy as possible for the rest to try out new practice activities by temporarily relieving them of other tasks. If one or more other staff members engage in the desired behaviors, consider teaming these individuals with a learner for a couple of hours and encouraging the assumption of tasks as he or she becomes more comfortable with them.

Pharmacy’s concern for the accuracy of its work is a constant theme in professional school training and continuing education. Consequently, one can assume that the professional socialization of pharmacists produces individuals who believe they must be competent to perform a practice task before they will willingly do it. A dominant personality characteristic of current practitioners is a keen sense of responsibility.<sup>1</sup> Gaining a personal sense of what the new practice model feels like is central to a change in attitudes and values, but a positive fit is unlikely to occur if pharmacists are placed in practice situations in which they feel incompetent. Therefore, provide staff with the opportunity to explore aspects of the new model when they reach the responding level, but allow them to establish a sense of competence at every step. If performance of the task threatens the practitioner’s feeling of competence and security, fear will intercede and there will be no growth toward pleasure in doing. Practitioners who are perceived as having the needed skills but who lack confidence should first be helped to recog-

nize that the skills are there. Then provide coaching until they recognize their own competence. Do not rush this step.

When external rewards for change can be offered (such as increased pay, increased job status, choice of work schedule, peer approval, and recognition), they will certainly factor into an individual’s consideration of what there is to gain by changing. We caution, however, that these external rewards are unlikely to move the individual beyond assiduous compliance and are unlikely to result in the reformulation of professional attitudes and values. These higher principles will develop only when the individual attaches sufficient worth to the new idea that a sense of satisfaction is produced by learning more about it.

Discuss with practitioners their inner response to the new practice activities. Such conversations, which should employ the skills of active listening, can help practitioners recognize the intrinsic rewards, such as personal and professional satisfaction, that may result if the practice model is adopted.

In addition to providing pharmacists the opportunity to experience the new practice activities, give them positive feedback about efforts they make to assume increasing responsibility for learning by doing.

As practitioners continue to experiment with the new type of practice, they will benefit from confirmation of their evaluation of the consequences through one-on-one interaction with near-peers already engaged in the new practice.<sup>5</sup> Therefore, provide opportunities for the practitioner to interact with others who engage in this type of practice and who obviously enjoy their work. This will provide both a valued place in which to check reactions to the new model and a sense of community—a new place to belong.

Practitioners may also think of reasons why it might not be practical to make a change. Persistent focus on barriers to change may slow or halt the growth of new attitudes or values. Airing perceptions of barriers, ideally in a

brainstorming session with colleagues and a near-peer engaged in the new practice, can defuse misconceptions. Let the staff freely list all the barriers they fear, and then consider them one by one, discussing their plausibility and ways to overcome them.

#### Level 3.0: Valuing

At the valuing level, the practitioner moves, through an internal valuative process, from belief in the new practice idea to conviction as to its worth. This mindset is consistent over time, reflecting the completed formation of a new set of attitudes and values. The pharmacist's behavior is guided by commitment to the underlying value of the new model.

**Stage 3.1: Acceptance of a value.** Representative statement: "This type of practice has a place in the role of the pharmacist." In the acceptance stage, pharmacists ascribe worth to the new practice idea and allow this attitude to consistently control their activities. Further inner exploration continues, however, as the practitioner willingly compares old beliefs about practice against the new ones.

Practitioners at this stage actively seek peers or near-peers with whom to discuss aspects of new practice activities they have performed. If, in these discussions, they indicate that they believe in this new approach, this public declaration indicates that they have accepted the value.

**Stage 3.2: Preference for a value.** Representative statement: "If you gave me a choice, I believe I'd choose this type of practice." The practitioner's belief in the new practice model has grown so strong that it arouses a need to become more involved. Pharmacists at this stage are fairly certain they want to engage in the new model.

Some practitioners manifest this stage of learning as a reflective process influencing their interest in what they want to do, as suggested by the representative statement for the stage. Others may act directly, as by obtaining self-study material that will help them to practice in the new way.

**Stage 3.3: Commitment.** Representative statement: "I am firmly convinced that this kind of practice is what I should be doing." Only at the commitment stage is the pharmacist's internal consideration of the merits of the new practice model finally resolved. Formation of attitudes and values is complete.

Pharmacists at this stage can be identified by observing how long they have espoused belief in the new form of practice and how much energy they put into identifying with it. Such individuals will frequently talk about the new model and will start relating this form of practice to all sorts of other aspects of their work and ideas. Drive and perseverance characterize these pharmacists' behavior.

**Strategies for facilitating valuing.** Pharmacists at the valuing level are engaged in an internal process of evaluation. They enter this level with a full understanding of the proposed form of practice and have tested it against their capacity to perform it and their interest in doing it. Now they begin an internal dialogue pitting their old beliefs against the new ones. Their task is to resolve all remaining uncertainty about the desirability of the new model. Because of the internal nature of this dialogue, we suggest that the manager's role is to arrange the environment so that the pharmacist's internal deliberations can proceed. Continue to provide access to near-peers who already engage in the model. This will provide valuing-stage pharmacists with a continuing reality check. Also, create opportunities for them to experiment with publicly identifying themselves as believing in the new model.

#### Level 4.0: Organization

At the organization level, the pharmacist makes room among the competing priorities of professional and private life for attaining the changed practice. This is accomplished by moving through a two-stage process in which the existing value system undergoes a shakeup. Relationships among values held are redetermined, and the

values are reprioritized.

**Stage 4.1: Conceptualization of a value.** Representative statement: "Let me tell you how, when a pharmacist practices this way, all the bases for a pharmacist's contribution to patient care are covered." Pharmacists at this stage have defined the concept of the new form of practice and how it relates to all other forms of practice. From a foggy, unarticulated feel for the new practice idea, they have progressed to being able to describe exactly how they see this form of practice relating to all other models with which they are familiar.

Pharmacists at this stage can be identified by their ability to describe the new practice model and why they believe it to be preferable to all others with which they are familiar. These pharmacists can accurately describe which attitudes and values concerning practice have changed and which ones have remained the same. They are also able to articulate why they prefer the new practice model.

**Stage 4.2: Organization of a value system.** Representative statement: "I have a plan for learning the new skills I need for this kind of practice, and I'm committed to using some of my personal time to do it." At this stage, pharmacists place the new professional attitudes and values into their existing value systems, reassigning priorities as needed to accommodate the desirability of the new model and achieve balance with all other life priorities.

The pharmacist who has reached this stage recognizes that additional knowledge or skills are needed for the new type of practice and designs a plan for acquiring them.

**Strategies for facilitating organization.** While the manager's role in facilitating the reorganization of the practitioner's value system remains limited during the first of the two stages of this level, the tasks of the second stage can be directly facilitated by contributions from knowledgeable peers.

The ability to conceptualize the desired practice attitudes and values can be enhanced by providing an environ-

ment that encourages discussion and exploration. Consequently, continued access to near-peers and other practitioners who use the new practice model is helpful at this stage.

This same type of forum may be of help to the practitioner who is debating how to balance making a change in practice with conflicting personal priorities. Talking with others in similar life circumstances who have “retooled” themselves for change can help practitioners formulate alternative approaches and get information from those they trust.

Pharmacists who decide they need more training will get maximum benefit from the manager who switches to fulfilling the responsibilities of the learning resources component of the Holland–Nimmo practice change model. In this role, the facilitator of practice change needs to know what the pharmacist needs to learn, what resources are available, and how to access them. The facilitator may also be of assistance in financing and providing work time for some or all of the training and learning.

The manager’s role in facilitating the development of attitudes and values associated with a new model of practice is complete at the organizing level. We discuss the next level simply to complete the picture of the developmental process.

**Level 5.0: Characterization by a value or value complex**

Practitioners who achieve the characterization level have integrated their approach to practice with their view of the world. Their practice is part of their personal credo and is congruent with answers to questions like “Who am I?” and “What do I stand for?”

**Stage 5.1: Generalized set.** Representative statement: “I can’t imagine practicing any other way.” The pharmacist who arrives at this stage has a predisposition to practice in a way that may be so internalized it is almost unconscious. One may observe a predict-

able pattern of behavior, thought, and expression that makes the person’s approach readily identifiable by others.

**Stage 5.2: Characterization.** Representative statement: “Carrying out this kind of practice gives meaning to my life.” At this ultimate stage, the pharmacist’s practice behavior is so encompassing as to virtually completely characterize the individual.

**Role of the manager.** Advancement to characterization by a value or value complex is produced by time and experience in practice. The manager is likely to play little or no part in this process.

### Discussion

Managers can play a key role in encouraging pharmacists who have the potential to achieve desirable practice changes through a process of attitude and value formation. Failure to change most often stems from a significant mismatch between the personality of the pharmacist and the personality characteristics required by the proposed form of practice. Another contributing factor can be very strong previous professional socialization.

Personality is highly stable and therefore effectively beyond the manager’s control. Professional resocialization, however, can be achieved through a systematic process for the development of new attitudes and values that is based on Krathwohl’s taxonomy for the affective domain. Managers can contribute to this process through a variety of facilitative activities. When the process is completed successfully, the pharmacist is committed to learning the new knowledge or skills required to engage in the new form of practice and to implementing it.

### Conclusion

Managers can help pharmacists adopt a new practice model by guiding them through stages of attitude and value formation.

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### Appendix—Krathwohl’s taxonomy of learning in the affective domain<sup>4</sup>

- Level 1.0, Receiving
  - Stage 1.1, Awareness
  - Stage 1.2, Willingness to receive
  - Stage 1.3, Controlled or selected attention
- Level 2.0, Responding
  - Stage 2.1, Acquiescence in responding
  - Stage 2.2, Willingness to respond
  - Stage 2.3, Satisfaction in response
- Level 3.0, Valuing
  - Stage 3.1, Acceptance of a value
  - Stage 3.2, Preference for a value
  - Stage 3.3, Commitment
- Level 4.0, Organization
  - Stage 4.1, Conceptualization of a value
  - Stage 4.2, Organization of a value system
- Level 5.0, Characterization by a value or value complex
  - Stage 5.1, Generalized set
  - Stage 5.2, Characterization