

When Dispensing Targets Compete with Patient Safety: A Normative Policy Framework for Pharmacy Performance Incentives, Professional Autonomy, and Organizational Accountability

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Abstract

Performance incentives in community pharmacy can support timely dispensing, service availability, and organizational sustainability, yet their ethical acceptability depends on how performance expectations interact with pharmacists' patient-safety obligations. This normative policy analysis examines the conditions under which dispensing targets and related productivity measures can coexist with independent clinical judgment. Drawing on evidence concerning pharmacy quality, dispensing safety, professional autonomy, organizational conditions, and incentive implementation, the analysis distinguishes legitimate performance coordination from arrangements that compromise essential clinical duties. It develops a framework grounded in proportionality, non-compensable safety obligations, effective professional discretion, institutional responsibility, and corrective accountability. The framework treats dispensing volume and service efficiency as permissible organizational objectives while requiring protected opportunities for clinical verification, patient counselling, justified interruption, and escalation of unsafe expectations. Organizational responsibility extends beyond setting targets to providing the resources, authority, and monitoring arrangements necessary for safe implementation. Incentive redesign must also distinguish reported safety concerns from measured harm and account for differences in pharmacy organization and regulatory jurisdiction. Performance incentives are ethically supportable when they remain subordinate to essential patient-safety duties, preserve meaningful clinical discretion, and incorporate enforceable mechanisms for identifying and correcting unsafe operational conditions.

Keywords: Community pharmacy, Performance incentives, Patient safety, Professional autonomy, Dispensing workload, Organizational accountability

Introduction

Community pharmacies operate at the intersection of professional healthcare provision, organizational service delivery, and financial sustainability. Their work includes supplying medicines, assessing prescriptions, identifying medication-related problems, counselling

patients, and coordinating with other healthcare professionals. Performance management therefore concerns activities with different purposes, resource requirements, and consequences. Evidence from English community pharmacies indicates that organizational configuration and commissioning context influence the quantity and perceived quality of services delivered [1]. International literature similarly identifies multiple dimensions of community pharmacy quality that cannot be captured through a single operational indicator [2]. Incentives may be attached to dispensing volume, service completion, operational efficiency, or achievement of specified quality indicators. These arrangements are not ethically equivalent. Some encourage the provision of services that might otherwise receive insufficient

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attention; others may create pressure when performance expectations compete with time needed for clinical assessment. An investigation of England's Pharmacy Quality Scheme demonstrates the importance of examining how financial incentives are implemented and experienced by pharmacy stakeholders [3]. The ethical question concerns the conditions governing their operation, including the authority to modify performance expectations when clinical circumstances require additional care.

Patient safety also presents a measurement problem. Dispensing-error studies use different definitions, ascertainment methods, and denominators, complicating comparisons across practice settings [4]. Staff perceptions provide another perspective: repeated national safety-climate surveys in Swedish community pharmacies demonstrate the value of examining organizational safety conditions over time [5]. Neither error estimates nor safety-climate responses, considered alone, establish whether a particular productivity target caused an adverse event.

This analysis addresses a specific policy question: under what ethical constraints, allocation of authority, and organizational accountability can pharmacy performance incentives coexist with professional patient-safety duties? It evaluates incentive arrangements as institutional choices that distribute time, decision-making authority, operational resources, and responsibility. Its contribution is a normative account of the conditions under which performance expectations remain acceptable, together with the institutional duties that arise when those conditions cannot be maintained.

Performance incentives and their relationship to pharmacy work

Dispensing targets can serve legitimate operational purposes. They may assist organizations in planning capacity, identifying delays, coordinating staffing, and maintaining access to medicines. However, a numerical measure represents only the activity selected for measurement. A pharmacy meeting an expected prescription volume may still differ substantially from another pharmacy in the complexity of its patients, the extent of counselling required, or the clinical interventions undertaken.

Administrative claims have been used to examine determinants of pharmacists' quality of care, illustrating the possibilities and limitations of routinely collected indicators [6]. Such information can support

organizational assessment, but clinical reasoning, patient communication, and decisions to delay dispensing may remain incompletely represented. Research examining how community pharmacists prioritize cognitive pharmaceutical services further demonstrates that professional activities compete for available attention and resources [7].

Performance arrangements should consequently be distinguished by their intended function. A dispensing-volume indicator describes output; a turnaround-time indicator describes workflow; a completion measure records whether a specified service occurred; and a clinical-quality measure attempts to capture an aspect of care. Each can become an incentive when remuneration, managerial evaluation, staffing decisions, or other organizational consequences depend on its achievement. Indicator selection also shapes which activities become visible to management. A systematic review of clinical pharmacy key performance indicators in hospital inpatient settings provides evidence of the diversity of measures used to represent pharmaceutical care [8]. Its inpatient context limits direct application to community dispensing, but the underlying measurement issue remains relevant. Economic evaluations introduce a further dimension. A scoping review of pharmacists' services among non-hospitalized patients examines return on investment, an outcome that is important for service sustainability without constituting a complete measure of clinical appropriateness [9].

The relationship between incentives and safety must be examined empirically where evidence permits. A systematic review of pay-for-performance interventions in acute care reported inconsistent patient-safety findings and limitations in the quality of available evidence [10]. Those findings do not establish the effects of dispensing targets in community pharmacies. They do, however, challenge the assumption that attaching financial consequences to selected indicators necessarily produces the intended clinical outcomes.

An ethically defensible incentive arrangement therefore requires clarity about what is being rewarded and what may be displaced when performance becomes consequential. Organizational efficiency remains a legitimate objective, provided that the arrangement does not make essential clinical activities practically incompatible with meeting ordinary work expectations.

Ethical tensions between dispensing productivity and patient safety

Productivity and patient safety are not inherently opposing objectives. Efficient workflow can reduce unnecessary delays, support medicine availability, and allow pharmacists to devote attention to clinically important tasks. Ethical tension arises when the organization treats the achievement of a numerical target as an obligation that remains unchanged despite variations in clinical complexity, interruptions, or available staffing.

Dispensing involves activities whose time requirements cannot always be established in advance. A prescription may require clarification, a medicine may present an interaction concern, or a patient may need additional explanation before treatment can be used safely. Research on interruptions and distractions in dispensing identifies work-process conditions that warrant attention in medication-safety interventions [11]. Such evidence supports concern about the conditions under which dispensing occurs, without establishing that every interruption produces an error.

The ethical distinction concerns the consequences of responding appropriately to these circumstances. A pharmacist who postpones completion to resolve a clinically significant question is fulfilling a professional obligation. If the resulting delay simultaneously exposes that pharmacist to an adverse performance assessment, the incentive arrangement creates a conflict between the measured expectation and the duty it should accommodate.

Moral distress offers a related perspective. Work examining moral distress among community pharmacists identifies professional circumstances in which perceived ethical obligations and practical working conditions may conflict [12]. Distress does not independently demonstrate patient injury, but it can indicate a need to

examine the organizational circumstances surrounding difficult professional decisions.

The experience of community pharmacists during the COVID-19 response further illustrates tensions between professional identity and working expectations [13]. Findings from this exceptional period require contextual interpretation. Research into compassion fatigue and satisfaction among pharmacists also establishes workforce wellbeing as a relevant area of investigation [14]. These findings should inform institutional attention to working conditions without being converted into unsupported claims about the motives of individual pharmacists.

Role theory helps explain why such tensions cannot be reduced to a simple opposition between commercial and professional identities. Community pharmacists encounter expectations associated with clinical care, medicine supply, organizational performance, and relationships with other healthcare professionals [15]. The significance of a target depends partly on whether these expectations can be reconciled in daily work.

Safety monitoring presents another difficulty. Research examining near-miss reporting among hospital pharmacists and perceptions of the work environment demonstrates why reporting behaviour requires interpretation within its organizational context [16]. Fewer recorded near misses cannot automatically be treated as evidence of improved safety. A workplace in which staff hesitate to report may appear successful according to an indicator while becoming less informative to those responsible for preventing harm.

The ethically relevant features of an incentive are therefore its operational consequences and the obligations potentially affected. **Table 1** distinguishes the performance characteristics that require examination from the professional duties that must remain practicable.

Table 1. Ethical qualification of dispensing-performance expectations according to their operational demands and affected clinical duties

Incentive feature	Potential pressure pathway	Professional obligation at issue	Ethical qualification
Prescription-volume expectation	Additional throughput may reduce available time when case complexity increases.	Prescription verification and clinically justified intervention.	Work expectations must accommodate clinically necessary variation.
Dispensing turnaround measure	A delay may be classified as underperformance even when clarification is necessary.	Resolution of medication-related concerns before supply.	Justified clinical delay must remain permissible.
Service-completion incentive	Measured completion may compete with unmeasured clinical work.	Appropriate prioritization according to patient need.	Numerical completion cannot substitute for clinical appropriateness.

Individual performance appraisal	Staff may perceive adverse consequences from interruption or escalation.	Independent judgment and communication of safety concerns.	Clinical decisions require protection from inappropriate performance penalties.
Incident-reporting indicator	Reporting behaviour may be confused with the underlying frequency of incidents.	Accurate disclosure, learning, and prevention.	Report counts require contextual interpretation.

Note: The ethical qualifications constitute the article's proposed normative synthesis. They are not empirically validated intervention effects. The pressure pathways describe possible mechanisms requiring contextual examination.

Professional autonomy and the duty to exercise independent clinical judgment

Professional autonomy is ethically significant because pharmacists are responsible for decisions that cannot be resolved through dispensing counts alone. Identifying a clinically relevant interaction, deciding whether clarification is required, or determining the adequacy of patient counselling involves judgment concerning an individual clinical situation. Such decisions require a degree of discretion that remains usable under ordinary employment conditions.

Research on pharmacist professionalism and autonomy identifies tensions between professional responsibility and the practical exercise of authority [17]. This distinction matters when considering performance policy. An organization may formally recognize clinical discretion while attaching adverse consequences to its exercise. Permission to intervene offers limited protection if the pharmacist cannot obtain the necessary time, communication support, or managerial response.

Clinical decision-making has been identified as an essential skill for contemporary pharmacy practice [18]. Its exercise entails considering patient-specific information and determining an appropriate course of action. An incentive can legitimately encourage timely completion, but it cannot establish clinical correctness simply through achievement of a prescribed output.

The relevant professional duty includes recognizing when routine workflow is insufficient. Depending on the circumstances, that may require further verification, communication with a prescriber, additional counselling, documentation, temporary withholding of supply, or escalation through an appropriate professional channel.

These actions should be judged against their clinical justification. Professional autonomy does not exempt decisions from scrutiny, and an individual pharmacist's preference is not equivalent to a safety obligation. The proposed protection concerns defensible professional judgment exercised within the pharmacist's responsibilities.

Assertiveness illustrates the relationship between practical professional action and workplace conditions. A

cross-sectional study of Japanese community pharmacists examined the association between assertiveness and experience of pharmacist-led deprescribing [19]. Its observational design does not establish that assertiveness training would correct unsafe performance expectations. It nevertheless directs attention to whether pharmacists can communicate a clinically justified position when other actors favour a different course.

Patient trust adds a further consideration. Research examining how patients develop trust in community pharmacists highlights the relational dimensions of professional care [20]. Patients depend on pharmacists to exercise judgment in their interests, including when an apparently routine transaction requires additional attention.

The resulting policy requirement is meaningful clinical discretion: pharmacists must have both legitimate authority and practicable opportunities to fulfil essential duties. Organizations remain entitled to examine clinical decisions, resource use, and service performance. However, performance accountability must accommodate the documented reasons for clinically justified deviation from an ordinary target.

A normative framework for evaluating pharmacy performance incentives

The ethical acceptability of a performance incentive depends on the arrangement through which it operates. Its stated objective, measurable indicator, consequences for non-achievement, available resources, and procedures for resolving conflict must be assessed together.

Implementation research on extended pharmacist roles demonstrates the significance of organizational context for professional activity [21]. Research concerning pharmacy leadership competencies and behaviours also identifies leadership as a relevant dimension of professional service organization [22]. These sources inform the conditions that an incentive policy should consider; they do not constitute empirical validation of the normative framework developed here.

The proposed framework rests on five connected principles.

Legitimate and specified purpose. An incentive should identify the organizational good it seeks to advance and distinguish that objective from the indicator selected to represent it. Improving access, reducing avoidable delay, maintaining reliable medicine supply, and encouraging appropriate services may constitute legitimate purposes. The organization should explain why the chosen measure is suitable and what dimensions of care it excludes. A numerical measure cannot acquire ethical authority merely because it is readily collected.

Proportionality of performance expectations. The demands imposed by an incentive should remain proportionate to the relevant clinical and operational circumstances. Expectations that appear reasonable during routine dispensing may require adjustment when staffing, patient complexity, medicine availability, or the frequency of necessary interventions changes. Proportionality also requires examination of whether an alternative arrangement could pursue the organizational objective while placing fewer competing demands on essential clinical work.

Non-compensable safety duties. Certain professional actions must not be treated as dispensable contributions to productivity. Necessary verification, clinically indicated counselling, justified withholding, and appropriate escalation cannot be exchanged for aggregate gains in dispensing volume. This principle does not imply unlimited time for every encounter. It establishes that a legitimate efficiency objective cannot authorize the omission of a clinically necessary action.

Effective professional discretion. A pharmacist must be able to exercise justified judgment without inappropriate performance consequences. This requires more than a formal statement that clinical decisions remain independent. Time, relevant information, access to communication, and a usable process for documenting exceptions are necessary institutional conditions.

Standardization of medication counselling raises a related question: consistency can support service quality, but the adequacy of a standardized process must still be considered in relation to the needs of an individual patient [23]. Clinical judgment remains relevant where a standard procedure does not resolve the presenting concern [18].

Corrective institutional accountability. An incentive cannot be assessed exclusively at the point of individual performance. The organization must examine whether the conditions it establishes allow the preceding principles to operate. When a recurring conflict arises between expected output and essential clinical work, responsibility extends to those authorized to allocate resources, revise targets, investigate concerns, and correct the arrangement.

These principles form a conditional test of acceptability. A performance measure may be appropriate where its purpose is legitimate, its demands are proportionate, and compliance does not compromise essential duties. Where a conflict arises, the organization must preserve clinical discretion and respond through an accountable correction process. Persistent failure to provide these conditions calls the arrangement's ethical acceptability into question even when numerical performance remains satisfactory. The framework also distinguishes responsibility from blame. A dispensing error cannot automatically be attributed to an organizational target, just as the existence of individual professional responsibility cannot absolve an organization of responsibility for foreseeable working conditions. Empirical investigation is necessary to establish the causes of particular incidents. Normative assessment asks whether those with relevant authority have discharged their obligations to make safe practice possible.

The relationships among incentive-setting authority, clinical judgment, essential duties, and corrective responsibility are represented in **Figure 1**.

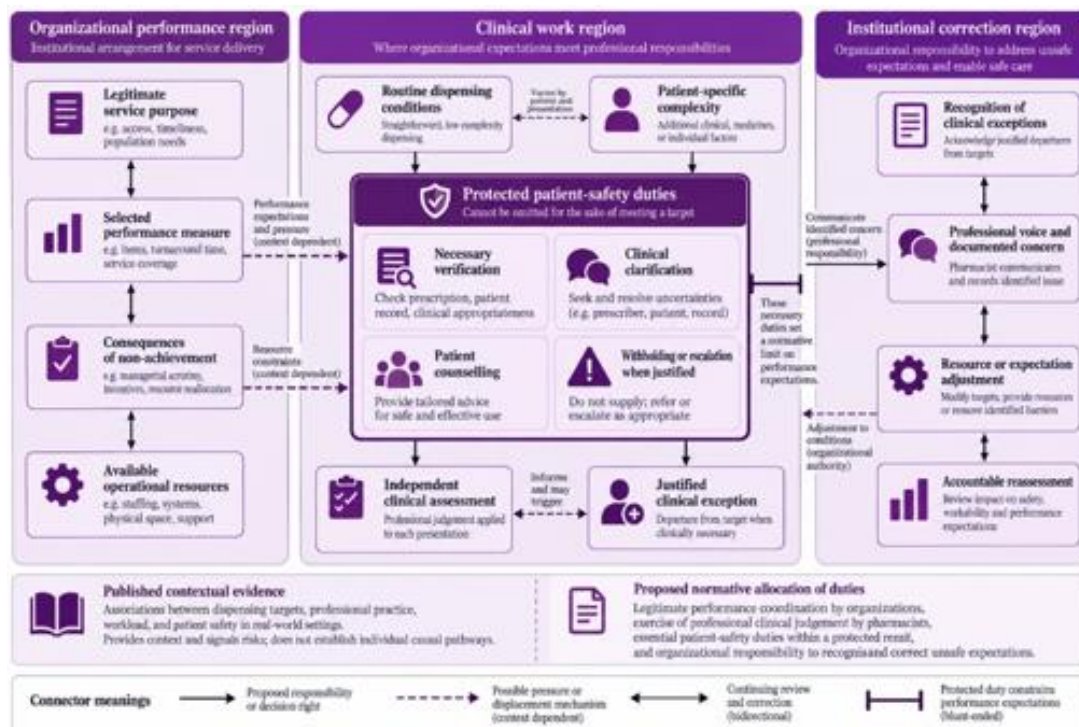


Figure 1. The permissible reach of dispensing targets across clinical and organizational decision rights

Organizational accountability for unsafe workload and performance expectations

Responsibility for safe dispensing cannot be allocated exclusively to the pharmacist performing the final clinical check. Pharmacy organizations determine staffing arrangements, workflow expectations, performance assessment, and access to operational resources. These decisions establish the conditions within which individual professional judgment must be exercised.

Organizational accountability begins with the identification of foreseeable conflicts between expected output and essential clinical work. A recurring need to defer counselling, postpone clarification, or work beyond available capacity warrants assessment of the underlying arrangement. Managers should distinguish occasional variation in performance from evidence that ordinary expectations cannot be fulfilled while maintaining necessary safeguards.

Research on crisis management in Finnish community pharmacies provides relevant, although context-specific, evidence concerning organizational preparation, shared decision-making, and collaboration [24]. Its findings also caution against assuming that every formal management arrangement improves outcomes. Organizational

responsibility is demonstrated through the adequacy of decisions and responses, not merely the existence of written procedures.

The Finnish national medication-safety programme provides another example of coordinated attention to safety across professional and institutional actors [25]. Such coordination is relevant because the authority to identify a hazard and the authority to correct its underlying conditions may reside with different individuals.

Accountability therefore requires a defensible distribution of responsibilities. Pharmacists must identify and communicate clinically significant concerns within their professional competence. Managers must respond to credible concerns about workload and operational expectations. Organizational leadership must ensure that performance policies, resource allocation, and accountability arrangements permit the necessary corrective action.

Risk-sensitive approaches may assist this process. The development and validation of a national high-risk medicine classification illustrates how structured medication-risk distinctions can inform safety-related decisions [26]. Classification does not establish an acceptable dispensing quota, but it supports the principle

that organizational expectations should accommodate clinically relevant differences between tasks.

Where an identified conflict persists, continued achievement of numerical targets cannot independently justify maintaining the existing arrangement. Institutional accountability requires examination of the resources, expectations, and authority structures responsible for the conditions in which dispensing occurs.

Policy safeguards, professional voice, and incentive redesign

An ethically acceptable incentive policy requires safeguards that operate during ordinary pharmacy work. A general commitment to patient safety provides insufficient protection when staff lack practical authority to interrupt a task, document a justified exception, or communicate an unresolved concern.

The design of these safeguards should distinguish immediate clinical decisions from subsequent organizational review. Pharmacists require a usable route for protecting patients during an encounter. Management subsequently requires sufficient information to determine whether the circumstances reflect an isolated event, a recurring operational problem, or an unsuitable performance expectation.

Evidence from a multinational intervention addressing community-pharmacy antibiotic dispensing demonstrates that dispensing practices can be examined through structured implementation and assessment [27].

Although that intervention did not test productivity quotas, it illustrates the importance of evaluating practice arrangements through their actual operation.

Regulatory implementation research likewise indicates that formal policy intentions must be considered alongside professional practice following change [28]. An incentive policy should consequently specify how concerns become actionable rather than relying solely on a statement of organizational priorities.

Professional voice is central to this arrangement. Staff should be able to raise clinically justified objections, request review of unsafe expectations, and receive a substantive response. Because incident-reporting frequency can reflect reporting behaviour as well as underlying events, raw report totals should not independently determine whether a workplace is safe [16].

Leadership responsibilities include making corrective decisions intelligible and ensuring that concerns are not routinely returned to the individual without the authority or resources needed to resolve them [22]. Shared decision-making and coordinated safety initiatives offer relevant institutional premises, although their outcomes remain context dependent [24]. National medication-safety coordination further demonstrates the importance of connecting professional activity with organizational responsibility [25].

Table 2 translates these principles into proposed safeguards, distinguishing the recognition of a problem from the institutional authority required to correct it.

Table 2. Institutional safeguards for clinically justified exceptions, professional voice, and correction of dispensing-performance expectations

Foreseeable operational problem	Proposed institutional safeguard	Actor with corrective authority	Monitoring and escalation condition
Clinically complex prescriptions exceed expected processing time.	Protected clinical exception with documented justification.	Pharmacist; supervising manager for operational adjustment.	Repeated justified exceptions prompt reassessment of workload expectations.
A productivity measure disadvantages necessary counselling or clarification.	Explicit protection of essential clinical activity.	Pharmacy management and policy-setting leadership.	Recurring conflict triggers review of the measure and available resources.
Staff identify unsafe workload but cannot obtain a response.	Accessible professional-voice and escalation procedure.	Designated organizational safety authority.	Unresolved concerns receive documented review and escalation.
Incident counts are interpreted as direct measures of safety.	Contextual assessment using complementary safety information.	Safety and quality leadership.	Unexpected changes prompt investigation rather than automatic performance judgment.
Operational conditions undermine agreed safeguards.	Corrective reassessment of staffing, workflow, and targets.	Organizational leadership with relevant professional input.	Safeguards are revisited when conditions materially change.

Note: All safeguards and responsibility allocations are proposed normative policy recommendations, not empirically validated effects of an implemented incentive programme. Their application requires adaptation to local professional, organizational, and legal arrangements.

Regulatory and practice implications

Regulatory and professional institutions should assess incentive arrangements according to their effects on the practical conditions of pharmacy care. The relevant questions extend beyond whether a numerical target has been achieved. Oversight should examine whether pharmacists can perform essential safety activities, whether justified exceptions are accommodated, and whether organizations respond adequately to recurring concerns.

Dispensing-error evidence provides one source of information, although variation in definitions and ascertainment methods limits direct comparison [4]. Safety-climate assessment offers complementary evidence concerning working conditions and professional perceptions [5]. Neither should serve as an isolated measure of compliance.

National medication-safety programmes can support coordinated expectations concerning prevention, professional responsibilities, and organizational learning [25]. Risk classifications may also inform differentiated safety procedures where medication characteristics warrant additional attention [26].

Regulatory responsibilities nevertheless depend on jurisdiction. The allocation of powers among pharmacy regulators, employers, professional bodies, and other institutions cannot be assumed to be uniform. Evaluation of regulatory change should therefore consider its practical implementation and effects on professional work [28].

For pharmacy organizations, the immediate implication is to examine the consequences attached to performance measures. Quality-incentive implementation research demonstrates why the design and experience of an arrangement matter alongside its stated objectives [3]. Employers should make clinically justified exceptions reviewable, ensure that escalation routes have practical authority, and reassess expectations when foreseeable safety conflicts remain unresolved.

Professional responsibility remains essential. Pharmacists must exercise defensible clinical judgment, communicate concerns, and participate in corrective processes. Institutional safeguards should support these duties without treating professional autonomy as exemption from accountability.

Results and Discussion

The proposed analysis does not establish that dispensing targets are inherently incompatible with patient safety. Quality-oriented incentive arrangements may pursue legitimate service improvements, and their implementation depends on organizational context [3]. Evidence from pay-for-performance programmes also cautions against assuming uniform effects across intervention designs and healthcare settings [10].

The framework instead identifies conditions under which performance expectations are ethically supportable. Its central distinction concerns the authority attached to a target. An organization may establish reasonable expectations for service delivery while preserving the pharmacist's responsibility to make clinically justified decisions. The arrangement becomes ethically problematic when achievement is pursued through conditions that predictably obstruct essential professional duties and lack a credible route for correction.

Organizational configuration is relevant because pharmacies differ in staffing, service models, and operational resources [1]. Formal recognition of autonomy may also differ from the practical opportunity to exercise it [17]. A policy that appears proportionate in one setting may therefore require modification in another.

Alternative designs deserve consideration. Quality-oriented indicators, shared organizational measures, and contextual review may reduce some tensions associated with narrowly defined individual output expectations. Nevertheless, the existence of a more elaborate management arrangement is not itself evidence of improved safety. Findings concerning crisis-management practices demonstrate why the actual consequences of organizational measures require examination [24].

Several limitations constrain the argument. Community pharmacy quality encompasses dimensions that are not represented by a single indicator [2]. Evidence about clinical pharmacy performance measures from inpatient settings cannot be transferred unchanged to community dispensing [8]. Incident-reporting activity is also influenced by reporting conditions and cannot independently establish underlying event incidence [16]. Furthermore, evaluations of interventions directed at specific dispensing practices do not establish the effects of general performance quotas [27]. These distinctions limit the empirical conclusions available from the selected evidence. The proposed framework remains a

normative contribution whose institutional arrangements require contextual examination before implementation. Its practical significance lies in allocating responsibility across actors who exercise different forms of authority. Pharmacists remain accountable for their clinical decisions; managers and organizational leaders remain accountable for the conditions and expectations they establish. When the two conflict, a credible correction process must connect professional concerns to those empowered to change the arrangement.

Future empirical research could investigate how different incentive configurations affect clinically justified exceptions, professional voice, organizational responses, and patient-relevant outcomes. Such evaluation would strengthen the evidence available for policy design without treating the present normative principles as already validated interventions.

Conclusion

Pharmacy performance incentives can coexist with patient-safety duties when their objectives are legitimate, their operational demands are proportionate, and their implementation preserves essential clinical responsibilities. Ethical acceptability requires meaningful professional discretion, sufficient organizational support, and accountable mechanisms for correcting unsafe expectations.

Dispensing targets may guide service coordination, but they cannot override clinically necessary verification, counselling, clarification, or justified intervention. Responsibility for maintaining these conditions extends beyond individual pharmacists to the organizations that establish performance expectations and control the resources required for safe practice.

The proposed framework establishes a basis for evaluating incentive arrangements without assuming that every target causes harm or that numerical achievement demonstrates safe care. Its application requires attention to organizational context, professional authority, regulatory arrangements, and the practical operation of corrective safeguards.

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References

1. Jacobs S, Fegan T, Bradley F, Halsall D, Hann M, Schafheutle EI. How do organisational configuration and context influence the quantity and quality of NHS services provided by English community pharmacies? A qualitative investigation. *PLoS One*. 2018;13(9):e0204304. doi:10.1371/journal.pone.0204304
2. Hindi AMK, Campbell SM, Jacobs S, Schafheutle EI. Developing a quality framework for community pharmacy: A systematic review of international literature. *BMJ Open*. 2024;14(2):e079820. doi:10.1136/bmjopen-2023-079820
3. Schafheutle EI, Moss AA, Hindi AMK, Gibson J, Lovatt E, Robinson K, et al. Do pay-for-performance schemes improve quality in community pharmacy? A mixed-methods study exploring stakeholder perspectives on implementation of the nationwide Pharmacy Quality Scheme (PQS) in England? *PLoS One*. 2025;20(4):e0319215. doi:10.1371/journal.pone.0319215
4. Um IS, Clough A, Tan ECK. Dispensing error rates in pharmacy: A systematic review and meta-analysis. *Res Social Adm Pharm*. 2024;20(1):1-9. doi:10.1016/j.sapharm.2023.10.003
5. Ljungberg Persson C, Nordén Hägg A, Södergård B. Measuring the patient safety climate in community pharmacies: An updated national survey. *BMJ Open*. 2025;15(1):e088323. doi:10.1136/bmjopen-2024-088323
6. Winslade N, Tamblyn R. Determinants of community pharmacists' quality of care: A population-based cohort study using pharmacy administrative claims data. *BMJ Open*. 2017;7(9):e015877. doi:10.1136/bmjopen-2017-015877
7. van de Pol JM, Koster ES, Hövels AM, Bouvy ML. How community pharmacists prioritize cognitive pharmaceutical services. *Res Social Adm Pharm*. 2019;15(9):1088-94. doi:10.1016/j.sapharm.2018.09.012
8. Magedanz L, Silva HL, Galato D, Fernandez-Llimos F. Clinical pharmacy key performance indicators for hospital inpatient setting: A systematic review. *Int J Clin Pharm*. 2024;46(3):602-13. doi:10.1007/s11096-024-01717-x

9. Silva Almodovar A, Blankenship B, Miller J, Trombetta M, Murphy EM. Return on investment of pharmacists' services among non-hospitalized patients: A scoping review. *Res Social Adm Pharm.* 2025;21(5):321-31. doi:10.1016/j.sapharm.2025.01.012
10. Slawomirski L, Hensher M, Campbell J, deGraaff B. Pay-for-performance and patient safety in acute care: A systematic review. *Health Policy.* 2024;143:105051. doi:10.1016/j.healthpol.2024.105051
11. Ayanaw M, Lim A, Khera H, Vu T, Goordeen D, Malone D. How do interruptions and distractions affect pharmacy practice? A scoping review of their impact and interventions in dispensing. *Res Social Adm Pharm.* 2025;21(9):667-78. doi:10.1016/j.sapharm.2025.05.001
12. Astbury JL, Gallagher CT. Moral distress among community pharmacists: Causes and achievable remedies. *Res Social Adm Pharm.* 2020;16(3):321-8. doi:10.1016/j.sapharm.2019.05.019
13. O'Donnell S, Hayden J, Quigley E, Adamis D, Gavin B, McNicholas F. "We're seen as part of the supply chain of medicines rather than as the professionals that we are": The wellbeing of community pharmacists during the COVID response. *Res Social Adm Pharm.* 2024;20(4):389-400. doi:10.1016/j.sapharm.2023.12.004
14. Salihu EY, Tewogbola P, Joseph DT, Ofuokwu-Oduniyi J, Chewning B. Compassion fatigue and satisfaction among pharmacists: Prevalence and associated factors. *Res Social Adm Pharm.* 2025;21(9):697-703. doi:10.1016/j.sapharm.2025.04.003
15. Yong FR, Garcia-Cardenas V, Williams KA, Benrimoj SIC. Factors affecting community pharmacist work: A scoping review and thematic synthesis using role theory. *Res Social Adm Pharm.* 2020;16(2):123-41. doi:10.1016/j.sapharm.2019.05.001
16. Noureldin M, Noureldin MA. Reporting frequency of three near-miss error types among hospital pharmacists and associations with hospital pharmacists' perceptions of their work environment. *Res Social Adm Pharm.* 2021;17(2):381-7. doi:10.1016/j.sapharm.2020.03.008
17. Dosea AS, de Castro Araújo-Neto F, Fonseca FL, Gois dos Santos L, Pimentel DMM, de Lyra DP Jr. "Reigns but does not govern": A reflection on professionalism and the autonomy of the pharmacist. *Res Social Adm Pharm.* 2023;19(7):1061-72. doi:10.1016/j.sapharm.2023.04.119
18. Wright DFB, Anakin MG, Duffull SB. Clinical decision-making: An essential skill for 21st century pharmacy practice. *Res Social Adm Pharm.* 2019;15(5):600-6. doi:10.1016/j.sapharm.2018.08.001
19. Ishii M, Ozone S, Masumoto S, Maeno T. Assertiveness in community pharmacists and their experience of pharmacist-led deprescribing: A cross-sectional study. *Res Social Adm Pharm.* 2025;21(7):517-22. doi:10.1016/j.sapharm.2025.03.002
20. Gregory PAM, Austin Z. How do patients develop trust in community pharmacists? *Res Social Adm Pharm.* 2021;17(5):911-20. doi:10.1016/j.sapharm.2020.07.023
21. Morris C, McDonald J, Officer TN, Tanuvasa AF, Smiler K, Parore N, et al. A realist evaluation of the development of extended pharmacist roles and services in community pharmacies. *Res Social Adm Pharm.* 2024;20(3):321-34. doi:10.1016/j.sapharm.2023.11.006
22. Aman M, Arakawa N, Anderson C. Leadership competencies and behaviours in pharmacy: A qualitative content analysis. *Res Social Adm Pharm.* 2025;21(5):340-50. doi:10.1016/j.sapharm.2025.02.001
23. Hämeen-Anttila K, Mikkola H. Is there a need for standardization of medication counseling in community pharmacies? *Res Social Adm Pharm.* 2024;20(5):547-52. doi:10.1016/j.sapharm.2024.02.005
24. Latonen SH, Neuvonen E, Juppo AM, Seeck H, Airaksinen M. Crisis management in community pharmacies during a pandemic. *Res Social Adm Pharm.* 2024;20(9):940-8. doi:10.1016/j.sapharm.2024.06.010
25. Mäkinen E, Koskenkorva T, Holmström AR, Airaksinen M, Kuusisto M, Kyllönen H, et al. Promoting outpatient medication safety in Finland: A mid-term review of a national medication safety programme for community pharmacies (2021–2026). *Health Policy.* 2025;155:105285. doi:10.1016/j.healthpol.2025.105285
26. Similä E, Jyrkkä J, Airaksinen M, Toivo T. Development and validation of the national High-Risk Medicine Classification using the Delphi

- method. Res Social Adm Pharm. 2025;21(5):371-91.
doi:10.1016/j.sapharm.2025.01.016
27. Lambert M, Benko R, Lykkegaard J, Søndergaard J, Olsen J, Garcia-Sangenis A, et al. Community pharmacists' role in optimising antibiotic use: The HAPPY PATIENT project to improve dispensing practices in five EU countries. Res Social Adm Pharm. 2025;21(8):597-607.
doi:10.1016/j.sapharm.2025.03.064
28. Lynch M, Kodate N. Professional practice following regulatory change: An evaluation using principles of "Better Regulation". Res Social Adm Pharm. 2020;16(2):208-15.
doi:10.1016/j.sapharm.2019.05.007