AUTONOMY AND ORIENTATION OF ENTREPRENEURIAL COMMUNITY PHARMACISTS AND CORPORATE PHARMACY MANAGERS: A COMPARATIVE STUDY

A national study of entrepreneurial community pharmacists and corporate pharmacy managers was conducted to explore the impact of ownership styles on autonomy and orientation of pharmacy management.

Introduction

Studies of community pharmacists (pharmacists in the retail environment) typically focus on their roles as health care professionals. What is less studied is pharmacists’ entrepreneurial energy and innovation in exploiting changes as opportunities (Drucker, 1995). This gap in the literature is surprising in that community pharmacists are also entrepreneurs, whether as owners of independent pharmacies, or as franchisees of franchise pharmacies. Of course, if the operative definition of an entrepreneur is sufficiently expansive, the pharmacist as entrepreneur is represented ever more extensively in the profession. However, for the purposes of this study, the definition of entrepreneurship draws on Stevenson and Gumpert (1985) and Drucker (1995).

Literature Review

Community pharmacy is an interesting case study to explore the relationship between the professional and business aspects of practice. On a daily basis the community pharmacist must balance professional and commercial obligations: providing a skilled service in the preparation and dispensing of medications, while selling commodities for profit in distributing that medication (Chappell & Barnes, 1984). In the context of all health care professionals, pharmacists are the most overtly involved in entrepreneurship (Young & Prichard, 1985).

If the Schumpeter model of entrepreneurship (Schumpeter, 1934) draws on the French economic model (Dees, 1998; Stevenson & Amabile, 1999) in promoting entrepreneurship as a “creative-destructive” process at the heart of economic progress, others have built on Schumpeter to promote heroic narratives of entrepreneurial change agents, courageously going where no business person has gone before. While risk is at the heart of many such accounts, Stevenson and Amabile (1999) rightly insist that risk is reluctantly accommodated and also apportioned across multiple players from lenders to employees. Similarly, Stevenson and Amabile (1999) challenge the reduction of entrepreneurship to the start-up phase of business life as well as simplistic case studies and analyses designed to produce a taxonomy of characteristics of the individual entrepreneur—which they concede leaves no room for academics intent on teaching entrepreneurship!
What Drucker (1995) usefully brings to the definition of entrepreneurship is a necessary distinction between small business and entrepreneurship, not all small businesses qualifying in terms of their grasping of innovative opportunities in and as change. Nor does the entrepreneur require profit as the defining motive. In their “anatomy” of entrepreneurship, Stevenson and Gumpert (1985) insist that entrepreneurship is a property of neither individuals nor organizations. Instead, they position entrepreneurship within a range of behaviours with a special focus on how the imaginative and innovative horizons of entrepreneurs refuse to be constrained by “trustee” or “administrative” management’s commitment to job descriptions, the limits of available resources, the benefits of predictability and reduced risk. What they stress is the resourcefulness of entrepreneurial management in thinking outside administrative boxes in seeing opportunities where others see barriers and mobilizing resources for business goals. In promoting entrepreneurship, government policy along with educational institutions has a role in health as in other professions (Stevenson & Gumpert, 1985).

Although community pharmacy’s main focus has been, and continues to be, the dispensing of prescriptions and related medication counselling, many of the pharmacists currently working in community practice are seeking a more service-oriented, patient-focused approach with greater emphasis on the use of their clinical skills (Amsler et al., 2001; Bissell et al., 2002; Harding & Taylor, 2001; Zellmer, 2005); in effect, transforming the social object – the focus of the profession – of pharmacy from the product (medication) to the patient. Furthermore, entrepreneurial pharmacists are looking to extend the boundaries of their business and profession by venturing into new areas of service offerings (Iyer & Doucette, 2003).

For example, in-depth, one-on-one counselling between a patient with diabetes and a pharmacist or a pharmacist working with a patient who is trying to quit smoking are service offerings that have not traditionally been offered in community pharmacies that are now being provided in some pharmacies. In particular, charging a fee-for-services provided when historically these services did not have a fee attached, the services were expected to be provided; one does not expect to receive ‘free’ advice from his/her accountant or mechanic, but traditionally expected the professional advice of a pharmacist to be ‘free’, or part of the prescription costs. However, most of the service offerings being introduced do not involve dispensing a prescription medication, and in many cases involve reducing the number of prescription drugs the patient requires.

As the profession seeks to re-define its role within health care, the business structure in which community pharmacists practice is also changing. The number of pharmacist-owned pharmacies is decreasing while the number of corporate-owned pharmacies is increasing (Rogers, 2005). As a result, community pharmacy is moving from practitioner-entrepreneurs and small-scale providers toward corporate, non-pharmacy owned and directed operations.

While the community pharmacy has, since the early nineteenth century, been viewed as much like a general store providing groceries, medications and photo supplies and services, community pharmacies today are moving progressively toward a one-stop-shop where people can purchase everything from cosmetics to consumer electronics (Beales & Austin, 2006). As large corporations come to dominate the evolving marketplace, opportunity to develop and introduce cognitive services in line with the professional ideal of pharmacy, with less reliable revenue potential, may be limited (Muzzin et al., 1993; Resnik et al., 2000; Taylor & Harding, 2003). Furthermore, corporate objectives and a business orientation focusing on maximizing shareholder value may not be in line with the professional objectives and ideals of pharmacy (Sundaram & Inkpen, 2004). While entrepreneur pharmacists have traditionally focused on the more professional responsibilities of pharmacists, corporate pharmacies are thought to discourage the professional activities if these activities are perceived to take up too much of the pharmacists’ time (Muzzin et al., 1994).
Although pharmacies have always been commercial in their operation, the commercial nature, as well as changes in legislation allowing ownership of pharmacies to extend beyond entrepreneur-pharmacists – with the exception of Quebec (Dube, 2006) – allows for the corporatization of pharmacies. As the ownership of pharmacies moves from entrepreneur-operated establishments toward more corporate-owned pharmacies, the influence of corporatization and business models of operation are sure to follow (Salmon, 1996). Whereas regulations exclusive to Quebec limit the ownership of pharmacies to pharmacists, all other provinces mandate only that a pharmacist must be working when the pharmacy is open (Self-regulated Professions - Balancing Competition and Regulation, 2007).

Community pharmacies offer a convenience to patients who seek health care related services and products. When patients visit a pharmacy, they tend to be seeking a product to relieve symptoms and/or a product to prevent symptom or disease progression. While many times there is an interaction with a pharmacist, the patient pays for the product (commodity), not the service and expertise provided by the pharmacist.

If patients select the pharmacy they frequent by its location and price (such as dispensing fee and product mark-up), and not the care provided by pharmacists, then community pharmacy may be viewed as providing only a commodity. This is exacerbated if one views the drug (product) as the reason for visiting a pharmacy, and not the accompanying care (professional service). As self-care and increasing access to medical information continues, through such mediums as the Internet, patients may in fact search for the most convenient and economical location in which to obtain the commodities to treat their condition (Stoeckle, 2000).

A loss of professional orientation results when health care is treated like a commodity (McArthur & Moore, 1997). Commodification results when patients are constructed as consumers who do not perceive a difference between a good/service from one supplier to the next; therefore, consumers select the good/service based on features such as cost and location. If the relationship between pharmacists and patients is considered commercial in nature, that relationship is likely to follow the “rules of commerce and the laws of torts and contracts rather than the precepts of professional ethics” (Pellegrino, 1999). The professional ethic of a corporate employee can start to be displaced by the ethic of the market, which is less demanding (McArthur & Moore, 1997; Pellegrino, 1999).

As in the United States, ownership of community pharmacies in Canada is becoming concentrated in a limited number of owners as corporations increase their market share. To increase power and control over the market, organizations modify the situations of economic competition (Aldrich, 1979); for example, by stimulating demand in the market for products and/or services unique to the organization, resulting in reactive moves by other organizations within the industry. Naturally, the larger the market share held by an organization within a given industry, the greater its influence in modifying situations of economic competition. While organizations are a vital part of society, people do not tend to think of the control organizations exert over society until a problem or crisis occurs (Aldrich, 1979).

Many times patients are not cognizant of the vital information they should obtain from their pharmacists with regard to medications, drug therapy, and associated risks (Hibbert et al., 2002). In reducing the ‘patient’ to a ‘consumer’, corporate pharmacy may take the view that it needs to attend to the desires of the consumer, while taking no responsibility for reconstructing patient as consumer, and if the consumer does not want to hear all that the pharmacist has to say, does conflict arise between the professional obligations of pharmacists and the corporate objectives of employers? Service quality may be a good measure of retail service (Parasuraman & Zeithaml, 2002; Parasuraman et al., 1985, 1988; Zeithaml et al., 1996), yet the services community pharmacists provide, while delivered within a retail
environment, are not easily measured as the very reason for professions – specialized knowledge that the lay person lacks – is hard for the non-professional to assess.

Corporate-owned pharmacies may be used as channels in which to change the way pharmacy is practiced in order to create the greatest profit potential and dividends for shareholders. When market influences are extended to medical care, and community pharmacy practice, providers may be relegated to a secondary role, especially once ownership dictates who to treat and how much to charge (Bergthold, 1990) – all in the name of efficiency without considering adequately efficiency for what or for whom (Gross Stein, 2001).

In the United States, for instance, Wal-Mart® introduced a four-dollar prescription program where a one month supply of 300 commonly prescribed generic prescription medications are available for a flat fee of four dollars, regardless of whether the patient has prescription drug insurance. One might view this as a move to the commodification of community pharmacy (Andrews, 2006; Stuart, 2006). In fact, these programs have increased prescribing trends toward prescription medications included in the program, regardless of payer type, providing evidence that prescribing habits can be influenced by corporations advertising discounted prescription medications (Evans et al., 2008). However, pricing strategies such as these are not a strategic direction that the entrepreneur pharmacist can take, especially in the context of the heightened intensity of competition (Iyer & Doucette, 2003) of increased numbers of corporate-owned pharmacies.

Ownership of community pharmacies may well become restricted to a few corporate chains, creating a monopoly of sorts, affecting the labour market (Muzzin et al., 1994). Indeed, one might argue that this has already occurred with the shortage of pharmacists being the result of too many pharmacies being open in larger, urban centres. In this context where pharmacists are increasingly becoming employees of large, corporate organizations, influence of the employer must be considered when “employers have the power to define and supervise work activities, thus affecting the amount of freedom or autonomy open to occupational members” (Kronus, 1976).

Restrictions of professional autonomy as the result of management structures have been criticized as ethically problematic (Zoloth-Dorfman & Rubin, 1995). They tend to weaken professional commitment to beneficence and non-maleficence, while failing to protect patients against substandard care in order to increase profits (Zoloth-Dorfman & Rubin, 1995). Moreover, the incentive to innovate can be reduced by external controls, and as a result professionals can become passive (Mintzberg, 1979).

Hypotheses

Ho1: Community pharmacy managers’ alignment to professional aspects of practice is not related to ownership type.

Ho2: Community pharmacy managers’ alignment to business aspects of practice is not related to ownership type.

Ho3: The level of conflict for a community pharmacy manager is not related to ownership type.

Ho4: Community pharmacy managers’ autonomy is not related to ownership type.
Ho5: Innovation in a community pharmacy is not related to ownership type.

Methods

Data Source

A self-administered questionnaire was mailed to community pharmacy managers across Canada between April 2 and June 4, 2007. Contact information obtained directly from provincial regulatory agencies was pooled to produce a master list of 6,342 community pharmacy managers in Canada. From this list a random, stratified sample of 2,000 community pharmacy managers was compiled based on the number of community pharmacy managers in each province. Contact information was not sought or obtained for community pharmacy managers in Quebec where ownership is restricted to a licensed pharmacist; therefore, no comparison is possible to other ownership structures within the province.

Orientation to Practice

The subject matter for the eleven items in this section surrounded role orientation, and was based on work by Quinney and Kronus (Kronus, 1975, 1976; Quinney, 1964); using the same items and wording as Quinney (1964), Kronus (1975, 1976) examined role strain, role orientation, and occupational values of retail (community) pharmacists. Quinney (1964) and Kronus (1975, 1976) used a four-point Likert scale from Very Important to Of No Importance, while this study used a five-point Likert scale from Very Unimportant to Very Important.

There were also two items added to this section for the purposes of this study: public service, such as presentations to community groups, etc. and mentoring students and interns. These items were added to reflect the roles pharmacists and pharmacy managers have in providing health care advice outside the pharmacy, as well as participating in socializing and training future pharmacists.

Practice Affinity

This section was also comprised of eleven items and centred on role orientation, based on the work of Hornosty (Hornosty, 1990) who adapted the work of Quinney (1964). For his study, Hornosty (1990) examined the subjective role orientation, conflict, and satisfaction of pharmacy students as they prepared to enter the profession. Hornosty (1990) used a five-point Likert scale from Like Very Much to Dislike Very Much; while the five-point Likert scale with the same labels was used for this study, the scale was reversed to Dislike Very Much to Like Very Much.

Organizational Experience

The six items in this section centred on the work environment, predominantly based on the work of Doucette and colleagues (Doucette, 2006; Doucette et al., 2006; Kreling et al., 2006; Mott et al., 2004; Mott et al., 2001; Schommer et al., 2006). The study population for Doucette and colleagues was pharmacists in all practice settings (independent, chain, government, hospital, etc.) and explored a number of issues including workload, stress, and job satisfaction; this particular section examined respondents’ work environment. Doucette and colleagues used a seven-point Likert scale with Strongly Disagree, Moderately Disagree, Slightly Disagree, Neither Agree Nor Disagree, Slightly Agree, Moderately Agree, and Strongly Agree as the response categories; in this study, the measurement scale was a five-point...
Likert scale with Never, Rarely, Sometimes, Often, and Always as the response categories. The change was done to reflect if and how often respondents may find themselves in a particular situation.

**Autonomy**

This section included six items, centring on autonomy, that were developed for the purposes of this study; therefore, items were not based on any one study or grouping of studies. Items in this section were developed to examine the amount of autonomy respondents possessed in their pharmacy. In an organizational context, and as used in this study, autonomy refers to the ability to take action in developing/exploring an idea without organizational constraints (Lumpkin & Dess, 1996). The five-point Likert scale used to measure responses ranged from Never to Always. Managers were asked to respond to statements regarding their professional autonomy and role as pharmacy manager.

**Organizational Characteristics**

Also based on the work of Doucette and colleagues (Doucette, 2006; Doucette et al., 2006; Kreling et al., 2006; Mott et al., 2004; Mott et al., 2001; Schommer et al., 2006), this section was composed of eight items and centred on innovation. For this study, innovation relates to the propensity to engage in, and support, new ideas and experimentation that may lead to the introduction of new products and/or services (Lumpkin & Dess, 1996). Items in this section were measured using a five-point Likert scale that was the same as that used by Doucette and colleagues.

The instrument was pre-tested with five community pharmacy managers not part of the study, as well as six academics. Ethics approval was received from the University of Saskatchewan’s Behavioural Research Ethics Board on February 28, 2007.

**Data Analysis**

All statistical tests were performed using SPSS 15.0 for Windows® (SPSS, Chicago, IL). In addition to descriptive statistics, exploratory factor analysis and reliability testing (alpha coefficient > 0.70) were performed to identify multi-item scales (constructs). One-way ANOVA, and post-hoc testing with Scheffe’s test were performed to identify significant differences between ownership types.

**Pharmacy Ownership Structure**

Pharmacy types identified in the questionnaire were subdivided into three categories according to their ownership structure: independent (independent, small chain, and banner), franchise, and corporate (large chain, grocery store, department store, and mass merchandiser). Pharmacy Ownership Structure was the main independent variable for this study. Independent and small chain pharmacies are pharmacies with fewer than five pharmacies under the same ownership. They may or may not belong to a buying group. Banner pharmacies are affiliated with a central office and pay fees for the right to use a recognized name; they participate in centralized functions such as buying, marketing, and professional programs that allow for greater economies-of-scale than independent pharmacies (Bisanz, 2005). The pharmacies remain independently owned, with owners retaining autonomy with regard to local marketing, merchandising, and professional services (Bisanz, 2005).

Franchise pharmacies vary in terms of the ownership structure: franchisees do not usually own the store or fixtures, and master leases are usually held by the franchisor (Bisanz, 2005). There is generally some form of revenue sharing with head office for the franchisee, with buying, marketing, professional services, training, and merchandising centrally directed by head office; there may be some autonomy in
local marketing, buying, merchandising, and professional services (Bisanz, 2005). Large chain pharmacies have five or more pharmacies under a single ownership and employ pharmacy managers who are generally salaried employees of head office (Bisanz, 2005). Head office directs all marketing, merchandising, buying, and professional programs; there is little to no adapting to the local market (Bisanz, 2005). Grocery store, department store, and mass merchandise pharmacies are pharmacies that are a single department within a greater outlet with other departments. As in large chain pharmacies, managers are typically salaried employees of head office, with all marketing, merchandising, buying, and professional programs centrally directed through head office (Bisanz, 2005).

**Results**

**Response Rate and Demographics**

At the end of data collection, a total of 646 responses were received. The sample of 2,000 community pharmacy managers was reduced to 1,961: 38 were deemed undeliverable and one pharmacy was in a long-term care home (the pharmacy manager felt the questionnaire did not reflect its practice). The final response rate was 32.9 percent (646/1,961). The majority of respondents (393, 60.8%) identified themselves as male. The average age of respondents was 44 years, with a range of 24 to 77 years (data not displayed). More than half of respondents (398, 61.6%) identified themselves as pharmacy managers, with 33.3 percent (215) identifying themselves as the owners. Of the remaining respondents who stated their position, 1.1 percent identified themselves as pharmacist (3) and other (4) (e.g. dispensing physician).

In terms of pharmacy type, 288 independent (independent, small chain and banner) represented 44.6 percent of respondents (40.2% female), 119 franchise represented 18.4 percent (13.8% female), and 229 corporate chain (large chain, grocery store, department store, and mass merchandiser) represented 35.4 percent of the sample (45.9% female). One mail order pharmacy and nine “other” were excluded from the main independent variable, because these pharmacies were not deemed community pharmacies and did not reflect the focus of the study.

**Practice Orientation**

Of the eleven activities presented to the study participants, the greatest importance (more than 90% of respondents) was placed on professional activities such as encouraging the proper use of medications, and being part of the health care team (Table 1). Least important were non-professional activities such as arranging displays and offering a variety of sundry goods, although approximately one-quarter of respondents rated these activities as important or very important. Being a good businessperson and maintaining a business establishment were important to most respondents, and fell within the range of some professional activities, such as dispensing medications and mentoring students and interns.

**Table 1**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Unimportant †</th>
<th>Neutral N (%)</th>
<th>Important ††</th>
<th>Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouraging the proper use of medications</td>
<td>2 (0.4)</td>
<td>2 (0.3)</td>
<td>635 (98.2)</td>
<td>639 (98.9)</td>
</tr>
<tr>
<td>Being part of the health care team</td>
<td>2 (0.4)</td>
<td>29 (4.5)</td>
<td>606 (93.8)</td>
<td>637 (98.6)</td>
</tr>
</tbody>
</table>
Practice Affinity

Of the eleven activities presented to the study participants, the vast majority of respondents (> 90%) indicated a preference for patient counselling, keeping up-to-date with health and drug-related issues, and providing information to other health care professionals (Table 2). Activities associated with non-professional aspects of pharmacy operation were disliked by the majority of respondents. The majority of respondents also indicated a preference for the operational activities such as dispensing prescriptions and managing the dispensary, associated with the pharmacy dispensary.

Organizational Experiences

Most respondents indicated a well-defined organizational structure, as suggested by a high degree of certainty about their level of authority, and having clear goals and objectives (Table 3). Most also indicate a low level of conflict between the professional and business aspects of their jobs. When it came to “bucking” company policy, however, respondents were somewhat more equivocal, though slightly more were generally more willing to go against company policy to carry out professional duties.

Table 2

Practice Affinity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Dislike † N (%)</th>
<th>Neutral N (%)</th>
<th>Like †† N (%)</th>
<th>Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling patients regarding prescription and over-the-counter related matters</td>
<td>3 (0.5)</td>
<td>7 (1.1)</td>
<td>627 (97.0)</td>
<td>637 (98.6)</td>
</tr>
<tr>
<td>Keeping abreast on health and drug-related matters</td>
<td>6 (0.9)</td>
<td>35 (5.4)</td>
<td>597 (92.5)</td>
<td>638 (98.8)</td>
</tr>
<tr>
<td>Providing information and advice to health care professionals</td>
<td>7 (1.1)</td>
<td>36 (5.6)</td>
<td>596 (92.3)</td>
<td>639 (98.9)</td>
</tr>
<tr>
<td>Dispensing prescriptions</td>
<td>22 (3.4)</td>
<td>57 (8.8)</td>
<td>555 (85.9)</td>
<td>634 (98.1)</td>
</tr>
<tr>
<td>Selling non-prescription medications</td>
<td>16 (2.5)</td>
<td>57 (8.8)</td>
<td>548 (84.8)</td>
<td>621 (96.1)</td>
</tr>
<tr>
<td>Management of personnel (including supervision and training of pharmacists and pharmacy technicians)</td>
<td>51 (7.9)</td>
<td>100 (15.5)</td>
<td>486 (75.2)</td>
<td>637 (98.6)</td>
</tr>
<tr>
<td>Management of dispensary stock</td>
<td>70 (10.9)</td>
<td>153 (23.7)</td>
<td>414 (64.1)</td>
<td>637 (98.6)</td>
</tr>
</tbody>
</table>
(ordering, inventories, storage, etc.)
Management of personnel (including supervision and training of non-professional staff) 144 (22.3) 171 (26.5) 314 (48.6) 629 (97.4)
Management of “front store” stock (buying, inventories, storage, etc.) 287 (44.4) 184 (28.5) 158 (24.5) 629 (97.4)
Management of cash (daily reports, deposits, change, etc.) 295 (45.6) 194 (30.0) 142 (22.0) 631 (97.7)
Selling non-medication related items (cosmetics, newspapers, etc.) 354 (54.8) 194 (30.0) 86 (13.3) 634 (98.1)

† Truncated dislike and dislike very much
†† Truncated like and like very much

Table 3

Organizational Experiences

<table>
<thead>
<tr>
<th>Item</th>
<th>Never N (%)</th>
<th>Rarely N (%)</th>
<th>Sometimes N (%)</th>
<th>Often N (%)</th>
<th>Always N (%)</th>
<th>Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel certain about the amount of authority I have</td>
<td>4 (0.6)</td>
<td>18 (2.8)</td>
<td>111 (17.2)</td>
<td>244 (37.8)</td>
<td>255 (39.5)</td>
<td>632 (97.8)</td>
</tr>
<tr>
<td>I am provided with clear, planned goals and objectives for my job</td>
<td>18 (2.8)</td>
<td>50 (7.7)</td>
<td>158 (24.5)</td>
<td>219 (33.9)</td>
<td>181 (28.0)</td>
<td>626 (96.9)</td>
</tr>
<tr>
<td>I am required to do things in my job that are against my professional judgment</td>
<td>293 (45.4)</td>
<td>255 (39.5)</td>
<td>72 (11.1)</td>
<td>7 (1.1)</td>
<td>3 (0.5)</td>
<td>630 (97.5)</td>
</tr>
<tr>
<td>I am willing to “buck” a company rule or policy in order to carry out my professional duties</td>
<td>43 (6.7)</td>
<td>105 (16.3)</td>
<td>255 (39.5)</td>
<td>91 (14.1)</td>
<td>112 (17.3)</td>
<td>606 (93.8)</td>
</tr>
<tr>
<td>I receive incompatible requests from two or more people</td>
<td>143 (22.1)</td>
<td>262 (40.6)</td>
<td>168 (26.0)</td>
<td>33 (5.1)</td>
<td>4 (0.6)</td>
<td>610 (94.4)</td>
</tr>
<tr>
<td>I often have to choose between the business and professional aspects of pharmacy</td>
<td>100 (15.5)</td>
<td>272 (42.1)</td>
<td>195 (30.2)</td>
<td>66 (10.2)</td>
<td>2 (0.3)</td>
<td>635 (98.3)</td>
</tr>
</tbody>
</table>

Autonomy

The majority of respondents reported a high level of autonomy in their pharmacy (Table 4). Of note is that respondents were more likely to have the information necessary to arrive at decisions regarding professional (clinical) practice than for business aspects.

Table 4
## Autonomy

As pharmacy manager:

<table>
<thead>
<tr>
<th></th>
<th>Never N (%)</th>
<th>Seldom N (%)</th>
<th>Half Time N (%)</th>
<th>Usually N (%)</th>
<th>Always N (%)</th>
<th>Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have final approval on implementing a new professional service</td>
<td>40 (6.2%)</td>
<td>122 (18.9%)</td>
<td>72 (11.1%)</td>
<td>228 (35.3%)</td>
<td>175 (27.1%)</td>
<td>637 (98.6%)</td>
</tr>
<tr>
<td>If you feel it necessary, you are authorized to alter company policies to specifications on patient care to better suit the needs of your patients</td>
<td>33 (5.1%)</td>
<td>96 (14.9%)</td>
<td>64 (9.9%)</td>
<td>244 (37.8%)</td>
<td>195 (30.2%)</td>
<td>632 (97.8%)</td>
</tr>
<tr>
<td>You have access to all information used to arrive at decisions on policies regarding clinical practice in your pharmacy</td>
<td>24 (3.7%)</td>
<td>81 (12.5%)</td>
<td>54 (8.4%)</td>
<td>241 (37.3%)</td>
<td>233 (36.1%)</td>
<td>633 (98.0%)</td>
</tr>
<tr>
<td>You have access to all information used to arrive at decisions on policies regarding business practices in your pharmacy</td>
<td>41 (6.3%)</td>
<td>126 (19.5%)</td>
<td>88 (13.6%)</td>
<td>195 (30.2%)</td>
<td>183 (28.3%)</td>
<td>633 (98.0%)</td>
</tr>
<tr>
<td>You are free to initiate research projects or educational programs</td>
<td>37 (5.7%)</td>
<td>77 (11.9%)</td>
<td>50 (7.7%)</td>
<td>207 (32.0%)</td>
<td>260 (40.2%)</td>
<td>631 (97.7%)</td>
</tr>
<tr>
<td>You are free to participate in research projects or educational programs related to your patient population</td>
<td>21 (3.3%)</td>
<td>63 (9.8%)</td>
<td>37 (5.7%)</td>
<td>223 (34.5%)</td>
<td>287 (44.4%)</td>
<td>631 (97.7%)</td>
</tr>
</tbody>
</table>

## Organizational Characteristics

Responses to the eight items in this section were somewhat ambiguous (Table 5). However, the majority of respondents reported shaping their business environment in a manner that enhances their presence in the market.

### Table 5

#### Organizational Characteristics

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree† N (%)</th>
<th>Neutral N (%)</th>
<th>Agree †† N (%)</th>
<th>Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This pharmacy usually takes action in anticipation of future market conditions</td>
<td>77 (11.9%)</td>
<td>176 (27.2%)</td>
<td>379 (58.6%)</td>
<td>632 (97.8%)</td>
</tr>
<tr>
<td>This pharmacy is known as an innovator among pharmacies in our area</td>
<td>134 (20.8%)</td>
<td>212 (32.8%)</td>
<td>287 (44.4%)</td>
<td>633 (98.0%)</td>
</tr>
<tr>
<td>We try to shape our business environment to enhance our presence in the market</td>
<td>46 (7.1%)</td>
<td>127 (19.7%)</td>
<td>461 (71.3%)</td>
<td>634 (98.1%)</td>
</tr>
<tr>
<td>We promote innovative professional services in this pharmacy</td>
<td>81 (12.5%)</td>
<td>154 (23.8%)</td>
<td>395 (61.1%)</td>
<td>630 (97.5%)</td>
</tr>
<tr>
<td>We take above average risks in our business</td>
<td>241 (37.3%)</td>
<td>231 (35.8%)</td>
<td>157 (24.3%)</td>
<td>629 (97.4%)</td>
</tr>
</tbody>
</table>
We are responsive to the activities of our rivals

Identifying new business opportunities is the concern of all employees

Because market conditions are changing, we continually seek out new opportunities

† Truncated disagree and strongly disagree
†† Truncated agree and strongly agree

Constructs

Constructs identified from the study data are displayed in Table 6. From the eleven items measured under orientation to practice, two viable constructs were identified. Professional orientation contained five items: attending professional meetings and conferences, being part of the health care team, reading the professional literature, public service such as presentations to community groups, and mentoring students and interns. Business orientation included four items: being a good businessperson, arranging counter and shelf displays, offering a variety of sundry goods, and maintaining a business establishment. Two items did not load into either construct: dispensing prescriptions and encouraging the proper use of medications.

<table>
<thead>
<tr>
<th>Construct</th>
<th>Number of items</th>
<th>Scale</th>
<th>Range</th>
<th>Mean (SD)</th>
<th>Alpha Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Orientation</td>
<td>5</td>
<td>Very Unimportant (1) – Very Important (5)</td>
<td>5-25</td>
<td>20.2 (2.57)</td>
<td>0.738</td>
</tr>
<tr>
<td>Business Orientation</td>
<td>4</td>
<td>4-20</td>
<td>13.4 (2.78)</td>
<td>0.749</td>
<td></td>
</tr>
<tr>
<td>Professional Affinity</td>
<td>3</td>
<td>Dislike Very Much (1) – Like Very Much (5)</td>
<td>3-15</td>
<td>13.6 (1.46)</td>
<td>0.736</td>
</tr>
<tr>
<td>Business Affinity</td>
<td>4</td>
<td>4-20</td>
<td>11.3 (3.08)</td>
<td>0.735</td>
<td></td>
</tr>
<tr>
<td>Role Conflict</td>
<td>3</td>
<td>Never (1) – Always (5)</td>
<td>3-15</td>
<td>6.2 (1.97)</td>
<td>0.691</td>
</tr>
<tr>
<td>Autonomy</td>
<td>6</td>
<td>Never (1) – Always (5)</td>
<td>6-30</td>
<td>22.8 (5.62)</td>
<td>0.875</td>
</tr>
<tr>
<td>Innovation</td>
<td>7</td>
<td>Strongly Disagree (1) – Strongly Agree (5)</td>
<td>7-35</td>
<td>24.4 (4.45)</td>
<td>0.849</td>
</tr>
</tbody>
</table>

From the eleven items measured under practice affinity, two viable constructs were also identified. Professional affinity contained three items: keeping abreast on health & drug-related matters, providing information and advice to physicians and other health care professionals, and counselling patients regarding prescription and over-the-counter related matters. Business affinity included four items: selling non-medication related items, management of cash, management of “front store” stock, and management of dispensary stock. Four items did not load into either construct: dispensing prescriptions,
selling non-prescription medications, management of dispensary personnel, and management of front store personnel.

From the six items measured under organizational experiences, one viable construct was identified. This construct is labelled *role conflict* and include three items: I am required to do things in my job that are against my professional judgment, I receive incompatible requests from two or more people, and I often have to choose between the business and professional aspects of pharmacy. Three items did not load: I feel certain about the amount of authority I have, I am provided with clear, planned goals and objectives for my job, and I am willing to “buck” a company rule or policy in order to carry out my professional duties.

All of the six items that were measured under autonomy loaded into one construct: *autonomy*. The last construct – *innovation* – came from seven of the eight items measured under organizational characteristics; only the item identifying new business opportunities is the concern of all employees did not load into the construct.

**Comparative Analysis**

The constructs were compared using the independent variable *Pharmacy Ownership Type* (Table 7). No statistically significant differences were found based on type of pharmacy ownership for either *professional orientation* or *professional affinity*. Comparative analysis of the *business orientation* and *business affinity* constructs resulted in statistically significant differences among respondents in corporate pharmacies and those in franchise and independent pharmacies ($p < 0.001$).

**Table 7**

Comparative Analysis of Constructs by Pharmacy Ownership Type (n = 636)

<table>
<thead>
<tr>
<th>Construct</th>
<th>Pharmacy Ownership Type</th>
<th>F-value (sig.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Independent (n = 288)</td>
<td>Franchise (n = 119)</td>
</tr>
<tr>
<td>Professional Orientation</td>
<td>Mean</td>
<td>Mean</td>
</tr>
<tr>
<td>Business Orientation *</td>
<td>20.04</td>
<td>20.25</td>
</tr>
<tr>
<td>Professional Affinity</td>
<td>13.45</td>
<td>13.64</td>
</tr>
<tr>
<td>Business Affinity *</td>
<td>13.86</td>
<td>13.63</td>
</tr>
<tr>
<td>Role Conflict †</td>
<td>11.80</td>
<td>11.98</td>
</tr>
<tr>
<td>Autonomy*</td>
<td>5.85</td>
<td>6.31</td>
</tr>
<tr>
<td></td>
<td>26.05</td>
<td>22.26</td>
</tr>
</tbody>
</table>
For **business orientation**, respondents in corporate pharmacies reported attaching less importance to the business-orientated aspects of practice than respondents in franchise and independent pharmacies. Via analysis of **business affinity**, respondents in corporate chain pharmacies reported less of an affinity for the business aspects of practice than respondents in either franchise or independent pharmacies.

Comparative analysis of the **role conflict** construct found a significant difference between corporate chain and independent respondents. Corporate chain pharmacy respondents reported a higher level of role conflict than independent pharmacy respondents.

Analysis of the **autonomy** construct resulted in statistically significant differences ($p < 0.001$) among all three ownership types: corporate, franchise, and independent. Corporate respondents reported the least amount of autonomy, followed by franchise respondents, with independent respondents reporting the most autonomy.

Comparative analysis of the final construct – **innovation** – resulted in statistically significant differences ($p < 0.001$) among corporate respondents, and independent and franchise respondents. Corporate pharmacy respondents reported being less innovative than respondents in independent and franchise pharmacies.

**Discussion**

The findings of this study suggest a high level of professionalism among entrepreneur-pharmacists and corporate managers, both in terms of the importance they place on professional activities, and their own stated preference to be engaged in professional activities. However, the respondents readily acknowledge the importance and enjoyment of non-professional or business aspects of their managerial positions, especially as they relate to supporting the professional operations of the community pharmacy. The participants in this study appear to be successful in wearing the dual hats of a health profession manager.

However, this high level of support does not seem to extend to “front store” managerial responsibilities. Historically, a community pharmacy manager could expect to derive a high proportion of the pharmacy’s income from non-professional goods and services, and a pharmacist assuming a management position could expect to take on significant non-professional responsibilities. The study findings suggest one of the hats may not fit as well as it did in the past. Alternatively, managers may perceive a different type of business hat than was worn in the past.

No significant differences arose among groups regarding **professional orientation**. This result was unexpected as prior studies have shown that bureaucratically-based professionals eventually become dedicated to the advancement of his/her bureaucracy by seeking to advance personally within the organization (McKinlay & Arches, 1985). This contradictory finding may indicate that corporate pharmacy managers identify more with professional objectives than with the more business oriented objectives of their employers (McKinlay & Stoeckle, 1990); maintaining a professional orientation may
create conflict for corporate managers if the professional objectives and ideals of the profession differ from the principles of the employing organization (Scott, 1966; Sorensen & Sorensen, 1974).

Analysis of the business orientation construct identified differences among the corporate chain respondents and the franchise and independent respondents. One explanation for this result is franchise and entrepreneur-pharmacists have a more personal connection to the financial viability and long-term success of the pharmacy than corporate managers. Along with being the owner or franchisee come the inherent risks and rewards of operating a business (Chappell & Barnes, 1984; Clark et al., 1994; Hibbert et al., 2002; Latif, 2000b; Ralph & Langenbach, 1987).

Corporate managers may choose to practice in a corporate environment to avoid the risks and responsibilities of being an owner or franchisee. This choice may also reflect a disinclination to become preoccupied with the business-orientated aspects of practice. The reality is not all pharmacists want to practice in an independent pharmacy, or desire to be an entrepreneur, just as not all pharmacists want to practice hospital pharmacy (Clark et al., 1994; Iyer & Doucette, 2003; Jambulingam et al., 2005; Ortiz et al., 1992; Ralph & Langenbach, 1987).

The professional affinity construct did not display any significant differences among the three ownership types. This finding is contrary to the literature that suggests employees in larger, bureaucratic organizations eventually start to identify more with the goals and objectives of the organization rather than with those of their profession (McKinlay & Arches, 1985). Corporate managers may be resisting situational pressure that can exist within organizations for employees to behave in a particular manner and this resistance is more likely if the proposed action is not congruent with professional ethics (Latif, 2000a, 2001).

Similar to the business orientation construct, differences were observed among corporate respondents, and franchise and independent respondents for the business affinity construct. Again, the personal connection for franchise and entrepreneur-pharmacist respondents may explain this difference (Chappell & Barnes, 1984; Clark et al., 1994; Hibbert et al., 2002; Latif, 2000a; Ralph & Langenbach, 1987). Franchise managers may be viewed as falling between entrepreneur-pharmacists and corporate managers, but on business aspects they tended to align with entrepreneur-pharmacist. This may be explained by the fact that while franchise respondents have less to personally gain or lose financially than entrepreneur-pharmacists, it is generally more than those in corporate pharmacies who risk little beyond their wage and potential bonuses.

Also relevant is the issue of organizational structure in that independent and franchise pharmacies are simple structures, with ownership more directly involved in the day-to-day operations of the business. Similar to the entrepreneur-pharmacist, the franchisee is financially invested in the business; however, they are required at varying levels to follow policies and procedures of a larger corporate entity to maintain a consistent image and brand.

In corporate pharmacies, the pharmacy manager is an employee within ones levels of organizational management: from management within the larger retail environment, as is the case with mass merchandisers and grocery store, and some large chains, to the district/regional manager and the various levels of management at corporate headquarters, including vice presidents and the chief executive officer. These larger, more complex business structures, and the resulting levels of bureaucracy, are magnified if the organization is part of a multi-national corporation.

If ownership continues to transition exclusively to corporate ownership, the profession may have no choice but to accept the direction of these owners. Furthermore, when relatively few organizations own
and direct the operations within an industry, the influence of those organizations in controlling the market and affecting human resources increases to satisfy those organizations’ missions (Aldrich, 1979; Muzzin et al., 1994).

In this study, corporate pharmacy managers reported more conflict than entrepreneur-pharmacists and this is consistent with the management literature (Hibbert et al., 2002; Kronus, 1975, 1976; Latif, 2000b, 2001; Quinney, 1964; Sitkin & Sutcliffe, 1991). This conflict may be explained by the fact that a corporate pharmacy manager does not own the pharmacy. There is a separation of the professional and higher managerial level. As a result, these pharmacy managers may be more limited in their ability to substantially affect the managerial decisions made at the upper levels of the organization. The manager in a corporate pharmacy is therefore more likely to experience conflict in managing the demands of the professional pharmacy practice, which may not align with the corporate mission/direction (Guirguis & Chewning, 2005; McKinlay & Arches, 1985; Quinney, 1964; Scott, 1966; Sleath & Campbell, 2001). The formalization of work may not be consistent with the corporate pharmacy manager’s view of the ideal concept of pharmacy practice, whereas entrepreneur-pharmacists may be better able to align business practices with the professional ideals of pharmacy practice (Mintzberg, 1979, 1981).

Based on the results of this study, as discussed above, Ho1 is accepted as regardless of where respondents’ practiced, they remained aligned to the professional aspects of practice. However, Ho2 and Ho3 are rejected, as entrepreneur-pharmacists, and to a lesser extent franchise respondents, identified more with the business aspects of practice than corporate respondents, while reporting less conflict than respondents in corporate pharmacies.

The autonomy construct provides a clear picture of the divide with certain aspects of practice among the three groups. There was a significant difference among all three groups, with greater than one standard deviation difference between corporate respondents and entrepreneur-pharmacists. Respondents all agreed with the professional authority aspects of practice, but there was a marked difference between what one identifies with professionally, and one’s autonomy. Corporate respondents report having less autonomy than entrepreneur-pharmacists, a result supported by the literature (Carroll & Jowdy, 1986; Engel, 1969, 1970; Kronus, 1975, 1976).

Society grants the professions the right to self-regulate. The professions maintain autonomy in exchange for placing the interest of society above personal and organizational interests. However, in this study entrepreneur-pharmacists reported more autonomy than corporate respondents, and to lesser extent franchise respondents. One needs to consider the impact of a reduction in the autonomy that should accompany professional practitioners, regardless of the practice setting. Not only does the potential for conflict, role strain and ambiguity increase when autonomy is not established (Kronus, 1975, 1976; Sleath & Campbell, 2001), but questions are raised as to the amount of influence and control corporate agendas have over the professional work of pharmacists in corporate pharmacies. Based on the results of this study, Ho4 is rejected, as respondents in corporate pharmacies, and to a lesser extent franchise pharmacies, reported having less autonomy than entrepreneur-pharmacists.

Differences were observed among corporate and independent and franchise respondents with regard to the innovation construct. The literature on innovation suggests the larger the organization, the less innovative the organization tends to be (Mintzberg, 1979, 1981), and this appears to be supported by the results of this study. Based on results of this study, Ho5 is rejected as entrepreneur-pharmacists and franchise respondents reported being more innovative than corporate respondents.

Limitations
Owing to the nature of the study, limitations are to be expected and acknowledged. First, as with any self-report methodology, one must approach the results with a certain level of caution as it relies on respondents to accurately reflect their perceptions/feelings/experiences. Moreover, this study was conducted in Canada, and therefore may include cultural specificities not applicable to other regions.

As with any survey research there is the potential for non-response bias between responders and non-responders. For this study a non-responder survey was not conducted. However, to assess the potential for non-responder bias the method of *early* versus *late* responder analysis was completed (Churchill & Iacobucci, 2002; Churchill & Peter, 1984; Latif, 2000a; Oppenheim, 1992). In this method of assessing non-responder bias, the assumption is that late responders respond similar to non-responders. Therefore, if any statistically significant differences are established between early and late responders, the same difference is assumed to occur between responders and non-responders (Churchill & Iacobucci, 2002; Churchill & Peter, 1984; Latif, 2000a; Oppenheim, 1992).

No statistically significant differences were observed when conducting chi-square analysis on the independent variable *Pharmacy Ownership Structure*. Chi-square analysis of the gender variable also did not result in any statistically significant differences between early and late responders. The final analysis of the age variable via an independent t-test also did not result in any statistically significant differences.

**Conclusion**

Community pharmacy managers are oriented to their professional role but those working in a corporate pharmacy environment are less orientated to their business role. It would appear that those practicing in a corporate pharmacy are different from entrepreneur-pharmacists, and to some degree those practicing in franchise pharmacies. There is a need to explore entrepreneurial orientation and the competitive environment to a greater extent to better understand the impact of the changing market place.

While competition is welcomed in a market economy, the impact of a reduction in the number of entrepreneurial pharmacists – based on the entrepreneurial definition used – highlighted in this study merits further investigation. Empirical study is also warranted to explore whether, based on Baumol’s distinction between the innovative and replicative entrepreneur (Baumol, 1993, 2004, 2007), the entrepreneur-owner is in fact innovative, or merely replicating what the market currently offers. Further to this would be to explore innovative entrepreneurship in community pharmacies and the influence of ownership and/or environment.
References


