

Selling Less to Protect More in Community Pharmacy: How Customer Retention Pressure and Professional Legitimacy Shape the Possibility of Collective Antimicrobial Stewardship

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Abstract

Community pharmacies occupy a consequential position in antimicrobial stewardship because decisions about antibiotic supply occur where clinical need, patient expectations, professional obligations, regulatory arrangements, and commercial relationships can intersect. Existing stewardship approaches commonly emphasize pharmacist knowledge, education, guideline adherence, or enforcement. These remain important, yet they do not fully explain why stewardship-consistent restraint may be difficult to sustain when pharmacies operate within competitive local markets and cannot assume comparable restraint by other outlets. This article develops an Institutional Stewardship Model to examine how customer-retention pressure, professional legitimacy, competing institutional logics, and collective expectations shape community-pharmacy antimicrobial stewardship. The model distinguishes individual compliance from collectively stabilized restraint and treats commercial pressure as conditional rather than determinative. Professional legitimacy may make refusal, referral, or delayed supply more defensible to customers and other stakeholders, while weak legitimacy can increase the relational cost of stewardship. However, legitimacy at the individual-pharmacist level may remain insufficient where pharmacies anticipate that competing outlets will satisfy displaced demand. Sustainable stewardship therefore depends partly on institutional conditions that make professional restraint recognizable, reciprocally expected, and less commercially asymmetric. The model generates a basis for distinguishing educational, legitimating, coordinative, and regulatory interventions and for specifying when each is likely to matter.

Keywords: Antimicrobial stewardship, Community pharmacy, Professional legitimacy, Commercial pressure, Institutional logics, Collective action

Introduction

Antimicrobial resistance is sustained by decisions distributed across patients, prescribers, dispensers, health systems, markets, and regulatory institutions. This distribution matters theoretically because antimicrobial use does not generate consequences only for the actor

making an immediate treatment or dispensing decision. Resistance creates linked collective-action problems in which individually understandable choices can accumulate into socially damaging outcomes, while the benefits of restraint are dispersed across populations and time [1]. Community pharmacy is therefore more than a terminal supply point. Pharmacists can influence whether antibiotic requests are supplied, questioned, redirected, or incorporated into a broader stewardship encounter, and recent European work has explicitly positioned community pharmacists within antibiotic-optimization interventions [2].

The stewardship problem is nevertheless heterogeneous. A global mixed-methods review of non-prescription antibiotic dispensing identified regulatory, financial,

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demand-side, access-related, and professional influences rather than a single dominant explanation [3]. Recent evidence from low- and middle-income countries likewise shows that non-prescription dispensing persists within diverse policy, market, and health-system environments [4]. Intervention evidence adds an important qualification: dispensing behaviour can change while customer demand, perceived business consequences, staffing constraints, and enforcement conditions continue to shape practice [5]. These findings justify an institutional analysis in which commercial considerations are taken seriously without being treated as an automatic cause of inappropriate supply.

This article asks how customer-retention pressure and professional legitimacy interact with competing institutional logics to enable or undermine collective antimicrobial stewardship in community pharmacy. The central argument is that stewardship becomes institutionally fragile when restraint imposes visible local costs on some pharmacies while the benefits of restraint remain collective and competitors are expected to accommodate displaced demand. Professional legitimacy can reduce that fragility by making stewardship-consistent action recognizable as appropriate professional conduct. Yet durable restraint also requires attention to reciprocity: pharmacists must be able to act professionally without reasonably expecting that the commercial value surrendered through restraint will simply be captured elsewhere.

Community pharmacy as a commercial and professional institution

Community pharmacy combines features that are analytically separated in many accounts of healthcare delivery. It is an accessible health-professional setting, a medicines-distribution organization, a site of public-health activity, and often a revenue-generating retail enterprise. Research on the public-health role of community pharmacy shows that expansion of professional responsibilities occurs within an occupational setting where commercial organization and professional purpose are simultaneously present [6]. This duality does not imply that pharmacists routinely subordinate professional judgment to commercial interests. It establishes that stewardship decisions occur inside institutions where several legitimate expectations can operate at once.

The meaning assigned to pharmacy work also depends on external recognition. Pharmacists responding during the

COVID-19 period described frustration at being treated primarily as components of a medicines supply chain rather than as fully recognized health professionals [7]. Such experiences are relevant because professional authority is partly relational: an actor's capacity to exercise judgment depends not only on formal competence but also on whether others recognize the actor as entitled to use it. Realist evaluation of extended community-pharmacy roles similarly indicates that new professional services become workable through context-dependent combinations of relationships, resources, expectations, and implementation conditions [8].

Professional identity is also constructed outside the pharmacy organization. Public-facing health media vary in how they depict pharmacists and which professional functions they make visible [9]. Within the occupation, organizational and employment conditions matter as well; pharmacy degree holders' job preferences respond to characteristics of work rather than to professional identity in isolation [10]. Community pharmacists may also experience moral distress when they perceive a professionally appropriate course of action but encounter conditions that constrain their ability to enact it [11].

Taken together, these findings support a view of community pharmacy as a commercial-professional institution: a setting in which professional authority, organizational viability, public accessibility, employment conditions, patient relationships, and market exchange coexist. For antimicrobial stewardship, the importance of this formulation is that refusal or redirection of an antibiotic request can simultaneously be a professional act, a public-health act, a customer interaction, and an organizational transaction. The theoretical question is therefore not whether pharmacy is “commercial” or “professional.” It is how these institutional dimensions are combined in situations where stewardship requires restraint.

Antimicrobial stewardship as a collective-action problem

The retail interface is materially relevant to antimicrobial stewardship because antibiotics remain obtainable without prescription in many community-pharmacy settings worldwide [12]. This makes dispensing behaviour a legitimate target of stewardship, while also showing why the problem cannot be reduced to prescribing alone. Pharmacists may evaluate prescription validity, question inappropriate demand, refer patients, reinforce responsible use, and communicate expectations

about antibiotics. A Delphi study on antibiotic dispensing has demonstrated that experts can articulate stewardship responsibilities for pharmacists within this interface [13]. The existence of professional responsibilities, however, does not establish that those responsibilities will become collective norms. Evidence from antimicrobial prescribing indicates that social-norm feedback can alter behaviour when practitioners receive information about how their actions compare with peers or accepted standards [14]. The relevance to community pharmacy is mechanistic rather than quantitative: behaviour can depend on expectations about what comparable professionals do, not solely on individual knowledge. Educational interventions aimed at community pharmacists can improve knowledge and aspects of antimicrobial dispensing practice [15]. Educational resources for community-pharmacy antimicrobial stewardship are also increasingly available [16]. These developments address capability and awareness, but availability of education does not itself demonstrate reciprocal restraint across pharmacies. A pharmacist may understand stewardship, endorse it, and comply with it while still believing that nearby competitors will respond differently to the same customer request. The collective-action problem therefore enters at the point where the outcome sought—reduced inappropriate antimicrobial use—depends on repeated decisions by multiple actors whose incentives and institutional conditions are not identical. Individual stewardship can occur without collective stabilization. The central theoretical challenge is to explain when isolated professional restraint becomes a credible shared expectation and when it remains vulnerable to defection, substitution, or uneven implementation.

Customer retention pressure

Customer-retention pressure is defined here as the perceived risk that stewardship-consistent refusal, deferral, or redirection of an antibiotic request may lead a customer to transfer the immediate request or future patronage to another outlet. The construct concerns anticipated commercial exposure, not documented customer loss in every case. Qualitative synthesis of non-prescription antibiotic sales in low- and middle-income countries identifies customer demand, business orientation, weak enforcement, beliefs about antibiotics, and competitive pressures among the influences reported by pharmacy personnel [17]. Empirical work in Nepal likewise shows that antibiotic-dispensing practices are

embedded in social and economic conditions surrounding community pharmacies [18].

This distinction between perceived exposure and observed loss is important. A pharmacist can experience retention pressure even if no customer ultimately leaves, because decisions are made under expectations about likely responses. Conversely, customer demand need not be commercially decisive where professional norms are strongly accepted, regulation is credible, or competing outlets behave similarly.

Recent qualitative evidence from Palestine illustrates how non-prescription dispensing can be shaped by patient demand, affordability, regulatory conditions, access constraints, and pharmacists' own professional judgments at the same time [19]. Multi-actor research in Bangladesh similarly identifies commercial determinants within a broader social-ecological system that includes health-service access and other structural influences [20]. These findings prohibit a simple causal story in which competition automatically produces inappropriate antibiotic supply.

Customer-retention pressure is therefore best treated as a conditional mechanism. It should become more consequential where customers can readily switch outlets, where stewardship-oriented refusal is poorly understood, where enforcement is uneven, and where pharmacists expect competitors to accommodate demand. Its influence should weaken where refusal is widely recognized as appropriate professional care, where alternatives are similarly constrained, or where customers value stewardship as an indicator of quality. This conditional formulation makes commercial pressure theoretically testable rather than rhetorically assumed.

Professional legitimacy

Professional legitimacy concerns whether relevant audiences recognize pharmacists' stewardship-consistent authority as appropriate. It is broader than legal permission. Pharmacists may possess formal scope while still having to negotiate whether patients, colleagues, organizations, and other health professionals accept them as credible clinical decision makers. Multiple-case research in primary care demonstrates how unclear professional identity can complicate pharmacists' role negotiation even when expertise is available [21].

Pharmacists also undertake active identity work to establish themselves as clinicians, indicating that professional status is continually interpreted and negotiated rather than automatically secured by

qualification alone [22]. For antimicrobial stewardship, this matters because refusal is easier to sustain when the customer interprets it as competent care rather than unwillingness to serve. A pharmacist who can credibly explain why an antibiotic should not be supplied occupies a different interactional position from one whose refusal is perceived merely as a retail obstacle.

A recent scoping review of community-pharmacy professionalism shows that professional practice is shaped by multiple influences, including organizational conditions, infrastructure, ethics, education, workload, and contextual pressures [23]. Research on community-pharmacy culture and professional identity similarly emphasizes occupational socialization and the environments in which professional norms are learned and maintained [24].

Professional legitimacy is therefore neither a personality trait nor a synonym for professionalism. In the Institutional Stewardship Model it functions as an audience-dependent authorization resource. Strong legitimacy can reduce the social and reputational cost of stewardship-consistent restraint because the pharmacist's action is more readily interpreted as appropriate professional judgment. Weak legitimacy can produce the opposite effect: the same act may be read as poor service, arbitrary obstruction, or failure to meet customer expectations. Legitimacy can consequently buffer customer-retention pressure, but it cannot by itself ensure that other pharmacies will behave similarly.

Competing institutional logics

Community-pharmacy antimicrobial stewardship occurs where different rationalities for appropriate action can coexist. A commercial/customer logic emphasizes responsiveness, service continuity, organizational

viability, and the maintenance of customer relationships. A professional-stewardship logic emphasizes competent judgment, patient safety, appropriate antimicrobial use, and obligations extending beyond the immediate transaction. Organizational and managerial expectations may introduce further considerations concerning workflow, staffing, targets, documentation, and regulatory compliance.

Research in healthcare organizations shows that professionals and managers can respond to competing institutional logics through accommodation and co-optation rather than through simple victory of one logic over another [25]. Frontline professionals may also draw on different logics fluidly according to the situation they confront [26]. Other organizational research demonstrates that multiple healthcare logics can be complementary in some configurations and conflictual in others [27]. Institutional relations can also evolve as markets, policies, and service arrangements change over time [28].

The implication is that a commercial orientation does not invariably displace stewardship, and professionalism does not invariably require rejection of commercial concerns. A pharmacy may preserve customer relationships by providing high-quality explanation, referral, symptom management, or follow-up rather than by supplying an antibiotic. Equally, commercial responsiveness may become difficult to reconcile with stewardship when customers define successful service as obtaining the requested medicine and can readily shift demand to a competing outlet.

The distinction is summarized in **Table 1**. The configurations are theoretical syntheses derived from the preceding evidence and are not presented as empirically estimated categories.

Table 1. Institutional logic configurations shaping antimicrobial-stewardship restraint in community pharmacy

Institutional configuration	Customer relationship interpreted as	Professional stewardship authority	Commercial exposure from restraint	Typical logic relationship	Collective stewardship vulnerability
Customer-accommodation dominant	Retaining demand through fulfillment	Weakly recognized or subordinated	High when requested supply is refused	Commercial/customer logic dominates	Restraint vulnerable to displacement toward accommodating outlets
Professionally authorized service	Retaining trust through competent care	Strongly recognized	Low to moderate because refusal can signal quality	Professional and service logics complementary	Individual restraint can be stable even without strong collective coordination
Contested professional restraint	Relationship threatened by refusal or referral	Formally present but weakly accepted	High	Professional and commercial logics conflict	Pharmacist may comply yet perceive recurrent relational and economic penalty

Conditional accommodation	Customer request negotiated through alternatives, explanation, or referral	Moderately recognized	Context dependent	Logics selectively combined	Stewardship depends on credible substitutes and communication
Coordinated stewardship environment	Relationship governed by shared expectations across outlets and audiences	Collectively reinforced	Reduced because alternatives are expected to apply comparable restraint	Professional, regulatory, and service logics mutually reinforcing	Greater potential for norm stabilization
Fragmented institutional field	Expectations vary among pharmacies, customers, organizations, or regulators	Unevenly recognized	Uneven and unpredictable	Logics vary across actors and sites	High risk of substitution, inconsistent restraint, and norm breakdown

The table distinguishes logic configuration from individual moral commitment. The same pharmacist may act differently across institutional environments because the meaning and anticipated consequences of restraint change. This observation provides the bridge from institutional-logics theory to the model developed in the next section.

Development of the institutional stewardship model

The Institutional Stewardship Model integrates four elements that the preceding literature usually treats separately: interdependent antimicrobial outcomes, customer-retention pressure, professional legitimacy, and the configuration of institutional expectations surrounding pharmacy practice. Its central proposition is that sustainable stewardship depends partly on whether professional restraint is both legitimate and reciprocally credible.

Community pharmacies have demonstrated the capacity for coordination and shared decision making under demanding conditions, indicating that interorganizational and professional coordination is not alien to the sector [29]. At the normative level, analyses of antimicrobial resistance emphasize solidarity, justice, and common-good obligations that extend beyond the immediate interests of a single transaction [30]. These strands create a basis for theorizing stewardship as institutional action: individual pharmacists act within relationships whose expectations can either support or destabilize restraint.

The model begins with a stewardship-relevant customer request. Professional judgment may indicate that supply should be refused, delayed, questioned, or redirected. Whether that judgment is enacted depends partly on pharmacist capability, but capability is only one element. The pharmacist also interprets how the customer is likely to understand the action, whether the organization supports it, what comparable pharmacies are expected to

do, and whether professional institutions have made stewardship visible and legitimate.

Professional legitimacy operates by changing the meaning of restraint. Where legitimacy is high, refusal can communicate competent care, public-health responsibility, or adherence to a recognizable professional standard. Where legitimacy is low, refusal is more likely to be interpreted as a service failure. Customer-retention pressure operates through a different pathway: it concerns the anticipated private cost of stewardship when customers can transfer demand elsewhere. The two mechanisms therefore should not be collapsed into a single “barrier” construct.

Collective coordination adds a third operation. It can alter expectations about reciprocity. If pharmacists reasonably expect comparable outlets to apply similar stewardship standards, the commercial asymmetry associated with unilateral restraint is reduced. Coordination need not imply identical decisions in every case; legitimate clinical variation remains possible. Its theoretical function is to make restraint less dependent on the willingness of a single pharmacy to absorb a disproportionate relational or commercial cost.

The emerging model therefore predicts several configurations rather than one universal pathway. High legitimacy with weak coordination may sustain principled individual action while leaving collective stewardship vulnerable to substitution. Strong coordination with weak public legitimacy may produce formal consistency but continued customer conflict. Where both legitimacy and reciprocal expectations are strong, professional restraint can become institutionally normalized. Where both are weak and competitive exposure is salient, stewardship is especially vulnerable to fragmentation.

This logic is represented in **Figure 1**. Solid connectors denote relationships grounded directly in the reviewed evidence base or firmly established manuscript reasoning; dashed connectors denote article-level

theoretical propositions that require direct empirical testing. Bidirectional connectors represent reciprocal institutional influence rather than assumed causal symmetry.

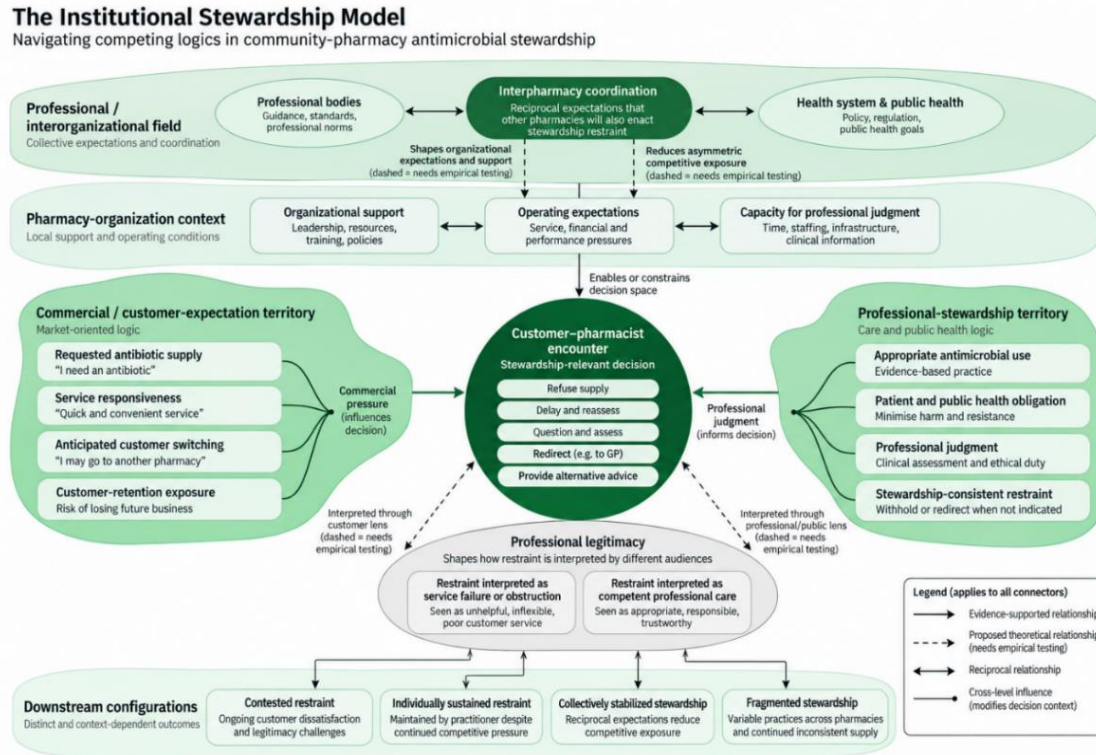


Figure 1. Institutional stewardship under customer-retention pressure, professional legitimacy, and reciprocal expectations

Individual compliance versus collective norm formation

Individual stewardship compliance and collective norm formation are analytically different outcomes. A pharmacist may consistently refuse inappropriate antibiotic requests because professional judgment, personal commitment, organizational policy, or regulation supports that action. Such compliance is important, but it does not establish that comparable pharmacies are expected to behave similarly. Formal modelling of antimicrobial use as a social dilemma demonstrates the underlying problem: actions that may be individually advantageous can impose costs on the collective through antimicrobial resistance [31].

Collective norm formation requires a further transition. Restraint must become sufficiently recognizable and reciprocal that pharmacists, customers, organizations, and other relevant actors can anticipate how comparable requests will ordinarily be handled. This does not require

perfect uniformity. Clinically justified variation must remain possible. What matters is whether differences in legitimate clinical judgment can be distinguished from systematic willingness to capture demand that other pharmacies decline.

The limited intervention literature reinforces the importance of this distinction. A Cochrane review of interventions intended to reduce non-prescription antimicrobial sales in community pharmacies found an evidence base too sparse and heterogeneous to support universal claims about any single intervention strategy [32]. Improving one pharmacist's competence, monitoring one outlet, or disseminating guidance may alter individual conduct without producing a stable collective expectation. Social-norm mechanisms become theoretically important precisely because practitioners act partly in relation to what they believe peers will do.

The Institutional Stewardship Model therefore treats collective stewardship as an institutional accomplishment rather than the numerical accumulation of compliant individuals. A field-level norm begins to form when restraint is professionally legitimate, sufficiently visible, and expected to be reciprocated under comparable conditions.

Free-riding and competitive disadvantage

The distinction between individual and collective restraint exposes a potential instability. Suppose one pharmacy declines an antibiotic request on stewardship grounds while another outlet is expected to supply the medicine with fewer restrictions. The first pharmacy bears the immediate interactional cost of refusal and may perceive a risk to customer retention; the public-health benefit of restraint, however, is shared broadly. Under these conditions, compliant restraint may be commercially asymmetric even when both pharmacists understand the stewardship rationale.

This is the article's specific use of free riding. It does not imply that pharmacies have been empirically shown to

calculate strategic payoffs or deliberately exploit competitors' restraint. It identifies a theoretically possible configuration in which one actor can benefit from customers displaced by another actor's stewardship-consistent decision while contributing less to the collective restraint that sustains the public good. The mechanism should be strongest where outlet substitution is easy, stewardship expectations are inconsistent, and professional refusal has weak external legitimacy.

Governance scholarship on antimicrobial resistance suggests that collective problems often require institutional arrangements capable of aligning incentives, expectations, and responsibility across actors [33]. Transferring lessons from other governance domains to community pharmacy must remain cautious, but the general implication is relevant: unilateral restraint becomes easier to sustain when institutions reduce uncertainty about what other actors are expected to do.

Figure 2 depicts these configurations without treating them as stages or assuming that one state inevitably evolves into another.

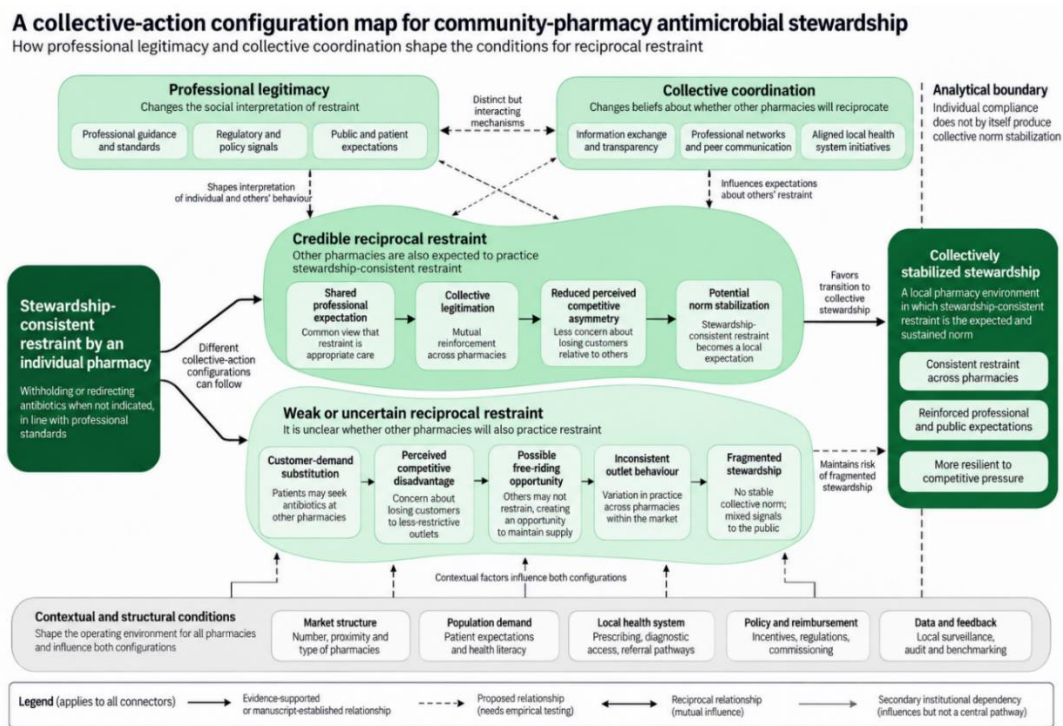


Figure 2. Reciprocal restraint, competitive exposure, and breakdown configurations in collective community-pharmacy stewardship

Mechanisms for collective legitimation and coordination
If fragmented expectations make restraint costly, durable stewardship requires mechanisms operating beyond

individual knowledge. Collective legitimation concerns the social authorization of stewardship: professional bodies, regulators, health systems, pharmacies, and

public communication can make refusal, referral, delayed supply, or alternative management recognizable as competent care rather than deficient service. Educational and professional-role initiatives contribute to this process when they clarify what responsible antibiotic dispensing entails, although education alone cannot create reciprocity.

Coordination performs a different function. It reduces uncertainty about how comparable actors are expected to respond. Shared standards, consistent enforcement, professional communication, interoperable referral pathways, feedback, and coordinated stewardship programmes can make restraint less dependent on one pharmacy accepting a disproportionate burden. Community-pharmacy crisis-management evidence shows that collaboration and shared decision processes

are feasible within the sector, even though that evidence does not directly validate an antimicrobial free-riding mechanism.

Multifaceted interventions are especially relevant because they can combine professional, behavioural, organizational, and communication mechanisms. The HAPPY PATIENT programme demonstrated that coordinated intervention across several patient-centred settings and European countries can alter antibiotic prescribing and dispensing practice [34]. The finding supports the feasibility of multicomponent stewardship; it does not isolate professional legitimation or reciprocal coordination as the unique causal pathway.

Table 2 distinguishes the institutional functions that may otherwise be collapsed into generic “support.”

Table 2. Distinct institutional functions for stabilizing collective antimicrobial stewardship in community pharmacy

Institutional mechanism	Immediate object of change	What becomes more credible	Collective-stewardship function	Failure if used alone	Context requiring adaptation
Professional education	Pharmacist knowledge and capability	Appropriate stewardship action	Improves capacity to recognize and enact restraint	Competent pharmacists may still face asymmetric customer or market pressure	Baseline competence, workforce capacity, available resources
Public/professional legitimation	Interpretation of pharmacist authority	Refusal, referral, or redirection as competent care	Reduces reputational and relational cost of restraint	Legitimate individual action may still be undercut by inconsistent competitors	Public expectations, professional identity, trust
Shared professional expectations	Beliefs about comparable practitioners	Peers will treat similar requests according to compatible stewardship norms	Supports reciprocal restraint	Expectations may remain symbolic without observable implementation	Local professional networks and practice visibility
Coordinated implementation	Organizational and interorganizational behaviour	Comparable standards will be enacted across participating settings	Reduces uncertainty and perceived competitive asymmetry	Coordination may become procedural without professional acceptance	Ownership structures, staffing, workflow, referral options
Regulatory consistency	Consequences of noncompliance	Rules apply across competing outlets	Limits advantage from systematically evading stewardship expectations	Enforcement alone may intensify access problems or conceal informal supply	Legal framework, enforcement capacity, medicine access
Access-aware referral and alternatives	Feasible response to unmet customer need	Restraint will not simply terminate care	Makes stewardship compatible with service responsibility	Referral without accessible care can weaken legitimacy	Prescriber access, affordability, geography, service availability

Feedback and peer comparison	Visibility of practice variation	Stewardship behaviour is observable relative to peers	Can reinforce emerging norms and reveal fragmentation	Measurement may lack meaning without trusted standards	Data quality, comparability, professional trust
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Propositions

The model yields propositions that distinguish its mechanisms from a generic list of stewardship barriers.

Proposition 1. Customer-retention pressure will be more likely to undermine stewardship-consistent restraint when pharmacists expect customers to obtain the requested antibiotic from competing outlets.

Proposition 2. Professional legitimacy will reduce the perceived relational cost of stewardship-consistent refusal when customers and other relevant audiences recognize pharmacist stewardship authority.

Proposition 3. High professional legitimacy may increase individual compliance without producing collective norm stability when expectations of reciprocal restraint across outlets remain weak.

Proposition 4. Credible coordination among pharmacies, professional institutions, regulators, or health systems will reduce perceived competitive asymmetry by increasing expectations that comparable actors will apply stewardship-consistent standards.

Proposition 5. The effects predicted above will weaken or change where unmet healthcare access, affordability constraints, clinical uncertainty, or inconsistent enforcement dominate dispensing decisions.

Proposition 6. Where customers interpret stewardship restraint as a signal of trustworthy professional care, professional legitimacy and customer retention may become mutually reinforcing rather than competing pressures.

Policy and practice implications

The model implies that interventions directed only at pharmacist knowledge address one component of the problem. Education remains valuable, but persistent commercial, access, organizational, and enforcement conditions can limit what knowledgeable pharmacists are able or willing to enact. Stewardship strategies should therefore diagnose whether the principal deficiency is capability, legitimacy, reciprocity, regulatory consistency, access to alternatives, or some combination. Professional organizations and health systems can strengthen legitimacy by communicating that appropriate refusal and referral are components of good pharmacy care. Regulators can reduce asymmetric exposure when

rules are credible and applied consistently across outlets. Pharmacy organizations can support employees through policies that do not penalize stewardship-consistent decisions. Coordination mechanisms should also preserve access: restricting supply without realistic referral or treatment pathways risks shifting the burden onto patients whose requests reflect deficiencies elsewhere in the health system.

The practical objective is not uniform refusal. It is a field in which clinically appropriate variation can coexist with sufficiently shared expectations that inappropriate supply is not commercially rewarded merely because another pharmacy exercised restraint.

Results and Discussion

The Institutional Stewardship Model explains why antimicrobial stewardship in community pharmacy cannot be inferred from pharmacist knowledge or ethical commitment alone. Its contribution lies in the interaction among three analytically distinct conditions: the legitimacy of professional restraint, the commercial exposure associated with customer substitution, and the credibility of reciprocal stewardship across comparable outlets. Institutional logics explain why these conditions can coexist without one permanently dominating the others.

Several rival explanations remain substantial. Non-prescription antibiotic demand may be driven by inadequate access to prescribers, affordability, weak enforcement, clinical uncertainty, cultural expectations, or health-system fragmentation. In such settings, customer-retention pressure may be secondary. Commercial incentives may also align with stewardship when customers value professional judgment or when pharmacies differentiate themselves through trusted care. These possibilities are theoretical boundary conditions, not exceptions to be explained away.

The evidence base also limits inference. Much of the direct dispensing literature is observational or qualitative and concentrated in settings where regulation and access differ markedly. Evidence on social norms frequently derives from prescribing rather than retail pharmacy. The free-riding mechanism proposed here has not been

directly estimated as a community-pharmacy market effect. Future research should therefore measure expectations about competitor behaviour, perceived customer switching, professional legitimacy, organizational support, and observed dispensing together. Designs comparing local pharmacy markets or examining institutional changes over time would provide stronger tests than studies of pharmacist attitudes alone.

Conclusion

Selling less to protect more becomes institutionally sustainable when stewardship-consistent restraint is not left as an isolated professional sacrifice. Customer-retention pressure can make restraint fragile when pharmacies expect displaced demand to be captured elsewhere, but commercial pressure is neither universal nor inevitably opposed to professional care. Professional legitimacy can make restraint intelligible and defensible, while collective coordination can make reciprocal restraint more credible. The strongest theoretical claim is therefore conditional: community-pharmacy antimicrobial stewardship is most likely to stabilize when professional authority, customer expectations, organizational support, and interorganizational reciprocity align sufficiently that responsible restraint is both legitimate and collectively sustainable.

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